

Chapter 13: Cultural Competence

The purpose of this chapter is to describe the state of culturally competent mental health and substance abuse services, including existing resources, strengths of current programs, and needs. The chapter includes narrative information gathered through focus groups and personal interviews, as well as existing data from ODMHSAS and other sources.

A. Existing Resources and Strengths

In 2005, ODMHSAS established a position for a Cultural Competence Coordinator to provide leadership around the provision of culturally competent care. The department also made more cultural competency training available. In 2006, a Cultural Competency Advisory Team was assembled, consisting of representatives of a range of cultural, racial and ethnic groups (not necessarily from the mental health or substance abuse fields), and including consumers and family members. The Team will respond to needs identified by the department, advise the department on promising practices for improving cultural competence, and will educate their own communities about substance abuse and mental health issues.

There are several ODMHSAS-certified programs throughout the state with a cultural emphasis. The Chickasaw Nation Alcohol and Drug Program is a 21-28 day residential treatment program for adult American Indian men and women. The Muscogee (Creek) Nation Behavioral Health and Substance Abuse Services (BHSAS) is an outpatient substance abuse program that believes “respect for culture and involvement in our Indian communities is essential to the success of our program.” Seventy percent of staff at this facility are American Indians with extensive educational backgrounds. The Latino Community Development Agency (LCDA) Adolescent Outpatient Substance Abuse Program provides individual and family counseling, group treatment, and crisis intervention and case management for individuals in the Latino community. Many other programs, both public and private, include a cultural emphasis. These programs include, but are not limited to: Citizen Pottawatomie Nation Health Complex, Community Adolescent Rehabilitation Effort (CARE) for Change, COPE, Inc., Inter Tribal Substance Abuse Prevention and Treatment Center, and Quapaw Tribal Family Services.

B. Needs and Existing Barriers

Multicultural Populations

As shown in Exhibit 13.1., Whites make up approximately 75 percent of the Oklahoma population, followed by Native Americans (7.4%), African-Americans (7.1%) and Hispanics (6.6%). People from multiple racial groups comprise 5.7 percent of the population, other racial groups 2.7 percent, Asian, 1.6 percent, and Pacific Islander .10 percent. When compared to the U.S. population, Oklahoma has a higher percentage of Native Americans and people from multiple racial groups (U.S. Census Bureau, 2006).

Exhibit 13.1. Oklahoma Population by Race/Ethnicity, 2005 American Community Survey.

Race/Ethnicity	Population Estimate	OK Percent	U.S. Percent
White	2,589,660	75.40%	74.70%
Black or African American	243,094	7.10%	12.10%
American Indian and Alaska Native	253,783	7.40%	0.80%
Asian	54,270	1.60%	4.30%
Native Hawaiian/Pacific Islander	3,598	0.10%	0.10%
Some other race	93,669	2.70%	6.00%
Two or more races	195,422	5.70%	1.90%
Hispanic or Latino (of any race)	227,767	6.60%	14.50%

Policies

The State has been straightforward in recognizing that systemic barriers exist that continue to create disparities in access to health care, mental health, substance abuse, and other human services for different cultural, racial and ethnic minority groups and persons with disabilities. Focus group participants commented on a number of these barriers (some of which are discussed in following sections), including what was perceived as a lack of urgency on the part of state agencies in addressing the root causes of these disparities. Among the root causes mentioned were a lack of understanding that people from different backgrounds may not share majority views about the nature, causes and appropriate responses to emotional distress and substance use; prejudice against people from non-majority backgrounds, which was seen as exacerbating many mental health and substance abuse problems; and a perception that cultural divides are so deep that they often make serious discussion of these issues difficult and frustrating for all parties. It was also noted that the cultures of mental illness, addiction, and/or the culture of poverty often overlay individuals' core cultural identity, and that this can even cause breakdowns in communication between professionals and clients who are from the same cultural, racial or ethnic groups.

Participants said that state agencies lack rigorous policies around translation and interpretive services. Some respondents reported that very specific types of expertise are required for translation services related to healthcare, adding that many other states have special certification requirements that Oklahoma does not have. It was noted that grant reviews often are critical of state agencies for not adequately addressing cultural competency issues. Focus group members and personal interviews from some groups stated that their needs did not seem to be taken seriously. Participants called for an agency-wide strategic plan to systemically address the development of culturally competent services.

Practices/Services

Focus group participants described a range of issues related to practices and services that interfere with providing culturally competent services to Hispanics, African-Americans, Native Americans, and other ethnic and racial minorities.

In order to compare ODMHSAS consumer racial/ethnic composition to that of ODMHSAS staff, the racial and ethnic composition of ODMHSAS consumers is provided in Exhibit 13.2. Compared to the Oklahoma population, African-Americans and Native Americans appear at a higher rate among ODMHSAS clientele than would be expected by population statistics. This could be due to several factors, such as higher rates of poverty and an increased prevalence of mental health and/or substance abuse problems. The 2005 National Health Interview Study demonstrated a higher prevalence for serious psychological distress (SPD) during the past 30 days for African-Americans compared with Whites, 3.7 percent versus 2.8 percent respectively. While the initial report did not include data on Native Americans, it did report that 3.8 percent of Hispanics experienced a SPD in the past 30 days, higher than both Whites and African-Americans (CDC, 2006). This national finding, combined with ODMHSAS client data and Oklahoma population estimates for Hispanics, indicates a significantly lower than expected number of Hispanic consumers among those served.

Exhibit 13.2. ODMHSAS Mental Health and Substance Abuse Treatment Clients by Race/Ethnicity.

Year	Total Clients	White alone or with another race		African American alone or with another race		Native American alone or with another race		Asian alone or with another race		Hispanic alone or with another race	
		#	%	#	%	#	%	#	%	#	%
FY 2001	32,881	25,271	77%	3947	12%	3728	11%	177	1%	942	3%
FY 2002	34,648	26,376	76%	4269	12%	3850	11%	251	1%	1123	3%
FY 2003	32,835	24,594	75%	4341	13%	3672	11%	197	1%	1173	4%
FY 2004	33,589	25,327	75%	4476	13%	3497	10%	209	1%	1201	4%
FY 2005	35,508	27,667	78%	4892	14%	3838	11%	187	1%	1412	4%

For Hispanics, language barriers were seen as a key issue. It was mentioned that in some parts of the state, Hispanics make up as much as 45% of the population, but that there are very few bi-lingual professional staff available to serve them. “There are no bilingual residential treatment programs for substance abuse services,” one professional said. “The only bi-lingual services available are AA and NA. If people are arrested for DUI, they can be mandatorily referred to outpatient treatment, but there are none available that are bilingual or culturally competent.” It was also noted that the same is true for mental health services. A recent survey in Tulsa County about disparities in healthcare and human services was mentioned; the study found that language was a significant barrier to access.

In the 2005 American Community Survey, it was found that about 4 percent of Oklahomans speak English less than “very well,” with the majority of these individuals speaking Spanish in the home (U.S. Census Bureau, 2006). Similarly, ODMHSAS non-English speaking consumers overwhelmingly prefer Spanish over other languages (see Exhibit 13.3.) It should be noted that less than 1 percent of ODMHSAS clients are non-English speaking compared with 8 percent of the population (U.S. Census Bureau, 2006), which may indicate a perceived or actual lack of services for non-English speaking individuals, or racial/ethnic stigma.

Exhibit 13.3. Preferred Language for ODMHSAS Mental Health and Substance Abuse Treatment Clients.

FY 2005	Number of Clients	
English Speaking	35,295	
Non-English Speaking	213	
PREFERRED LANGUAGE	#	%
Spanish	160	75%
Native American	31	15%
Sign Language	8	4%

The bilingual status of ODMHSAS direct care staff is presented in Exhibit 13.4., by primary type of service (PTS) provided. This table shows that for those PTS displayed the percentage of staff bilingual in English and Spanish has increased since FY 2001. While this increase demonstrates improvement, it should be noted that the location of Spanish speaking service provides does not necessarily coincide with the location of Spanish speaking clients. This table also shows a need for more Native American speaking and Sign Language capable staff. Moreover, to become more culturally competent ODMHSAS staff and data system should take into consideration the numerous Native American languages spoken in Oklahoma to see if those languages most needed by consumers are those spoken by staff.

Exhibit 13.4. ODMHSAS Direct Care Staff by Bilingual Status for select Primary Types of Service.								
Psychological or Counseling Services								
Year	Total Staff	Percent Bilingual	Language Spoken Other than English					
			Spanish		Native American		Sign Language	
			#	%	#	%	#	%
FY 2001	1,040	5%	23	2.2%	5	0.5%	3	0.3%
FY 2002	1,400	4%	30	2.1%	4	0.3%	4	0.3%
FY 2003	1,474	5%	36	2.4%	5	0.3%	6	0.4%

FY 2004	1,542	5%	36	2.3%	7	0.5%	5	0.3%
FY 2005	1,794	5%	51	2.8%	9	0.5%	5	0.3%

Exhibit 13.4. continued

Medical Services								
Year	Total Staff	Percent Bilingual	Language Spoken Other than English					
			Spanish		Native American		Sign Language	
			#	%	#	%	#	%
FY 2001	462	8%	7	1.5%	1	0.2%	3	0.6%
FY 2002	581	9%	11	1.9%	2	0.3%	3	0.5%
FY 2003	563	9%	11	2.0%	3	0.5%	4	0.7%
FY 2004	557	9%	11	2.0%	3	0.5%	4	0.7%
FY 2005	613	9%	15	2.4%	3	0.5%	5	0.8%
Case Management Services								
Year	Total Staff	Percent Bilingual	Language Spoken Other than English					
			Spanish		Native American		Sign Language	
			#	%	#	%	#	%
FY 2001	291	4%	8	2.7%	1	0.3%	0	0.0%
FY 2002	386	5%	15	3.9%	2	0.5%	1	0.3%
FY 2003	402	5%	15	3.7%	2	0.5%	0	0.0%
FY 2004	463	5%	15	3.2%	2	0.4%	1	0.2%
FY 2005	548	5%	22	4.0%	4	0.7%	2	0.4%
Administrative								
Year	Total Staff	Percent Bilingual	Language Spoken Other than English					
			Spanish		Native American		Sign Language	
			#	%	#	%	#	%
FY 2001	366	2%	2	0.5%	1	0.3%	1	0.3%
FY 2002	452	2%	2	0.4%	1	0.2%	1	0.2%
FY 2003	453	2%	3	0.7%	2	0.4%	2	0.4%
FY 2004	455	3%	6	1.3%	1	0.2%	1	0.2%
FY 2005	468	3%	6	1.3%	1	0.2%	1	0.2%

Beyond language, there are additional issues facing Hispanics who have mental health and substance abuse problems, including cultural values that tend to place a particular stigma on being labeled as “loco.” For undocumented residents, fear of deportation is often a barrier to seeking assistance; this was seen as true not only for Latinos, but for smaller populations of undocumented individuals from Africa and Asia.

A number of participants stated that “mental health” was a Western concept that is not a part of Asian, African, and Native American cultures. Interviewees commented that, for most non-European cultures, mental and emotional difficulties are traditionally handled within the family, the community, and the church, so that the idea of seeking help for these issues from a paid stranger seems peculiar to many people from other cultures. It was noted that this is as true for African-Americans as it is for people born abroad. Some providers noted that African-Americans are often very reluctant to be seen by Caucasian staff if they sense that the provider is not culturally attuned to them. “There is a huge lack of cultural competency; we need staff who can really relate to individuals from another culture,” one consumer said.

The racial/ethnic composition of ODMHSAS direct care staff is provided in Exhibit 13.5. While the race/ethnicity of service providers does not guarantee cultural competency, it does provide some reference when considering the reluctance of some clients to be seen by providers of a different race/ethnicity. In 2005, 14 percent of ODMHSAS consumers were African-American (see Exhibit 13.3.) compared to 12 percent of all direct care staff and 9 percent of psychological or counseling service staff. This disparity lends support to the focus group comments on African-American reluctance to seek treatment. Native American and Hispanic service providers are also slightly under represented when compared to client racial/ethnic composition.

Exhibit 13.5. ODMHSAS Direct Care Staff by Race/Ethnicity.											
All ODMHSAS Direct Care Staff											
Year	Total Staff	White alone or with another race		African American alone or with another race		Native American alone or with another race		Asian alone or with another race		Hispanic alone or with another race	
		#	%	#	%	#	%	#	%	#	%
FY 2001	3,045	2,458	81%	311	10%	270	9%	56	2%	65	2%
FY 2002	4,038	3,210	79%	424	11%	378	9%	82	2%	90	2%
FY 2003	4,250	3,352	79%	464	11%	395	9%	83	2%	109	3%
FY 2004	4,621	3,610	78%	531	11%	418	9%	83	2%	121	3%
FY 2005	5,203	4,036	78%	614	12%	473	9%	92	2%	148	3%
ODMHSAS Psychological Or Counseling Services Staff											
Year	Total Staff	White alone or with another race		African American alone or with another race		Native American alone or with another race		Asian alone or with another race		Hispanic alone or with another race	
		#	%	#	%	#	%	#	%	#	%
FY 2001	1,040	879	85%	87	8%	81	8%	9	1%	27	3%
FY 2002	1,400	1,167	83%	124	9%	119	9%	11	1%	34	2%
FY 2003	1,474	1,211	82%	142	10%	124	8%	17	1%	39	3%
FY 2004	1,542	1,277	83%	141	9%	121	8%	14	1%	37	2%
FY 2005	1,794	1,476	82%	160	9%	155	9%	13	1%	50	3%

While Native Americans can receive mental health and substance services through the Indian Health Services, they are also eligible for ODMHSAS-funded services, although it was noted that cultural competence may be lacking in these programs. Others commented that some providers tend to refer Native American consumers back to their tribes for service, and that this may not be what the consumer wants. The tribes are small, close-knit communities, and individuals seeking help may not want people from their tribe to know about their problems. It was also noted that some tribes lack access to non-tribal services because of their rural location: “For example, the Osage tribe has no access to local outpatient services, or psychiatric services, which are 45 miles away.” The lack of good public transportation in the state and the fact that services are not often located in minority communities was seen as another barrier to access.

Respondents called attention to the fact that cultural competence is a factor not only for racial and ethnic minority groups, but for other cultural groups as well. For instance, language/communication barriers affect not only people who speak languages other than English, it is a major concern for people who are deaf. Community-based

providers said that there is a lack of funding for sign-language interpreters, and that deaf consumers can only get inpatient care at Griffin Memorial Hospital, the only State facility where there are interpretation services.

According to the 2004 National Survey of Substance Abuse Treatment Services State Profile (N-SSATS), there were 59 facilities in Oklahoma capable of providing services in either sign language and/or a language other than English, including both public and private facilities. A total of 56 facilities offered services for the hearing impaired. Of those facilities with other language capabilities, 22 facilities had staff or on-call interpreters for Spanish speaking consumers, and 5 facilities had this coverage for Native American languages (SAMHSA, 2005).

Cultural competence is also an important issue for gay, lesbian and trans-gendered individual seeking services. "The gay and lesbian population in the state has been growing," one person noted. "This has led to a growing unmet need, as there are few services for them and a general lack of cultural sensitivity." Participants stated that hostility toward this population often leads to or exacerbates substance abuse problems and depression, and that gay youth may have trouble accessing services because they need parental consent but may be unwilling to come out to their parents.

Workforce Development and Training

For many respondents, workforce development and training were seen as the primary mechanism for remedying many of the problems noted above. There was a consensus that cultural competence training should be required for all staff. It was also suggested that one-time training on cultural competence issues was not sufficient to change agency cultures, and that leadership from the top and supervision are vital for the kind of environmental change needed within the system.

A significant shortage of mental health and substance abuse professionals from minority cultural groups was identified as a key barrier to the delivery of culturally competent services. Focus group members called for ODMHSAS to develop a targeted outreach and recruitment program aimed at people of color. A Latina professional said that large segments of the Hispanic population are not receiving services, primarily because there is not enough trained Hispanic or bilingual staff. She also noted that there is still little ethnic diversity among students in professional training programs, partly because successful students from cultural minority groups chose to go into higher-paying professions than human services. She suggested that scholarship programs to support master's level study for students from ethnic and cultural minority groups would be one way to increase the diversity of the system's staff.

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