ISM Culturally Responsive Treatment Study:

Challenges & promising solutions implementing culturally competent integrated care in Los Angeles County

Learning Brief

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As part of Los Angeles County Department of Mental Health's (LACDMH) Innovation program, the Community-Designed Integrated Service Management Model (ISM) model took on the task of creating culturally relevant integrated services for designated ethnic communities throughout Los Angeles County. Integration involved coordination of mental health, physical health, and substance abuse services across multiple community-based partners. Programs also incorporated "non-traditional" services during outreach and engagement and after enrollment. These services included culturally traditional healing and wellness activities such as beading, acupuncture, and knitting groups as well as other activities such as Zumba.

While the ISM providers implemented culturally competent and responsive services to the people and communities they served, they struggled to combat significant stigma related to the receipt of mental health services and to align traditional cultural practices, values, and norms into an integrated care context. A great deal of learning took place among ISM providers through this process; the Innovation evaluation team sought to document this learning so that it can be applied in future work. Informed by focus groups with the ISM programs (*see Purpose and Methodology call out box on page three for more information*), this learning brief highlights their promising solutions to mitigate stigma, break down trust and confidentiality barriers, increase awareness about mental health issues and services, and address language and cultural expectations. This information is intended to help inform future work by Los Angeles service providers, LACDMH, and the continuum of care locally and nationally.

Culturally Competent & Patient-Centered Approach

Cultural competence has been defined and framed in a variety of ways across academic and applied settings. Published definitions focus on a range of practices and approaches, including the use of specific language, engaging in social practices, and being knowledgeable of the target populations' cultural and political history. It is widely understood that culture "influences beliefs and belief systems surrounding health, healing, wellness, illness, disease, and delivery of health services" (National Institutes of Health). It is thought that providers who are culturally competent are more likely to deliver services that are respectful of and responsive to the health beliefs, practices, and cultural and linguistic needs of diverse patients, which in turn should yield better health/mental health outcomes.

Providers who participated in this study offered a wide variety of interpretations of the meaning of cultural competence:

- *"To me culturally competent means from the front door to the back, meaning as they come in [are] they greeted by the receptionist? As they walk through the offices do they see faces? Do they see artifacts? Do they see things that speak to their culture? When they call after hours is the recording in their language? To me these are culturally competent tangible things."* – Asian Pacific Islander ISM provider

- *"What are the effects on people because of the earthquake, because of communism, because of genocide, and how everything that has happened. They want to know where were you in history. Do you understand the pain that was caused upon me during that stuff?"* – Eastern European/Middle Eastern ISM provider

- *"We understand their language…and that we have at least some basic understanding of their ethnicity and culture, so that when they're talking to you, you'll understand…since we share a similar language, ethnicity, and culture that they're not being judged."* - Latino ISM provider

In addition to the need for culturally competent care, patient centered care was promoted extensively by all the ISM programs. Patient centered care customizes treatment and services based on the client's needs, motivations, beliefs, and preferences. There is common ground between patient centeredness and cultural competence. ISM program staff frequently reflected on efforts to get to know their clients in the context of the client's own social world by listening to them, respecting them, and being involved compassionately in their care. *"We support them to speak for themselves and advocate and that's what we want them to do,"* explained an ISM case manager. An ISM therapist added, *"It's just being there for them individually and helping them in the process of finding themselves and their voice and their kind of strength. I work with a lot of women… being there for them and then seeing them grow."* Another therapist commented, *"We try to really see where our clients are and try to match them as best we can and give them all the opportunities that are available. We don't assume that they wouldn't want to do this or they're not interested in that. We help guide them to get to wherever they need to go."*

Study Purpose & Methodology

In fall 2013, thirteen focus group interviews were conducted with a total of 70 staff from ISM agencies. The priority for this qualitative study was to document (1) strategies used by each of the ISMs to facilitate outreach and engagement with their respective communities, (2) different examples of wellness or healing activities that resonated for ISM clients, (3) procedures established by each ISM to promote cultural competence in the services offered, and (4) challenges in sustaining cultural competence for the programs and the agency as a whole.

The 13 ISM programs that participated in the focus groups work with the following ethnic communities: African and African American (A/AA - two programs), American Indian and Alaska Native (AI/AN - one program), Asian and Pacific Islander (API - four programs includes Cambodian, Chinese, Korean, and Samoan), Eastern European and Middle Eastern (EE/ME - three programs) and Latino (three programs). Each focus group lasted between 60 and 90 minutes in which a five question interview guide was used to direct discussion. There were five to ten interviewees per focus group.

The focus groups were transcribed verbatim and redacted of any personal identification data (i.e., names, geographical locations, program names, agency names, clinic names). A copy of the redacted interview file was provided in late February 2014 to each ISM program manager as a record of their participation in the focus group study. Content analysis (Milne & Oberle, 2005; Sandelowski, 2000) was conducted to pull out central ideas emerging across and between the ISM agencies interviewed. ATLAS.ti was used to facilitate coding and inter-rater reliability checks were used to verify codes. Quotes included in this brief were identified by one of the five ISM ethnic communities. They were redacted of provider identifying information such as a specific language or ethnicity.

At the time data collection took place, most of the ISMs were still in the outreach and enrollment phase of their Innovation program. The ISM programs have continued to progress and evolve beyond outreach and enrollment

Challenges & Promising Solutions

Across the ISM programs four interrelated challenges were highlighted during focus groups. For each challenge ISM staff shared strategies and solutions that they have successfully used to mitigate those challenges.

CHALLENGE 1: Stigma

Stigma was cited as a major impediment to the ISM programs particularly during the outreach and enrollment phase. Many people with mental health issues are not only struggling with the symptoms that result from their illness, but they are also challenged by the stereotypes and prejudice that stems from misconceptions about mental health. According to Davey (2013), "Mental health stigma can be divided into two distinct types. ***Social stigma*** is characterized by prejudicial attitudes and discriminating behavior directed towards individuals with mental health problems as a result of the psychiatric label they have been given. In contrast, ***perceived stigma*** or ***self-stigma*** is the

internalizing by the mental health sufferer of their perceptions of discrimination.[1] Perceived stigma can significantly affect feelings of shame and lead to poorer treatment outcomes.[2]"

Issues of stigma were present across all ethnic groups served by ISM programs. Staff from an API ISM program shared that within the population they serve, "*They are ashamed of it [mental health issue]. Sometimes they send that family member to someplace else to hide the situation, or the whole family disappears from the town…it's such a huge shame attached to mental health issues.*" Another API ISM provider noted, "*You're going against the culture if you're going to talk about your problems…If you have a problem, take care of it at home, don't bring it outside*." A Latino ISM program staff member commented, "*The clients are like 'I'm not crazy.' That's their first thing. 'Why are you calling me? I am not crazy.'* " An A/AA ISM shared "*With African Americans, one of the first things with mental health is feeling judged, feeling criticized because of where they are or what they've gone through, because of their experiences…"* A provider from an EE/ME ISM explained that *"in [language], the word 'client' doesn't really exist. It just means 'patient' which translates into 'the sick'…So to grapple with the idea of a person coming in to be just a client, and just somebody seeking mental health services for preventative measures or whatever it may be…it has not historically existed…whether it's a physical, or a mental issue, you're still 'the sick.'* " These perceptions made outreach and enrollment challenging for all ISM programs.

Promising Solutions:

ISM providers developed and refined a number of different strategies to overcome the challenge of stigma. Most programs utilized more than one of the strategies that follow.

Select terminology and word choice carefully: Providers discussed that, particularly during the outreach and enrollment phase, it was useful to avoid using mental health terminology. For example, a provider from an A/AA ISM described *"when we interact with our clients, even before they become a client, we don't use big words because those tend to scare our clients away. So we soften some of our language by saying, 'someone to talk to, an area that is safe,' and so that's been a way that clients have at least gotten their foot in the door."* Some alternative language used by the providers to introduce mental health related issues without the use of mental health terminology or jargon included: "improve your self-confidence," "do you feel stressed?," or "health screening." Programs embraced this terminology for verbal communications with current and potential clients as well as in written materials, such as program brochures. Programs also considered terminology implications in the native languages spoken by clients and assured that words were translated in a manner to help reduce stigma.

Incorporate non-mental health focused activities: ISM staff reported that they used programs and activities focused on non-mental health issues and topics to engage people and to make it safe for them to become a "client" of the program. For example, one API ISM instituted an "educational workshop" series focused on physical health issues on Thursday afternoons because they found that:

> *"When [prospective clients] hear 'mental health,' they run away. They shut down right away; they stop talking to you…We noticed that now in API communities high blood pressure, diabetes and arthritis are major issues that clients comes across, especially the seniors, so we have a workshop, and my nutritionist, who will be able*

[1] Link, Cullen, Struening, Shrout, & Dohrenwend (1989)

[2] Perlick, Rosenheck, Clarkin, Sirey, Salahi, Struening, & Link (2001)

to speak [client's language], specifically--to give a weekly workshop and also acupuncturist to talk about acupuncture and to talk about some of the traditional approach to solving, let's say, arthritis issues or pain management…We provide that platform, where clients will be able to interact with each other or even prospective clients, so that when they come, they don't think of this as, 'I'm in a mental health clinic'…they see it as, 'You know what? I'm here to meet friends. I'm here to have a good time, to play chess, to cook with my peers, my friends, people who understand me, people who understand my immigrant background, immigrant experience and also the language.' "

When one of the A/AA ISMs first launched, *"people were like, 'Oh, acupuncture, yeah, I want that,' or, 'Ooh, some yoga. That sounds good,' or 'YMCA.' And then we're like going through the orientation and they go, 'I don't need mental health though, that's not why I'm here' …Now we see that these clients really enjoy and value the program because it's so comprehensive, and are very open and trusting of other process and understanding the importance of a full body and how mental health is connected to that, so I think it's really about how we communicate."*

Consider setting and signage: Signage at the site where services were offered, especially when it referred to mental health services, may have dissuaded some clients from accessing services. Providers from an A/AA ISM described how *"it was planned to have this program away from the main building…[with] the big sign that says, 'Psychiatric Hospital' "* but their building has no sign, so *"there's no stigma associated, no one identifies what kind of building. So coming out of it no one knows why people are coming in and out. And it works perfect, it's a good camouflage."* A staff member from a Latino ISM shared, *"We were located at a different site initially… one mile away but they were servicing HIV+ patients and our clients said why are we coming here?"*

CHALLENGE 2: Overcoming confidentiality and trust concerns

Another consistent challenge across many of the ISMs was clients' concerns about confidentiality. For some clients, confidentiality was an unfamiliar concept. For example, one provider from an API ISM said, *"there is no concept of confidentiality that much in [specific country]. It's more of a collective society and that everybody shares together all of the information, and when you go to this doctor he's not your doctor but he's sharing this information….I'm dealing with older adults so they really don't have idea about this confidentiality like are you going to not say anything to your friends."* This was echoed in an EE/ME ISM, *"confidentiality is new to them. Because I mean, they're almost not used to it. They're used to things being heard in the community."*

Providers also reported that initial lack of trust and the time to build trust with clients presented a barrier. In some cases trust can take up weeks, months, and even years to establish. A provider from an AI/AN ISM noted that often people do not want *"to voice or speak to a therapist or an authority figure because a lot of times Native people are quiet and don't share their problems…it has to do a lot with multigenerational trauma so just educating them on that, giving them an awareness about it, and letting them know it's okay to speak, and allowing us to help them."* A provider from an EE/ME ISM stated, *"I think it's a lot longer the engagement period than with an American client per se who is willing to come in and right off the bat kind of tell you exactly what's happening. With [a specific ethnic group] client you may have weeks and weeks of 'So how are you? I'm fine, how are you? No really, what's going on? Nothing much, what's going on?' before that kind of trust like is gained."* A provider from an API ISM explained *"from a narrative standpoint, when you have a culture that has gone through a season of their history where trust has been just*

destroyed…When I offer an intervention for instance, it's always an invitation. What do you think about this, and getting their feedback….And I can tell, as a session or an intake process goes on, the more detail I get because I can see my currency of trust is being built…even in that one and a half hour, two hour period."

Providers felt that some clients were hesitant to enroll in ISM services because they feared it would affect their immigration status or lead to deportation. One of the API ISM providers explained that potential clients are *"scared to come out from the door and release all this information about my past and my name and my family information and they keep asking the same question about 'You're not related to the immigration?'* Similarly, a provider from an EE/ME ISM shared, *"I've had a few potential clients that were concerned about going to a mental health program, that it might affect their immigration or citizenship status…Through educating them and kind of explaining what goes on, confidentiality and the benefits of the program, we're able to get them to sign on."* Empowerment was also discussed by a provider from a Latino ISM, *"Our population can feel somewhat marginalized, especially due to the legal status…So really to inform them and to empower them to know that they have rights…and they have resources available to them."*

Promising Solutions:

Emphasize confidentiality procedures: One EE/ME ISM provided shared, *"Every time a client called or a potential client calls the office to speak about getting the service, 'What do you do with my Social Security Number? What are you going to do with my name? Where do you get your money from? What are you going to do with that money? What's the hidden agenda?"* ISM programs consistently shared information about their confidentiality procedures and reiterated and repeated that information over time to help reassure clients.

Build relationships and rapport over time: A provider from an A/AA ISM, discussed how *"once you explain to them in a way that they can understand it, they're pretty much okay…once you kind of break down the shell and you're able to comfort them on a certain level, then that makes a world of a difference with them opening up to different things and being accepting of whatever the services that we suggest for them."* An AI/AN ISM provider noted, *"Coming to an organization that has a sense and is understanding of their ancestry makes them feel more welcome or accepted."* Providers shared that trust can take a long time to build and they noted the importance of being persistent and patient.

Build community and trust through group-based activities: Activities that allow clients to socialize helped build community and trust. One example from a Latino ISM was knitting which gave clients an opportunity *"to join a group and be able to talk to others [which] can also help with their depression… Latino clients feel more comfortable attending a group that they feel like they might know something or might be familiar with."* An important social activity that was discussed by one of the EE/ME ISMs is *"Coffee Talk…For many, many years and centuries [specific ethnic group], wherever they were, they used to just have this coffee and gather together and then drink the coffee and talk about everything…So that was a good approach to just talk to people and identify if they would have any problems or any needs of mental health services…And then by drinking the coffee, start a conversation. And always we have new people who are coming with others and they are just trying to get more information."* For one of the API communities, spas were a good place to gather, and one of the ISM described how they have *"a relationship with the local spa in [neighborhood] that offers these services that are pretty commonly used by the [specific population] community to this area. So we've negotiated a reduced rate day pass. And what we do is provide it as an alternative activity for*

individual-based clients…for them to kind of congregate and as a form of stress reduction." These group activities provided a venue for potential clients to meet program staff (who facilitated and/or participated in activities) and to develop trust over time. Staff could then talk with clients on a more individual basis about their needs and the resources the program has for addressing their needs.

CHALLENGE 3: Lack of awareness about mental health issues and expectations about treatment and recovery

Providers noted that another barrier for clients enrolling in ISM services was the lack of awareness of mental health issues and processes. As a substance abuse provider for an API ISM explained, *"sometimes clients come to me and they want to change it right away and stop it, the using the drug. But it's impossible."* Another provider from an API ISM explained, "*my experience, even with substance abuse, [is] a lot of families view it as a character flaw. That it's by willpower. If he was stronger, if she was stronger, if we would have been stronger with him, it's really that. And that's why if you look at the Twelve Step of recovery you don't see too many [specific ethnic group] involved."* Another challenge, as a provider from an EE/ME ISM described, was that the population she works with "*has a tendency to seek services from a primary care physician or psychiatrist before even going to a therapist. So, their perception is that 'I need my medication and that's how I'm going to get well and psychotherapy is just a waste of time.' "*

Cultural recognition of mental health issues and the lack of translation of mental health information into their native language was also a hindrance for some clients. Providers from an EE/ME ISM explained that "*for years they didn't have any information about mental health. They didn't believe in medication. If it's a depression, 'Oh, we can handle it.' If it's an anxiety, they don't know what it is"* and that *"part of our work involves psycho-educating them about that and helping them to see how important the one-on-one psychotherapy is for them."* A provider from an API ISM explained how some of their clients *"don't have the words to describe the feelings so we really tried to educate them about their friend's feelings and their friend's words, 'this is the word that you use when you feel this way.' A lot of them also use some physical condition as their feeling indicator. 'I feel tired.' "* Along the same lines, *"there's no good word in [language] for mental health. When the mental health comes they immediately think negative."*

Promising Solutions:

Educate about treatment: As a way to educate their clients, an API ISM tried to compare it to other illnesses, for example, *"when you have a cold or a flu, so we try to break it down so that they can recognize it like that. Your body needs medication when you're having a pain…So what we do is we give you a pill to take care of that problem…the mind, it needs help…And then they look at you like 'oh you can do that about the mind?' "* Similarly, a provider from another API ISM explained that their clients *"understand [if] they have stomachache, they have to go see a health care provider….there isn't an institution that promotes mental health in that sense…they're not aware that these different factions are part of that treatment system."*

Reflect on process and progress on a regular basis: Working with the clients to consider their progress was a useful strategy for some providers. A provider from a Latino ISM described how *"a lot of my clients…they come in expecting to be cured…I have to really explain to them also that therapy is not an instant gratification type of model type of thing. So it's a process...they have progressed in so many ways but they don't see that as progress. So we have to*

constantly remind them of the small steps…So I think just being able to praise them and point out 'Let's reflect where you were at when you started, three months, look where you're at now. Now you're engaging in social activities. You're going out. You're meeting with the case managers. You're exercising. You're learning how to play your instrument.' "

CHALLENGE 4: Language and Cultural/Social Norms

ISM staff noted strong client preferences for services provided in their native language and for providers who share their ethnicity. Two main issues emerged around the issue of language: 1) language itself can be a barrier to receiving services and 2) the quality of services is different, perhaps more meaningful, when services are offered in the client's native language. In some instances, non-English speaking clients face barriers when trying to access services or receive the care they need. Not having services provided in their native language may even serve as a hindrance to initial engagement for some clients. A provider from a Latino ISM, explained that, *"one of the things they value is that they're able to communicate in their own language, in Spanish… A lot of the times, I feel like they don't seek out or obtain the services they need because there is a language barrier. So, I think when they come in to see us they're very comfortable."* This was echoed by the API ISM providers.[3] Furthermore providers felt that for some clients, it was critical to provide psychotherapy services in the client's native language because it facilitated the creation of a close bond between therapist and client, increasing the efficacy of the therapy. One of the providers from an EE/ME ISM explained that, *"You can know the language, but to do therapy in the language, it's completely a different world."*

For some clients, ISM staff noted that ethnicity did not matter as much as speaking the same language. As explained by a provider from an EE/ME ISM, *"Some [specific ethnic group], they want to have a [language] speaking therapist. Even if I am not [specific ethnic group], but they are really nice, they are very welcoming me and we can make a very good connection."* For other clients, however, having a provider that is the same ethnicity as them is an important factor. One provider explained, that for the EE/ME community:

> *"They love the fact that they can relate to someone who understands them both language and culturally. It's really important I think for every culture but specifically for ours also because they are so indirect. You need somebody who understands the culture to really understand and dig and find the source of what is causing their issues or what is going on really in their life. So I think they really benefit and also really appreciate that A) we can understand them and speak the language, and B) we're from the same culture and we've had parents who are immigrants or ourselves."*

An A/AA ISM provider also noted the importance of staff and clients sharing a cultural/ethnic background, *"A lot of people of different nationalities, they have a difficult time working with just anyone that's not of their culture. It's like, 'Well how can I work with this person, because they don't know anything about me. They know nothing about my history.' "* On the other hand an A/AA ISM provider also noted the importance of thinking about this aspect related to individual client interest. *"…asking the client what their desires are…There was somebody who was of African descent who did not want to have an African therapist."*

[3] During the vetting of this brief with the participating ISM programs, one API ISM shared a related challenge that became more clear to them after these focus groups – the shortage of potential staff that have the language and social/cultural knowledge of the population they serve. They noted this as a workforce issue.

Promising Solutions:

Use native language: Nearly all ISM staff noted the importance of communicating with the clients in their native language verbally and in writing. Not having services provided in their native language may serve as a barrier to engagement for some clients. As one Latino ISM provider said, *"Several of my clients have mentioned that they value that I can speak to them in their language. I have one particular client who said he was seeing a therapist in English who was able to speak to him a little, but he said that he wasn't able to express himself fully like he could in his own language."*

Ensure staff have knowledge of and practice cultural/social norms: Incorporating cultural and social norms was cited as important by many ISM programs. This may include practices such as addressing elders in formal terms, hugging, and bowing. As one Latino ISM provider described, *"Latinos are very touchy-feely people by nature anyway…we've had termination sessions where they've hugged and cried and I've cried too…So there are certain rules I think clinically that are broken when it comes to working with a specific population because I think that's what makes you connect to them."* For one of the API communities, greetings were especially important. *"You have to understand about the culture, especially with the greeting…and when you talk to the older people, what kind of word that you talk to them…You don't call them by name…call them Auntie, or…brother, older brother, older sister, or younger, something like that."* This also included being sensitive to certain issues of historical importance to people of that ethnic group, such as genocide and wars. One API ISM noted that the incorporation of peers, family advocates, and/or trained community members was as a helpful means to ensure deep knowledge of the cultural/social norms as well as the language.

Partner with faith communities and include religious/spiritual practices: Many ISM programs incorporated religious and spiritual practices into their programs. Some providers reported that they partnered with religious organizations to help with outreach and to be involved with program activities. Some ISM providers also incorporated religious and spiritual practices specific to the cultural group into their work with the clients. For example, an AI/AN ISM provider shared that clients *"… are taught the fundamental aspects of healing that are involved and what drumming does to the brain and the spirit and how this kind of connects their spiritual base, which is kind of a solid place of mental health, well-being, and how this is beneficial to your cultural identity, and kind of filling in that void of what we would call historical-based trauma…having your cultural identity put aside in that. This is helpful for your mental health."* A Latino ISM provider described how *"one of the things that I have done in session is prayed with them…we do different techniques for anxiety and we're holistic like the deep breathing and stuff."* Providers from an API ISM described that *"integrated care to us and our community…is the integration of mind and spirit and physical health, and you have to find the pathways for your population to be able to access it."* Including religious and spiritual practice, this API ISM coordinated blessing ceremonies for their clients and others to attend as part of this integrated care.

Conclusion

While each ISM program developed specific strategies to target the unique population they serve, many of the approaches were common. The promising solutions described in this learning brief are applicable to any provider facing similar challenges, such as clients with stigma related to mental health services and clients with low levels of trust and awareness about mental health treatment. Overall, the ISM programs overcame significant challenges with their creative and flexible approach to outreach, engagement, and deep cultural competence.

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