A report for the Cultural and Linguistic Competence Steering Committee for the Department of Behavioral Health and Developmental Services

"I WORK AT A STATE PSYCHIATRIC HOSPITAL. MINIMAL TRAINING IS REQUIRED"

AN EXPLORATION BY SELF-PERCEPTION OF CULTURAL COMPETENCY IN VIRGINIA MENTAL HEALTH CARE PROVIDERS

Erin Casey, MA
Cori Howard, MA

Introduction

The need for culturally competent mental health practitioners is increasingly important because of the demographic shifts and increasingly diverse population base of the United States. Given the stigmatizing nature, complex clinical and embedded family and community relationships that mental illness and substance abuse treatment often involve. However, even with the acknowledgement and understanding of its importance knowing how to assess, perceive and develop cultural competency in the realm of behavioral health is still relatively in its infancy. Whaley and Davis (2007) wrote, “The need for cultural competence and the need for evidence-based practice in mental health services are major issues in contemporary discourse, especially in the psychological treatment of people of color” (p.563).

WHO (2015) stated “the highest attainable standard of health is a fundamental right of every human being” (2006, p.1). This idea is defined as health equity (Department of Health and Human Services, 2010). To achieve health equity, it is imperative that every individual “attain their full health potential” and no one is “disadvantaged from achieving this potential because of their social position or other socially determined circumstance” (Braveman, 2003, p.181). However, due to the biomedical model’s emphasis on reductionism, control, dehumanization, and decontextualization, the biomedical model does not support the idea of health equity and limits opportunities to all of those in need of health care access. As stated by Airhihenbuwa (1995), it must be recognized that Western or “modern” process are not always just or correct. Additionally, it is necessary to uncover and address the negative and long lasting effects of letting the biomedical model singly remain dominant (Airhihenbuwa, 1995).

“Health professionals are now more aware of the challenges they face when providing healthcare to a culturally and racially diverse population” (Bhui, Warfa, Edonya, McKenzie, & Bhugra, 2007, p. 1).Beyond the general health setting, mental health care has experienced the same effects of widespread globalization, increasing diversity and the socio-demographic shifts that have occurred over the last several decades. Because of this, culturally competent mental health care is needed increasingly to support the growing needs of populations within the United States (Whaley & Davis, 2007).

Cultural competence is the capacity to function effectively as an individual (or organization) within the context of the cultural beliefs, behaviors, and needs presented by consumers (or patients) and their communities. Specifically within mental healthcare and substance abuse, including and valuing culture as a part of a patient or client’s treatment because of the added stigma attached and complex relational dynamics present. Additionally, vocabularies, cultural beliefs, norms and practices can be interpreted behaviorally in incorrect ways if not, at the very least acknowledged and valued by the providers. This could potentially lead to incorrect care, added distress, lack of treatment and/or noncompliance (DBHDS, 2014b).

The purpose of this study is to investigate how Virginian mental health clinicians define cultural competence and perceive their individual

Understanding Culture

Because culture is a large part of individual and patient identity it is important to understand what “culture” is. According to the Office of Cultural and Linguistic Competence (2001) and the National Institute of Mental Health (2001), as cited by the Virginia Department of Behavioral Health and Developmental Services (2012) culture is “the thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups” (Cross, Bazron, Dennis, & Issacs, 1989).

Understanding Cultural Competence

Cultural competence is conceptualized as a process that recognizes healthcare providers' and receivers' perspectives and promotes knowledge and awareness of individuals to better serve populations (Ahmed, 2007; Ahmed & Bates, 2010). The goal of culturally competent behavioral health care is to engage with clients in ways and environments that provide optimal development for both the client and the client's various systems. The task of competency falls on the provider, as it is the provider, clinician or counselor's job to be able to create spaces and relationships that embody these values. Sue and Torino (2005) wrote:

> Multicultural counseling competence is achieved by the counselor's acquisition of awareness, knowledge, and skills needed to function effectively in a pluralistic democratic society (ability to communicate, interact, negotiate, and intervene on behalf of clients from diverse backgrounds) and on an organizational/societal level, advocating effectively to develop new theories, practices, policies, and organizational structures that are more responsive to all groups. (p. 8)

Organizational Background

The Virginia Department of Behavioral Health and Developmental Services (DBHDS) established the Office of Cultural and Linguistic Competency (OCLC) in August 2008 in an effort “to provide improved services to multicultural consumers and works toward eliminating the disparities within the state’s mental health, developmental, and substance disorder system” (DBHDS, 2014a). The office’s vision is to advocate for culturally competent mental health care across the state of Virginia that is first “given with respect for the consumer’s health-related beliefs and cultural values”, second given by staff that respects “health beliefs, interpersonal styles, and attitudes and behaviors of the consumers, families, and communities they serve”, and third organized by “administrative, management and clinical operations that include routine assessment and implementation of processes which result in a workforce that is culturally and linguistically competent and a system that provides the highest quality of care for all communities” (para. 2).

The Virginia Office of Cultural and Linguistic Competency is tasked with several activities including: 1) Expanding the number of culturally and linguistically competent service providers, stakeholders, and staff within the public and private sector. 2) Identifying issues and providing technical support for language access needs. 3) State plan development that incorporates cultural competence as a key component in planning, quality, contracts and staff training. 4) Identifying relevant data elements needed to report program and service outcomes measures and identify progress (DBHDS, 2014a). The office is staffed by three full time employees and utilizes a statewide advisory committee comprised of 40 members from across the state of Virginia. The committee informs the Director of the Office of Cultural and Linguistic Competence regarding issues related to training, policies, and procedures. The aim of the committee is to enhance the Department’s “ability to provide a culturally and linguistically competent system of care”. This committee will also provide legislative recommendations to the Commissioner of the Department of Behavioral Health and Developmental Services. (DBHDS, 2012)

Providers & Cultural Competence

[A] culturally competent person is able to acknowledge, accept, and value the cultural differences of others. That is, such a person has the knowledge and skill that enable him or her to appreciate value and celebrate similarities and differences within, between, and among culturally diverse groups" -Bhui et. al (2007, p.7)

The understanding, awareness, and value of cultural identities, beliefs, norms and practices reside at the heart of providing culturally competent care. In order for healthcare practitioners to provide culturally competent care, "knowledge of cultural beliefs, values and practices is necessary otherwise health practitioners can easily fall prey to errors of diagnosis, inappropriate management and poor compliance" (Bhui et al., 2007, p. 1). Furthermore, this type of care is known for the way it encourages clinicians to pay attention to, respect, and incorporate culture on all levels of care (Whaley & Davis, 2007).

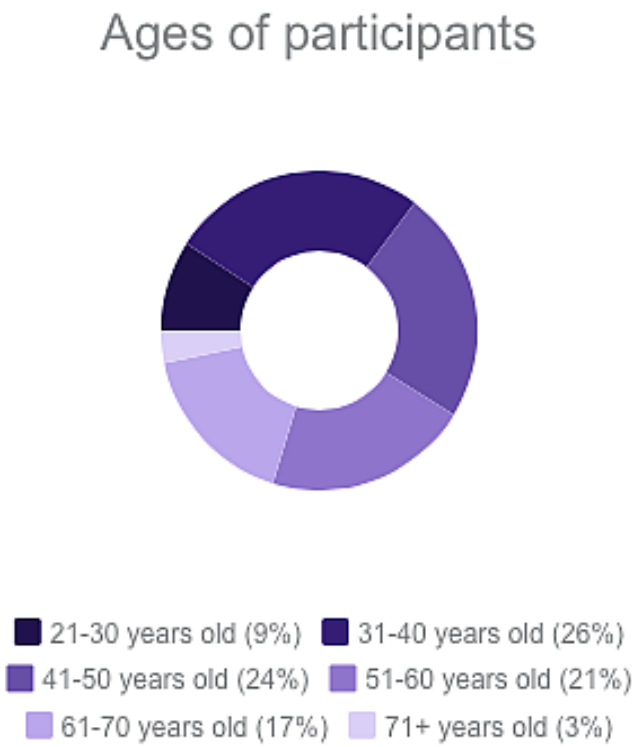
Method

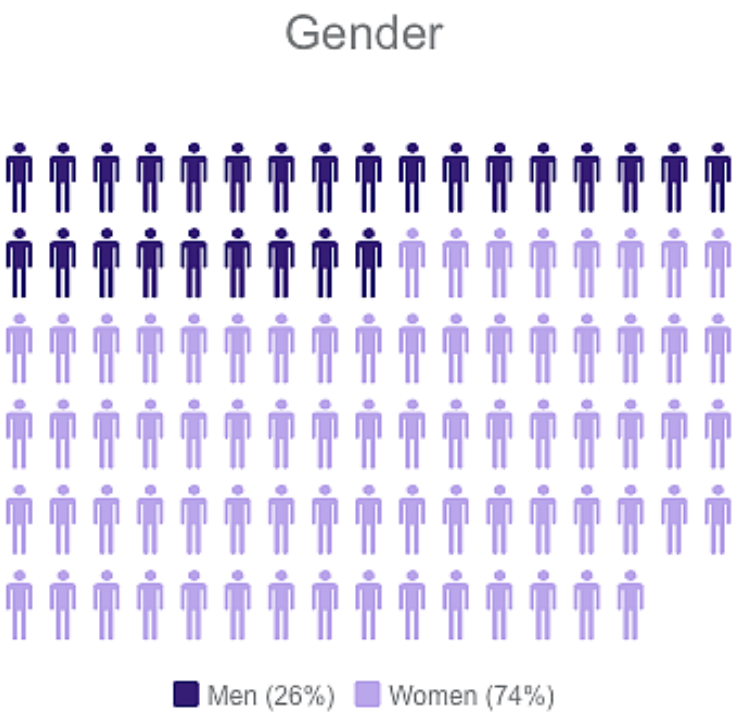
After obtaining Institutional Review Board (IRB) approval, The Office of Cultural and Linguistic Competency of the Department of Behavioral Health and Developmental Services identified individuals in the target population and asked for their participation via email. Randomization was not used to distribute surveys to practitioners because of the small target sample; instead all eligible individuals were asked to participate. The email contained a link to a Qualtrics survey, an online survey tool vetted by James Madison University.

The survey was an anonymous, online, and self-administered 39-item questionnaire. Practitioners were advised that their participation was voluntary, and they could refuse to complete or quit at any time. At the end of the survey, participants were taken to a different online document that allowed them to send their contact information for the Office of Cultural and Linguistic Competency of the Department of Behavioral Health and Developmental Services in order to receive continuing education credit. A total of 123 clinical providers responded.

Participant Demographics

A total of 154 mental health care clinicians participated in the study. Participants were both male (26%) and female (74%) with ages ranging from 22 to 74. The surveyed population represented all levels of experience, including practitioners who had been in practice for less than a year and individuals who have been in practice for over 45 years (m= 17). Additionally, all nine regions of the state of Virginia were represented.





Measures

Two scales were used to measure clinical perceptions of cultural competence. The Cultural Competence Assessment Instrument- University of Illinois at Chicago (CCAI-UIC) was used to measure licensed mental health practitioners' perception of their cultural competency. Specifically, the CCAI-UIC assesses cultural knowledge, skills, and organizational support (Balcazar, Suarez-Balcazar, & Taylor-Ritzier, 2009). The complete CCAI-UIC scale can be viewed in Appendix A. The CCAI-UIC had a Cronbach's alpha, or reliability rating from 0-1, of .82. Responses for the CCAI-UIC were given on a 4-choice Likert-scale. The scale ranged from 1- "Strongly Disagree" to 4- "Strongly Agree". Items include statements such as "I do not consider the cultural backgrounds of my clients when food is involved" and "It is difficult to practice skills related to cultural competence" (Balcazar, Suarez-Balcazar, &Taylor-Ritzler,2009).

To further understand the perception of cultural competency of the work place, the Cultural Competence Workplace Assessment Instrument- James Madison University (CCWAI- JMU) was created. The complete CCWAI-JMU scale can be viewed in Appendix B. The CCWAI-JMU is a 6-item scale and had a Cronbach's alpha of .79. Responses for the CCWAI-JMU were given on a 5-choice Likert-type scale. The scale ranged from 1- "Easily Accessible" to 5- "Not Available". Items include statements such as "How accessible are interpreters for your patients?" and "How accessible are intake and confidentiality forms in languages other than English?"

Findings and Recommendataions

Important information surrounding mental health providers, culture, and cultural competence was explored through this research, The following key findings and recommendations are provided by the authors for use by the Cultural and Linguistic Competency Committee, the Virginia Department of Behavioral Health and Developmental Services, and all Virginia mental health facilities. In addition, the following information and tips included in this report came directly from mental health providers' survey responses.

The definition of culture

The way that clinicians define culture can help better shed light on how clinicians view the intersection of culture and their clinical practice as well as how they perceive culture to influence their work as mental health providers.

The 39% of clinicians who used primarily a group frame for defining culture emphasized the collective nature of culture and the connection that it facilitates between people:

"A collective body of practices, attitudes, beliefs and worldview shared by a group or subgroup of individuals. The group can be defined by different dimensions including ethnicity and even geographic region."

"The way a group of people look at the world and the traditions, music, food, religion that connects them."

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The 26% of participants that defined culture from an individual frame did so from the idea that culture is something that influences an individual in different way:

"Culture is the way someone is socialized to his environment, communication style, faith, kind of family one is raised in and mainly life experience that makes you different from another human being around at work, school…"

"One's view of the world through life lessons and upbringing."

The definition of cultural competency

The following three examples showcase how cultural competency has been defined throughout the participants within the study. They demonstrate that there is still a fair amount of ambiguity surrounding the concept and definition of cultural competency.

Participants described cultural competence through the awareness of themselves and the awareness of others:

"...having an awareness of personal cultural bias"

"...the awareness of diverse and differing cultures other than you own"

"...sensitivity to and awareness of differences in culture and how those differences affect personal interactions."

Participants also defined cultural competency through types of knowledge a clinician can acquire:

"Knowledge, skills, and sensitivity related to ethnic or racial groups that impacts actions when relating or working with that group or persons from that group."

"Culturally competent means a person has knowledge of other cultures and how these impact the delivery of effective services."

"Basic knowledge of the unique cultures of the people in your community and work site."

Finally, other participants define cultural competency as state of being and acting:

"Being willing and open to learn from other's culture and respect their culture…"

"Being open, informed, intellectually curious, respectful, accepting and flexible…"

"Being aware and respectful of the influence of culture, and having the drive to learn about the culture influence of those we work with."

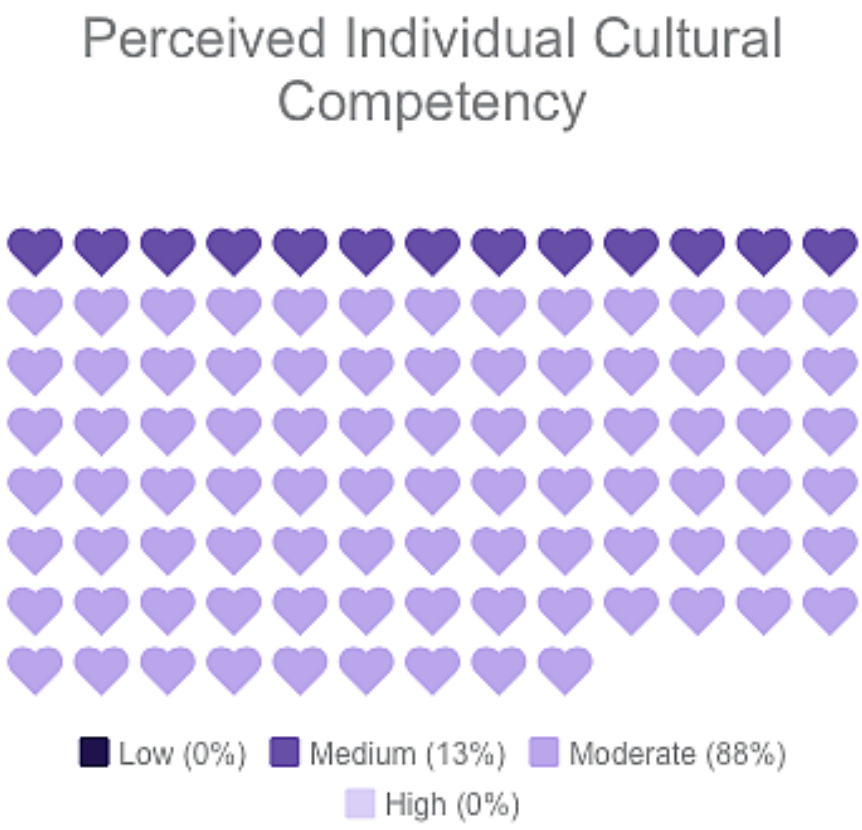
The way that clinicians are talking about culture can help better shed light on how clinicians view the intersection of culture and their clinical practice as well as how they perceive culture to influence their work as mental health providers. While it is great that most providers are able to provide a competent definition of “culture”, their inability to define “cultural competence” may show that there are unclear expectations of how cultural competency is practiced in the clinical workspace. Without a consistent definition it is hard to grasp what the ideal culturally competent interaction looks like between patient and clinician.

In light of this finding, cultural competence training should be redesigned to emphasize and demonstrate the definition of “cultural competency” adopted by the VDOBHDS. By adding the definition of “cultural competence,” it is possible that providers can, and will, become as comfortable with term as they are with “culture.” In addition, a statewide campaign familiarizing practices with cultural competence could also aid in the recognition of a unified definition

Perceived individual cultural competency

The Cultural Competence Assessment Instrument examined licensed mental health practitioners' perception of their cultural competency. On a scale that ranked 1-low, 2-medium, 3-moderate, and 4-high, most participant scores (88%) indicated a "moderate" perception of self cultural-competence.

Within the CCAI scale, there were two questions in which participants ranked themselves particularly high. Item 5 said: "I am sensitive to valuing and respecting differences between my cultural background and my client" The average answer for this item was 3.51. This placed most individuals (n=151, 99.34%) between "agree" and "strongly agree". Additionally, item 6 said: "I feel that I can learn from my ethnic minority clients." The average answer for this item was 3.65. Again, this placed most individuals (n=152, 99.34%) between "agree" and "strongly agree".



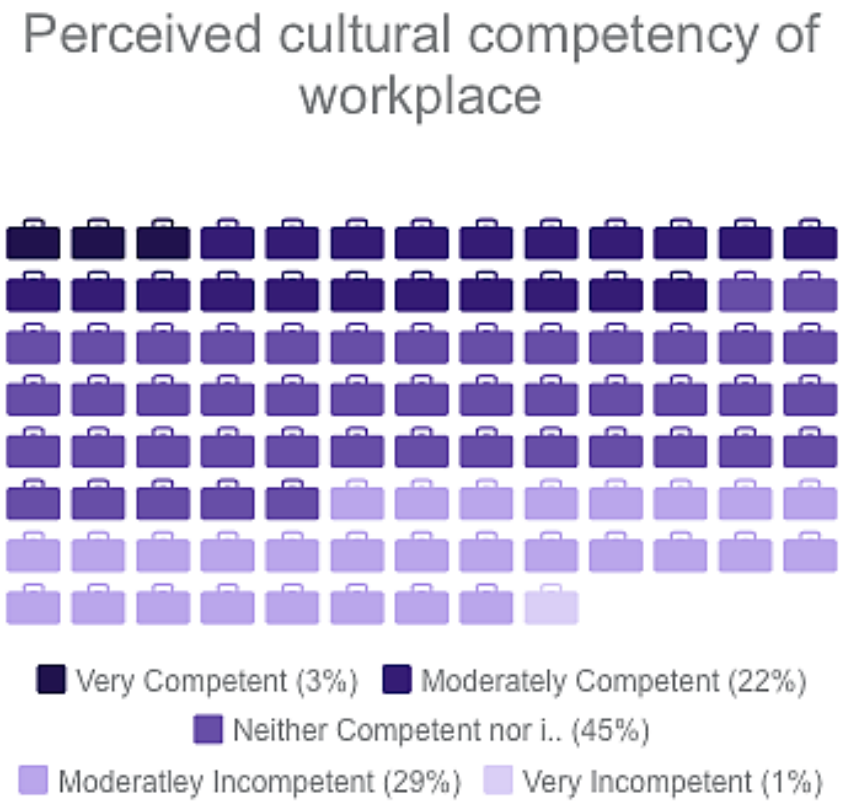
Perceived individual cultural competency

Most clinicians reported that they had an “average” level of cultural competence. This is really interesting given that throughout the data a consistent definition of “cultural competence” did not emerge. Thus, how can one be culturally competent when one does not know what cultural competency is? Furthermore, it was indicated that clinicians were not receiving feedback on culturally competent practices from their supervisors. In turn, clinicians feel that they do an “average” job, but are not told by others what they are doing well or poorly. Moreover, this calls into question if they are having conversations in the workplace surrounding cultural competence.

As stated early, having a consistent definition of cultural competence displayed through CLC and VDBHDS trainings, workshops, events, and materials could help alleviate the ambiguity surrounding cultural competence and assist in the development of culturally competence practices. Additionally, increased emphasis during trainings on how supervisors can communicate about cultural competence to their staff could increase the number of conversations surrounding cultural competence and therefore affect the relevance felt by clinicians in their practices.

Perceived cultural competency of the work place

The CCWAI was used to further understand the perception of cultural competency of the work place. “Neither competent nor incompetent” was the most common answer to the items on the scale. Furthermore, most participant scores (45%) indicated a “neither competent nor incompetent” perception of workplace cultural-competence, on a scale that ranked 1-very competent, 2- moderately competent, 3- neither competent nor incompetent, 4-moderatly incompetent, and 5-very incompetent



Within the CCWAI scale, there was one question in which participants ranked their workplaces particularly high. Item 6 said: “How wheelchair accessible is your facility?” The average answer for this item was 1.61. This placed most individuals (n=135, 88.81%) between “very competent” and “moderately competent.”

However, both items that scored the lowest involved accessibility for individuals who have difficulty reading or seeing. Item 5 asked: “How accessible are human readers for your patients?” The average answer for this question was 3.55. This placed most individuals (n=126, 82.35%) between “neither competent nor incompetent,” “moderately incompetent,” and “very incompetent.” Furthermore, item 3 asked: “How accessible are large print or braille intake and confidentiality forms?” The average answer for this question was 3.9. This placed most individuals (n=106, 69.74%) between “moderately incompetent” and “very incompetent.”

To encourage the creation of more culturally competent work environments, the CLC and VDBHDS should prioritize the importance of providing access to mental health care to those with sight imparities. This could be achieved through a number of ways including forming a committee that specializes on this issue,incorporating these needs into goals that are given a strategic plan within the CLC, or applying for a grant that would help distribute resources to mental health practices throughout Virginia.

Receiving cultural competency training

Participants were asked if they had received cultural competency training. Of the 152 participants, 143 (94%) said they had received cultural competency training and 9 (6%) said no.

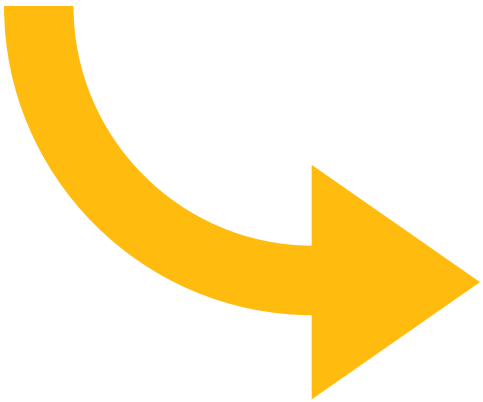
Out of 152 participants 47% of them reported that they have either never received cultural competence training or that they have only received in one time in their professional career. Additionally, 37% of clinicians in this survey reported that they participated in cultural competency training through their workplace annually and only 17% of clinicians reported that they receive cultural competency training more two or more times per year.

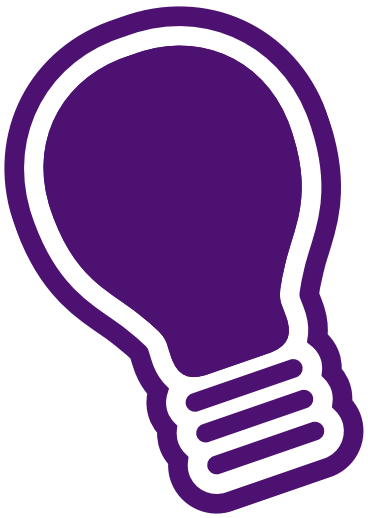
Additionally some clinicians noted that because of their workplace's refusal to provide training they have been forced to seek out cultural competency training on their own:

"I work at a state psychiatric hospital. Years ago, there was some, minimal, cultural training.The training I have received (presentations, workshops, etc.) were obtained on my own."

Receiving cultural competency training

While many clinicians reported attending some cultural competency training, most of that training took place while either in school or outside of the workplace. When describing training experiences, clinicians reported a high number of web-based trainings and trainings that relied heavily on PowerPoint-styled lectures. Having such a limited scope for information dissemination may hinder some individual's willingness to participate in cultural competency training.





Thus, further research regarding the best style of training may prove beneficial for creating training programs that are appealing, educational, and interesting. One factor not discussed in this report that may also be influencing the number of cultural competency trainings attended are the communication channels through which information regarding the time, place, and topic of trainings are being sent. Therefore, we recommend that the CLC and VDBHDS spend additional time creating a strategic plan for disseminating information for trainings, events, and workshops related to cultural competency. An event, training, or workshop provides continuing education credit to clinicians and should be highlighted. Furthermore, if possible other incentives should be included in these trainings and advertisements to encourage clinician participation.

Conclusion

In conclusion, this study explored mental health clinicians' self-reported perceptions of culture competence for both themselves and their workplace. While clinicians perceived a high level of individual cultural competence, they felt that the workplace could be improved. Both positive and negative findings were analyzed and discussed. Recommendations were provided. Recommendations included ideas such as training, campaigns, and a strategic plan. Lastly, it is recommended that more research be conducted to understand the most effective method and frequency for cultural competency training.

The authors are proud to present this research to the Cultural and Linguistic Competency Committee of the Department of Behavioral Health and Developmental Services of the state of Virginia.

Appendix A

Cultural Competence Assessment Instrument- University of Illinois at Chicago (CCAI-UIC) (Balcazar, Suarez-Balcazar, & Taylor-Ritzler, 2009)

1. I openly discuss with others issues I have in developing multicultural awareness.
2. I learn about different ethnic cultures through educational methods and/or life experiences.
3. I examine my own biases related to race and culture that may influence my behavior as a service provider
4. I actively strive for an atmosphere that promotes risk-taking and self-exploration.
5. I am sensitive to valuing and respecting differences between my cultural background and my client's cultural heritage.
6. I feel that I can learn from my ethnic minority clients.
7. It if difficult for me to accept that religious beliefs may influence how ethnic minorities respond to illness and disability.
8. I do not consider the cultural backgrounds of my clients when food is involved.
9. Cultural competence is included in my work place's mission statement, policies, and procedures.
10. My organization does not provide ongoing training on cultural competence.
11. My workplace does not support using resources to promote cultural competence.
12. My workplace does not support my participation in cultural celebrations of my clients.
13. At work, pictures, posters, printed materials, and toys reflect the culture and ethnic backgrounds of ethnic minority backgrounds.
14. I receive feedback from supervisors on how to improve my practice skills with clients from different ethnic minority backgrounds.
15. The way services are structured in my setting makes it difficult to identify the cultural values of my clients.
16. I have opportunities to learn culturally responsive behaviors from peers.
17. I am effective in my verbal communication with clients whose culture is different from mine.
18. I am effective in my nonverbal communication with clients whose culture is different from mine.
19. I would find it easy to work competency with ethnic minority clients.
20. I feel that I have limited experience working with ethnic minority clients.
21. It is difficult to practice skills related to cultural competence.
22. I feel confident that I can learn about my clients' cultural background.
23. It is hard adjusting my therapeutic strategies with ethnic minority clients.
24. I do not feel that I have the skills to provide services to ethnic minority clients.

Appendix B

Cultural Competence Workplace Assessment Instrument- James Madison University (CCWAI-JMU)

1. How accessible are intake and confidentiality forms in languages other than English?
2. How accessible are large print or braille intake and confidentiality forms?
3. How accessible are interpreters for your patients?
4. How accessible are translators for your patients?
5. How accessible are human readers for your patients?
6. How wheelchair accessible is your facility?

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