Report
of the
Cultural Competence Workgroup
for the
Projects for Assistance in Transition from Homelessness
(PATH)

August 2002

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Finally, the workgroup thanks Debbie Webster for taking on the role of Coordinator and presenting this report to the State PATH Contacts. Chris Ringwald of Advocates for Human Potential, Inc. provided final editing.

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PATH Cultural Competence Workgroup Report

A Executive Summary

The national Projects for Assistance in Transition from Homelessness (PATH) State Contacts group comprises representatives of the 50 States, the District of Columbia, Puerto Rico, and four U.S. Territories. At its June 2000 meeting, this group identified cultural competence as a critical topic for PATH, a formula grant program that funds outreach and services to people with serious mental illnesses (and those with co-occurring substance use disorders) who are homeless or at risk of becoming homeless.

Between February and November of 2001, a small workgroup of State PATH Contacts examined cultural competence by collecting and reviewing related documents from State PATH Contacts and other public and private agencies, convening teleconferences, and using e-mail discussions. Workgroup members synthesized the available information and developed this report to 1) define cultural competence in the context of the PATH program; 2) identify guiding principles for the development of culturally competent services within PATH programs; 3) suggest action steps to help implement these principles; and 4) recommend self-assessment tools to help PATH programs judge the degree of cultural competence they have achieved.

For purposes of PATH-related activities, the workgroup defined cultural competence as:

"An ongoing and evolving process that comprises knowledge attainment and the development of behaviors, attitudes, policies, and practices that come together in a system of care enabling agencies, programs, and individuals to increase access to services and to develop or adapt services that are appropriate to specific cultural needs."

Guiding principles for the development of culturally competent services within PATH programs are noted below:

1. ***Cultural competence requires development of a plan that is integral to an agency's strategic plan.***

2. ***Cultural competence requires services to be driven by consumer needs and preferences***.

3. ***Cultural competence requires services to be delivered in the languages clients use***.

4. ***Cultural competence requires a diverse and well-trained staff***.

5. ***Cultural competence requires opportunities for continuing education and ongoing knowledge development***.

6. ***Cultural competence requires self-assessment, including measurement of program outcomes and client satisfaction***.

B Introduction

B.1 Background

Projects for Assistance in Transition from Homelessness (PATH) is a formula grant program created under the Stewart B. McKinney Homeless Assistance Act of 1987 (P.L.100-77). This program funds the 50 States, the District of Columbia, Puerto Rico, and four U.S. Territories to provide outreach and services to people with serious mental illnesses (and those with co-occurring substance use disorders) who are homeless or at risk of becoming homeless. PATH is administered by the Center for Mental Health Services (CMHS) in the Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

Each of the PATH-funded entities has a State Contact who provides oversight to the program's local implementation. At their biennial meetings, State PATH Contacts identify topics that are of special interest to the PATH program and select workgroups to study these topics in depth. At their meeting in June 2000, held in Washington, DC, State PATH Contacts chose *mainstream services*, *consumer issues*, and *cultural competence* as the areas they would explore. This is the report of the cultural competence workgroup.

Jim Chesnik of the Iowa Department of Human Services chaired the first phase of the cultural competence workgroup, which included State PATH Contacts from around the country; and Debbie Webster chaired the final phase. A list of workgroup members is included in Appendix E.2. Pam Rainer of Advocates for Human Potential, Inc., the PATH technical assistance contractor, participated in the group's deliberations and provided ongoing support. Dr. Michael Hutner and Dorrine Gross represented the CMHS Homeless Programs Branch.

B.2 Description of Work

Between February and November of 2001, we examined the issue of cultural competence by collecting and reviewing documents from other State PATH Contacts, as well as materials from numerous federal, state, and private agencies (see Appendix E.1 for a list of the resources we consulted). While this effort yielded numerous documents, the process also revealed that there is still a great lack of attention to, and knowledge of cultural competence. In particular, we found little information on cultural competence that specifically relates to people who are homeless and have serious mental illnesses. States varied in the degree to which their PATH programs were addressing cultural competence, and most State PATH Contacts said they would welcome additional information on this critical topic.

In teleconferences and e-mail discussions, we examined and synthesized the available information and developed this report with four key goals in mind:

- To define cultural competence in the context of the PATH program.
- To identify guiding principles for the development of culturally competent services within PATH programs.
- To suggest action steps to help implement these principles.
- To examine self-assessment tools and their relevance and importance in assisting PATH programs in judging the degree of cultural competence they have achieved.

B.3 The Need for Cultural Competence

Culture counts. That simple but profound statement is at the heart of the U.S. Surgeon General's report *Mental Health: Culture, Race, and Ethnicity*, published as a supplement to *Mental Health: A Report of the Surgeon General* (see Appendix E.1). Culture, in its many forms, is primarily a source of creativity, strength and resilience for society, as a whole, and for individuals. The Surgeon General's report notes that America's boundless diversity yields, "incalculable energy and optimism", by bringing "global ideas, perspectives, and productive contributions to all areas of contemporary life."

As culture shapes the nation, so too does it shape individuals. It provides them with the skills, manners and attitudes with which they make their way through life. In times of trouble, culture prepares or predisposes them for difficulties; it also determines their reaction and recovery or resolution. While important for health and health care, generally, the role of culture appears all the more critical in mental health, itself the product of a complex and incompletely understood interplay among biology, psychology, society and culture.

Race, ethnicity and culture impart many gifts. But differences among these often correlate with differences in mental health care due to discrimination, inequality, and poverty or disease, suffering, depression and anxiety that may cause or exacerbate problems. Research cited by the Surgeon General indicates that racial and ethnic minorities are over-represented among the nation's most vulnerable groups, including people who are homeless. Further, though the prevalence of mental disorders for racial and ethnic minorities in the United States is largely the same as for whites, minorities are less likely than whites to receive needed mental health services and more likely to receive poor quality of care.

"Taken together," the Surgeon General concluded, "these disparate lines of evidence support the finding that minorities suffer a disproportionately high disability burden from unmet mental health needs." Consider the prominent role of culture in these disparities. One of the major causes of untreated or under treated mental health problems is the stigma associated with admitting to such problems or receiving care. The shape, type and consequences of stigma are all shaped or determined, to varying degrees, by culture.

Culture, as well as race and ethnicity, can influence how individuals express problems, whether or not they seek help, and the type of services they will accept. Culture, the Surgeon General reported, "can account for variations in how consumers communicate their symptoms and which ones they report. Some aspects of culture may also underlie

culture-bound syndromes – sets of symptoms much more common in some societies than in others."

What does this mean in real terms? The Surgeon General's report gave examples.

Many African Americans, for instance, still bear the legacy of slavery, racism and discrimination socially and economically. And when they are treated, it is more often in primary care settings or by "safety net" providers. American Indians have a suicide rate that is 50 percent above the national average and a greatly reduced access to mental health services. Among Asian Americans and Pacific Islanders, though the prevalence of mental disorders is similar to the general population, their utilization of services is lower. Hispanic Americans, the largest and fastest growing minority group, display considerable variations among sub-groups. Mexican Americans have nearly double the poverty rate of Cuban Americans, while foreign born Hispanic Americans have lower rates of mental illness than do their native-born counterparts. Minority groups share many characteristics, especially in access and treatment. Both African American and Hispanics are less likely than whites to receive evidence-based care.

The cultures of the clinician and the service system are important, as well. These cultures, both social and professional, shape the attitudes, manners and methods of counselors, administrators, nurses, doctors, case managers and social workers. These affect diagnosis, treatment, and the organization and financing of services. Indeed, the Surgeon General notes, "culture is important because it bears upon what *all* people bring to the clinical setting."

Despite their universal nature and influence, cultural and social influences on mental health and the treatment of mental illness or disorders have been historically underestimated. To ensure that minorities, and all Americans, receive the best possible mental health services, culture must be considered, studied, and incorporated into research, prevention and treatment.

To reduce the disparities in mental health care, the Surgeon General suggests we must reduce social, geographic, and financial barriers to care; improve access to services; and better understand cultural competence. We must, therefore, remain aware of the changing nature of the populations we serve. Lack of awareness leads to a poor understanding of real needs and to miscommunication that, in turn, leads to poor care. ***Why are we unaware?*** As suggested by our workgroup and DiversityRx (see Appendix E.1), some possible reasons include the following:

- Insufficient knowledge that results in an inability to recognize differences.
- Self-protection and denial leading to the attitude that differences are insignificant.
- Fear of the unknown—It can be challenging and intimidating to try to understand something new.

- Feeling pressure due to time constraints in our lives and jobs.

- The belief that cultural competence refers only to race, rather than to the whole range of differences that diversity represents.

B.3 Definitions of Culture and Diversity

To examine cultural competence, we began by reviewing definitions for two key terms: *culture* and *diversity*.

Culture is defined by, among other things, the shared values, traditions, customs, arts, and history of a group of people unified by such characteristics as age, gender, race, ethnicity, spirituality, language, English language proficiency, literacy levels, sexual orientation, education, employment, income, geography, immigrant status, and disabilities. In turn, culture defines a person's reality.

Diversity is the combined differences in race, ethnicity, language, nationality, and religion among community groups.

We believe there is a difference between cultural *competence* and cultural *sensitivity* (which is an awareness of the cultures around us). There are important distinctions between these terms.

What, then, is cultural *competence*?

C Workgroup Findings

C.1 Definition

Our research shows that there is no single, commonly accepted definition of cultural competence, but most of the definitions share a number of common elements. In particular, cultural competence is *a process*, rather than a single point in time. Further, cultural competence requires *the attainment of knowledge and skills* that will help providers and programs work more effectively with people who have diverse backgrounds and experiences. Finally, cultural competence requires *action to increase access and cultural adaptation of services* based on what is learned about individuals and communities.

One of the more widely cited definitions of cultural competence was developed in 1989 as part of a monograph on effective services for minority children with severe emotional disturbances. As cited in the Surgeon General's Report on Mental Health, this early work defines cultural competence as "a set of behaviors, attitudes and policies that come together in a system or agency or among professionals that enables that system, agency, or professionals to work effectively in cross-cultural situations."

Many of the more recent definitions of cultural competence build on this work. In our definition of cultural competence specific to PATH-related activities, we include the importance of a system of care for people with serious mental illnesses who are homeless and the need to *improve access and adapt services* to address specific cultural needs. For the purposes of PATH-related activities, we define cultural competence as:

"*An ongoing and evolving process that comprises knowledge attainment and the development of behaviors, attitudes, policies, and practices that come together in a system of care enabling agencies, programs, and individuals to increase access to services and to develop or adapt services that are appropriate to specific cultural needs."*

Cultural competence requires ongoing education, training, managerial dedication, and organizational commitment at all levels, as well as appropriate public policy and consumer involvement. These points are addressed in the guiding principles and action steps that follow.

C.2 Guiding Principles and Suggested Action Steps

The core of culturally competent service delivery involves improving access to services for racial and ethnic minorities and adapting those services to individuals' specific cultural needs. Our workgroup identified the following six guiding principles to help PATH programs achieve the goals of improved access and cultural adaptation.

The first two principles are value-driven and reflect the need for cultural competence and consumer centeredness to be woven into the fabric of everything a PATH program does. The next four principles offer specific guidance on how PATH-funded programs can develop culturally competent services. Each principle is accompanied by a set of suggested action steps that can be used to help implement these principles. The action steps can also be cross-referenced as we found them to be relevant to more than a specific principle. We encourage PATH programs to identify action steps of their own and/or to apply the action steps we have suggested to meet their own goals and priorities.

1 ***Cultural Competence Requires Development of a Plan That Is Integral to an Agency's Strategic Plan***. Cultural competence must be addressed at the administrative, organizational, and individual levels of the delivery systems that serve people with serious mental illnesses who are homeless. Effective cultural competence requires "buy-in" both vertically, within an organization, and horizontally, across the various systems with which PATH-funded providers collaborate.

Suggested Action Steps:

1.1 Ensure that your organization or program has a cultural competence plan that is integral to the agency's strategic plan, including action steps and

provision for oversight. A cultural competence committee should be involved in developing this statement.

1.2 Convene a cultural competence committee or task force within your organization. This committee should be ethnically diverse and should represent all key stakeholders, including policy makers, administrators, providers, and consumers. The committee can serve as the primary governing body for planning, implementing, and evaluating organizational cultural competence.

1.3 Develop collaborative partnerships with organizations and programs that have begun developing and implementing culturally competent service delivery systems. Adapt processes and information that are consistent with your program's needs and interests.

1.4 Identify state or local representatives of the cultures that you may serve (potential system users) in your PATH project and include them as members of advisory groups to help you develop or expand culturally competent outreach, intake, treatment, and discharge protocols.

1.5 Clearly articulate organizational linkages and establish dialogues about cultural competence with community groups that provide services to your enrollees (e.g., shelters, workshops, faith-based groups, housing providers, childcare providers, primary health care providers, hospitals, emergency rooms, natural supports, alternative/supplementary healers, etc.).

1.6 Advocate for cultural competence in other groups to which your agency belongs or with which you collaborate, e.g., community development boards, United Way, Continuum of Care planning groups, involvement with the ConPlan development, or input into the development of Public Housing Authority administrative plans.

1.7 Include criteria for cultural competence in requests for proposals and other contracts. Emphasize the ability of the contractor/consultant to demonstrate success in achieving positive results that are culturally appropriate and applicable for the population(s) served.

2 ***Cultural Competence Requires Services to Be Driven by Consumer Needs and Preferences***. Consumers, families, and stakeholders from the cultural groups represented in your service areas must be involved in developing policies for the delivery of PATH-funded services to people with serious mental illnesses who are homeless. The services themselves must be compatible with individuals' cultural beliefs and preferred languages.

Suggested Action Steps:

2.1 Conduct active outreach to ethnically diverse groups in your community to improve their access to services and to involve them in the organization and delivery of culturally adapted services and programs.

2.2 Provide the full range of services that make it possible for diverse populations to gain access to your programs, including language assistance (see principle 3), transportation, flexible hours, convenient locations, etc.

2.3 Clearly articulate methods that a PATH program will use to operate as a consumer-driven, community-based organization, e.g., consumer representation on program development committees and seeking consumer input related to hiring homeless services staff.

2.4 Seek consumer input, recognize consumer strengths, and adopt self-help and recovery concepts when setting individual treatment goals.

2.5 Build collaborative, respectful partnerships with natural helpers (including immediate and extended family members), native healers, community informants, and other experts who have knowledge of the culturally, linguistically, racially, and ethnically diverse groups served by your program.

3 ***Cultural Competence Requires Services to Be Delivered in the Languages Clients Use.*** PATH-funded programs must provide services that are linguistically relevant and offer mandated language assistance at no cost to people with limited English language proficiency.

Suggested Action Steps:

3.1 Offer services in relevant languages, provided by people who are bilingual and bicultural. These are people who are native speakers of the language(s) and/or fluent in the language(s), and who have direct experience with the social, cultural, historical, and familial context of the groups you serve, either by virtue of being a member of the group or having received (and continuing to receive) extensive cultural competence training. These individuals will be more adept at responding to a host of non-verbal cues, including hand gestures, eye contact, tone of voice, and personal space.

3.2 When the individuals described in step 3.1 are not available, identify the capacity in your state, territory, or community to provide translation services, and use these services to offer appropriate outreach and treatment. Translation services may be required for people who are deaf or hard-of-hearing and for others for whom English is not their primary language. Develop and implement training for translators in special issues

related to mental health and homelessness. Because of the need to maintain client confidentiality, it may not be appropriate for an individual's family member to serve in this role.

3.3 Identify how your state is responding to federal legislation or state regulations related to limited English proficiency and become partners in this effort.

3.4 Translate relevant program materials, including the right to receive language assistance, in various languages to help improve access to services. As per step 3.1, consider having such material written first in the clients' native language(s).

3.5 Use not only the *language* of the community, but also relevant communication *media* that are used in the community, e.g., radio stations, community newspapers (both rural and urban), bilingual television stations, videos, grocery store windows, community bulletin boards, etc. Include audio, video, and print materials developed for people who are deaf or hard-of-hearing and people who are visually impaired.

3.6 Work with community leaders to develop materials designed to reduce the stigma associated with mental illness, homelessness, race, and ethnicity; acknowledge value differences; and raise awareness of the dynamics of cross-cultural communication.

4 ***Cultural Competence Requires a Diverse and Well-Trained Staff***. Human resource policies, practices, and procedures (e.g., performance appraisals, promotions, raises, etc.) must be designed to promote and enhance a staff that reflects the diversity of clients being served in PATH-funded programs. Staff at all levels of the organization must be trained in providing culturally competent services.

Suggested Action Steps:

4.1 Use principles of cultural competence in the recruitment, hiring, and orientation of staff members and volunteers. Program staff should reflect the race, ethnicity, and culture of the community members being served.

4.2 Survey staff about what they need to be more effective in cross-cultural situations. Tailor training to address their concerns.

4.3 Involve representatives of your community's cultures in staff training and in-service training activities.

4.4 Train PATH staff at all levels in the provision of culturally designed or adapted services. Remember that training is only a single component of a

broader process of developing cultural competence. Training should not be considered the only approach or the end of the process; all training should be progressive and ongoing. Effective training includes provision for performance monitoring and continuing education (see principle 5).

5 ***Cultural Competence Requires Opportunities for Continuing Education and Ongoing Knowledge Development***. Staff of PATH-funded programs must have ongoing opportunities to expand their cultural knowledge and increase their understanding about how to improve service quality for all PATH consumers.

Suggested Action Steps:

5.1 Articulate a plan to deliver information about cultural competence to all staff within the organization.

5.2 Provide regular access to resource materials related to cultural competence, in general, and to the primary cultures served by PATH projects, in particular.

5.3 Collaborate with academic institutions, human or civil rights organizations, and national researchers to remain current and to further develop culturally competent practices.

5.4 Seek technical assistance and resources on cultural competence from federally funded technical assistance providers, such as Advocates for Human Potential, Inc., the PATH technical assistance contractor, and Policy Research Associates, Inc., which operates the National Resource Center on Homelessness and Mental Illness and maintains the PATH Web site. Contact information for these organizations is included in Appendix E.2.

5.5 Identify and include resources in each year's budget to facilitate professional and personal development through staff participation in conferences, workshops, and seminars on cultural competence.

5.6 Facilitate staff participation in events that may celebrate the culture, traditions, artwork, and dance of racial and ethnic groups. Encourage consumers to share their knowledge about the cultural groups to which they belong.

6 ***Cultural Competence Requires Self-Assessment, Including Measurement of Program Outcomes and Client Satisfaction***. PATH-funded programs must adopt or adapt self-assessment tools that allow them to gauge their progress toward developing culturally competent services. Consumer satisfaction surveys can be an important part of this effort.

Suggested Action Steps:

6.1 Develop or adapt an instrument that best matches the needs and interests of your organization or program, and conduct a comprehensive agency self-assessment related to cultural competence at least once a year. Use the self-assessment results to develop a long-term plan, with measurable goals and objectives, to incorporate culturally competent principles, policies, structures, and practices into all aspects of your organization or program. This may include, but is not limited to, changes in the following: mission statement, policies and procedures, administration, staffing patterns, service delivery practices and approaches, outreach, telecommunications and information dissemination systems, and professional development activities.

6.2 Identify and collect objective data to verify progress in meeting cultural competence goals and objectives.

6.3 Identify and collect objective data to verify whether service adaptations are appropriate to consumers' race, ethnicity, gender, age, and primary language, among other variables.

6.4 Examine how cultural competence is evolving in your state or local projects and identify ways to report this with your PATH annual reports to CMHS, or with other reports within your state or territory.

6.5 Request assistance from diverse groups and stakeholders with a PATH investment (e.g., families, neighborhoods, cultural leaders, supplemental funders, other programs serving people with serious mental illnesses who are homeless) to develop consumer satisfaction surveys, outcome measures, and evaluation components of your PATH project.

6.6 Develop and use surveys to measure individuals' satisfaction with services relative to specific cultural factors.

6.7 Examine and strengthen current feedback mechanisms and articulate methods for using consumer satisfaction information to improve and adjust program services.

C.3 Self-Assessment Recommendations

Assessment for cultural competence is a fairly new endeavor. Formal self-assessment programs have been developed, but their effectiveness needs to be further explored. Our workgroup reviewed materials for developing and reviewing cultural competence plans and concluded that more research is needed to provide a comprehensive view and possible recommendations for specific tools.

Program evaluation also includes consumer satisfaction surveys, ongoing staff supervision, training provided by community group members of various cultures, as well as development of agency specific performance measures. Currently, on a national level, additional evaluation tools are under development.

Regardless of the specific tools they choose, PATH programs must develop a plan that includes assessment, a budget to accomplish it, and the commitment to implement it and to adapt program delivery methods if suggested by the results. We must continue to follow state and national cultural competence assessment activities, some of which, the results are on the horizon at the conclusion of the workgroups' efforts.

D Conclusion

The workgroup learned a great deal about cultural competence by studying this topic and preparing this report. We hope State PATH Contacts and others will use this information to take an active role in improving access and adapting services for people of diverse racial, ethnic, and cultural groups.

Just as cultural competence itself is an ever changing and evolving process, we expect that the information in this report represents a work in process and will change, too, as State PATH Contacts implement some of these ideas and provide feedback. We encourage you to do so.

We consider this report a first step in raising awareness about the importance of cultural competence among State PATH Contacts and PATH-funded providers. We will discuss next steps for ongoing workgroup activity at the September 2002 national State PATH Contacts meeting.

E Appendixes

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