

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH  
OFFICE OF THE MEDICAL DIRECTOR

**4.8 Parameters for the Delivery of Culturally Competent Clinical Services**

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## **I. Introduction**

1. Cultural competence is defined by State Department of Mental Health as a set of congruent practice skills, knowledge, behaviors, attitudes, and policies that come together in a system, agency, or among providers and professionals that enables that system, agency, or those professionals and consumer providers to work effectively in cross-cultural situations.
2. Los Angeles County Department of Mental Health (DMH) defines organizational cultural competency as personal characteristics and organizational structure and practices causally related to the effective provision of culturally and linguistically appropriate services, where differences are acknowledged, valued, respected, and embraced.
3. Clinical cultural competence is defined as the ability to relate to diverse individuals and to shape clinical assessment and interventions by awareness, knowledge and understanding of relevant personal, cultural, ethnic, language, and racial characteristics of consumers.

## **II. General Considerations**

1. All DMH clinicians should know how to apply relevant cultural variables to shape clinical outreach, assessments, interventions, and supportive services.
2. All DMH clinicians should know how to apply relevant cultural variables to shape clinician/consumer/family interaction, dialogue, and relationship.
3. All DMH clinicians should have skills to rapidly locate sources of cultural information regarding health and mental health through web-based resources, e.g. <http://www.geocities.com/SoHo/Study/8276/CulturalMed.html>.
4. DMH should provide ongoing training in the unique cultural issues in our consumer population that affect clinical practice.

## **III. Assessment and Psychotherapy**

1. DMH clinicians should consider the following culturally specific health-related factors:
  - a. Degree of acculturation
  - b. Help seeking behaviors
  - c. Verbal and nonverbal communication
  - d. Variance in need for personal space
  - e. Interpretation of symptoms
  - f. Perception of mental illness versus mental health
  - g. Cultural expectations about the therapist and the therapy
  - h. Accessibility to indigenous or alternative treatments



2. DMH clinicians should consider the following culturally specific social and psychological factors
  - a. Impact of cultural and socio-economic differences between therapist and client
  - b. Social experiences and/or obstacles, such as racism
  - c. Economic and political conditions
  - d. Experience of migration (migrant or refugee)
  - e. Degree and individual characteristics of client's acculturation
  - f. English language proficiency level and educational background
  - g. Family's issues, such as the cultural gap and generational gap within one's family
  - h. Utilization pattern of social and/or individual support system
  - i. Culturally based view about self, others, and the world
  - j. Values, belief (such as religion and spirituality), and custom
  - k. Racial, ethnic, and cultural identity
  - l. Collective cultural experience
  - m. Other attributes, such as physical characteristics
  
3. DMH clinicians should ensure readiness in providing culturally sensitive and appropriate treatments through:
  - a. Trainings
  - b. Education
  - c. Supervised clinical experiences
  - d. Examination of personal attributes: values, attitude, and biases
  
4. DMH clinicians should provide services in client's best interest. When cultural differences between therapist and client pose as an obstacle in the therapy process, therapist should initiate consultation with appropriate individuals. When cultural differences preclude useful treatment despite all attempts to resolve the differences, the client should be timely transitioned to a more appropriate resource, with complete documentation of reasons for transfer.
  
5. DMH assessment of substance use should consider:
  - a. Culturally specific substance abuse patterns and rates
  - b. Culturally sanctioned substance use patterns
  
6. DMH treatment services should have the following characteristics:
  - a. An understanding of how social and cultural factors operate across a cultural, ethnic, and linguistic groups to affect mental illness in diverse communities.
  - b. Basis in client's preferred language (this also applies to all written materials or hand-out distributed to clients)
  - c. Component of a well-coordinated effort with other involved entities and/or service providers when appropriate, such as client's family and primary health care.

## **IV. Culturally Competent Outreach**

Advocacy within scope of DMH mission for elimination of adverse social conditions and enhancement of intrinsic community strengths

### **V. Clinical Environment**

1. Food served at DMH clinics during various community and client-centered events should be culturally appropriate to consumers at those clinics.
2. Cultural words and symbols (political, religious, or social) displayed in clinics should be culturally sensitive to consumers at those clinics, with special care taken to avoid display of symbols that may have culturally-specific negative connotations.
3. Esthetic objects and decorations displayed in clinics should, when possible, be welcoming and comforting within the cultural traditions of consumers in clinics.
4. Security personnel should interact with consumers in ways that are as minimally threatening as possible to consumers whose cultural background or refugee status includes negative connotations to individuals wearing police or military uniforms.

## **VI. Cultural Perceptions Relevant to Mental Health Services**

1. DMH clinicians should be familiar with the cultural traditions regarding mental illness, treatments, traditional “healers,” healthcare providers, and healthcare facilities for consumers that they treat.
2. The giving or acceptance of gifts in the context of the treatment relationship should be based upon an understanding of gift giving customs in the particular culture of the consumer and adhere to any relevant DMH policies.

### **V. Managing Situations In Which Requisite Competence Is Not Available**

1. DMH clinicians should be familiar with the steps necessary to obtain translator services when they do not speak the language of a consumer.
  - a. See Appendix I “Sample Procedure for Language-specific Mental Health Services”
2. DMH clinicians should be familiar with the techniques necessary to conduct clinical assessment and treatment with use of a translator, including
  - a. A brief orientation by the clinician to the translator about what is needed and expected.
  - b. Proper introduction of translator and explanation of procedure
  - c. Soliciting and addressing client concerns about a translator

- d. Obtaining client's permission to use a translator
  - e. Speaking in clear, simple, and appropriately parsed phrases that are idiom-free
  - f. Asking for clarification from translator of ambiguous translation
  - g. Appropriate physical arrangement of interview, with translator apart but completely visible to client
  - h. Making appropriate eye contact with client.
  - i. Appropriate conclusion of interview with thanking and dismissing of translator before patient leaves.
3. DMH clinicians should be familiar with appropriate clinical procedures in instances when clinical intervention is necessary and no professional translator is available.
- a. When immediate interpretation is required and no interpreter access is available in the primary language, and the client agrees, a reliable family member or friend may interpret. *Children and/or adolescents should be used as translators only in instances where no other options exist.*
  - b. Clinician should provide a brief orientation to the non-professional translator regarding the role of a translator and need for the most accurate interpretation of what the client is saying.
  - c. Family members or friends should not be used as interpreters for ongoing services.

## VI. Psychopharmacology

1. DMH clinicians should be familiar with procedures for identifying medications produced in other countries, based on drug names (generic and proprietary) and on description of pills, and should document such identification in the medical record. When the clinician is unable to identify a medication, the clinician should seek consultation and document in the medical record efforts made to identify the substance.
  - a. DMH Clinicians should have skills to rapidly locate sources of medication
    - information through web-based resources, e.g., [www.rxlist.com](http://www.rxlist.com)
2. DMH psychiatrists should be familiar with unique racial and gender-related metabolic characteristics that affect patient response to specific doses of medication.
3. DMH clinicians should be familiar with psychoactive and relevant metabolic effects of herbs, foods, and other substances used medicinally and recreationally by consumers in cultures of consumers that they are treating (See Appendix II).
4. DMH clinicians should be familiar with relevant pharmacokinetic effects (e.g., drug levels) of cultural dietary habits.

## VII. Resources

1. Cultural Assessment in Clinical Psychiatry, Formulated by the Committee on Cultural Psychiatry, Group for the Advancement of Psychiatry, Report No. 14.
2. Culture and Psychotherapy, A Guide to Clinical Practice, Edited by Wen-Shing Tseng, MD and Jon Streltzer
3. A Concise Guide to Cross-Cultural Psychiatry, Albert C. Gaw
4. The Latino Psychiatric Patient, Assessment and Treatment, Albert G. Lopez, MD, MPH, Ernestina Carrillo, MSW
5. Mental Health: Culture, Race, and Ethnicity, Executive Summary, A Supplement to Mental Health: A Report of the Surgeon General, US Dept of Health and Human Services, <http://www.surgeongeneral.gov/library/>.

### Appendix I:

#### Sample Procedure for Language-Specific Mental Health Services

1. Identify and document the consumer's preferred language (the Disposition Screening and the Referral Log for Language-specific Mental Health Services).
2. Document where the referral came from (the Disposition Screening and the Referral Log for Language-specific Mental Health Services).
3. Assign the case to the program staff that best meets the beneficiary's language need based on the attached sample list "Language Capacity of Program Staff, " and document on the Referral Log for Language-specific Mental Health Services.
4. If no program staff speaks the consumer's preferred language, two options can be given to the consumer: referring him/her out to the appropriate agency or using the interpreter outside of the program.
5. When a referral is made, the referring staff must document on the Referral Log for Language-specific Mental Health Services.
6. The staff from the receiving program must provide the referring staff with verification of completed referral and document on the Referral Log for Language-specific Mental Health Services.
7. If the consumer did not keep the scheduled appointment, the referring staff must take follow-up measures and document on the Referral Log for Language-specific Mental Health Services.
8. When interpreter service outside the agency is to be used, program staff select an interpreter based on the attached sample "List of Interpreters" that will best meet the needs of the beneficiary.
9. The use of interpreter service outside the agency should include an appointment with the consumer indicating time and date.
10. If an interpreter from the "List of Interpreters" is not available for the language that is needed, the attending staff can call ACCESS Center at (800) 854-7771, and document on the Disposition Screening and the Referral Log for Language-specific Mental Health Services. ACCESS Center has linguistic capabilities via AT&T Language Line Services 24 hours a day/7 days a week.
11. If a referral is made to the outside agency or kept within the agency, the required information on the Referral for Language-specific Mental Health Service log must be documented.

## Appendix II

Ethnic and cultural variation in diet, alternative medicine and smoking habits is well recognized. Less well known is the influence these practices have on an individual response to medication. Dietary, herbal, and environmental (i.e. smoking interactions with medications are often due to changes in drug metabolizing enzyme activity. The most important enzyme involved in the metabolism of medications used in psychiatry is the Cytochrome P450 enzyme system (CYP). Among the various CYP enzymes, CYP1A2 and CYP3A4 appear to be the most impacted by these culturally determined practices. Below are a few examples.

### 1. Medications Metabolized by CYP1A2

#### a. Antidepressants:

amitriptyline, imipramine, fluvoxamine

#### b. Antipsychotics:

clozapine\*, fluphenazine\*, haloperidol\*, olanzapine\*, thiothixine

#### c. Misc.:

acetaminophen, caffeine, cyclobenzaprine, estradiol, mexiletine, naproxen\*,

ondansetron\*, propranolol\*, riluzole, ropivacaine, theophylline, tacrine, zileuton,

zolmitriptan

2. Diets rich in Cabbage, broccoli, brussels sprouts, cauliflower, onions, garlic, grilled foods, meat, and smoking (cigarettes, or other herbs) may decrease drug levels of medications metabolized by CYP1A2.

3. Black and white pepper (or herbal combinations that contain piperine-see below) may increase levels of medications metabolized by CYP1A2.

### 4. Medications Metabolized by CYP3A4

#### a. Antipsychotics:

clozapine\*, haloperidol\*, pimozide, quetiapine, risperidone\*, thioridazine\*, ziprasidone

#### b. Antidepressants/ Mood Stabilizers/ Anticonvulsants:

carbamazepine, ethosuximide\*, mirtazapine\*, nefazadone, sertraline, tiagabine,

trazadone\*, zonisamide\*,

#### c. Benzodiazepines/ Sedative Hypnotics:

alprazolam, buspirone, clonazepam, diazepam\*, midazolam, triazolam, zaleplon,

zolpidem

#### d. Antibiotics/Antifungals/Immune modulators/Chemotherapy:

clarithromycin, cyclosporine, erythromycin, dapsone, indinavir, ketoconazole, nelfinavir,  
saquinavir, ritonavir, taxol\*, tamoxifen, vincristine

e. Misc.:

alfentanil, astemizole, chlorpheniramine, cisapride, cocaine, codeine\*, estrogens,  
fentanyl, hydrocortisone, methadone, progesterone, salmeterol, terfenadine, testosterone,

Viagra

5. Grapefruit juice, Corn, Ginkgo biloba, and Panax ginseng may increase drug levels of medications metabolized by CYP3A4.
6. St. Johns Wort will decrease levels and effectiveness of medications metabolized by CYP3A4.



## Appendix II Resources

1. Fugh-Berman, A. (2000) Herb-drug interactions. *Lancet*, 355 (1998), 134-8.
2. Schulz, H. T. (1997). *Rational Phytotherapy*. Berlin, Heidelberg, New York: Springer.
3. Wong, A. H., Smith, M., & Boon, H. S. (1998). Herbal remedies in psychiatric practice. *Arch. Gen. Psychiatry*, 55, 1033-1044.
4. Internet-Comprehensive Natural Medicine Database: <http://www2.naturaldatabase.com/>.