

CHAPTER IV

CULTURAL COMPETENCE AND TRANSITION AGE YOUTH

*“We do not see things the way they are;
we see things the way we are.”*

—TALMUD

CHAPTER IV

CULTURAL COMPETENCE AND TRANSITION AGE YOUTH

OVERVIEW

This chapter presents Cultural Competence in Transition Age Youth (TAY) programs and practices not as a distinct concept or idiom, but as a foundation to the formulation of this entire manual, and as an integral component of quality care, equity, social justice, and the promotion of emotional and spiritual well being. As such, the California Mental Health Director's Association (CMHDA) TAY Subcommittee included this chapter on cultural competence and TAY with the expressed intent to infuse its concepts and principles. This manual is culture-based; therefore, each section presents information from a cultural competence perspective and recognizes such elements as race, ethnicity, age, gender, sexual orientation, socioeconomic status, geography, cross-cultural relations, religion, and language. The participation and involvement of TAY and their family members in the design, development, implementation, evaluation, and ongoing monitoring of programs and services is also recognized. In addition, there is an understanding that these efforts must occur at all levels of a system and in the provision of services to all young people with emotional and behavioral difficulties and their families.

CULTURAL COMPETENCE

Cultural Competence is a multilevel and multidimensional set of principles and practices, the aim of which is to: a) eliminate disparities and increase access and utilization; b) provide for more appropriate treatment; and c) improve outcomes for people in need of services. The expectation is that these individuals, regardless of race, ethnicity, gender, age, socioeconomic status, geographic location, religion, or language, receive the best available consumer and family driven services they need with dignity, respect, sensitivity, appropriateness, appreciation, and their full participation, as well as that of their family members and community. In California and across the country, recent efforts around cultural competence, not exclusive to TAY, have revolved around the implementation of significant and substantive changes to the community mental health systems. These efforts have involved system planning such as in development of new cultural competence managed care standards, institutional change protocols for system self-assessment and system-wide change to address disparities, and especially efforts to address the areas of quality of care and access. At its core cultural competence is about *equity and social justice*. This chapter is not presented as a TAY cultural competence *checklist*, linear in scope, but as a framework that can be used in local planning for system transformation and for new services. There are four overarching themes that should be considered in efforts to address culturally competent TAY programs and practices: a) elimination of disparities; b) quality and appropriateness of consumer and family driven care; c) outcomes; and d) systemic change. Each of these issues will be addressed in this chapter.

Elimination of Disparities

To set the context for cultural competence in California, let's look at the current and emerging demographics of the State.¹ Thirty-four percent of persons in California nineteen years of age or younger are what the census refers to as *White Alone/Not Hispanic*. Conversely, 66% of this same age segment is individuals from racially and ethnically diverse groups, with the greatest

¹ This information was taken from the California Department of Finance website: www.dof.ca.gov.

proportion occurring in the *Hispanic/Latino* population (43.5%). Similarly, when looking only at those young people ages 10 to 19, we find similar distributions, roughly 37% *White Alone/Not Hispanic* and about 63% from racially and ethnically diverse communities. Therefore, data has shown that the number of *White Alone/Not Hispanic* and *Hispanic/Latino* populations is relatively the same for individuals under the age of 19 as it is for individuals over the age of 19 years old. Additionally, language needs to be addressed when planning services to TAY and their families. The U.S. Census Bureau reports that in California 12.4 million individuals or 39.5% of the population speak a language other than English at home, and 8.1 million Spanish speaking individuals alone speak English *less than very well*.² The implication is that as this state continues to grow, its diversity will increase dramatically, and programs and services will have to keep pace in order to continue providing culturally and linguistically responsive and relevant mental health care.

In the provision of health and mental health services in the United States there exist service disparities and inferior health and mental health status has been documented for racially, ethnically, and linguistically diverse communities (National Center for Health Statistics, 1998; DHHS, 2001; Institute of Medicine, 2003). Further, minority groups are less likely to utilize mental health services more likely to drop out of mental health services at higher rates, and more likely to be misdiagnosed by practitioners. They often receive a poorer quality of care despite having similar prevalence rates of mental health disorders when compared to other groups. Young people in California from diverse populations have numerous unmet mental health needs which subsequently expose them to our system's most undesirable consequences: homelessness, incarceration, hospitalization, and misdiagnosis; poorer quality of care, out-of-home placements, and school failure. In fact, Hispanic/Latino American and African American youth have the highest high school drop out rates in California and nationally (See Taylor-Gibbs and Huang, 2003). Hispanic/Latino American and African American youth are more likely to attend schools with less experienced teachers and with difficult social environments (such as overcrowded classrooms and numerous episodes of violence) and they are less likely to participate in advanced coursework in math and science. They are also more likely to engage in high-risk behaviors; for example, Hispanic/Latina American young women have the highest rates of teen pregnancy (Fuligni and Hardway, 2004).³

A 2001 issue of *Focal Point*⁴ which focused on youth in transition reported that young adults ages 15-24 were more than twice as likely to suffer a psychiatric disorder compared to 45-54 year olds. However, at the same time, insurance coverage for young adults ages 18-25 was weaker and more tenuous than for all other age groups. Additionally, Yohalem and Pittman (2001)⁵ stated that when one looks at vulnerable youth, it is impossible to ignore the fact that cultural and social diversity play a significant role. They suggested that many diverse youth have faced discrimination on multiple fronts in the very systems designed to help them. As a result, their disproportionate confinement within the justice system, their over-representation in special education, foster care and out-of-home placements, and their experience with institutionalized

² U.S. Census Bureau, Census 2000 Summary File 3, Matrices P18, P19, P21, P22, P24, P36, P37, P39, P42, PCT8, PCT16, PCT17, and PCT19.
http://factfinder.census.gov/servlet/QTTable?_bm=n&_lang=en&q_r_name=DEC_2000_SF3_U_DP2&ds_name=DEC_2000_SF3_U&geo_id=04000US06.

³ See also www.futureofchildren.org for more information.

⁴ FOCAL POINT: A National Bulletin on Family Support and Children's Mental Health. (2001). Transitions. A publication of the Research and Training Center on Family Support and Children's Mental Health, Portland State University.

⁵ Yohalem, N. & Pittman, K. (October 2001). Powerful Pathways: Framing Options and Opportunities for Vulnerable Youth. Discussion Paper of the Youth Transition Funders Group. Takoma Park, MD: The Forum for Youth Investment, International Youth Foundation.

racism within the health care system is well-documented. Transitioning foster care youth who were at the most vulnerable period of their lives were cut off from most services merely because they reached a cut-off age. Half of these transitioning young people did not complete high school; about half were unemployed; fewer than 20% were economically self-sufficient; 25% had been homeless at least one night; and 60% of the females had given birth. These outcomes are important to understand when developing or improving mental health services and those of other TAY-serving agencies.

Providing culturally competent mental health services to TAY is about providing culturally appropriate services to all young people who need them. However, the fact that ethnically and culturally unserved and underserved populations are over-represented among vulnerable populations is a critical aspect to this population that we cannot ignore. Clark and Davis (2000) stated that in order to be culturally competent, mental health professionals and systems must demonstrate sensitivity and responsiveness to individual variation in gender, ethnicity, sexual orientation, social class, and other unique orientations and needs of each TAY and his or her family members. This responsiveness and sensitivity are essential to quality care. Taylor-Gibbs and Huang (2003) noted that race and ethnicity play a major role in child and adolescent development. It is important for programs and practices for TAY to address these developmental constructs when developing, implementing, and evaluating services, and to address safeguards against increasing disparities for diverse TAY. Sue, et al. (1992) stated the need and rationale for a multicultural perspective in our society, particularly in counseling and education. There is a high need for a multicultural approach to culturally competent assessment, practice, training, and research.

There are important policies and accepted standards that guide the provision of culturally competent mental health services. These can be summarized under federal and state policies, how culture and cultural competence have been applied by the Department of Mental Health (DMH), and the relationship between cultural competence and evidence based practices.⁶ First, we begin with the federal and state regulations, which mandate such provision of services. Title VI of the Civil Rights Act of 1964 and the Americans with Disabilities Act of 1990 provides protections to individuals receiving services from being excluded from participating in, or denied benefits of, or being subjected to discrimination by any federally financed program or activity on the basis of race, color, or national origin. Also, the U.S. Department of Health and Human Services, Office of Minority Health, issued national standards for culturally and linguistically appropriate services in Health Care, which addressed the need to ensure that all people entering the health care system receive equitable and effective treatment in a culturally and linguistically appropriate manner. These standards were developed as a means to correct inequities that have existed in the provision of health services and to make those services more responsive to the individual needs of all service recipients.

At the state level, several California statutes have addressed issues related directly to or in connection with culturally and linguistically appropriate services and service provision, including the Welfare and Institutions Code Sections 4341, 14683, 14683 (b), 14684 (h), 5600.2, 6600.2 (g), 5600.9 (a), 5802 (a)(4), 5855 (f), 5865 (b), 5880(b)(6), as well as California Government Code Sections 7292, 7295, and 7296.2. Lastly, in 1998 the California Department of Mental

⁶ Some of the information in this section on Cultural Competence was taken, in part, from the California Department of Mental Health's (DMH) Revised Addendum (4-2002) Plan for Culturally Competent Specialty Mental Health Services (CCP) and the Adult System of Care (ASOC) and Children's System of Care (CSOC) frameworks. In addition, other referenced sources within this section were included to give the section more clarity, uniformity, purpose, and vision.

Health mandated county mental health departments to create *Cultural Competence Plans*,⁷ with the purpose of establishing standards and plan requirements for county mental health plans (MHPs) toward achieving cultural and linguistic competency. As stated in the mandate, its intent was to assist MHPs in creating a more responsive and accessible system for Medi-Cal beneficiaries in the delivery of quality and cost-effective specialty mental health services.

Second, it is important to describe cultural competence and its application to California's public mental health system. The recognized definition of *culture* by DMH comes from Cross, et al (1989) and is defined as *the integrated pattern of human behavior that includes thought, communication, actions, customs, beliefs, values and institutions of a racial, ethnic, religious or social group*. Additionally, they define cultural competence as *a set of congruent practice skills, knowledge, behaviors, attitudes and policies that come together in a system, agency, or among consumer providers and professionals that enables that system, agency, or those professionals and consumer providers to work effectively in cross-cultural situations*. Additionally, the DMH Emergency Regulations for Managed Care, Title 9 of the California Code of Regulations, Section 1705, defines culturally competent services as *a set of congruent behaviors, attitudes and policies in a system or agency to enable effective service provision in cross-cultural settings*.

Third, given the current demographic composition of California's child, youth, and young adult population, it becomes essential for TAY programs and the provision of related services to recognize, adopt, and commit to providing culturally and linguistically competent mental health services. "Evidence Based Practices" (EBPs) may have achieved acceptance due to rigorous testing; however, that does not always mean that the practices have been adequately tested with sub-groups such as ethnically – or culturally – different groups of people. It is critical that practices that have been deemed *evidence-based or effective* recognize the importance of culture in determining what is effective for diverse populations, as well as address issues of access to services and the utilization of those services. Cautious optimism should be the guide when determining what populations these EBPs are applied to. Further, cultural and language considerations should drive the types of outcomes that are important to research and evaluation efforts, and to strive for in service implementation.

Quality and Appropriateness of Care

The Surgeon General's Supplemental Report on Mental Health stated that culture and language affect the perception, utilization, and outcomes of mental services (DHHS, 2001). Consequently, the provision of culturally and linguistically appropriate consumer and family driven mental health services are critical components for any programming designed to meet the needs of diverse communities. The report suggested that mental health programming should include such components as language access for persons with limited English proficiency; services provided in a manner that is congruent, rather than conflicting with cultural norms; and the capacity of the provider to convey an understanding for the consumer's worldview, level of acculturation, and real-life experiences, among other factors. To be effective, services must incorporate culturally sensitive assessments and responsive treatment modalities. In addition, a service provider's awareness of their own cultural orientation, their skills with different cultural groups, language capacity, and their knowledge of a consumer's background are essential to improving access, utilization, and the quality of mental health services for diverse populations. Depending on which segment of the TAY population you wish to target programming and services to (CSOC to ASOC; CSOC to community; or community to ASOC), there will be multiple cultural factors to

⁷ Revised Addendum (2002). Required Components for Implementation of Specialty Mental Health Services: Consolidation of Specialty Mental Health Services (Phase II).

consider. Therefore, ongoing appropriate and intensive assessment, training, evaluation, and community stakeholder involvement should be central components of any TAY programming.

Researchers agree that four critical areas need to be addressed when developing systems of care for TAY: *employment, education, living situation, and community participation* (see Clark and Davis, 2000). Entities which provide services to TAY must recognize the differing significance to young people across cultures within these four areas. For example, when considering *employment*, it is likely that in some diverse cultures, many of the young people have already worked, either alongside parents, or as individuals, early on in life. The implication for providers is that in some cultures, employment may not always be a new experience or the most important outcome. In *education*, it is critical to become knowledgeable of the differing effects for diverse groups. For example, in California, racially and ethnically diverse young people are more likely to drop out of high school than other groups – the highest group comprising the Hispanic/Latino population. In addition, it may be the case that language will become a primary area to be responsive to for the young people in this state. It is also important to offer vocational and/or technical certification training programs as alternatives to mainstream education.

Living situation includes living environment and family structure, among other factors that are highly culturally determined. For example, in some diverse communities living independent of the family is not necessarily a meaningful outcome, let alone a norm. So striving to motivate a young person to become independent of his or her family or community may actually be an inappropriate strategy reflecting a mainstream value system of independence and self-sufficiency, rather than a reliance on family and a more culturally inclusive view of interdependence and role-extended view of family. Policy planning and program designing for TAY must be cognizant of individualist cultural views, when collectivist worldviews may be more appropriate. Become aware of your service population's cultural worldviews in addition to individual and family living situations.

Community participation in and of itself has some cultural implications. Although stigma can be a detriment to full community integration, it, it may play a larger role in racially and ethnically diverse communities. Community participation can take on differing manifestations (e.g., spiritual resources, transportation, general health care, behavioral management, leisure activities, etc.). Racially and ethnically diverse adolescents are more likely to be in poor physical health and engage in high risk behaviors. Compared to White Alone/Not Hispanic adolescents, youth from diverse communities and immigrant families are less likely to have regular access to health care. It is also important to differentiate between person-centered care and cultural competence. Person-centered care revolves around individual client needs, whereas cultural competence revolves around the client's individual needs, the cultural interpretations of those needs, as well as the components of the system or program attempting to meet them. In a collectivist culture (often found in diverse communities) the adolescent is viewed from the family-self (self in relation to others) and in mainstream cultural worldviews it is more typically based on individual-self first. What would a family-centered approach mean for service design for TAY? This question must be considered when enhancing or developing programs and services for all TAY.

Outcomes

TAY outcomes should be culturally relevant and appropriate, as well as measurable, practical, and in the best interest of the young person in relation to his or her family. In addition, the outcomes should be driven by the young person and their family. Often, programs and services are driven by outcomes that are not necessarily congruent with the worldview of particular cultures. As a consequence, service strategies lead to meaningless results. In relation to quality of care and outcomes the Surgeon General's supplemental report (DHHS, 2001) defined appropriateness as *receiving an accurate diagnosis or guideline-based treatment* based on a careful assessment and evaluation of a person's symptomatology in relation to the diagnostic criteria established in the Diagnostic and Statistical Manual IV (pg. 17). If treatment efficacy is defined as the attainment of positive outcomes, then appropriate outcomes must be defined within the cultural context of the individual, given a culturally sensitive assessment. For example, the over-diagnosis of conduct disorder in young people from diverse cultures may characterize a lack of appropriateness in serving systems, and therefore, can lead to the establishment of less appropriate treatment and outcomes (DHHS, 2001).

Programs which provide services for diverse young people should take extra steps to gain feedback from them to establish the desired objectives of treatment, and hence the outcomes. It is critical to assess and evaluate your services' capacity to gain this vital information. Further, utilizing the cultural formulation model, as prescribed in the DSM-IV, should be an essential component to any TAY program, whereas the following areas should be explored with each young person throughout their transition:

- Cultural identity of the individual including religious and spiritual beliefs
- Cultural explanations of individual's illness
- Cultural factors related to psychosocial environment and levels of functioning
- Cultural elements of the relationship between the individual and provider
- Overall cultural assessment for diagnosis and care
- Family assessments and acculturation factors

The involvement of the family and working in partnership with community based organizations in the young person's treatment, where appropriate, may have significant cultural relevance and result in more appropriate outcomes for both the young person and his or her family.

SYSTEMIC CHANGE

Systemic change involves a dedicated and concentrated effort to transform systems. The goal of cultural competence therefore is not only to infuse its principles and practices for individuals, but also to establish a more comprehensive system transformation so that agencies ensure that cultural reflection, innovation, and acceptance exist at every level. The Institute of Medicine (2003) released a report titled *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*, which set forth the following:

Systemic interventions to improve healthcare delivery for diverse populations include organizational accommodations that may promote equity in healthcare, policies that reduce administrative and linguistic barriers to care, and practices that enhance [consumers'] knowledge of and roles as active participants in the care process. These efforts are likely to be most effective when applied in a systemic, simultaneous, multi-level, coordinated fashion, and follow a well-developed strategic plan that has [consumers], their families, and the communities in which they live; clinicians;

administrative staff; and health systems leadership. Systemic interventions also include changes to healthcare law and policy that promote equality of healthcare delivery (p. 180).

Further, the Focal Point issue on transitioning young people revealed that successful transitions were facilitated when treatment planning, services, and supports:

- build in and build on what remains stable in the child’s life, particularly family relationships and relationships with others who are providing ongoing support;
- are individualized and family- and child-driven, taking into account the unique situations and the particular capacities, needs, cultural values and goals of children, their families, and their communities;
- capitalize on and enhance the strengths of the child and maintain activities, program involvement, and other supports which have worked in the past;
- anticipate and prepare for transition well in advance and maintain transition supports past the actual point when a setting or situation changes;
- are coordinated, while also managing and sharing information in a way that is both efficient and respectful to the young person and their family.

Furthermore, the series pointed out that much of the trauma associated with transition could be eliminated when transitions were made less frequent or when they were avoided altogether. However, the reality of our mental health service system is that transitions are unavoidable due to program designs and funding issues. The series added that implementing transition programs and plans based on the above list would be difficult to do well. As a result, each transition plan or program would have to fill in the specifics behind these generalities in ways that creatively address the challenges surrounding a given type of transition.

CONCLUSION

By the year 2050, diverse racial and ethnic groups will make up almost half of the total U.S. population. In California, this figure is already over half. Because of these demographic changes, human service systems must change or adapt programs and services to meet the needs of the largely diverse and growing number of young people and their families in this state. Systems and programs must consider cultural competence at the policy-making level, the organizational level, and the direct service level.

Applying effective TAY programs and practices which address issues related to cultural competence should be the norm in all program design. Evidence based practices should be implemented with cautious optimism, unless the program has been tested with the same cultural groups and languages of the local populations of diverse communities. Further work may need to be done to match the practice and make adjustments for the diverse community.

RECOMMENDATIONS

The following recommendations regarding cultural competence and TAY are offered to guide mental health systems in promoting a more culturally competent system of care. These recommendations were derived from a multitude of sources including the members of the committee, the cultural competence literature, and the good work in *practice* occurring across California.

1. Efforts to eliminate barriers to accessing mental health care for TAY including discrimination, bias, stigma, and costs need to be continued and expanded.
2. Efforts to eliminate disparities in access to and quality of mental health care for TAY need to be continued and expanded.
3. The involvement of family members and community in the young person's treatment, where appropriate, is essential, given that this involvement will have significant cultural relevance and may result in more appropriate outcomes for both the young person and his or her family.
4. Mental health systems should include a description and an objective or goal for the delivery of services to TAY as part of any Cultural Competence mandates or requirements.
5. TAY should be specifically mentioned when describing unmet needs in your service populations.
6. Mental health professionals and systems must demonstrate sensitivity and responsiveness to individual variation in gender, ethnicity, sexual orientation, social class, and other unique orientations and needs of each TAY and his or her family members.
7. Programs or practices which have been deemed *evidence-based or effective*, if implemented, must recognize the importance of culture in determining what is effective for diverse populations, as well as address issues of access to services and the utilization of those services, through continuous quality improvement and program evaluation.
8. The selection of a treatment practice for TAY needs to be based on mutual decision-making between informed young people, their family members or caregivers, and their providers.
9. Programs and practices for TAY must address developmental constructs when developing, implementing, and evaluating services, and address safeguards against increasing disparities.
10. A multicultural approach to culturally competent assessment, practice, training, and research should underlie programs and practices for TAY.
11. Language must be addressed when planning services to TAY and their families.
12. Given the current demographic composition of the child, youth, and young adult population it becomes essential for TAY programs and the provision of related services to recognize, adopt, and commit to providing culturally and linguistically competent mental health services.
13. Ongoing appropriate and intensive assessment, training, evaluation, and community stakeholder involvement should be central components of any TAY programming.
14. Offer vocational and/or technical certification training programs as alternatives to mainstream education.
15. Policy planning and program designing for TAY must be cognizant of individualist cultural views, when collectivist worldviews may be more appropriate.
16. TAY outcomes should be culturally relevant, appropriate, and driven by the young person and their family, as well as measurable and practical
17. Utilizing the cultural formulation model, as prescribed in the DSM-IV, should be an essential component to any TAY program.
18. A major goal of cultural competence is to infuse its principles and practices into daily activities, but it is also a more comprehensive attempt to transform systems into entities which include cultural reflection, innovation, and acceptance at all levels – systemic change involves a dedicated and concentrated effort to transform systems.

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