The Challenge of Sustaining Cultural and Linguistic Competence

By Katherine Lazear

Systems of care approaches that are tailored to be culturally and linguistically competent include the beliefs, customs, and behaviors of specific cultural groups. Programs that are culturally relevant can have improved quality, effectiveness and outcomes, particularly with regard to underserved communities. The challenge of cultural and linguistic competence (CLC), once the structure for it is in place, often is how to sustain the effort to continue to meet the needs of an increasingly diverse population. Sustaining the infrastructures, processes, and practices that have been effective in decreasing disparity and unequal treatment is an important part of being culturally and linguistically competent. The process does not end once CLC efforts are in place; addressing CLC is to be constantly learning and listening through quality assurance processes; producing and implementing effective practices, treatments, services and supports; and, conducting participatory evaluations and assessments.

While disparity and disproportionality persist for minority youth, recent data suggest some improvement in certain areas. For example, the disproportionality of African American children in foster care, while still present, has decreased. Access to behavioral health care for Hispanic children has increased in terms of Medicaid. Are we making headway for certain populations or within certain systems? If so, what are contributing factors? What programmatic or systemic approaches are contributing to changes within certain child-serving systems or among certain populations? What should policymakers know? What areas are not improving and why? What is it about cultural and linguistic competence that improves outcomes? The answers to these and other relevant questions will help us know what needs to "stick" on the road to sustainability.

In 1991, Isaacs and Benjamin wrote*, "The development of cultural awareness and cultural competence must be a distinct and separate activity and, at the same time, woven into every aspect of an agency's or system's operation. It must meet the paradox of being separate but being integrated in order to be effective. When cultural diversity is simply integrated, it is observed that, like many American attempts at integration, it soon loses its relevancy and uniqueness and is quickly forgotten*."[1] (Towards a Culturally Competent System of Care Volume II, p.38)

Although there are a number of elements included in maintaining effective processes and structures in system of care, for cultural and linguistic competency values and efforts to be

[1] Isaacs, M.R. & Benjamin, M.P. (1991). Towards a Culturally Competent System of Care, Vol II. National Technical Assistance Center for Children's Mental Health, Center for Child Health and Mental Health Policy, Georgetown University Child Development Center

sustained, four aspects are especially critical: leadership and constituency building; workforce development; a diverse provider network; and, standards-based monitoring and evaluation.

First, **outreach to and engagement of diverse minority individuals who can be leaders—and providing** support to help these individuals build their leadership capacity—is a key element of sustaining a culturally and linguistically competent system. Constituency-building fosters supportive partnerships and allies and facilitates community, youth, and family involvement in designing and implementing CLC-related activities.[2]

For example, over the past several years, Kentucky System of Care has worked to develop important partnerships among state and local government agencies, existing Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex, and Two-Spirit (LGBTQI2-S) advocacy groups, and family and youth leaders. Collaborative efforts led to the first ever LGBTQI2-S youth and family conference in 2013 and the enhancement of a statewide LGBT Consortium. Partnerships with the Kentucky Department of Health, Office of Health Equity and the Kentucky Department of Behavioral Health, Developmental and Intellectual Disabilities, have resulted in the development of a series of online modules giving public and behavioral health service providers across the state an opportunity to learn more about the LGBTQI2-S community and the disparities and disproportionalities that exist, along with strategies for addressing them. (For more information, contact Christopher Duckworth at christopher.duckworth@eku.edu)

The second aspect is building a **culturally and linguistically competent workforce**. The imbalanced composition of the U.S. health care workforce contributes to the gap in health status and the impaired access to health care experienced by many of our children, youth, and families. *The Sullivan Commission on Diversity in the Healthcare Workforce* (2004) found that African Americans, Hispanics, American Indians, and certain segments of the nation's Asian/Pacific Islander population are not present in the healthcare workforce in significant numbers.[3] Increasing racial and ethnic diversity among health care professionals is important because evidence indicates that it is associated with improved access to care for racial and ethnic minority patients, greater patient choice, increased consumer satisfaction, and better educational experiences for students in the health professions, among many other benefits.[4]

[2] CLAS Standards implementation tips. QSource. Underserved Quality Improvement Organization Support Center. (2005) http://www.mmaonline.net/Portals/mma/PDFs/MinorityAffairs/Implementing%20Clas%20Standards%20Tips.pdf

[3] Sullivan, Louis W (2004) Missing Persons: Minority in the Health Professions, A Report of the Sullivan Commission on Diversity in the Healthcare Workforce.

[4] Smedley, B.D., Butler, A.S., & Bristow, L.R. (Eds.). The Institute of Medicine of the National Academies (2004). In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce.

To address this issue, Vermont's Youth in Transition is taking an early intervention approach, integrating CLC into high school programs and university curriculums. CLC training is now a 3-credit course at the University of Vermont's College of Nursing and Health Sciences, and a second fourth-year medical student course, "Cultural Competence and Health," is also offered. In addition, 145 refugee and immigrant young adults are being trained on youth leadership strategies; 10 refugee young adults started college in a health- or mental health-related field last fall; two refugee community members are Policy Fellows at the University of Vermont (UVM's College of Medicine), working with the National Council for Behavioral Health to address disparities in health and mental health; and 11 refugee young adults were part of a six-week residential program for 11th-graders interested in health careers (2012 and 2013). These are but a few of the initiatives Vermont has implemented to institutionalize cultural and linguistic competence into their system of care and broader state efforts. (For more information, contact Maria Mercedes Avila at maria.avila@med.uvm.edu)

Third, **creating policies and structures** focused on a broad service array can be an effective strategy to sustain cultural and linguistic competence efforts by providing greater choice for families and youth in the selection of services, supports, and providers. *The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care: A Blueprint for Advancing and Sustaining CLAS Policy and Practice* includes strategies to recruit, promote and support a culturally and linguistically diverse workforce that is responsive to the population in the service area.

Wraparound Milwaukee has put this principle into practice with a broad benefit plan of over 80 core mental health, social, and supportive services. Wraparound Milwaukee has developed a network of nearly 200 community agencies and 1,600 individual providers (i.e., independent psychiatrists, psychologists, therapists) to deliver services based on a comprehensive fee-for-service approach. No formal contracting with providers is used. Instead, community agencies are invited to apply to provide services based on service needs, which are reevaluated throughout the course of the year. Wraparound Milwaukee then gives credentials to providers who seek to become network providers as agencies or individuals. There are policies on cultural competency/diversity in service provision, including provider non-discrimination, and the provider network offers language translation services. Approximately 40 percent of the provider agencies are minority owned and operated, and three of eight care coordination agencies are minority owned. Wraparound Milwaukee has considerable cultural diversity among its care coordinators; at least one-third of the 120 coordinators are African American, Hispanic, Asian, or American Indian. Wraparound Milwaukee's policies and structure create a level playing field, enabling culturally diverse, smaller community providers to compete for service contracts with larger, more established providers; thus, families have a great deal of choice related to who is providing services to their child and family. (For more information, contact Bruce Kamradt at bkamradt@hotmail.com)

Finally, sustaining cultural and linguistic competence in systems of care takes **effective and reliable cultural organizational and system assessment measures.** The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care[5] (known as the CLAS) are helping many communities hold their systems of care to standards that help improve access, and provide effective appropriate treatment and support.

One example is Miami-Dade County's FACES in Florida. Miami has incorporated the CLAS standards into all provider contracts. Utilizing data from the provider CLC survey, which is based on the Enhanced CLAS Standards, each provider has developed a CLC action plan that will act as a guide to improving adherence to the Standards. In addition, the project team is working with each provider to add measurable objectives around improving access to care for the LGBTQ population and reducing disparities. Finally, the data are being used to identify trainings that would target opportunities for improvement across the provider network. (For more information, contact Nicole Attong at nattong@sfbhn.org)

Another example of sustaining CLC efforts through organizational assessment is the work being conducted by The Jacksonville System of Care Initiative (JSOCI). The JSOCI Cultural and Linguistic Competency Committee is committed to promoting CLC through education/training, outreach, and assessment with mental health and child-serving organizations in Duval County, Florida. To assist organizations in creating sustainable change, the CLC Committee has launched CLC organizational assessments. The Committee revised the Cultural Competency Assessment Scale developed by the Nathan Kline Institute Center for Excellence in Culturally Competent Mental Health to meet local community needs. JSOCI also partnered with the University of Florida, Center for Health Equity and Quality Research, in creating a web-based format of the organizational assessment. The results of the assessments, along with youth/caregiver focus group information, will be used to recommend strategies to improve and celebrate cultural responsiveness. The CLC Committee named the organizational assessment component the *Mirror Project*. The Mirror Project is an opportunity for agencies to *reflect* on their cultural responsiveness across various domains, such as organizational values, communication, monitoring, and evaluation. (For more information, contact Selena Webster-Bass at selenawb@coj.net)

While only five system of care communities have been mentioned in this article,, many more communities are implementing exciting, effective, and creative strategies. Common to all is that sustaining cultural and linguistic competence takes an inclusive strategic planning process that

[5] Think Cultural Health, Office of Minority Health, U.S. Department of Health and Human Services. https://www.thinkculturalhealth.hhs.gov/Content/clas.asp

results in a strategic plan with clear cultural competence goals, objectives, and actions for every structure and process involved in building and sustaining systems of care.

For more CLC related resources, please click here.

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