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Culturally Responsive Care in Mental Health

Introduction

Culturally responsive care is vital in mental health care. Understanding cultural traditions and values enables providers to treat clients with dignity and compassion and to respond appropriately to their wishes and desires. Culturally responsive care is the intentional and consistent decision mental healthcare providers make to see, respect, and celebrate the characteristics that make each person unique. Clinicians must work toward fully seeing and valuing clients for all aspects of their identity, background, and experiences. In addition, culture impacts the health comprehension, treatment options, and diagnostic claims of an individual, as well as help-seeking behaviors.

Cultural competence is integrating and transforming knowledge about individuals and groups into attitudes, practices, standards, and policies used in appropriate cultural and care settings to improve the quality of services and thereby produce better outcomes (CDC, 2021).

Furthermore, such competence requires individuals and organizations to communicate and work effectively in multicultural situations by adopting and implementing strategies to guarantee appropriate awareness, attitudes, and actions through the use of policies, structures, practices, procedures, and dedicated resources that support this capacity (HHS, 2019).

Terms

Culture

A unique and meaningful system shared by a group and transmitted across generations. It allows the group to meet basic survival needs through coordinated social behavior to maintain existence, transmit social behaviors, pursue happiness and well-being, and attain meaning from life. There are a variety of aspects to

culture, and individuals may focus on different areas of their culture depending on the circumstances they are experiencing. Culture impacts one's behaviors and one's health. Culture includes elements such as race, ethnicity, nationality, religion, socioeconomic status, and even geography.

Cultural Adaptation

A modification of an evidence-based treatment or intervention model to incorporate culture, language, and context in a manner that is compatible with the client's cultural meaning, values, and patterns.

Cultural Competency

A developmental process in which providers or organizations acquire increasing levels of awareness, knowledge, and skills along a cultural competence continuum. Cultural competence includes valuing diversity, conducting self-assessments, avoiding stereotypes, managing the dynamics of difference, acquiring cultural knowledge, and adapting to diversity and cultural contexts in one's community.

Cultural competency is NOT treating all people the same without acknowledging their cultural identity or ignoring differences between yourself and your client. Cultural competency is a lifelong learning commitment. Cultural competency includes attributes such as:

- Learning about your own culture and that of others
- Respecting the beliefs, languages, behaviors, and interpersonal styles of clients and colleagues
- Avoiding bias and stereotypes
- Exploring new cultural experiences

- Engaging with one's local community
- Practicing cultural humility

Cultural Identity

A person's cultural identity encompasses numerous overlapping social identities. These include such characteristics as race, ethnicity, religion, socioeconomic status, sex, gender identity, sexual orientation, age, education, geography, environment, language, military service, ability, and more. Cultural identity is complex and can change over time. Individuals often assign different meanings to various social identities they hold. Therefore there are just as many differences within a group as there are between people of varied groups.

Cultural Humility

A person's ability to remain open in regard to aspects of the cultural identity that is most important to others. Clients are more open to working with providers who take the time to understand their values and worldview.

Cultural humility includes:

- A continuous examination of one's biases and stereotypes
- Learning about clients' cultures, beliefs, values, and worldview
- Prioritizing the client's cultures, beliefs, values, and worldview
- Acknowledging one's limitations
- Commitment to continued growth and development
- Acknowledging that even with training in cultural competency, there is always more to learn

Cultural Safety

Cultural safety is a holistic and shared approach where all persons feel safe, can learn together with dignity, and participate in deep listening. It is set in a social justice framework, and individuals are expected to engage in personal reflection.

Bias

Conscious or unconscious judgments a person has on a daily basis impact all aspects of one's life. Biases are often based on cultural beliefs, attitudes, or opinions that we are frequently unaware of. Biases may be formed by early experiences, patterns seen in movies or TV, or something one was taught about "those people." Biases can lead to discrimination against a group of people. Implicit bias is the attitudes or stereotypes that affect one's understanding, actions, and decisions in an unconscious manner.

Explicit Bias

A bias that individuals recognize; they are aware of their prejudices, who they like and don't like.

Implicit Bias

An involuntary bias outside of a person's conscious awareness, making it more difficult to change. Despite one's best intentions and outside one's awareness, stereotypes and negative assumptions take hold, affecting one's behaviors, decisions, and evaluations.

Health Disparities

A type of health imbalance that is connected to social, economic, or environmental disadvantage. Health disparities negatively impact groups of people who have experienced systemic barriers to healthcare services based on their racial or ethnic group, socioeconomic status, religion, gender, sexual orientation or gender identity, age, mental health, cognitive, sensory, or physical disability, geographic location, or other characteristics historically linked to discrimination or exclusion.

Intersectionality

The multiple social identities (such as race, sexual orientation, socioeconomic status, and disability) that overlap for a person and are also areas that are typically associated with privilege and oppression (such as racism, sexism, classism, and ableism) at the societal level.

Linguistic Competency

A provider or organization's ability to communicate effectively at every level of client contact. Effective communication includes the ability to convey written and oral information in a way that diverse groups can easily understand. This should include people with low literacy skills or who are not literate, as well as those who have other linguistic challenges.

Linguistic competency includes the ability to communicate with clients who:

- Have limited English proficiency
- Are more comfortable communicating in their native language
- Have limited health literacy
- Have disabilities

- Are deaf or hard of hearing
- Are blind or have limited vision

Microaggressions

Brief and commonplace daily verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults, especially toward people of color. Microaggressions are the everyday slights, putdowns, invalidations, and insults aimed at people from non-dominant groups by people who may be unaware that what they have said or done is harmful.

Patient-Centered Care

The goal is to elevate the quality of care for all patients. The individual patient's needs and outcomes are taken into consideration and are the driving force of the treatment planning.

Stereotypes

A set of beliefs about individuals within a social group that usually involves personality traits, behaviors, and motives (HHS, 2019 & Gurung, 2018 & Jones-Smith, 2019).

Culturally Responsive Care

Culture can play a significant role in overall health and well-being. According to the U.S. Surgeon General Report on Mental Health, "The cultures that patients come from shape their mental health and affect the types of mental health services they use. Likewise, the cultures of the clinician and the service system

affect the diagnosis, treatment, and the organization and financing of services" (HHS, 2019).

Culture is the force that humanizes us. Culture is vital in determining who we are, what we think, what we eat, the music we listen to, what we believe about family and gender, and how we respond to our environment. Cultural experiences are lifelong, and one could argue that individuals are exposed to culture in the womb based on what foods, music, and living conditions the mother experiences and transfers. Even how one is born is influenced by culture (hospital, home birth, doctor, midwife, etc.). Culture influences the meaning people give to their symptoms and to the cause and implications of the personal difficulties they experience in life (Jones-Smith, 2019).

Per the U.S. Census Bureau, racial and ethnic minority communities make up about 38% of the United States population and will become the majority nationwide within 30 years. The increasing diversity of the United States presents a need for a culturally and linguistically competent behavioral health workforce (HHS, 2019).

Population projections predict that by 2060 the United States will be a minority-majority country. As the population becomes more racially and ethnically diverse and more people identify as LGBTQ+, it is becoming increasingly important that behavioral health professionals provide ethically and culturally informed therapeutic work (Renetia et al., 2020).

Culturally competent care is an essential part of social and ethically responsive quality healthcare. The majority of cultural competence training focuses on clients, families, and the community; however, it must also be addressed on a larger scale that includes the education community, healthcare, and professional organizations (Purnell, 2021).

One of the issues with cultural competency training is that it is frequently addressed in a way that is limiting. This includes setting goals to gain knowledge

pertaining to characteristics, cultural beliefs, and practices of different minority groups, as well as building skills and attitudes of empathy and compassion in assessing and communicating with minority groups. It is often presented in a way that "competence" is an achievable end result, such as learning all the steps of completing a mental status exam. Cultural competence is not achieved through completing a checklist. Rather, it is a dynamic process that continually addresses knowledge, skills, and attitudes (Curtis et al., 2019).

Cultural Safety

Curtis et al. (2019) suggest that cultural safety, rather than cultural competence, is the preferred ideology to address culturally responsive care. Culturally safe environments are grounded in critical reflection and action. Providers use this framework to provide culturally secure, consistent, and effective care in partnership with individuals, families, and communities. Social and political impacts on care are also taken into account when providing care from a culturally safe perspective.

Cultural safety acknowledges the barriers to clinical effectiveness due to the imbalance of power between the provider and the client. Under the cultural safety model, the provider does not need to focus on the cultural knowledge of different groups. Cultural safety's aim is better care through consideration of differences, recognition of decolonization, awareness of power relationships, executing reflective practice, and allowing the client to determine if a clinical interaction is safe. Cultural safety requires providers to examine themselves and the potential impact their own culture may have on clinical interactions. This requires providers to assess their own biases, attitudes, assumptions, stereotypes, and prejudices that may lead to lower quality of care for some clients. Cultural safety focuses on the culture of the clinician and the clinical environment rather than on the culture of the client (Curtis et al., 2019).

Regulatory and educational health organizations tend to frame their understanding of cultural competency toward individualized rather than organizational or systemic processes and on acquiring cultural knowledge rather than reflective self-assessment of power, privilege, and biases. There are numerous reasons why this approach can be harmful and undermine attempts to reduce mental health inequities (Curtis et al., 2019).

Individual-level focused approaches for cultural competency exacerbate the process of "othering," identifying those who are believed to be different from the provider or the dominant culture. The consequences on those who experience othering include alienation, decreased opportunities, marginalization, exclusion, and internalized oppression. To foster safe and effective mental health care interactions, those in power must seek to identify and end othering practices (Curtis et al., 2019).

Other-focused cultural competency approaches perpetuate oversimplified explanations of different cultures based on cultural stereotypes. This includes a tendency to homogenize minority people into a collective 'they' group. This type of cultural stereotyping can lead to health care providers making inaccurate assumptions about patients, which can undermine providing good quality care, and also reinforces a racialized and binary ideology. By ignoring the power differences, narrow approaches to cultural competency encourage deficit approaches that place responsibility for problems on the affected individuals or communities, overlooking the role of the mental health professional, the mental health system, and broader socioeconomic structures.

Cultural competency approaches that focus on building knowledge, skills, and attitudes are problematic as such focus suggests that cultural competency can be achieved through this static process. Cultural competency does not have an endpoint, and a checklist approach can cause practitioners to have false confidence in their approaches, which can be dangerous and short-sighted. A cultural safety approach encourages an ongoing and reflective process focused on

critical awareness. While there is always a need for mental health professionals to have a working knowledge and understanding of other cultures, this alone is not sufficient to address cultural safety. Only having information on other cultures can be harmful if there is not also significant self-reflection on how power and privilege have been redistributed and the implications that they have on systems and practice (Curtis et al., 2019).

By ignoring the organizational and systemic drivers of mental health care inequities, individual-level focused positionings for cultural competency are fundamentally limited in their ability to impact such injustices. Organizations influence provider bias through the structure of the mental health care environment. This includes factors such as an organization's commitment to workforce training, accountability for equity, workplace stressors, and diversity in the workforce and governance. Working toward cultural safety should not be seen or expected as an intervention only at the individual professional level, although a critically conscious and empathetic health professional is certainly important. The evidence clearly emphasizes the important role that healthcare organizations, and society at large, can have in creating culturally safe environments. Cultural safety initiatives should target both individual mental health professionals and mental health organizations when working toward achieving health equity (Curtis et al., 2019).

Cultural competence and safety in the health care and behavioral health care setting is recognized as an important aspect of high-quality care delivery, contributing to improved knowledge and attitudes among professionals as well as increased patient satisfaction. Culturally responsive care has resulted in improved provider-patient relationships, increased engagement and adherence to treatment, and improved patient outcomes and well-being. (McGregor et al., 2019).

Culture's Impact on Health and Wellness

In the United States, minorities are less likely to receive mental health treatment and are more likely to wait until symptoms are severe before seeking help. 66% of minority adults have a primary health care provider compared to 80% of white adults. This number is even lower for Hispanics (58%) and Asians (60%) (Mental Health First Aid, 2019).

Culture can impact the perception and treatment of mental health in four ways:

1. **Cultural stigma.** Every culture looks at mental health in a different way. For many, there is a stigma around mental health, and mental health difficulties are viewed as weakness and something that needs to be hidden. This can make it hard for people who are struggling with their mental health to talk freely and ask for help.
2. **Understanding symptoms.** Culture can affect how individuals describe and feel about their symptoms. It can influence if the person chooses to recognize and address only physical symptoms, only emotional symptoms, or both.
3. **Community Support.** Cultural factors can dictate how much support people receive from their family and community regarding their mental health. Because of stigma, some minorities are alone in finding mental health treatment and support.
4. **Resources.** When seeking mental health treatment, individuals should talk to someone who understands their unique experiences and concerns. At times it can be difficult or time-consuming to find resources and treatment options that take into account specific cultural factors and needs (Mental Health First Aid, 2019).

Various cultures define health in different ways. In Western medicine, people are considered to be healthy if they are free from disease. In Traditional Chinese

Medicine, health is defined by yin and yang balance. One way of accomplishing this is by eating and drinking equal amounts of items that have hot and cold qualities. In Ayurveda medicine, the focus of health is on the balance of body, mind, and soul. In traditional American Indian medicine, the goal of health is to achieve a balance between the spiritual world and one's physical and mental health. There is also a large component of living in harmony with nature. Most of the world's cultures use a broad approach to assessing health, beyond just the absence of disease, to determine a person's health status (Gurung, 2018).

The use of traditional treatment appears to be based on underlying cultural beliefs about the causes of mental illness. In several cultures, medication is seen and used as a symptomatic treatment, while traditional treatment is used as a cure for the cause of the illness. Traditional healers are able to treat individuals using culturally acceptable rituals and practices that are non-stigmatizing and are frequently preferred over modern mental health practitioners (Al-Krenawi, A. 2019).

Socioeconomic status (SES) is another aspect of culture that impacts a person's health. Typically, the more money one has, the better one's health is. Those with lower socioeconomic status have higher rates of chronic and infectious disorders and higher occurrences of nearly every major cause of mortality and morbidity. Even neighborhood SES has been linked to poorer health practices and other health conditions, including coronary heart disease (Gurung, 2018).

Cultural congruence is a positive relationship between individuals' cultural identity and their behavior and lifestyle. Cultural incongruence is the inconsistency between how people live and their cultural identity. People who have a high level of cultural incongruence may be more predisposed to mental difficulties (Jones-Smith, 2019).

People's beliefs about the causes of psychological and physical illness vary across cultures. In some cultures, illnesses are believed to result from supernatural agents or spiritual causes. The influence cultural beliefs have on the causes of

mental health diseases is important to understand. Furthermore, cultural beliefs and perceptions related to causes of mental illness have been found to influence illness experiences, presentation of symptoms, help-seeking behavior, and the course of treatment approach used in many cultures (Al-Krenawi, A. 2019).

In numerous cultures, mental health issues may present as somatic physical illness (headaches, body aches, fatigue, or weakness). Rather than recognizing or acknowledging emotional pain, symptoms are presented as physical pain. Some cultures may not have the language/words for specific mental health symptoms, so, instead, they are described as physical ailments. Providers may not consider the cultural aspects of the person's presenting problem and focus solely on the physical aspect, attempting to rule out problems with medical tests and procedures. As such, they fail to screen for emotional or mental health difficulties, and those issues will go untreated (Al-Krenawi, A. 2019).

It is vital for behavioral health providers to have an understanding of cultural values, norms and beliefs, and how they may impact symptom presentation and specific diagnoses. Providers need both knowledge and clinical judgment to be able to look beyond presenting somatic complaints, in order to evaluate the full picture. An understanding of these cultural issues will assist in making an accurate diagnosis and appropriate treatment decisions. It is imperative that, in every clinical encounter, the client's culture and perceptions be considered by the mental health provider. Failure to understand cultural issues can lead to misdiagnosis and inappropriate treatment (Al-Krenawi, A. 2019).

Another consideration when working with those from different cultural backgrounds is that certain practices, behaviors or beliefs that are culture-specific could be mistaken as mental illness symptoms. This can complicate mental health diagnosis if cultural norms regarding these symptoms, behaviors, and ideas are not taken into consideration. The action or belief is only abnormal when it exceeds the standards set by the specified cultural-linguistic group. The following are two examples to be considered:

1. Treatment toward aggression and violent behavior

   Depending on the culture, aggression, and violence can be interpreted in different ways. Though most cultures would agree violent and aggressive behavior is wrong, determining what is considered "wrong" lies in the cultural norms and cultural context. For example, some may believe that violence or aggression is perfectly acceptable when defending someone's honor or as a way to handle conflict. A provider may not understand this and may assume that aggressive individuals are "mentally ill" or "deviant" when in fact it is not that black and white. Before making such assumptions, clinicians must investigate the behavior in terms of cultural, familial and community context, and must consider these factors when determining which interventions are most appropriate.

2. Attitude toward dreams and their interpretations

   Another important cultural consideration is dreams, especially recurring dreams. For individuals from certain cultures, describing dreams in great detail to a clinician would be very important because they believe that dreams help provide a better understanding of themselves and how they relate to the world around them. Many providers are reluctant or unable to access the symbolic world of the client's dreams due to cultural gaps and lack of understanding. This can lead to misdiagnosis or poor treatment outcomes because the provider has simply not had adequate cultural training and therefore is not able to help clients make sense of their dreams (Al-Krenawi, A. 2019).

Culture Bound Syndromes

Culture-bound syndromes are a combination of psychiatric and somatic symptoms that are recognizable diseases in a specific culture or society. They are unique

mental health conditions tied to specific cultures or ethnic groups. An example of a culture-bound syndrome is "Ataque de Nervios," which is experienced in Latino communities. Symptoms include uncontrollable shouting, crying, trembling, and sometimes aggressive behavior, and this is a recognized condition often associated with a stressful event such as a panic attack. Another example of a culture-bound syndrome is "Ghost Sickness," experienced in Native American communities. Symptoms include feelings of terror, weakness, and a sense of impending doom, often linked to the perceived presence of the supernatural (Ahad, 2023).

Addressing culture-bound syndromes can influence and reduce mental health stigma across cultures. Misinterpretation of these syndromes can contribute to stigma, as individuals might be wrongly diagnosed or misunderstood. Practices that raise awareness of culture-bound syndromes offer a deeper, richer perspective on cultural influences on mental health. Additionally. awareness and understanding of these syndromes can enhance diagnostic and treatment approaches, optimize patient outcomes, and potentially contribute to reducing mental health stigma across various cultures (Ahad, 2023).

It can be difficult to diagnose mental health problems when cultural factors impact the clinical picture. This highlights the importance of understanding how cultural competency and appropriate Western mental health practices can support accurate diagnosis and treatment decisions.

Behavioral health providers should also be aware of the historical aspect of colonial rule, and how this has created trauma and negative experiences for underrepresented groups and individuals. For many, this has resulted in adverse interactions with Western medical services. This historical context must be taken into consideration when addressing cultural-based access to health care services. There is a general trend of underutilization of mental health services among ethnic and indigenous minorities, since social and cultural aspects play a role in accessing services. Education and training around culturally responsive care is greatly needed so that clinicians and organizations can deal more effectively with

the diverse populations they serve and individuals can receive the care they need (Al-Krenawi, A. 2019).

Cultural Beliefs and Stigmas Impact Mental Health

The negative stigma about mental health symptoms or therapy services that occurs in many cultures can lead to major barriers to accessing professional help. Studies have shown that people in racial and ethnic minority groups in the United States are less likely to seek outpatient therapy services than White people. Individuals from minority groups are more comfortable going to their primary care doctor or to family members for help with mental health symptoms rather than speaking with a behavioral health professional. People want to be accepted by their communities, and sometimes fear, shame, or embarrassment prevents them from seeking mental health treatment (Modir et al., 2023).

African American families may be reluctant to seek mental health treatment due to historical discrimination, racism, and mistreatment from healthcare providers. They may instead take an active approach to handling adversities independently and directly. They also tend to rely more on spiritual resources for emotional support.

Latin American families are less likely to trust mental health providers and are more likely to rely on social support from extended family or community members. When Latinx individuals do share their stressful experiences or emotional difficulties, the focus is often on physical symptoms such as loss of appetite or trouble sleeping instead of on the thoughts and feelings that are concerning them.

Asian American and Middle Eastern American communities often have cultural beliefs that seeking mental health treatment will bring shame or dishonor to the family, leading many to internalize their symptoms instead of seeking help. Many Asian American children report feeling pressured to appear perfect and

successful, and this causes them to keep their struggles and symptoms secret. More frequently, Middle Eastern American teenagers will seek support from family or religious community members rather than a mental health professional.

While these beliefs and approaches are valid, overly negative views of therapy can keep people who need a higher level of care from getting help. These examples are broad, but they show a few reasons why minorities are less likely to seek out therapy when they may need it. Parents can examine their family's cultural beliefs around treatment and find ways to advocate for their children to access help when necessary. Ultimately it is the responsibility of the healthcare system to ensure services are more accessible to underserved communities and to advocate for change to counteract myths and stigmas on mental health symptoms and treatment (Modir et al., 2023).

Those from the LGBTQ community have a higher risk than other individuals of facing institutionalized prejudice, social stress, exclusion, and rejection, as well as homophobic hatred and violence resulting in hostile and stressful social environments that can lead to mental health problems (Anglin et al., 2020).

The stigma surrounding mental health care causes delayed treatment, increased morbidity, and decreased quality of life. Stigma impacts individuals, their families, healthcare providers, and communities in the following ways:

Individuals: Stigma can cause fear and avoidance of mental health care, resulting in delays in seeking help, even if the person is in extreme need. Delays in care can result in exacerbated mental health conditions leading to worse outcomes and reduced quality of life.

Families: Stigma can cause shame and isolation, making seeking support and resources more difficult.

Healthcare Providers: Stigma can lead to burnout and demoralization, reducing the quality of care provided. Stigma can create barriers between

providers and patients, making it difficult to establish a trusting and therapeutic relationship, which is essential for care to be effective.

Communities: Stigma can lead to a misallocation of resources, and mental health services are often underfunded and overlooked (Ahad et al., 2023). Mental illness stigma across cultures is a significant barrier to mental health care. The stigma can lead to delayed diagnosis and treatment-seeking behaviors, reduced quality of life, and an increased risk of social exclusion and discrimination. In addition, mental illness stigma often intersects with other forms of stigma, such as gender, race, and socioeconomic status, causing even more marginalization of already vulnerable groups. This makes it challenging to provide equitable, culturally sensitive, and effective mental health care to people with mental illness.

Mental illness stigma is common in various cultures, which can impact mental illness diagnosis, treatment, and management. This type of stigma presents differently across cultures and is influenced by cultural beliefs, attitudes, and values. The stigma surrounding psychiatry and mental health disorders has numerous detrimental effects on individuals and communities, including:

1. Delayed Treatment-Seeking Behavior

   Stigma plays a significant role in delaying treatment-seeking behavior for people struggling with their mental health. The fear of being labeled, ostracized, or misunderstood due to their condition often deters individuals from seeking help promptly. This can lead to symptoms worsening, escalating the condition's severity and making treatment and prospective recovery more challenging. Healthcare delays can also lead to decreased self-esteem and increased depressive symptoms, creating a vicious cycle of self-blame, isolation, and hopelessness. Prolonged untreated mental health issues can further impair a person's functioning in various life domains, including work, relationships, and self-care, and lowers their overall quality of life.

2. Social Isolation and Discrimination

   Stigma can lead to social isolation and discrimination for those affected by mental health issues. One study found that people with mental health disorders often face discrimination in multiple life domains, including employment and interpersonal relationships. The negative stereotypes and misconceptions surrounding mental illness often result in a lack of understanding and empathy from others, leading to social exclusion. People with mental health issues might face discrimination in various aspects of life, including the workplace, where they may encounter bias in hiring, job retention, and career advancement. Discrimination can cause additional strain in personal relationships, as friends and family may distance themselves due to discomfort, fear, or misunderstanding, exacerbating feelings of isolation and loneliness.

3. Reduced Treatment Adherence

   Stigma can lower adherence to mental health treatments. Perceived stigma can predict treatment discontinuation in older adults with depression. People living with mental health conditions may avoid or discontinue treatment due to fear of being identified as a mental health patient. This fear could stem from concerns about the stigma associated with visiting mental health facilities, taking psychiatric medications, or being seen engaging in therapeutic activities. Non-adherence to treatment regimens can lead to suboptimal treatment outcomes, hinder recovery, and increase the risk of relapse or worsening symptoms. Furthermore, stigma can diminish self-efficacy, making individuals less likely to actively engage in their treatment process, which is crucial for successful recovery.

4. Perpetuation of Misconceptions

   Stigmatizing attitudes toward mental illness contribute to the perpetuation of harmful stereotypes and misinformation. Stereotypes such as appearing

dangerous, unpredictable, or culpable for their illness can make people with mental illness perceived inaccurately as dangerous or to blame for their condition, both internally and externally. Stereotyping can create a culture of fear, rejection, and discrimination against individuals with mental health conditions. Misconceptions often result in people with mental health issues being perceived inaccurately as dangerous, unpredictable, or responsible for their condition. Misinformation can hinder public understanding and acceptance of mental illness, exacerbating stigma while negatively influencing policy and legislation, leading to inadequate funding and support for mental health services.

5. Influence of Gender on Stigma

   The impact of stigma on individuals with mental illness is known to vary across different social and demographic categories, including gender. Research evidence indicates that the experience of stigma related to mental illness can be significantly different for men and women, and these differences can be further influenced by cultural context.

6. Influence of Culture on Stigma

   The stigma around mental health varies across cultures. Individuals may internalize their mental health issues differently depending on their cultural backgrounds. This internalization impacts a person's self-perception and openness to seeking help. Cultural beliefs play a critical role in shaping attitudes about mental health in families. Experiencing shame and blame from family members exacerbates the stigma individuals will feel about their mental health issues (Ahad et al., 2023).

Strategies To Address Stigma

There are a number of strategies that can be implemented to combat mental health stigma across cultures. They include:

1. Public Awareness Campaigns

   Awareness campaigns are key to dismantling misconceptions and improving understanding of mental health disorders. Public campaigns can dispel myths, reduce stigma, and encourage empathy toward affected individuals by promoting accurate information about mental illnesses, their prevalence, and the possibilities for recovery.

2. Cultural Competency Training for Providers

   Education providers with knowledge and skills to understand and respect their patients' cultural backgrounds and experiences are critical for reducing stigma in healthcare settings. Providers who lack cultural competence can inadvertently contribute to stigma, discouraging people even more from seeking help. Training improves a provider's understanding of cultural influences on behaviors and choices around health and results in improved communication between provider and client, also reducing perceived stigma.

3. Peer Support Programs

   People with lived experiences of mental health disorders who share their stories can normalize mental health issues and challenge stigma. By providing real-life examples of individuals living with and managing their mental health disorders, peer-to-peer advocacy programs may debunk myths and reduce the perceived 'otherness' of mental illness.

4. Community-Based Mental Health Services

   Integrating mental health care into primary care and community settings can reduce the stigma associated with seeking psychiatric help. Integrating mental well-being measures along with other routine and standard primary care protocols leads to mental health care being more accessible and less intimidating, encouraging individuals to seek help when needed.

5. Evidence-Based Approach

   Research shows that evidence-based interventions, including education and contact-based interventions, can be effective at reducing mental health stigma across cultures. Ths goal of education-based interventions is to increase knowledge and awareness of mental illness and reduce negative stereotypes. They may include workshops, online courses, and media campaigns. Contact-based interventions facilitate engagements between those with mental health diagnoses and members of the general community with the goal of challenging negative attitudes and beliefs (Ahad et al., 2023)

Addressing the stigma around mental health can improve the effectiveness of psychiatric health care. Developing programs and strategies that foster a culture of understanding and acceptance may encourage more people to seek help when they need it, resulting in improved early detection and intervention, which are essential for better outcomes. Challenging and changing stigmatizing attitudes can improve the therapeutic relationship between healthcare providers and patients, leading to more personalized and effective treatment strategies. It is important to remember that stigma varies across cultures, distinct societal norms, values, and beliefs. Understanding these cultural variations is necessary to develop effective and culturally sensitive interventions (Ahad et al., 2023).

Health Disparities

Racial and ethnic health disparities in behavioral health continue to persist in the United States, despite the implementation of healthcare strategies to address disparities. A national survey of over 200,000 people comparing disparities between Whites, African Americans, and Hispanics reported that there was a 10.8% difference Black-White and a 10.9% difference in Hispanic-White mental health care. Contributing factors to these differences include lower access to

mental health care, lower help-seeking for mental health concerns, and a lower likelihood of receiving evidence-based mental health treatments. In addition, racial and ethnic minorities are overrepresented among low socioeconomic populations and experience racism and bias, and cultural mistrust of the healthcare system, all of which place an additional burden on access to care and healthcare outcomes. Racial and ethnic minorities experience higher rates of cardiovascular disease, diabetes, and cancer, all conditions that are preventable for many and are overrepresented among those with behavioral health conditions. Both poor behavioral health and preventable physical diseases have similar contributing factors, including inadequate access to healthcare resources, lack of health insurance, limited income, language barriers, transportation barriers, and poor healthcare quality (McGregor et al., 2019).

Not everyone seeking services receives the same level of care. Reasons for health disparities include:

- Less access to care
- Language and communication barriers
- Negative past experiences with healthcare services
- Lower quality of care (HHS, 2019)

Examples of health disparities in the United States:

- American Indians have limited access to mental health services as most Indian Health Services are on reservations, but most do not live on reservations.
- African Americans experiencing microaggressions from their therapists have lower therapeutic bonds and satisfaction with their treatment experience.
- LGBTQ people report experiences of providers denying care or blaming the person's sexual orientation or gender identity as the cause of illness.

- Not having English as their primary language leads to frequent poor assessment and undertreatment.
- Heart disease deaths are 40% higher for African Americans than for European Americans.
- Suicide rates are 2.2 times higher than the national average for American Indians.

Incident rates of healthcare, mental health, and disease differ greatly across cultural groups (HHS, 2019 & Gurung, 2018).

It is important to be aware of healthcare disparities, as overcoming such differences can lead to improved healthcare delivery and outcomes. Health disparities occur when disadvantaged social groups such as the poor, racial or ethnic minorities, women, and other groups who have persistently experienced social disadvantage or discrimination systematically experience worse health or greater health risks than more advantaged social groups. The term describes an increased presence and severity of certain diseases, poorer health outcomes, and greater difficulty in obtaining healthcare services for these races and ethnicities. When systemic barriers to health are avoidable but still remain, they are referred to as health inequities. Learning about disparities can help reduce inequalities. Racial and ethnic disparities are morally wrong, fiscally unwise, and stress the healthcare infrastructure (Purnell, 2021).

A plethora of data from around the world suggests that minority groups experience a disproportionately higher rate of illness, more severe complications, and increased mortality and morbidity related to cardiovascular disease, diabetes, asthma, and cancer. Multiple factors external to the healthcare system influence health disparities—namely, lower socioeconomic status of minorities, hazardous jobs with increased incidence of injury, lower educational and literacy levels, lack of or inadequate health insurance, fear of the healthcare system, overuse of over-

the-counter medications and home remedies, and the use of the emergency department for care (Purnell, 2021).

The root causes of health disparities relate to a disconnect between patients' health beliefs, values, preferences, and behaviors and those of the dominant healthcare system. This lack of congruence includes variations in patient recognition of symptoms, thresholds for seeking care, the ability to communicate symptoms to a provider who understands their meaning; the ability to understand the prescribed treatment plan, including the use of medications; expectations of care access to and utilization of diagnostic and therapeutic procedures and adherence to preventive measures. These core factors are some of the primary influencers for decision-making among patients and healthcare providers, physicians in particular, and the degree to which patients access and interact with the healthcare delivery system (Purnell, 2021).

Explicit Bias Impact on Disparities

Explicit bias or conscious bias are biases, prejudices, stereotypes, or assumptions one is aware of having regarding a group of persons. It takes a clear understanding of one's beliefs, values, and feelings to be able to acknowledge and address one's biases. The following questions may assist in identifying and addressing explicit biases held towards race, ethnicity, age, gender, gender identity or expression, sexual orientation, English language proficiency, literacy, body size, or socioeconomic status.

Do my biases:

- Impact the amount of time I spend with clients and their families?
- Influence how I communicate with clients?
- Hinder my ability to feel and express empathy toward my clients?
- Affect my recommendations for treatment and medications?

- Interfere with my capacity to positively interact with my clients and their families.

Additionally:

- Are you ever less comfortable with clients of a different race?
- Do you believe that your colleagues whom you routinely work with think that your attitudes and behaviors show bias? Are you open to discussing these issues with them to elicit their point of view?
- Have clients or their families, directly or through satisfaction surveys, raised concerns about your attitude or how you communicate with them? (NCCC, 2023)

Implicit Bias Impact on Disparities

Implicit bias or unconscious bias is unintentional prejudice or attitudes a person unconsciously holds based on group stereotypes that impact a person's decision-making process. Unconscious bias can be expressed in non-verbal communication and it may negatively impact the client's services access. Implicit bias is often subtle and outside the person's conscious awareness (NCCC, 2023).

While providers want to believe they are providing their clients with equitable care, research has found two-thirds of providers hold some form of implicit bias against a marginalized group. Implicit biases can negatively influence a provider who is working with diverse populations. Adverse results have been seen in providers' ability to engage in client-centered care, offer referrals to specialized treatment, and adhere to evidence-based guidelines. Mental health organizations are particularly vulnerable to implicit bias's negative effects because diagnosing and treating mental health conditions relies heavily on provider discretion. As such, providers' unconscious attitudes about groups such as homeless persons, veterans, people of color, or incarcerated individuals, among others, can have

multiple negative consequences for individuals seeking mental health treatment (Merino et al., 2018).

Legal Implications of Bias

When trust is compromised, clients may feel that providers are not working in their best interest. This could lead a client or a group of people to perceive that bias occurs in their care.

Although beliefs themselves are not discriminatory, beliefs that result in inferior or lesser treatment may be considered discriminatory. If such beliefs affect the quantity or quality of health care provided, then the treatment may amount to discrimination under the law. One example is unequal treatment in federally funded healthcare treatment, as indicated below.

Title VI of the Civil Rights Act of 1964 states that recipients of Federal financial assistance may not, on the basis of race, color, or national origin:

- Deny or restrict an individual's enjoyment of a service, aid, or benefit under the program
- Provide a benefit that is different or provided in a different manner
- Subject an individual to segregation or separate treatment (HHS, 2019).

Disparities in Healthcare and Recommendations

The Institute of Medicine (IOM) assesses the differences in the types and quality of healthcare in the United States received by racial and ethnic minorities and nonminorities.

The IOM report found that:

- Racial and ethnic healthcare disparities exist and are associated with worse health outcomes.
- Healthcare disparities occur in the broader context of historical and contemporary social and economic inequalities.
- Across health systems, providers, patients, and managers, there are many sources that contribute to disparities.
- Healthcare providers' bias, prejudice, stereotyping, and clinical uncertainty add to disparities.
- Some research has shown that racial and ethnic minority patients have a greater likelihood to refuse treatment, but patient refusal does not fully contribute to healthcare disparities.

Based on the IOM report's findings, the following recommendations were made to reduce the differences in healthcare quality minorities receive in the United States in seven categories.

General Recommendations

- Increase awareness of racial and ethnic healthcare disparities among the general public and key stakeholders.
- Increase healthcare providers' awareness of disparities.

Legal, Regulatory, and Policy Interventions

- Avoid the division of healthcare plans along socioeconomic lines.
- Increase the stability of patient-provider relationships in publicly funded healthcare plans.

- Increase the number of underrepresented racial and ethnic minorities among healthcare professionals in the United States.
- Enforce the same managed care expectations to publicly funded HMO participants that apply to private HMO participants.
- Provide greater resources to the United States Department of Health and Human Services Office for Civil Rights to enforce civil rights laws.

Health Systems Interventions

- Encourage consistency and equity of care through the use of evidence-based guidelines.
- Set up payment systems to provide an adequate amount of services to minority patients and restrict provider incentives that encourage disparities.
- Provide financial incentives to practices that reduce barriers and encourage evidence-based practice to enhance patient-provided communication and trust.
- Encourage using interpretation services where community need exists.
- Support the use of community health workers.
- Implement multidisciplinary treatment and preventive care teams.

Patient Education and Empowerment

- Enact education programs for patients to increase their knowledge on how to access care and participate in their treatment decisions.

Cross-Cultural Education in the Health Professions

- Integrate multicultural education into the training of all current and future health professionals.

Data Collection and Monitoring

- Collect and report information on healthcare access and utilization by patients' race, ethnicity, socioeconomic status, and primary language.
- Assess racial and ethnic disparities in performance measures.
- Monitor progress toward eliminating healthcare disparities.
- Collect racial and ethnic data and use subpopulation groups when possible.

Research Needs

Conduct research on

- identifying sources of racial and ethnic disparities and assessing promising intervention strategies.
- ethical issues and other barriers that need to be addressed to eliminate disparities (Gurung, 2018).

Culturally Responsive Clinicians

Most professional organizations call for culturally responsive clinical practices when working with people from diverse cultural backgrounds. Culturally responsive therapy happens when the client and therapist are of different backgrounds, and the therapist is aware of the significance of their separate cultural stories, has knowledge of the client's culture, and uses culturally appropriate clinical skills while working with the client. Culturally responsive

therapy can be used with any theoretical approach (ex. CBT, DBT, FFT) and is not a specific treatment modality of its own. A therapist can not ethically treat someone without taking into consideration cultural influences on the therapeutic relationship (Jones-Smith, 2019).

Basic competencies for culturally responsive counseling include the following:

Awareness of one's own cultural values and biases

Clinicians must be aware of how their own culture impacts their values, choices, manners, and privileges. They should understand the impact of discrimination and stereotyping and seek training in diversity issues. They are aware of how their own background affects service delivery and the counseling relationship. They are comfortable with cultural and other differences that may exist between themselves and their clients.

Knowledge of their clients' worldviews

Clinicians must demonstrate a level of multicultural knowledge of different ethnic and cultural groups' worldviews, including race, ethnicity, class, gender, sexual orientation, disability, and religion. They have knowledge of their clients' cultural group(s).

Competence in implementing culturally appropriate clinical intervention strategies for their clients

Clinicians are capable of using individual and system intervention techniques for the benefit of their clients (Jones-Smith, 2019).

Cultural competency develops along a continuum and develops over six stages.

1. Cultural Destructiveness

   This is the lowest level of cultural competence. It is characterized by policies and practices that are destructive to cultures and individuals. One extreme

example of cultural destructiveness is cultural genocide or the purposeful destruction of a culture.

2. Cultural Incapacity

   Although therapists might not purposely act to be culturally destructive, they may lack the ability to help culturally diverse clients. Therapists deliver counseling services from an extremely biased perspective. They may believe in the racial superiority of the dominant group in society. Therapists operate with a biased therapy system and with a paternal attitude toward other groups. They may fear other groups and cultures or participate in discriminatory practices, thereby lowering expectations or devaluing certain groups.

3. Cultural Blindness

   Therapists and agencies operate with the certainty that their attitudes and practices are unbiased. They may even post their philosophies for everyone to see. Culturally blind therapists and agencies are characterized by the belief that counseling approaches used by the dominant culture are universal and without bias. Although the cultural blindness philosophy appears to be well-intentioned, it actually represents a Eurocentric and ethnocentric approach.

4. Cultural Pre-Competence

   This stage is characterized by acceptance and respect for cultural differences and by continual self-assessment regarding culture. The therapist might make a variety of cultural adaptations to therapy models in order to better serve the needs of diverse clients. The agency may make a deliberate attempt to hire unbiased employees and actively seek advice and consultation from the culturally diverse communities representing the clients they serve. Therapists understand their own weaknesses in working with people from other cultures and may engage in culturally

responsive training.

5. Cultural Competence

   The therapist and agency accept and respect cultural differences. The therapist has acquired culturally relevant intervention skills and adopts a policy of being open and sensitive to other cultures. Therapists actively engage in expanding their cultural knowledge and sensitivity.

6. Cultural Proficiency

   Therapists hold a wide range of cultures in high esteem. They obtain training in new counseling approaches for working with culturally diverse clients. They become advocates for cultural competency at the individual and agency levels (Jones-Smith, 2019).

Cultural self-awareness requires a lifelong commitment to self-evaluation. As clinicians become more aware of their cultural backgrounds and the influence it has had on them, the more capable they will be of responding sensitively to clients. Culturally aware clinical skills include:

1. Clinicians have taken steps to learn about their own cultures. Before entering a counseling relationship, practitioners must be aware of their cultural and historical backgrounds. Individuals who recognize the different influences of their own cultural experiences can better recognize the different influences of clients' backgrounds and histories.

2. Clinicians understand their worldview and are aware of how their cultural backgrounds may affect the clinical relationship.

3. Clinicians appreciate their multiple identities and understand their cultural identity and the stage of cultural identity they are in. Most people have identities related to gender, age, religion, ethnicity, socioeconomic status, professional status, etc.

4. Clinicians have cognitive and emotional knowledge of their implicit and explicit biases toward group members that are culturally different from their own.
5. Clinicians understand, appreciate, and are respectful of the culture and worldview of their clients and understand the cultural identity stage that their clients are in.
6. Clinicians recognize the limits of their cultural competency in working with culturally diverse clients and realize that cultural awareness requires a lifelong commitment to self-evaluation (Jones-Smith, 2019).

Improving Culturally Responsive Care

Professionals at all levels continue to recognize the importance of cultural competency and cultural safety to achieve equitable healthcare delivery at both individual health practitioner and organizational levels (Curtis et al., 2019).

Although racial and ethnic minorities make up 38% of the United States population, they represent a significantly smaller ratio of behavioral health providers. According to the U.S. Department of Health and Human Services, the percentage of racial and ethnic minority individuals in the behavioral health field is as follows: 19% of psychiatrists, 18% of social workers, 10% of counselors, 8% of marriage and family therapists, and 5% of psychologists. (HHS, 2019).

Individual

Training

Since the way that providers are trained affects the way they provide care and services, it is important to take into consideration what training opportunities are available for behavioral health providers in the United States. Many providers are

educated with very narrow but widely accepted views of mental illness. Training that focuses on a restricted model of care delivery may result in practices that are harmful to clients from diverse backgrounds (Marcelin et al., 2019).

Professional Culture

The mental health profession has its own culture or worldview, and each profession has its own guidelines and expectations on how care should be provided. Examples of beliefs and values that are held by behavioral health professional groups include (Marcelin et al., 2019):

- The belief that someone's health and well-being reflects on that individuals' ability to achieve goals
- The tendency to place more weight on psychological symptoms of distress than bodily symptoms of distress
- The belief that mental health problems are more explainable in biological terms than spiritual terms
- An emphasis on the mind's vulnerability to dysfunction or disability in response to adverse life events

Research Awareness

To improve one's quality of care provided to clients from diverse backgrounds, the following questions are important to consider (Marcelin et al., 2019):

- What populations were included in the research samples used to develop the assessment methods and treatment protocols you use?
- What is the potential for cultural bias in the tools, treatments, or interventions you use?

- How do the assessment methods, treatments, or interventions used in your practice address clients' cultural beliefs and practices?

These questions are important to consider as research participants are frequently American college students, with their results then being generalized to society as a whole. Studies have found that up to 80% of psychology study participants fall into the WEIRD category (Western, Educated, Industrialized, Rich, and Democratic), but WEIRD societies comprise only 12% of the world's population (Marcelin et al., 2019).

Implicit Association Test

Active self-reflection deepens our learning and understanding of ourselves, and self-assessment is a key component of providing culturally competent care. Taking the Implicit Association Test is one way a person can engage in self-assessment. The Implicit Association Test asks the test taker to look at pictures or word combinations and pick a concept associated with that picture or word. For example, it starts by categorizing people by labels of African American and European American and categorizing a list of emotions by bad or good. It then leads to categorizing people and emotions at the same time. How quickly and accurately one completes the sorting processes impacts the level of implicit bias the test identifies the test taker as having.

Taking the Implicit Association Test can be unsettling or upsetting, depending on one's results. The test measures unconscious bias, and even those who are fair-minded and hate prejudice at a conscious level often have unconscious biases based on race, gender, age, and other demographic factors. Remember, being able to identify one's implicit biases now can lead to taking responsibility for them and addressing them.

Important points that should be emphasized when using the IAT as part of diversity training include: people should be aware of their own biases and reflect

on their behaviors individually, the IAT can generally suggest how groups of people with certain results may behave, rather than how each individual will behave and on its own, and the IAT is not a sufficient tool to mitigate the effects of bias, because if there is to be any chance of success, an active cultural/behavioral change must be engaged in tandem with bias awareness and diversity training (Marcelin et al., 2019).

Behavioral health providers do not provide care in a vacuum. Many factors impact the quality of care clients receive. These can include workplace limitations such as high client volume, paperwork, and time limitations. Despite these restraints, it is still important that providers be aware of cultural and linguistic factors and how they impact the care that is provided. This awareness can help prevent practices that are harmful to clients from diverse backgrounds.

RESPECT Model

It is essential to remain open and respectful when engaging with one's clients. The RESPECT model is one way to remember and address factors of culturally and linguistically competent care. These factors are essential throughout assessment, diagnosis, treatment, and termination.

Respect

Understand how respect is shown within given cultural groups. Counselors demonstrate this attitude through verbal and nonverbal communication.

Explanatory Model

Devote time in treatment to understanding how clients perceive their presenting problems. What are their views about their own substance abuse or mental symptoms? How do they explain the origin of current problems? How similar or different is the counselor's perspective?

Sociocultural Context

Recognize how class, race, ethnicity, gender, education, socioeconomic status, sexual and gender orientation, immigrant status, community, family, gender roles, and so forth affect care.

Power

Acknowledge the power differential between clients and counselors.

Empathy

Express, verbally and nonverbally, the significance of each client's concerns so that he or she feels understood by the counselor.

Concerns and Fears

Elicit clients' concerns and apprehensions regarding help-seeking behavior and initiation of treatment.

Therapeutic Alliance and Trust

Commit to behaviors that enhance the therapeutic relationship; recognize that trust is not inherent but must be earned by counselors. Recognize that self-disclosure may be difficult for some patients; consciously work to establish trust (HHS, 2019).

Organization

Culturally competent healthcare is a set of congruent behaviors, attitudes, and policies that come together in a system or agency that enable professionals to work effectively in cross-cultural situations. The competencies are not exclusive to one healthcare discipline and must be inclusive of all, including professional disciples, clerical, technical, and support personnel. Providing culturally safe care ensures that all members of the healthcare team receive consistent information about the needs of the diverse patients, families, and communities for which they

provide services. Cultural competency is a process and not an end result. There is always more to learn rather than simply a checklist to complete (Purnell, 2021).

A culturally competent organization incorporates healthcare at all levels to meet the cultural needs of those they serve. While the goal of enhanced quality care is to reduce health disparities and improve health outcomes for at-risk and underserved populations, it also has benefits for the organization. Culturally competent healthcare organizations outperform competitors and have higher outcome measures, improved consumer access to care, increased market share, greater financial sustainability, and high levels of patient and staff satisfaction (Purnell, 2021).

Creating change requires more than just a climate survey, a vision statement, or the creation of a diversity committee. Organizations must commit to a culture shift by building institutional capacity for change. This might include recruiting underrepresented individuals and promoting leaders with the power to create equitable environments. Organizations can recruit, retain, and promote a diverse staff and administration that is representative of the demographics they serve. Having a diverse workforce that matches the local demographics of consumers being served reduces health disparities that are often due to discordance in the consumer-provider relationship. Cultural and language discordance can lead to decreased access to care, decreased quality of care, increased cost of care, decreased patient satisfaction, recidivism, discrimination, and poor health outcomes (Marcelin et al., 2019; Purnell, 2021).

Organizations may designate diversity champions who have the required knowledge and skills to provide culturally responsive care at all levels of the organization. These champions can mentor other providers to expand their consumer care and service influence (Purnell, 2021).

Another way organizations can implement changes is by implementing a person-centered system of care. In person-centered care, the focus is shifted from a deficit or disease model toward an articulation and addressing of a person's

values, preferences, and goals, emphasizing coproduced rather than expert-driven care. Person-centered care shows promise in enhancing therapeutic alliances, incorporating stakeholder perspectives, addressing disparities, and improving engagement and outcomes. Organizations must also recognize that, at times, it is the culture of the mental health system itself that may pose substantial barriers to client diversity and not the provider's lack of engagement with multicultural populations in person-centered care. These structural barriers and organizational biases persist despite emerging practices focused on empowering the client (Desai et al., 2021).

Culturally competent organizations integrate diversity throughout the organization from the mission statement, strategic plans, and goals. To a diverse workforce that includes mentoring, community internships, collaborations with academic programs, and faith-based communities. And expanding recruitment to include minority health, advertising in multiple languages, and job listings in minority publications (Purnell, 2021).

Finally, organizations need to have a method to regularly assess their cultural competence so that they can identify strengths and weaknesses and where additional training and mentoring are needed. Reliable assessment measures access to care, quality of healthcare, health outcomes, and patient and staff satisfaction. Organizations must remember to consider language during their cultural competence assessments and ensure that their resource bank is up to date with trained medical interpreters and translators, including sign language interpreters for the deaf and hearing impaired and Braille documents for those who are blind and visually impaired (Purnell, 2021).

Organizations must also consider linguistic competence. Ways organizations can be linguistically competent include:

- Bilingual staff
- Contract interpreters

- Telephonic interpreters or language lines
- Videoconferencing interpretation
- Translated materials

Failing to provide someone with limited English proficiency with language assistance may be identified as national origin discrimination (HHS, 2019).

Organizations & Cultural Safety

Cultural safety requires mental health practitioners and their associated professional organizations to examine themselves and the possible impact of their own culture on clinical interactions and mental health service delivery. This requires individual mental health professionals and behavioral health organizations to recognize and evaluate their attitudes, assumptions, biases, stereotypes, prejudices, characteristics, and structures that may be affecting the quality of care they are providing. Cultural safety encompasses a critical consciousness where mental health professionals and behavioral health organizations engage in continuous self-reflection and self-awareness and also hold themselves accountable to provide culturally safe care. Culturally safe care should be defined by the clients and their communities, not the provider or organization, and is measured through progress toward health equity achievement. Cultural safety requires mental health professionals and their associated professional organizations to influence mental health care to reduce bias and achieve equity within the workforce and working environment.

To optimize this cultural safety approach, mental health organizations, from professional associations to community agencies, should start with a self-review to assess to what extent they meet expectations of cultural safety at a systemic and organizational level. They can then identify areas of weakness in providing culturally safe care, and develop an action plan to address areas of need. The

following steps should also be considered by mental health organizations and regulators to encourage a more comprehensive approach to cultural safety:

- Mandate cultural safety activities as a part of vocational training and professional development with documentation of growth.
- Require evidence of cultural safety (at both the organization and individual practitioners level) as part of accreditation and continuing certification.
- Verify the assessment of cultural safety through the systematic monitoring and assessment of inequities (this can be done by monitoring mental health workforce diversity and mental health outcomes of clients).
- Require cultural safety training for staff, supervisors, and quality assessors and continuous performance monitoring.
- Recognize that cultural safety is an independent requirement that relates to expectations for competency in culturally diverse mental health care (Curtis et al., 2019).

Organizational Cultural Competency

For organizations to address cultural competence, it is important to maximize diversity in both the workforce and administration leadership. This can be done through:

- Creating programs or strengthening existing ones for minority leadership development. The goal is to increase the number of minority professionals in leadership positions at all levels of academia, government, and private industry.
- Hiring and promoting minorities in the mental health care workforce.
- Engaging community representatives in the organization's planning and quality improvement meetings (Curtis et al., 2019).

This is key as lack of diversity in organizations' workforce and leadership has been shown to be a barrier to culturally competent care and lower quality of care.

Systemic Cultural Competency

For systems to address cultural competence, initiatives must be activated, such as conducting community assessments, developing mechanisms for patient and community feedback, and implementing systems for clients' racial, ethnic, and language preference data collection. In addition, developing quality measures for diverse client populations and ensuring availability of culturally and linguistically appropriate mental health education materials, including prevention and treatment information, is also important. Knowledge acquired through data collection should then be used to inform strategic planning. Data can help when planning systemic improvements, including access to services and outcomes of care (Curtis et al., 2019).

Six Dimensions of Quality Healthcare

Individuals and organizations should take the following dimensions into consideration when assessing for quality, and to ensure effective and consistent health care implementation.

Safe

Avoiding client harm from services that are supposed to help them. Cultural competency helps avoid miscommunications and, therefore, errors.

Effective

Providing scientific-based services to those who will benefit and avoiding those services for those who will not benefit. Cultural competency improves the accuracy of diagnoses and avoids misuse or underutilization of treatments.

Patient-Centered

Providing services that are respectful and responsive to the individual client's needs, values, and preferences and having the client guide clinical decisions. Cultural competent care is patient-centered care and is responsive to the client's cultural beliefs and communication needs.

Timely

Reducing wait times and potentially harmful delays. Cultural competent care connects patients to the services they need in a timely manner.

Efficient

Avoiding waste of equipment, supplies, ideas, and energy. Cultural competent care is a higher quality of care and, therefore, more efficient, and it reduces the waste of resources.

Equitable

Providing quality care regardless of personal characteristics. Cultural competent care addresses the clients' unique needs. It does not mean giving everyone the same treatment, but rather giving them the best treatment possible for their particular concerns (HHS, 2019).

Multicultural Ethical Competence

Most behavioral health professional organizations have provisions in their codes of ethics to address cultural competency. Multicultural ethical competence is a framework that draws on the behavioral health providers' human responsiveness to those they work with and awareness of their own boundaries, competencies, and obligations. It is not enough to be only aware of one's own cultural values and biases but also to critically consider the ways one's values interplay within the context of the counseling situation.

Multicultural ethical competence and ethical decision-making must begin with behavioral health providers taking inventory of their values and beliefs and understanding how their Ideology influences their interpretation of ethical principles and standards as well as how they solve ethical dilemmas. It is also necessary to understand that ethics exist within a cultural, social, political, and historical context (Renteria et al., 2020).

Having a model for ethical decision-making can help navigate and resolve ethical dilemmas.

One model of ethical decision-making is the Tarvydas Integrative Model, which has four stages as follows:

1. Interpreting the situation through awareness and fact-finding
2. Formulating an ethical decision
3. Selecting an action by weighing competing, nonmoral values, personal blind spots, or prejudices
4. Planning and executing the selected course of action

Another example of an ethical decision-making model from the National Latinx Psychological Association follows the following steps:

1. Clarifying the nature of the dilemma

2. Analyzing legal and ethical responsibilities
3. Consulting with other professionals, sources, and community members that could be potentially affected by the decision
4. Brainstorming for many possible actions and myriad consequences.

Ethical decision-making can go beyond clinical decisions and shift into legal implications. This is important to be aware of when working with marginalized communities, as many are exposed to legally oppressive systems. Whether clients encountered oppressive systems in their pasts, or if they are currently exposed to them, they may still be impacted by the repercussions. The behavioral health provider has an ethical duty to be aware and proactive in preparing for challenges when multicultural ethics may be at odds with the law (Renteria et al., 2020).

The following are two current examples of multicultural ethical and legal issues in the United States.

Conscience Clause

The state of Arizona passed a statute that states that a university or college can not discipline or discriminate against a student intern in a counseling, social work, or psychology program if the student refuses to counsel a client about goals that conflict with the student's sincerely held religious beliefs. As such, this allows clinical intern students to refuse to see clients who present with characteristics or values that contradict the interns' religious beliefs (including sexual minority orientation, gender minority orientation, and differing religious beliefs). However, all behavioral health professionals' codes of ethics state the importance of competence in working with diverse clients, and call for professionals to seek competency through training, supervision, and consultation when it comes to conflicts of an ethical nature. When working with culturally diverse clients, they may have little experience or knowledge. The conscience clause, which enables

professionals to refuse services based on moral obligations, could be a violation of professional organizations' principles and ethical practices (Renteria et al., 2020).

Immigration and DACA

There are 10.7 million undocumented immigrants living in the United States and 700,000 people enrolled in the Deferred Action for Childhood Arrivals Program (DACA). For these groups of people, the lack of recognized legal status by the government has impactful psychological and social implications. Ethical multicultural behavioral health providers working with these community members must be informed of the legal issues that impact these communities, and the social, cultural, and health impacts their legal status may have. Sensitive consideration must be given regarding someone with this identity. Additional clinical practice safeguards may be put into place regarding confidentiality and note-taking. Confidentiality is more critically emphasized given the huge risks of deportation that could occur if a client's legal status was discovered. Within the context of virtue ethics and multicultural ethical practice, practitioners need to be prepared in advance to advocate on behalf of and protect their client's documentation status in the case of a medical emergency, legal status, or in a situation where a client may need to contact the authorities. Participating in Know Your Rights workshops and educating clients about their rights is a necessity when working with this community.

Multicultural competence is a fast-growing and dynamic field. The framework that guides multicultural ethics must also be changing to meet new challenges and to help the communities mental health professionals serve. While having an ethical decision-making process is important, more pressing is for practitioners to develop a critical consciousness regarding moral frameworks and ethical guidelines and continue engaging in self-reflection to further develop multicultural ethical competence. By engaging in the process of continuous self reflection, and addressing one's own privileges, power dynamics, and cultural biases in relation

to "morality," practitioners can better practice remaining open to new cultural frameworks of morality. The critically important role of behavioral health providers is to prioritize the welfare and well-being of their clients and to utilize training, supervision, consultation, and empirical research to continue ethical practice with diverse clients (Renteria et al., 2020).

Conclusion

The United States is a multicultural country with differing demographics throughout the country. It is imperative that behavioral health providers understand the aspects that make up culture, how that impacts one's behaviors and health, and how to build cultural competency and cultural safety to diminish health disparities and offer all people quality healthcare. Culturally responsive care goes beyond a checklist of knowledge and skills and is an ongoing self-assessment of one's own beliefs and values and how that impacts one's work with clients.

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Appendix A

NATIONAL CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES STANDARDS

Retrieved July 2023. https://thinkculturalhealth.hhs.gov/clas/standards

The National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations to:

Principal Standard

1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Governance, Leadership and Workforce

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement, and Accountability

9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.
10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.

14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

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