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Assessing cultural competence in a mental health outpatient facility.

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ASSESSING CULTURAL COMPETENCE IN A MENTAL HEALTH OUTPATIENT
FACILITY

By

Alexis N. Keen Crook
B.A.,B.S. University of Louisville, 2014

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A Thesis Approved on

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DEDICATION

This thesis is dedicated to the loving memory of my amazing great-grandmothers Neva

Embrey and Helen Owen.

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ABSTRACT

ASSESSING CULTURAL COMPETENCE IN A MENTAL HEALTH OUTPATIENT
FACILITY

Alexis Keen Crook

April 13, 2016

Cultural competence is a concept that has been thoroughly investigated in healthcare, but

there is a dearth of literature and research on this topic as it pertains to mental health

services. In healthcare, research has shown that a lack of cultural competence is directly

linked to high levels of misdiagnoses, mistrust of healthcare and professionals, and

overall poor health in minority populations. Using the Campinha-Bacote model for

cultural competence in health care, I explore how cultural competence is defined and

operationalized in an outpatient mental health facility. I hypothesize that, similar to

research addressing cultural competency in healthcare systems, cultural competence

within this mental health facility is not adequately defined and carried out in its daily

operations. In order to assess the potential institutional knowledge and awareness of

cultural competence, I initially analyzed all policies, procedures, and training documents

of the organization. Next, I conducted 15 semi-structured qualitative interviews of

various mental health professionals that worked in the outpatient facility in order to

ascertain how each individual defined and employed cultural competence, if at all,

throughout their work. In my findings, I discovered that there was no clear definition of

cultural competence in any of the organizations handbooks or policies. Furthermore, I found that mental health professionals did not have a clear understanding of cultural competence or that cultural competence is an ongoing process. Lastly, I found that the facility offered no trainings or professional development courses on cultural competence. The information gathered from the study can be beneficial to the facility's work with diverse populations and aid in future research directions on this subject.

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CHAPTER I

INTRODUCTION

"Only about one quarter of African Americans seek mental health care, as opposed to 40% of Whites. This is due in part to misdiagnoses, inadequate treatment and lack of cultural competence by mental health professionals that breeds distrust and prevents many African Americans from seeking or staying in treatment."

-National Alliance on Mental Illnesses (NAMI)

There has been much research conducted on cultural competence in healthcare over the past decade (Paniagua & Yamada, 2013). This research has shown a connection between a lack of cultural competence by healthcare providers and misdiagnoses, mistreatment, loss of trust in the healthcare system, and ultimately higher morbidity and mortality rates, particularly in minority populations (Paniagua & Yamada, 2013). Although there has been much research done on cultural competence in healthcare, there is a lack of research pertaining to cultural competence, specifically relating to mental health and minorities.

With this project, I hope to explore cultural competence in a mental health outpatient facility and the role this plays in health disparities. By analyzing the literature and interviewing mental health professionals, I hope to gain a better understanding of how mental health providers practice being culturally competent and how this care

impacts their clients, both positively and negatively. Additionally, by analyzing mental health organization policies, I hope to understand how the organization as a whole promotes cultural competence.

In this study, I analyze research previously conducted on cultural competence in healthcare and the effects that it has on clients, and how this potentially leads to further health disparities. I also will present recommendations for a more culturally competent healthcare system and explain how these recommendations aim to provide the highest quality of care to all clients. In addition to examining previous works, as mentioned, I also interview various mental health providers, asking questions regarding what cultural competence is to them, how they practice being culturally competent, potential barriers, the risks of not being culturally competent, and any trainings they attend to further explore cultural competence in mental health facilities.

My goal with this study is to further explore the impact that cultural competence has, specifically in mental health facilities. With this study, I hope to demonstrate that cultural competence is very important in mental health and when providers are not culturally competent, their clients are more at risk for negative health outcomes (Brach & Fraserirector, 2001).

By exploring policies of the organization and conducting interviews with individual providers, my goal is to provide recommendations for outpatient mental health facilities, to improve their organization as a whole and individual providers' cultural competence. These recommendations could potentially improve client outcomes and begin to decrease the adverse mental health outcomes that disproportionately affect African Americans.

The second chapter of this study discusses African Americans and mental health. This chapter situates mental health in healthcare and reviews the health disparities that African Americans face. Moreover, barriers to treatment and the health seeking behaviors of African Americans are explored. African Americans are much less likely than their non-Hispanic White counterparts to seek mental healthcare (Brach & Fraserirector, 2001). This is something that could be directly related to cultural competence, as many studies have found African Americans describe mental health providers as older White men that do not understand struggles that the minority community faces(Saxena, et al., 2007).

The third chapter of this study defines cultural competence and speaks to the importance of cultural competence in mental health. In this chapter, the Campinha-Bacote model for cultural competence in healthcare is introduced. The Campinha-Bacote model is very important, and I would argue that this model should be used in mental health outpatient facilities all over the country. This revolves around the notion that cultural competence is not something that can merely be achieved or "taught," but that it is an ongoing process and something that must be continually strived for (Campinha-Bactoe, 2002). This is very different from some other models where cultural competence can simply be learned in a matter of trainings or classes. Here, cultural competence is ever evolving and culturally competent providers are continuously learning.

The fourth chapter, examines cultural competence, primarily with regards to African Americans in mental health. This chapter demonstrates that various health disparities arise when mental health providers are not viewed as culturally competent to their African American patients. Negative outcomes such as misdiagnoses and

mistreatment, perpetuating mistrust, and failure to complete treatment all have the possibility of occurring when providers are not culturally competent (Saxena, et al., 2007).

The last four chapters explore the facility that I collected information from, my research methodology, results, and conclusion/further directions. These chapters highlight my findings with regards to cultural competence in an outpatient mental health facility and highlight recommendations to improve overall treatment of culturally diverse populations, and with that, hopefully improve health outcomes in these populations.

CHAPTER II

MENTAL HEALTH IN AFRICAN AMERICANS

Mental Health in Healthcare

According to the World Health Organization (WHO) health is the state of complete physical, mental, and social well being and is not merely the absence of disease or infirmity (Jadad & O'Grady, 2008). This definition has been adopted by various notable healthcare organizations including the Centers for Disease Control (CDC) and Acton for Global Health. In regards to mental health in health services, at times mental health is integrated in primary care, but there are also independent mental health organizations, both inpatient and outpatient, that employ only psychiatrists and mental health providers (Kohn, et al., 2008).

Mental health includes emotional, psychological, and social well being. A mental illness has the ability to be chronic and debilitating, just as chronic physical illnesses. A mental illness is also similar to physical illness, as mental illnesses significantly affect how an individual thinks, behaves, and interacts with others (Wang, et al., 2002). Mental illnesses can be caused from a variety of complex factors including stress, biological predispositions, use of illicit substances, cognitive deficits, and social and environmental factors (Wang, et al., 2002).

Mental health is becoming increasingly more important in the United States healthcare structure due to the high number of people with mental illnesses that are not being treated. According to the National Alliance on Mental Health (NAMI) one in four

adults in America or 61.5 million individuals experience at least one mental illness in their lifetime (Icard, et al., 2003). Of these individuals experiencing mental illnesses, over 60% receive absolutely no treatment. Even more troubling is the fact that African Americans use mental health services at about one half of the rate as their non-Hispanic White counterparts (Icard, et al., 2003).

Studies have shown that when people receive appropriate mental health care, their use of medical services declines and vice versa (Kohn, et al., 2008). For instance, untreated depression, generally diagnosed by a family doctor or general practitioner, has been linked to increased morbidity in heart disease. Individuals with untreated depression are at a 67% increased risk of death from health disease. Likewise, individuals suffering from schizophrenia, again usually diagnosed by a general practitioner or family doctor, that are not being treated are three times more likely than their counterparts to die from respiratory diseases (Hackney & Sanders, 2003). Furthermore, people with untreated or undiagnosed mental health problems visit medical doctors for physical conditions more than twice as often as people who receive mental health care (Kohn, et al., 2008).

As noted above, mental healthcare is very important when discussing overall health and wellbeing. The United States currently spends $113 billion a year on mental health services, which is approximately 6% of the entire national healthcare spending (Saxena, et al., 2007). Even with the large amount of the budget spent for mental health, access to mental health services is deemed to be worse than other types of health services. Lack of access to mental health services is often attributed to issues with insurance, general unavailability of treatment and services, and high costs of prescription medications. Lack of access can also be attributed, in part, to cost, as 45% of individuals

with untreated mental health conditions cite cost as a barrier to access services (Saraceno, et al., 2007). Over 25% of Americans receiving some type of mental health service list themselves as the payers for services (Saraceno, et al., 2007). Out of pocket costs for mental health services average around 5,000$ per year (Saraceno, et al., 2007).

Because of cost being a barrier as well as mental health services not being covered on some insurance plans, mental health outpatient facilities in low income and urban areas have become more prevalent (Chow & Jaffee, 2003). These mental health facilities often do not accept private insurances, but do treat individuals with plans such as Medicare or Medicaid. However, individuals with no insurance plans must self-pay, which generally costs over 100$ per hour.

Public mental health treatment facilities employ medical providers such as psychiatrists, mental health nurse practitioners, and nursing staff. These facilities also employ therapists and mental health counselors for individual, group, and family therapy. Treating mental health illnesses often includes the use of medication prescribed by doctors or nurse practitioners, along with cognitive and behavioral therapy provided from therapists and social workers (Krupnick, et al., 1996).

Mental health therapists and counselors come from a variety of educational and professional backgrounds. Social workers are employed as therapists and include individuals with both undergraduate and graduate degrees in social work. Graduate level social workers hold professional licensures such as Certified Social Worker (CSW) and Licensed Clinical Social Worker (LCSW), who can function autonomously and provide supervision to CSW's. There is also a Licensed Social Worker (LSW) certification for individuals with a Bachelor degree in Social Work. Individuals with graduate degrees in

clinical psychology are also employed as therapists and counselors. An example of a professional licensure in psychology is Licensed Psychological Associate(LPA). Individuals with graduate degrees in education that focus on counseling can also be employed as therapists. Professional licensures in this field are Licensed Professional Clinical Counselor (LPCC) and Licensed Professional Counselor Associate (LPCA). Other advanced licenses can be obtained as related to therapy and counseling including Licensed Marriage and Family Therapist (LMFT), Certified Drug and Alcohol Counselor (CDAC), and Registered Art Therapist (ATR).

These professionals all have the opportunity to work directly with individuals and families seeking mental health services. This means that they work with very diverse groups of people and it is very important that they are somewhat familiar with barriers to services and health seeking behaviors in different populations. This familiarity with barriers and health seeking behaviors is very important when discussing cultural competence in providers.

Health Seeking Behaviors in African Americans

Health seeking behavior is much different in African American communities than it is in non-Hispanic White communities. Research has continued to show that African Americans tend to follow a culturally specific health care seeking pattern, and this pattern is significantly influenced by sociocultural factors (Cauce, et al., 2002). For instance, some African Americans choose to maintain a self-care regimen rather than see a healthcare provider when they become ill, with this, many times herbs or vitamins are used, as well as things such as prayer.

When exploring health-seeking behaviors in mental health by African Americans, it should be noted that research has consistently shown that African Americans utilize mental health services at a rate much lower than their non-Hispanic White counterparts (Snowden, 2011). Although some of this can be explained by factors related to income, insurance, and access, it is important to note that they do not account for all of the difference since racial disparities persist even when these factors are controlled (Snowden, 2011). Even when African Americans have the same income and access to mental health services as their non-Hispanic white counterparts, they continue to utilize these services at a lower rate.

Access to health care services continues to be a serious issue when exploring health-seeking behaviors. Recent data shows that 45% of low-income African Americans report difficulties getting the care they need (Price, et al., 2013). This is very different compared to the 25% of White Americans that report difficulty getting the care they need and 15% of high-income earners, regardless of race (Shi, et al., 2013). This lack of access can be seen when looking at treatment of conditions such as breast cancer and diabetes. The mortality rate from breast cancer for African American women is 50% higher than their non-Hispanic White counterparts (Shi, et al., 2013). Disparities in screening can account for some of this, as African American women do not have the same access to screenings as their non-Hispanic White counterparts. This is the same with mental health services, lack of access and treatment of mental heal illnesses leads to lower quality of life and in some cases, shorter life expectancy.

Because of factors such as no primary care physician, low socioeconomic status, and the absence of insurance, African Americans often do not get needed treatment. It is

because of this, there has been an increase in the use of hospital outpatient departments, namely the emergency room, by African Americans (Algeria, et al., 2014). African Americans are four times more likely than their non-Hispanic White counterparts to use hospital outpatient clinic for reasons that are considered non-emergent (Algeria, et al., 2014).

Reasons for this increased usage of emergency rooms for routine medial issues include socio-demographic factors such as income, education, employment, insurance coverage, and place of residence (Algeria, et al., 2014). For individuals that are low-income, the ER is typically a first choice for care, as they are treated regardless of their ability to pay. For this reason, individuals with no insurance coverage that live below the poverty line often use the ER for routine health issues, as there are no mandatory co-pays. There are also many additional barriers to see a primary care physician including cost, scheduling, transportation, and referrals (Kangovi, et al., 2013).

Without insurance, it is much more difficult for an individual to have a primary care physician, leaving few options other than the ER if a person is ill. Moreover, even if individual without insurance have a primary care physician, it is often self pay and the payment is due before the person can be seen or treated. Furthermore, ER's are often much more convenient for individuals living in poverty or with no insurance, as these individuals are treated the same day they go in. The hours are also more accommodating, as the individual being seen does not have to take off work, a sometimes implausible task for low-income families (Kangovi, et al., 2013).

Culturally shaped ideas greatly impact mental health seeking behavior in African Americans. Most markedly, the stigma associated with mental health deters individuals

from seeking and participating in treatment (Corrigan, 2004). The beliefs that mental illnesses do not exist, are only for weak people, or that you can simply pray it away, run rampant in the African American community, often times stopping people from seeking treatment of any kind (Corrigan, 2004).

Barriers to Services in African Americans

The lack of information and knowledge regarding mental health may be a reason why African Americans are less likely to seek and obtain treatment. For instance, in a national survey, 63% of African Americans classified depression as a personal weakness rather than a health issue (Richardson, 2001). African Americans answered in the same manner regarding other illnesses including anxiety and ADHD. African Americans also have the tendency to associate symptoms of depression (fatigue, hopelessness, worthlessness, sadness) with the "blues" and believe it is something that they will snap out of. The same is true with attributing symptoms of generalized anxiety disorder (GAD) (panic attacks, trouble with concentration, irritability) to having "bad nerves."

Historically, in African American communities, mental health is a taboo topic that is often not openly discussed (Hines-Martin, et al., 2003). Moreover, there is often a shame or stigma associated with mental health in these communities, which leads to individuals being too ashamed to seek treatment (Hines-Martin, et al., 2003). Seeking mental health treatment in the African American community can often cause perceptions of shame, indignity, guilt, embarrassment, and feebleness (Hines-Martin, et al., 2003). There is some speculation that this shame is associated with religion in the African American community. The beliefs that mental health illnesses are caused by sin or should be treated with prayer are quite common in African American communities.

Faith and spirituality in the African American community also play a part in the resistance to mental health treatment. Although research on this is somewhat mixed, some research has shown a correlation between religion and resistance to mental health treatment. In African American communities' faith is often a strong source of support. Prior research has indicated that many African Americans rely on faith, family, and social communities for emotional support rather than seeking mental health care from professionals (Taylor, et al., 2000). This becomes problematic when mental health care and treatment is warranted but not received. Furthermore, mental health issues are often seen as spiritual problems in the African American community. There are many people in the African American community that think that you can simply "pray away" mental illness, and prefer that over seeking professional help (Taylor, et al., 2000).

Historically, African Americans have been subjected to medical discrimination and unethical treatment in both mental and overall healthcare. This discrimination and unethical treatment has spanned vast periods of time, since slavery. This discrimination encompasses things such as the unethical medical treatment or lack thereof during slavery, experimentations such as the Tuskegee experiment, and current issues such as the Flint water crisis and exposure to lead in both water and homes (Hanna-Attisha, et al., 2016). During slavery, slaves were not seen as "human" and were subjected to various surgeries and experiments with no anesthesia or pain control, often with many complications and sometimes resulting in death. After slavery, African Americans were still subjected to unethical treatment and experimentation. The Tuskegee experiment is one of the most well-known and documented cases of this treatment, as healthy African American men were unknowingly injected with syphilis and not given treatment. Even

now, we are seeing high levels of lead in drinking water and homes of mostly poor, African American communities- researchers are interested in examining the effects of lead poising, but not with eliminating the problem of lead exposure.

Along with this, African Americans have faced exponential rates of misdiagnoses and mistreatment, along with inadequate treatment and lack of cultural competence by healthcare professionals (Kessler, et al., 1999). Moreover, as noted above African Americans are often diagnosed with mental illnesses by general practitioners due to lack of access to mental health. These practitioners often do not have advanced trainings in mental health illnesses and how culture has an impact on mental health, so misdiagnoses are possible.

Low socioeconomic status (SES) in African American communities contributes to low mental health treatment rates. Individuals that are unemployed, do not have stable housing, and live in poverty are at the highest risk for mental illness, however they have the least access to treatment (Hudson, 2005). Furthermore, 19% of African Americans do not have any type of health insurance, which makes treatment options much less readily available (Jackson, et al., 2004). All of these factors compounded contribute to the disproportionate rate that African Americans seek mental health treatment.

Historical discrimination and unethical treatment often leads African Americans to be even more apprehensive to seek treatment or trust mental health professionals. Along with the mistrust of mental health professionals, there is a lack of African American mental health professionals. African Americans make up only 3.1% of the members in the American Psychiatric Association, and only 1.5% of the members in the American Psychological Association (Fischer & Shaw, 1999). Although the National

Association of Social Workers (NASW) does not report their racial demographics, only 7% of US social workers identify as African American (Abrams, 2009).

Provider bias, which includes unconscious stereotypes, perpetuates mistrust towards mental health providers in the African American community. African American patients are over 70% more likely to experience conscious or unconscious bias from providers than their non-Hispanic White counterparts (Thompson, et al., 2004). Not having bias or stereotyping thoughts of certain groups of people or clients is a major factor when discussing providers being culturally competent. Furthermore, lack of cultural competence skills by mental health providers contribute to misdiagnoses and poor quality care for African Americans.

Lack of cultural competence skills can cause misdiagnoses in African Americans such as the increased diagnosis of schizophrenia in African American males when expressing symptoms of mood disorders or posttraumatic stress disorder (Snowden, 2001). Another example of misdiagnosis is that depression in African American women often manifests as somatic or physical, symptoms, but mental health professionals who are not culturally competent may not recognize these symptoms as relating to a mental health disorder (Turner & Mills, 2016). Providers will often treat it as a physical illness, often disregarding the fact that it is a mental illness that should be treated.

CHAPTER III

CULTURAL COMPETNCE

Defining Cultural Competence

The idea of cultural competence began to exponentially grow after the Civil

Rights Movement in the United States. This growth in the idea of cultural competence

occurred along with the demonstrated awareness and integration of population specific

issues in health, including health-related beliefs and cultural values, diseases incidence

and prevalence in specific populations, and treatment efficacy in specific populations

(Lavizzo-Mourey & Mackenzie, 1996). In essence, health care providers began to more

seriously examine culture as it directly impacts individuals' health and treatment.

Culture is defined as the beliefs, customs, and arts of a particular society, group,

place, or time. Competence is defined as the ability to do something successfully and

efficiently (Betancourt, et al., 2003). Cultural competence has grown to have a variety of

different definitions, but it is widely defined as a set of corresponding behaviors,

attitudes, and policies that come together in a system, agency or even among

professionals and enable that system, agency or those professionals to work effectively in

cross cultural situations (Cross, et al., 1989).

In healthcare, specifically, cultural competence is clearly defined. The U.S.

Department of Health and Human Services defines cultural competence as the ability to

provide services to clients that honor different cultural beliefs, interpersonal styles,

attitudes and behaviors and the use of multicultural staff in the policy development,

administration and provision of those services (US Department of Health and Human Services, 2005).

Nearly all of the definitions of cultural competence revolve around providers being both aware and responsive to their clients' cultural perspectives and beliefs (Betancourt, et al., 2003). Simply defined, cultural competence in healthcare is the ability of both individual providers and organizations to deliver healthcare services that meet the cultural, social, and linguistic needs of clients' (Whaley &Davis, 2007). Cultural competence encompasses religious beliefs, behaviors, values and institutions, cultural traditions, language, ethnicity, and attitudes related to care.

Furthermore, cultural competence does not refer to only attitudes and behaviors of individual providers, but it is also referring to a set of policies that come together with these behaviors and attitudes that enable professionals and the organization as a whole to work effectively in cross-cultural situations (Saha, et al., 2008). Providers and organizations must value diversity and adapt to the cultural contexts of the communities they serve in order to be culturally component in treatment.

Cultural competence requires individual providers to develop an understanding with their patients that are from a different background, and be respectful to their beliefs and attitudes. Relationship building has been called a fundamental facet of being a culturally competent provider, as trust is viewed as an essential element of treating patients (Betancourt, et al., 2002). Without trust, there is no real patient-practitioner relationship, and meeting set health outcomes becomes significantly less likely. Along with respecting and acknowledging cultural perspectives and beliefs, it is also important

for culturally competent providers to be aware of their own worldview and possible biases or stereotypes.

Due to the growing cultural diversity in the United States, it is unequivocally important for individual providers and organizations to be culturally competent. This can lead to the improvement of overall healthcare and health outcomes in minority populations, and subsequently lead to the closing of the disparities in various health outcomes that is so prevalent in US society. Racial and ethnic minorities, on average, have a higher morbidity and mortality rate due to chronic health conditions compared to their non-Hispanic White counterparts (Brach & Fraserirector, 2000). This finding, in part, can be due to the lack of cultural competence of the providers, along with an overall distrust of healthcare systems. Individuals with chronic conditions require more healthcare than the average person, meaning they have more interactions with providers and the institution of healthcare (Brach & Fraserirector, 2000).

When providers and organizations do not provide culturally competent care, clients are at an exponentially higher risk of having negative health consequences, receiving poor quality care, and being dissatisfied with their care (Johnson, et al., 2004). Receiving poor quality of care and not being satisfied with one's care not only perpetuates the mistrust in healthcare, but contributes to non-compliance rates as well as individuals not following providers' recommendations. Not providing culturally competent care can include things such as not gathering relevant information, not respecting cultural belief systems or values, not including beliefs and values in treatment, being dismissive of culture, or not communicating effectively. When providers do not gather information that is relevant to the client's care, clients are often misdiagnosed and

do not receive the appropriate treatment (Johnson, et al., 2004). Furthermore, when a client's belief system or values are not respected or included in treatment, the probability of non-compliance and not following recommendations rises significantly.

As a direct result of this lack of cultural competence, ethnic minorities report distrust in providers, less participation in medical decisions, and a much lower satisfaction with care and treatment (Johnson, et al., 2004). Distrust in providers leads individuals to not continue treatment or follow recommendations, thus not receiving appropriate treatment. Lack of participation in medical decisions also leads to not following recommendations. Furthermore, when clients do not understand what professionals are telling them, the quality of their care can be greatly compromised, leading to lower satisfaction with treatment.

When providers are culturally competent, clients are much more likely to comply with treatment recommendations (Purnell, 2012). Research has shown that when clients report that they feel like they are receiving care specific to their cultural needs, they trust the professional and follow recommendations strictly (Purnell, 2012). Moreover, this positive relationship with the client and provider leads to improved health outcomes and continuity of care (Purnell, 2012).

Importance of Cultural Competence in Mental Health

As the U.S. population continues to become more ethnically and racially diverse, cultural competence in healthcare will become increasingly more important (Bhui, et al., 2007). With a more diverse population, mental health providers will begin to see clients with a broad range of perceptions regarding mental health and treatment, which are often strongly influenced by their cultural background (Bhui, et al., 2007). With different

cultures comes difficult issues such as limited capability to speak English, different presentation of symptoms, different expectations of treatment, and beliefs that influence whether they follow recommendations and complete treatment (Whaley & Davis, 2007).

The language barrier is a factor that greatly affects cultural competence in mental health. Data from the 2012 US Census shows that 60.6 million people, or approximately 21% of the population speak a language other than English at home (Ryan, 2013). Of these 60.6 million people, only 58% rated their English speaking ability as well or very well (Ryan, 2013). These numbers are very important when discussing cultural competence because communication is a big factor in provider-client relationship and care. Clients with a language barrier report not feeling empowered, not understanding the care or treatment they are receiving, and feeling ignored (Fernandez, et al., 2004).

The presentation of mental health symptoms also differs between cultures of people. If a provider is not culturally competent or is not aware of cultural differences in symptomology, misdiagnosis and mistreatment is possible and will often occur(Paniagua & Yamada, 2013). For example, a symptom of depression in African Americans is often aggression, this could be misdiagnosed as a conduct disorder or oppositional defiant disorder (ODD) in children (Paniagua & Yamada, 2013). African American women are also more likely to experience somatic (physical) symptoms as a part of depression or anxiety, which can also be misdiagnosed (Paniagua & Yamada, 2013).

Cultural beliefs also influence whether clients follow treatment and recommendations. When providers are not aware of these beliefs impacting care, recommendations and treatment are sometimes not followed. Cultural beliefs can pertain to things such as treatment of illnesses; some cultures do not believe in taking

medications but rather use traditional remedies (i.e., herbs) or spiritual healing (Renzhao, et al., 2013). Gender roles also effect treatment; some cultures have a belief that men should be in authority roles and therefore would take issue with a woman provider giving treatment recommendations (Renzhao, et al., 2013).

Previous research has shown that provider-client communication is directly linked to patient satisfaction, adherence to recommendations and treatment, and overall outcomes (Whaley & Davis, 2007). When a client does not understand recommendations or treatment, they are much less likely to comply. Moreover, if a provider is not communicating well with a client, the client is also less likely to follow recommendations and treatment. Not following recommendations and treatment is often classified as non-compliance in most cases. Poor health outcomes often exist when cultural differences between patients and providers exist and are not "reconciled" (Whaley & Davis, 2007).

Campinha-Bacote model

Due to the extreme importance of cultural competence in healthcare, there have been a variety of models used to teach and educate providers on being culturally competent with diverse populations. Many of these models include things such as improving interpersonal skills, eliminating biases and stereotypes, and learning and understanding other cultures. Perhaps one of the most important factors when discussing cultural competence is that it is not simply something that can be quickly taught or achieved, but it is a continuing process and one that has the ability to change over time. For this reason, the Campinha-Bacote model is ideal when educating providers on cultural competence.

The Campinha-Bacote model centers on cultural competence as being an ongoing process in which providers continually learn and strive to achieve cultural competence (Campinha-Bacote, 2002). In this model, providers see themselves as continuously becoming culturally competent, rather than already being culturally competent or being taught how to be culturally competent in a short period of time. This model also asserts that cultural competence is an essential factor when rendering services and treatments to diverse patients (Campinha-Bacote, 2002).

Since cultural competence is not an event, but a process, this model has five concurrent constructs in order for providers to become culturally competent. The constructs include cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire (Campinha-Bacote, 2002). The constructs function together, but also have an independent relationship with each other. But, all five constructs must be experienced and addressed for providers to become culturally competent. By following this model and viewing cultural competence as a process, client care and treatment can be enhanced and health outcomes become more positive. Positive health outcomes include improved overall functioning, improved provider-client relationship, and higher compliance rates relating to recommendations and treatment.

Cultural Awareness

Cultural awareness involves self-examination and exploration of the providers own background and beliefs (Campihna-Bacote, 2002). This step is exceptionally important because it allows individuals to recognized their, sometimes unconscious or subtle, biases, stereotypes, prejudices, and assumptions of individuals who are different from themselves (Campihna-Bacote, 2002). If a provider is not aware of their own

cultural and potential biases, there is a risk that they may be culturally incompetent to clients, which can cause many negative outcomes. Furthermore, they may impose their own beliefs or values on clients, which is also very detrimental and can ruin the provider-client relationship (Campihna-Bacote, 2002).

Cultural Knowledge

Cultural knowledge is the process of seeking and obtaining an educational foundation about diverse and different cultural and ethnic groups (Campihna-Bactoe, 2002). When researching and obtaining knowledge it is important to focus on issues in healthcare including health-related beliefs and cultural values, diseases incidence and prevalence, and treatment efficacy (Campihna-Bacote, 2002). Obtaining this knowledge is of the upmost importance because it has the ability to increase health outcomes by giving the provider a glimpse in the clients' worldview and way of thinking with regards to their health and wellness. This knowledge also improves the relationship with the client and gives the provider a clearer understanding of how culture affects healthcare and outcomes.

Cultural Skill

Cultural skill involves the ability of a provider to collect relevant cultural data regarding the client along with preforming a culturally based assessment (Campihna-Bacote, 2002). This involves knowing how to speak to culturally diverse populations in a way that is respectful to their particular culture. Assessments are a very important tool in healthcare and if a provider cannot conduct an appropriate culturally based assessment and gather the needed information for the client it causes serious problems with

treatment. This is where cultural knowledge will become useful, in knowing things that are normal and abnormal for different cultures and ethnicities (Campinha-Bacote, 2002).

Cultural Encounters

A cultural encounter involves providers and clients directly engaging with one another. It is important for providers to be comfortable interacting with people from other cultures and this will prevent possible future stereotyping and refine existing beliefs (Campinha-Bactoe, 2002). Cultural encounters also involve assessment of linguistic needs, for example if a client would benefit from getting an interpreter, a provider should accommodate this. This will improve data collection and overall health outcomes due to having the correct information.

Cultural Desire

Cultural desire refers to the motivation of the provider to want to, not have to, engage in a process of being more culturally aware, knowledgeable, skillful, and familiar with cultural encounters (Campinha-Bacote, 2002). Cultural desire comes when providers have a desire to provide care that is culturally competent and responsive. Cultural desire involves passion to accept differences and build on similarities of patients from diverse cultural backgrounds. This is a life-long process and is also referred to as cultural humility (Campinha-Bacote, 2002).

It is important to note that these five constructs are both independent and dependent. Meaning, they have the ability exist alone, but also are used to build on one another. In order to become a culturally competent provider one must go through each of the five constructs and continue the life long process of cultural humility.

CHAPTER IV

CULTURAL COMPETENCE IN MENTAL HEALTH AMONG AFRICAN

AMERICANS

African Americans and Mental Health

In the United States, troubling statistics exist when exploring African Americans and mental health. For instance, African Americans are 20% more likely to report serious psychological distress than their non-Hispanic White counterparts (Schiller, et al., 2012). Even with this self-reporting of psychological distress, African Americans are 50% less likely to seek services or to receive treatment or medication for mental health illnesses (Schiller, et al., 2012).

The most common mental health disorders among African Americans are major depression, attention deficit hyperactivity disorder (ADHD), and post traumatic stress disorder (PTSD) (Kilpatrick, et al., 2003). Evidence also shows that African Americans are more likely to experience circumstances that increase the chances of having a mental illness or challenge. Factors including homelessness or unstable housing and exposure to violence, that usually takes place in the community can cause an increase of a person's likelihood of developing a mental illness (Kilpatrick, et al., 2003). Homelessness or instability in housing can cause extreme stress and anxiety, resulting in higher rates of anxiety and depression in individuals that are chronically homeless. Exposure to violence during childhood often results in children and adolescents developing disorders such as PTSD or even acting out behaviorally, and getting diagnosed with a conduct disorder.

ADHD is defined as the persistent pattern of inattention and/or hyperactivity-impulsivity (Maddox & Wilson, 2012). Between 2001 and 2010 there was a 70% increase in ADHD diagnoses among African American children from ages 5 to 11 (Maddox & Wilson, 2012). African American boys are diagnosed with ADHD at a much higher rate than any other population. However, children that experience abuse or trauma are often misdiagnosed as having ADHD because the symptoms of post traumatic stress disorder (PTSD) mimic this disorder (Maddox & Wilson, 2012).

PTSD is defined as a mental health condition that is triggered by a traumatic event- either experiencing or witnessing it and symptoms include flashbacks, nightmares, and extreme anxiety (Carter, 2007). African Americans have a 9.1% prevalence rate of PTSD, compared to non-Hispanic Whites' 6% prevalence rate (Carter, 2007). African Americans are more likely to develop PTSD due to high exposure to community violence as well as exposure to racial violence and what is known as race-based trauma. Race-based trauma is defined as emotional pain that a person may feel after encounters with racism, this emotional pain is often expressed through anxiety, anger, rage, depression, low self-esteem, shame and guilt (Bryant-Davis, 2007). Racial discrimination has been directly linked to an increase in individuals with PTSD, suggesting that racism itself can be considered a traumatic experience (Chou, et al., 2012).

To fully understand the state of African Americans' mental health, one has to examine the gross adversity that African Americans, as a group, have suffered. Slavery, sharecropping, and race-based exclusions in education, occupation, and politics all translate into socioeconomic disparities that are previously and currently experienced by African Americans (Baker & Bell, 2014). African Americans are more likely to

experience oppression and discrimination, causing continued economic hardship. African Americans are more likely, compared to members of other racial groups, to be homeless or incarcerated. (Algeria, et al., 2015). This is important because socioeconomic status is linked directly to mental health, and poor mental health is more common among those who are impoverished (Baker & Bell, 2014).

Currently, much research has focused on how discrimination and racism perpetuate mental health disorders in the African American community. This research has shown that African Americans who are victims of discrimination face a higher risk of developing anxiety, depression, and/or substance abuse (Clark, et al., 2014). Discrimination and racism has been conceptualized as a stressor, with overtly racist acts being considered life events that lead to chronic stress (Clark, et al., 2014). High levels or chronic stress due to perceived discrimination have been linked to an increase in individuals reporting anxious or depressive symptoms (Bhui, et al., 2003).

CHAPTER V

AGENCY DESCRIPTION

I gathered all information for this study from Seven Counties Services, Inc. Seven Counties Services is the largest non-hospital, non-profit (501 ©(3))entity in the Louisville Metro area. Seven Counties Services is also the preferred provider of mental and behavioral health services for individuals in Jefferson, Oldham, Spencer, Trimble, Bullitt, Hardin, and Shelby counties in Kentucky. The staff at Seven Counties delivers community-based treatment, support and services for persons with severe mental illnesses, children with severe emotional and behavioral disorders, individuals with developmental or intellectual disabilities, and persons with addiction and substance abuse disorders.

Seven Counties was opened in Kentucky in 1978 with a goal of becoming a primary safety net for persons with severe mental illnesses, children with severe behavioral issues, persons with drug or alcohol addictions, and persons with developmental disabilities. Seven Counties is one of the few outpatient mental health facilities in the state of Kentucky that accepts individuals who have no insurance or are on government-funded plans such as Medicare or Medicaid. In Kentucky 793,271 individuals are on some form of Medicare or Medicaid and 20.4% of Kentucky's population was uninsured in 2014 (Altman, 2015).

Because Seven Counties is considered a non-profit organization, Kentucky's Attorney General oversees both the entire agency and rules governing donor solicitation and registration. Seven Counties is also licensed by the Kentucky Cabinet for Health and

Family Services and the Joint Commission. Seven Counties also gets regular audits from government agencies related to funding from Medicare and Medicaid. Furthermore, Seven Counties has a board of directors with external members that oversee complex issues such as budget, marketing, and collaborative work with the government.

Seven Counties has a variety of outpatient treatment centers including facilities specifically for children and families, adults, individuals with substance abuse, and individuals with developmental disabilities. Facilities for adults include various outpatient sites in Jefferson County and a site in each of the rural counties. A facility for adults with court ordered treatment is also located in Jefferson County. Each of these facilities employ temporary or permanently licensed therapists that have advanced degrees in education, social work, psychology, and sociology. In addition to therapists, adult sites also employ case managers, who assist clients with tasks such as finding housing, resources, and legal issues, all who have a bachelors' degree or higher in a human services related field. There are additional high school graduate-level staff who serve as peer support specialists and assist clients in securing employment, creating a budget, and other activities of daily living. Lastly, adult services employs psychiatrists and nurse practitioners who prescribe and monitor medication for mental illnesses. In addition to outpatient services, Seven Counties has partnered with the University of Louisville hospital as an inpatient emergency mental health service (EPS) that evaluates and provides inpatient care for adults who are a risk to themselves or others. EPS employs therapists and psychiatrists to treat and evaluate these clients.

Developmental services has one central location in Jefferson County that works with individuals with cognitive and developmental disorders. These disorders include

things such as Autism Spectrum Disorders (ASD), individuals with traumatic brain injuries (TBI), and individuals who are mentally retarded (MR) or have mild intellectual disabilities (MID). Developmental services, like adult services, employs therapists, case managers, peer support specialists, and psychiatrists. Seven Counties also provides stable housing to individuals with developmental disabilities that would otherwise not be able to live independently.

In addition to these services, Seven Counties acts as the payee for many of these clients who are on Michelle P. Waivers. The Michelle P. Waiver is a home and community based waiver program of the Kentucky Medicaid program developed as an alternative to institutional care for people with intellectual or developmental disabilities. The waiver allows individuals to remain in their homes with services and supports. Seven Counties provides this community and home based support through trained staff that provide community supports as well as respite care.

Seven Counties also has inpatient and outpatient treatment centers for individuals with drug and alcohol addictions. Jefferson Country alcohol and Drug Abuse Center (JADAC) provided medically supervised detoxification and residential treatment to Kentucky residents struggling from chemical dependency. During inpatient detoxification, participants receive medical evaluation, withdrawal assistance, counseling, addiction education, and resource referrals. Residents receive counseling, life skills coursework, and 12-Step services. JADAC also provides outpatient treatment for up to twelve weeks, after which time clients are referred to aftercare treatment that provides services such as group counseling and medical assessment to continue their road on recovery. JADAC employs psychiatrists, nurse practitioners, and registered nurses to

provide treatment and observation while clients are detoxing. Along with medical professionals, JADAC also employs therapists with advanced degrees in education, psychology, sociology, or social work- most therapists at this facility hold an additional certification in drug and alcohol counseling (CDAC). Bachelors level staff serve as case managers at JADAC and assist clients in securing needed resources and maintaining sobriety.

There are several outpatient facilities in Jefferson County, as well as one in each rural county that Seven Counties serves, that provide care for children age 2-18 that have mental health illnesses. Along with therapists, case managers are employed to assist families in finding resources related to housing, education, and finances. There are also psychiatrists and nurse practitioners on site to prescribe and monitor medications.

In addition to site-based services, there are also school based services that employ therapists that strictly work in Jefferson County Public Schools (JCPS) with children who have behavioral or emotional disorders. In addition to school-based services, Seven Counties also offers intensive in-home services for children and families that struggle in the home setting. Home based services employs therapists with advanced degrees in psychology, sociology, social work, or education; these therapists meet with children and their families two to three times a week for extended therapy sessions.

There are several therapists that are trained in trauma-focused cognitive behavior therapy (TF-CBT) that work in the Transitions Unit of Seven Counties with children that have a history of trauma related to abuse or are in the family court system. There are also therapists that have training in advanced family therapy that are employed in the Family Connections Unit of Seven Counties. Therapists with training in drug and alcohol abuse

are also employed at Lighthouse; an adolescent substance abuse inpatient program at Seven Counties.

Seven Counties has a variety of outpatient facilities for children and families, as noted above. The interviews for this study took place at an outpatient facility for children and families, Acute Child Psychiatric Services (ACPS). ACPS is the site where mental health professionals work with children that are at risk of harming themselves or others.

Acute Child Psychiatric Services (ACPS) is the Seven Counties department for children in crisis. The mission at ACPS is to keep children and their families safe in the least restrictive environment possible, meaning that the hospital is the very last choice after all other options are exhausted. ACPS provides 24 hour a day assessment, intervention and treatment to these children and their families. ACPS employs therapists with advanced degrees in social work, psychology, sociology, or education to provide family and individual therapy to children and their families. Adjunctive therapists are also employed, these therapists have bachelors' degrees in psychology or sociology and provide individual and family therapy to children in the community (home, school, daycare). Bachelors level staff also serve as crisis phone counselors, these staff answer the crisis line 24/7 and make the appropriate referrals. ACPS also employs psychiatrists who evaluate and monitor clients' medication. Lastly, the Crisis Stabilization Unit (CSU) is a part of ACPS; the CSU is an intensive, short-term inpatient program for children who do not need hospitalization, but require intervention beyond outpatient treatment.

Clients at ACPS include children and adolescents ages 2-18 that have one or more mental health illnesses. Patients at ACPS generally come from low-income families and have Medicaid or Passport insurance. Over 70% of patients seen at Seven Counties are

African American. The remaining 30% of patients include Latino/a's, Asians, Native Americans, non-Hispanic Whites, and Middle Eastern individuals. In the past decade there has been an influx of patients that are refugees be treated at ACPS. Approximately 5% of patients at ACPS are considered refugees. Most refugees from the Middle East, Africa, and South East Asia. Because of the influx of refugees, approximately 7% of patients and families at ACPS require translators. Translators are secured from Catholic Charities and other non-profit agencies throughout the city of Louisville.

CHAPTER VI

RESEARCH METHODOLOGY

The overall objective of this study is to examine the cultural competence of mental health providers in an outpatient mental health facility. This facility serves a population represented by large numbers of underserved and underrepresented groups. Cultural competence in healthcare has gained much attention from health policy makers, providers, insurers, and educators as a strategy to improve health quality and eliminate racial disparities in healthcare (Betancourt, et al., 2005). Research has shown that a lack of cultural competence leads to high rates of misdiagnosis and mistreatment, along with low quality of care, which further perpetuates disparities (Betancourt, et al., 2005). However, there is a lack of literature on cultural competency as it pertains to strictly mental health and direct practice of mental health providers.

Hypotheses 1: Cultural competence will have a variety of meanings to each individual interviewed and will often encompass just race and ethnicity, while leaving out extremely important factors such as socioeconomic status, religion, culture, and language.

Hypotheses 2: Barriers to culture competence will include language, cultural beliefs and attitudes, and the stigma related to being treated for a mental health disorder.

Hypotheses 3: There will be a lack of training on the subject of cultural competence throughout the organization.

Hypotheses 4: Negative implications for being culturally incompetent will be recognized and mental health providers will recognize that negative health outcomes arise when providers are not culturally competent.

Specifically, in this study, I aim to explore what cultural competence means to mental health providers and how this can impact the individuals they serve, both positively and negatively. The questions I asked all revolve around cultural competence and how this competence impacts client care and treatment. Follow-up questions involved education and trainings, as well as possible improvements for culturally competent care on both an individual and agency scale. Along with interviews of professionals, I explored and inventoried trainings offered by Seven Counties. With this information, I hope that strategies to improve cultural competence in outpatient mental health facilities can be identified and subsequently implemented on both an individual and agency level.

Sample

Of the 15 mental health providers interviewed, six were therapists, two were crisis counselors, three were supervisors that still see clients, one was a child psychiatrist, two were substance abuse counselors, and one was an adjunctive therapist. Four of the interviewees were men and the other eleven were women. Twelve interviewees identified as White/Caucasian. One respondent identified as African American, one identified as biracial (African American and Puerto Rican), and one identified as East Indian. Interviewees ages ranged between 26 to 45, with the mean age of 32.

The educational attainment of the interviewees varied as well. Six interviewees have a Masters in Education (MEd), five have Masters of Science in Social Work

(MSSW), one has a Medical Doctorate (MD), and three have Masters of Arts (MA). It is important to note that there are also variations of concentrations in each of these degrees. Of the six interviewees that have an MEd, one respondent has a background in Clinical Mental Health, whereas the other two respondents note Counseling as their area of expertise. Two respondents are in Educational and Counseling Psychology, and one is in Personnel Services with an emphasis on Art Therapy. Of the five interviewees that have MSSW's; two had an additional certification in Drug and Alcohol Counseling (CDAC), two had an additional certification in Marriage and Family Therapy (MFT), and one had no additional certification. The three interviewees that have MA's all concentrated on Clinical Psychology.

Each interviewee has a specific license. Three interviewees are Certified Social Workers (CSW), two are Licensed Clinical Social Workers (LCSW), three are Licensed Professional Clinical Counselors (LPCC), two are Licensed Professional Counselor Associates (LPCA), three are Temporary Licensed Psychology Associates (TPA), one is a Mental Health Associate (MHA), and one is a Medical Doctor (MD).

Each interviewee has worked for at least 6 months at Seven Counties with the tenure range from 7 months to 16 years. The average time interviewees worked at Seven Counties was 4 years. Lastly, each interviewee had an extensive background in working in human services that ranged from 7 to 21 years, with an average time worked in human services being 13 years.

Procedure

To explore data such as diversity statements, ethical considerations, and cultural competency at an agency level, I reviewed the official Seven Counties staff handbook.

The handbook included policies and procedures as well as official rules and regulations. In addition to the handbook, I reviewed staff trainings and offerings, that were both voluntary and required. After I reviewed the handbooks and trainings, I interviewed fifteen mental health professionals at ACPS. I chose to interview mental health professionals at ACPS due to their variety of backgrounds, both educationally and professionally and the fact that they serve a very diverse clientele.

All persons interviewed were employed by Seven Counties for over six months and have at minimum a bachelor's degree from an accredited university. Individuals with different positions within the agency were chosen to be interviewed to examine if there was a difference in answers between positions within the agency. Also, individuals with different educational backgrounds (i.e. MSSW vs. MEd) were chosen to account for any variations in answers among individuals with different educational backgrounds.

All interviewees signed an informed consent prior to being interviewed. All interviews were audio recorded and subsequently transcribed. A series of ten open-ended questions regarding cultural competency in mental health were asked to interviewees. Questions included views on cultural competency, ability to practice culturally competent based treatment, barriers in being a culturally competent provider, and how to improve overall cultural competence in the mental healthcare field. Depending on both clarity and answers, some follow-up questions were asked as necessary. At the end of the interview, interviewees were asked if there was any other information they wanted to provide that was missed in the interview. Personal demographics including age, race, gender, education, profession, and years in human services were asked of all participants

following the interview. Each interview was conducted at Seven Counties Services, Inc.

at 914 East Broadway and lasted approximately 40 minutes to one hour.

Data Analysis

All interviews were completed and transcribed, the information was entered into

QDA Miner. QDA Miner is a qualitative data analysis software that is used to analyze

interview transcripts, along with other documents (Lewis & Maas, 2007). In this study

QDA Miner was used to assist in identifying recurrent themes and phrases in the data

along with comparing the results of each question.

CHAPTER VII

RESULTS

Data analysis was centered on the topic of cultural competence and the extent to which it is woven into the culture of a specific mental health outpatient facility. Examining this question involved a review of the organization's handbook/policy manual, as well as the findings from the in-depth qualitative interviews. Coding from the interviews revealed several themes related to cultural competence including defining cultural competence, cultural competence as a process, barriers to cultural competence, staff perceptions of cultural competence training, and the prevalence of cultural incompetence

Organizational Handbook

After reviewing the Seven Counties official employee handbook I found that there was no mention of cultural competence. However, the handbook does contain a code of ethics section. The code of ethics contains ethical principles that reflect the organization's fundamental commitment to provide competent mental health services (Seven Counties Handbook, 2015). These ethical principles include: professionalism, dignity and worth, competency, integrity and evidence-based practices, self-determination, and billing and internal controls. However, none of these principles was thoroughly explained within the handbook.

Furthermore, the handbook outlines ethical practice standards for staff. These standards include: confidentiality and privacy, abuse reports, dual relationships, respect,

admission and availability of care, informed consent, least restrictive services, terminations and referrals, billing practices, internal controls, impairment of professional judgment, protection of human subjects, conflict of interest, staff requests, and external communications (Seven Counties Handbook, 2015).

The client Bill of Rights states that the client has a right to receive quality treatment within the agencies capabilities regardless of race, religion, sex, age, ethic background, mental or physical disabling condition, or ability to pay (Seven Counties Handbook, 2015). There is no statement of definition of diversity or cultural competence in the handbook. Moreover, there are no offered trainings or professional development courses on cultural competence or diversity in the organization.

Cultural Competence

Cultural competence is the ability of both individual providers and organizations to deliver healthcare services that meet the cultural, social, and linguistic needs of clients (Whaley & Davis, 2007). Cultural competence encompasses religious beliefs, behaviors, values and institutions, cultural traditions, language, ethnicity, and attitudes related to care. However, to the question "what is cultural competency?", answers varied greatly among all providers that were interviewed.

Race and ethnicity were mentioned by all of the individuals being interviewed when discussing cultural competency. Each person interviewed mentioned that cultural competency was the ability to work with individuals of different racial and ethnic backgrounds. Religion, culture, and language were often left out, with only three interviewees discussing any of these factors when asked to define cultural competence.

Defining Cultural Competence

One interviewee described cultural competency as not expecting everyone to be like "me:"

Cultural competency is being able to be aware of differences that I as a provider might have with a client or colleague and know the importance of these differences. It means not expecting people to be like me. (37-year-old White female)

Other interviewees discussed that cultural competency means being aware of sensitive things that are specialized to a race or group of people, which related back to the first step in the Campinha-Bacote model:

Cultural competency is just about knowing about diverse backgrounds. Whether its African American, Caucasian, Asian, etcetera. Just knowing things that are sensitive to that population or race and just being aware of things that are specialized to that race or group of people. (31-year-old Biracial female)

I think it means awareness of the client's background and culture and whatever that means for them. (29-year-old White female)

Cultural competence is awareness of your culture and your clients culture and the differences that may exist. It also means being sensitive to different cultures. In my job, I think it involves realizing how cultures perceive treatment and taking this into consideration when treating clients from different cultures. (27-year-old African American female).

Cultural Competence as a Process

When asked questions regarding how interviewees, as mental health professionals, are culturally competent or become more culturally competent, answers

again varied. Many people discussed asking questions to families that have a perceived "different culture" from their own.

I ask a lot of questions about the family culture, since it is different from my own. Continue to explore norms and ask more questions (37-year-old White female)

[Try to be actively] aware that my culture is different and ask questions regarding their culture and how that will affect clinical relationships and treatment (31-year-old White female)

When a non-White professional was asked about cultural competence, he was somewhat aware that it was a process and not something that could simply be learned, once noting that he was doing constant consultation and research on cultures that he is unfamiliar with.

Since I am not always presented with a culture I am familiar with I educate myself, do some research. I think research and educating myself is something that is really important. I also have consulted with providers from different cultures to obtain more knowledge on a particular culture and that has helped. (43-year-old East Indian male)

Other interviewee's mentioned looking up things that they are unfamiliar with and doing research, as well.

I look up things that I don't know about and take into account any cultural factors they feel are a factor in treatment. (27-year-old White male)

If something is very unfamiliar culturally I tend to do some reading to know the level of further study (28-year-old White female).

Other things interviewees cited as helping them become more culturally competent included translators for clients and families that do not speak English, being aware of differences and respecting these differences, treating clients from different backgrounds just like "any other client," and continuing to interact with people of different cultural backgrounds and "carrying" that knowledge. It is important to note that many of the professionals interviewed discussed race and ethnicity a lot, while leaving out factors such as culture and religion. They often talked about diversity while discussing being culturally competent.

Barriers to Cultural Competency

Responses to questions regarding barriers and challenges in working with individuals that come from different cultures were much more similar than previous questions. Families that do not believe in therapy or treatment for mental health issues was one of the biggest barriers that was repeatedly motioned by providers.

> *The biggest challenge is getting people that have different cultures to buy in to therapy. Some cultures do not believe in mental health services, so trying to get them to understand that they, or one of their children need therapy, is really tough most of the time. (28-year-old White female)*

Other interviewee's reported that they were aware of the stigma of asking for and accepting help in mental health as a barrier.

> *One thing that has been coming up a lot is working with populations where culturally asking for help is not okay. When this happens the families are not trusting and they are very slow to open up. (37-year-old white female)*

The biggest barrier is the stigma of mental health in some cultures. They feel like they do not need help and there is a reluctance to accept mental health problems or disorders. Belief systems in different cultures are sometimes the hardest barriers to get through. (43-year-old East Indian male)

People of different cultures do not value therapy or trust mental health professionals. (32-year-old White female)

Another barrier consistently brought up was working with clients and families that do not speak, or speak limited, English.

The hardest is when someone does not speak English. Even with a translator it is difficult to connect (31-year-old White female)

The language barrier is the hardest and most common issue in dealing with diverse populations (28-year-old White male)

Building trust and rapport, especially with people who do not speak English and need an interpreter. (26-year-old White female)

Interestingly enough, three interviewees specifically mentioned their race aa barrier to cultural competency.

I've been told that clients and families don't want to work with me because I am White. (28-year-old White female)

It is hard when we cannot accommodate clients. For example, a family may ask to be evaluated by an African American clinician and sometimes we cannot accommodate that. We used to have a much more diverse team. (37-year-old White female)

Other barriers discussed included things such as resources, which often include translators and differences in socioeconomic statuses.

Sometimes I think families aren't aware of things they need to let us know about so it's hard to ask questions in the right way to get the information we need to know about the family. Resources are also sometimes an issue, there have been crisis situations where I have had to go somewhere and the whole family speaks Spanish and I don't have an interpreter. (27-year-old African American female)

I think we all have barriers, especially if there is a difference in their socioeconomic status. Also, in the past I have had trouble getting a translator, so I wish that those resources were more readily available and we had better communication within departments here. (31-year-old Biracial female)

Trainings in Cultural Competency

Cultural competence is an ongoing learning process, which means that regular trainings are essential for mental health providers. Trainings are invaluable when teaching providers how to provide services in a culturally competent manner (Sue, 1998). Since cultural competence is considered to be a process rather than an ultimate goal, it is important to have trainings that build on prior knowledge and experience. Training often starts with increasing knowledge of various, culturally diverse groups that include beliefs about healthcare and behaviors and then builds upon this foundational knowledge. (Hardy & Laszloffy, 1995).

When asked questions about specific trainings at Seven Counties, all of the interviewees were not sure if Seven Counties offered cultural competency trainings.

No, there are no trainings offered for cultural competency at Seven Counties. (28-year-old White female)

Right now there is not anything offered on cultural competency here. Maybe they cover it in the ethics training, though. (37-year-old White female)

Technically, no. (43-year-old East Indian male)

No there are none inside the agency, but there should be (26-year-old White female)

No, I think that is a big problem. We should revisit cultural competency issues regularly and have mandatory trainings on them (31-year-old Biracial female)

Cultural incompetence

When questioned about the potential negative effects of cultural incompetency, all interviewees agreed that there are possible serious negative effects if a mental health provider was culturally incompetent. Interviewees discussed that clients will not come back and receive the treatment they need if a provider is cultural incompetent:

They won't come back and get the help or treatment they need. (26-year-old White female)

They won't come back to treatment, they won't be compliant because I feel like there is already a distrust in the system, especially with the population we serve. So if we can't respect them and make a genuine connection then we fail that child. (27-year-old African American female)

It could be perceived that we don't understand them or we don't care, so people wont come back and wont want to work with us. (28-year-old White female).

Interviewees also discussed clients and their families that are not given culturally competent care having a further distrust in the healthcare system and mental health.

Not only will they not come back and not get the treatment that they need, but they will also have a bad view of mental health. This bad view can also be brought back to certain communities and cultures and it can perpetuate the mistrust of mental health. (31-year-old White female)

In a grander scheme, we have a whole community that doesn't trust the mental health field. Smaller communities, for instance the Somalian community here, talk a lot and if they have bad experiences here they will tell others and then we have a whole community of people avoiding services. This is really detrimental, as the mental health of an entire community can deteriorate. The same is true with the more urban communities we serve. (43-year-old East Indian male)

Lastly, some interviewees discussed safety concerns related to non- compliance and terminating services when individuals and families feel professionals are not culturally competent.

When families don't come back that can lead to safety risks due to not getting treatment, a client may harm themselves or someone else. (28-year-old White female)

It sets them (the clients) up to be unsafe. (37-year-old White female)

The worst case would be that something tragic happens such as a client hurting themselves or someone else (43-year-old East Indian male)

You could misinterpret what they (the client) are saying, you could misread a symptom, you could involve them in treatment that they do not believe in, say

because they are Wiccan and their religion doesn't allow it. All of this could easily lead to individuals and families not coming back or following the treatment and safety plan. With the kiddos we serve this could be very harmful, if not in treatment, they could potentially hurt themselves or somebody else. (27-year-old African American female)

Recommendations

When asked about recommendations for themselves, all interviewees discussed ways in which they could become more culturally competent. Most answers were standard and included doing more research, traveling, asking questions, more exposure, and attending trainings.

I feel like I can improve upon my own cultural competency. I could start by reading about and asking for feedback from clients. Self awareness is also important, knowing that I don't know everything and asking when I have questions. (27-year-old African American female)

I think time and more exposure would help. Asking questions and getting answers (26-year-old White female)

Traveling. And doing more of what informs me of different cultures- reading, watching TV, talking, exposing myself to more information related to a culture other than mine. (28-year-old White female)

To be able to go to trainings. (28-year-old White female)

When asked about how the agency could improve cultural competence, answers varied. One thing many people focused on was trainings:

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Have mandatory cultural trainings for all staff. Also, offer additional multicultural trainings for staff as elective trainings. (26-year-old White female)

Trainings that are mandatory. Culture is changing and it is different than it was 5 years ago (31-year-old White female)

Trainings are most important. (28-year-old White female)

Regular trainings for staff. More explicit and active cultural competence training and make it mandatory and standardized. (43-year-old East Indian male)

Well, I feel like we need to be trained in the beginning. (31-year-old Biracial female)

Interviewees also mentioned that cultural competence would have to come from the top down, meaning that supervisors would need to be trained and start conversations with staff regarding cultural competence.

I tend to think big, we need to raise supervisor awareness. Have the supervisors trained first then have open discussions in supervision regarding cultural competence. You are more likely to create a change like that. (37-year-old White female)

Management should get training and then talk to staff. We, as an agency, need to recognize and talk about culture. If its not taught to us as important, we don't focus on it. (28-year-old White female)

It has to come from the top down, the administrators have to think that it is a priority, we can't do anything big individually without the administrators' support, they have to see this as something that is very important. (27-year-old African American female)

Interviewees also mentioned that it would be helpful for the agency to hire a more diverse staff. They also mentioned having interpreters readily available and having handouts available in other languages.

CHAPTER VIII

DISCUSSION

The purpose of this study was to examine cultural competence in an outpatient

mental health facility serving a diverse group of people. Along with this examination, the

purpose was to create recommendations for a more culturally competent agency and

workforce, in hopes that this would provide more positive health outcomes to the

individuals being treated. To do this, mental health professionals at an outpatient mental

health facility were interviewed regarding their beliefs on cultural competence.

In examining these issues of cultural competence, mental health professionals

engaged in in-depth qualitative interviews. The interviews and policies provided a great

wealth of information regarding cultural competence in mental health. Along with a

review of previous research and literature, this information was used to develop

recommendations for mental health facilities to improve cultural competence.

Defining Cultural Competence

When asked to define cultural competence, no two mental health providers had

the same answers. Moreover, almost everyone asked defined cultural competence as

treating people of different races and ethnicities. Religion, culture, and language were

almost never mentioned when defining cultural competency. There was also no mention

or definition of cultural competence in any of the organizations policies or procedures

listed in the official handbook. Although, ethics and competency were used in the

handbook, they were not clearly defined or discussed with regards to mental health treatment.

This lack of knowledge with regards to cultural competence is worrisome because in order to be culturally competent, a provider must first have an adequate understanding of what it means to be culturally competent. Cultural competence should also be seen as an ongoing process, where one continuously strives to become cultural competent, not simply a one-time training or learning experience. Cultural competence encompasses religious beliefs, behaviors, values and institutions, cultural traditions, language, ethnicity, and attitudes related to care (Betancourt, et al., 2003). By not defining cultural competence with all of these factors, a provider does not have a true understanding of cultural competence.

The organization as a whole also does not define cultural competence in the handbook, which could account for providers not having streamlined answers defining cultural competence. In order for an organization to strive to be culturally component, both the organization as a whole and the providers must have an understanding of the meaning of cultural competence.

Therefore, my first recommendation is for the organization to place a definition of cultural competence and its importance in the handbook. By doing this, providers can have a clear understanding of what cultural competence is and why it is important in a mental health setting.

Cultural Competence as a Process

The Campinha-Bacote model clearly states that cultural competence is a process, not something that can simply be taught or learned quickly. In order to become more

culturally competent, providers must constantly seek to gain knowledge and apply this knowledge with their clients (Campinha-Bactoe, 2002). Providers in the interviews often overlooked the actual process, but many did discuss research and asking questions as a way to become more culturally competent.

When asked about cultural competence being a process, most mental health providers stated that they ask questions and do research to help them work with people of different cultures. This fits in with the cultural knowledge step of the Campinha-Bacote model, the providers are constantly wanting to seek knowledge to assist them interact with and treat their patients appropriately.

Unfortunately, many of the other steps were missed. Providers did not discuss examining their own biases or negative subconscious thoughts of other cultures, which is the first step, cultural awareness. Cultural encounter and skill were often looked over as well when providers' discussed cultural competence as a process. These steps also involve making treatment relevant to the patient, which can involve things like integrating herbs and spiritual healing in treatment, which mental health providers did not discuss.

Lastly, cultural desire was vaguely mentioned but not discussed as an impactful part of the process. Providers did not discuss that cultural competence was a process that one constantly goes through, but rather referred to it as something that they could obtain through research or learning.

Due to mental health providers lack of understanding that cultural competence is a process, it is important that this is clearly defined, both at a personal and organizational level. Another important recommendation would be to implement and teach cultural

competence through the Campinha-Bacote model, as a process rather than a one time learning experience.

Barriers to Cultural Competence

Providers were able to identify a variety of barriers to cultural competence; some of these barriers were mentioned several times. Almost half of the providers interviewed noted language as a barrier to cultural competence, meaning a patient and their family speaking limited or no English. Therefore, an important recommendation would be to employ, or have on hand, translators that are available daily to assist with families that do not speak English. Also, having handouts and other important information (i.e., paperwork family has to sign for treatment) in a variety of different languages.

Providers also described the stigma associated with mental health and reluctance to participate in mental health therapy and treatment as a barrier to cultural competence. If providers were following the Campinha-Bacote model, and were going through steps such cultural encounter and skill, families may have an easier time agreeing or "buying into" therapy and treatment. Often times, when individuals or families understand the process of mental health care and treatment and are comfortable with this process and treatment, they are more likely to follow treatment recommendations (Corrigan, 2004).

Lastly, three providers mentioned a barrier being there own race (non-Hispanic White). These providers stated that at times patients come in and request an African American provider and cannot be provided with one. For this reason, another important recommendation is for the organization to hire a more culturally diverse staff.

Trainings

There are no trainings offered or required in cultural competence at this facility. Regular trainings are so important because cultural competence is a process and it is imperative for providers to regularly learn new material and have a space to consult and ask questions specifically related to cultural competence. A very important recommendation would be for organizations to have a mandatory cultural competence training for new hires, and require at least two subsequent cultural competence trainings per year. Again, since cultural competence is an ongoing process, this is of the upmost importance.

Furthermore, there are no professional developments offered that center on cultural competence or diversity. It is important for the agency to offer professional development courses and courses for continuing education units (CEU's) that focus on this competence and diversity.

Other Recommendations

Many providers that were interviewed also mentioned that cultural competence trainings coming from the "top down" would be helpful. For instance, the supervisors and managers would be trained first and then the rest of the staff would be trained. This would help if staff had any questions or concerns and would also aid in making cultural competence a priority. Thus, a last recommendation would be for supervisors to undergo trainings before their staff and to be readily available to answer questions and provide feedback to their staff in regards to cultural competence.

Limitations

The limitations to this study include that interviews and policies were only examined at one mental health facility. There is the possibility that findings and results

would change if other mental heath facilities were examined. Along with this, the interviews I conducted were on a small sample size of one specific department. There is also the possibility if interviews were conducted outside of this one department and with more employees results and findings could be changed. Moreover, this study only includes one data collection wave. Therefore, changes in cultural competence over time cannot be accounted for. Furthermore, clients that were treated at this facility were not interviewed, so there is no real measure of culturally competent treatment other than the providers own self-rating.

Future Directions

This research has been extremely helpful in discussing how an outpatient mental health facility and their professionals are culturally competent. The literature on cultural competence often does not mention mental health outpatient facilities. The interviews and policies in the handbook have shown a gap in things such as trainings and continuing education in cultural competence. Because of this gap, recommendations were formed for this particular agency. From this study, barriers to cultural competence were explored, as well as the consequences associated with being culturally incompetent.

With this part of the research complete, I plan to interview clients and their families regarding how they feel mental health providers treat them with respect to cultural competence. This is very important, because it is a much different viewpoint on how cultural competence effects the treatment of patients at mental health facilities. With this information, I believe that additional recommendations can be made and implemented at both an individual and organizational level to improve cultural competence and thus improve mental health outcomes.

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APPENDICES

1. What does cultural competency mean to you?
2. How do you, personally, practice being "culturally competent" or treat patients that come from diverse backgrounds?
3. Do you have opportunities inside your agency to take any cultural trainings or trainings on discrimination in mental health? If so what are these trainings and what are your thoughts on them?
4. Are you required to take a cultural diversity or competency training for your current position? If so what does the training entail? With this, do you feel your agency promotes being cultural competent? Why or why not?
5. What are some of the challenges, if any, you have encountered in working with patients from diverse populations?
6. If you suspected a patient was experiencing challenges (not following treatment plan, missing appointments, etc.) due to cultural preferences, what steps would you take to understand their preferences and assist them in overcoming these challenges?
7. How would you go about building rapport with a patient who is from a background different from yours? Is this approach different than your approach for patients with similar backgrounds? Is this difficult for you?
8. Do you feel being culturally competent could make a difference in people your agency serves?
9. If anything, what do you believe could improve your own cultural competency? Your agency's?
10. Do you believe that there are any repercussions for cultural incompetence in the mental healthcare field? What are these?

Interviewee demographics:
Age, Gender, Racial Identity/Ethnicity, Position Held, Education, and How long at the agency, Total years of experience in human services.

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