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Addressing Disparities in Mental Health Agencies: Strategies to Implement the National CLAS Standards in Mental Health

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Historically, the mental health system has not effectively addressed the needs of culturally and linguistically diverse individuals (President's New Freedom Commission on Mental Health, 2003), which has contributed to significant racial and ethnic disparities in mental health care (USDHHS, 2001). This paper focuses on exploring how a U.S. Department of Health and Human Services' Office of Minority Health policy initiative, the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care (or the National CLAS Standards), may be used by mental health agencies to reduce mental health care disparities. The National CLAS Standards are a set of action steps that inform and facilitate the implementation of culturally and linguistically appropriate services. We first discuss the role of cultural and linguistic competency in mental health care disparities reduction efforts, and then describe specific strategies to facilitate the organizational implementation of the National CLAS Standards.

Keywords: cultural and linguistic competency, health policy, National CLAS Standards

Cultural and Linguistic Competency and Mental Health Care Disparities

A specific goal offered in the President's New Freedom Commission Report on Mental Health of 2003 was that disparities in mental health services be eliminated (President's New Freedom Commission on Mental Health, 2003). However, despite the increased attention and research since the publication of the seminal report, racial and ethnic disparities in mental health care have remained constant, or have even increased, since the Commission Report in 2003 (e.g., Ault-Brutus, 2012; Blanco et al., 2007; Cook, McGuire, & Miranda, 2007). Racial and ethnic minorities continue to be less likely to receive mental health care when needed (Broman, 2012; Dobalian & Rivers, 2008; Harris, Edlund, & Larson, 2005; U.S. Department of Health and Human Services [USDHHS], 2001), and are more likely to receive a poorer quality of care once in treatment (e.g., Snowden, 2012; USDHHS, 2001; Wang, Demler, & Kessler, 2002). In addition, racial and ethnic minorities use deeper-end services (i.e., hospitals, inpatient facilities) to address their mental health needs, rather than community based mental health services (Snowden, Masland, Fawley, & Wallace, 2009; USDHHS, 2001), which has significant implications for community-based and public sector organizations.

Historically, the mental health system has not effectively addressed the needs of culturally diverse populations (President's New Freedom Commission on Mental Health, 2003), which has contributed to racial and ethnic disparities in mental health access, availability, and utilization (Hernandez, Nesman, Isaacs, Callejas, & Mowery, 2006; USDHHS, 2001). While the causes of mental health care disparities are multifactorial, a frequently cited factor has been the inability of the mental health system to understand the cultural needs of diverse populations and adapt services accordingly (e.g., Alegria, Atkins, Farmer, Slaton, & Stelk, 2010; Isaacs, Huang, Hernandez, & Echo-Hawk, 2005; Redmond, Galea, & Delva, 2009). In some mental health agencies, the inability to understand the cultural needs of diverse populations may be reflected in the agency's and its providers' lack of consideration of and respect for clients' cultural beliefs about mental illness and care (Stanhope, Solomon, Pernell-Arnold, Sands, & Bourjolly, 2005), and in their unconscious or conscious bias and discriminatory policies toward particular groups (e.g., White-Means, Dong, Hufstader, & Brown, 2009). Furthermore, though there are many mental health organizations that purport to deliver culturally tailored services to diverse populations, without genuine organizational-level consideration of and respect for clients' cultural beliefs, the persistence of disparities may be exacerbated. Research suggests that failure to understand cultural beliefs about illness and care create mistrust between the provider and client

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(e.g., Earl, Alegria, Mendieta, & Linghart, 2011; Isaacs et al., 2005; Whaley, 2001), which can significantly impair effective communication between the provider and client and lead to lower client adherence to treatment recommendations (USDHHS, 2001).

The adoption of culturally and linguistically competent practices has been offered as a strategy to reduce disparities in mental health care (Betancourt, Green, Carrillo, & Ananeh-Firempong, 2003; Brach & Fraser, 2000; McGuire & Miranda, 2008; Pumariega, Rogers, & Rothe, 2005; Smedley, Stith, & Nelson, 2003; Sue, Zane, Nagayama Hall, & Berger, 2009). The extant literature suggests that the provision of culturally and linguistically competent mental health care increases the utilization of mental health services by improving client satisfaction with services, and increasing racial and ethnic minorities' perceptions of receiving competent care (e.g., Constantine, 2002; Griner & Smith, 2006; Sue et al., 2009; USDHHS, 2001). Other research has found that increases in organizational-level cultural and linguistic competency are associated with increased participation in mental health treatment (Barksdale et al., 2012).

Though several definitions of cultural and linguistic competency have evolved over time, the U.S. Department of Health and Human Services Office of Minority Health (OMH) uses an adaptation of the definition developed for the Child and Adolescent Service System Program (CASSP) by Cross, Bazron, and Isaacs (1989) (USDHHS OMH, 2012). Specifically, the HHS Office of Minority Health defines cultural and linguistic competency as a "set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enable that system, agency, or those professionals to work effectively in cross-cultural situations," where culture refers to an integrated pattern of human behavior, and competence implies the capacity to function effectively (USDHHS OMH, 2012). Building upon this definition are the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care (or the National CLAS Standards), which are a set of action steps developed by the HHS Office of Minority Health that inform and facilitate recommended practices related to culturally and linguistically appropriate services. In the following sections, we describe the National CLAS Standards in more detail, provide the rationale for their adoption in mental health, and present strategies mental health agencies can use to facilitate their implementation.

The National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care (the National CLAS Standards)

Culturally and linguistically appropriate services (CLAS) are defined as those services that are respectful of and responsive to an individual's cultural health beliefs and practices, preferred languages, health literacy levels, and communication needs (USDHHS OMH, 2013). The National CLAS Standards, originally published in 2000 and subsequently revised and republished in 2013, inform and facilitate practices related to health service delivery by articulating a set of recommended action steps that organizations can use in their quest to become more culturally and linguistically competent. The underlying assumption of the National CLAS Standards is that by providing culturally and linguistically appropriate services to clients, health and health care organizations can improve access to care, quality of care, and, ultimately, health outcomes. Thus, the Standards aim to provide an action-oriented framework for organizations to operationalize, and therefore more concretely address, cultural and linguistic competency.

The National CLAS Standards are organized into one Principal Standard that establishes the essential goal of all the Standards and three themes comprised of several Standards each (see the Appendix for the complete list). The themes will be discussed in more detail under the Implementation Strategies for the National CLAS Standards in Mental Health section.

Rationale for the National CLAS Standards in Mental Health

Several existing cultural competency guidelines, models, and frameworks recommend approaches to support and improve the delivery of culturally and linguistically competent mental health services. For example, the American Psychological Association's Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists (hereafter referred to as the APA Guidelines) provides psychologists with the rationale for, information about, and resources to understand the importance of culture and cultural competence in the practice of psychology (American Psychological Association, 2003). Similarly, Sue's (2001) Multiple Dimensions of Cultural Competence model provides a conceptual framework that defines and identifies cultural competence from three core dimensions: racial/cultural group perspective, components of cultural competence, and foci of cultural competence. In addition, Cross and colleagues (1989) identified five essential organizational characteristics that should be present throughout an agency to facilitate the establishment of a culturally and linguistically appropriate service delivery system.

Though such models and guidelines are widely available, and much overlap exists between their fundamental principles and those of the National CLAS Standards, the Standards are distinct for a number of reasons. The Standards offer a set of specific action steps that any health or health care organization can take to implement culturally and linguistically competent practices (e.g., Diamond, Wilson-Stronks, & Jacobs, 2010; Kairys & Like, 2006; Shaw-Taylor, 2002). In contrast to the APA Guidelines, which provide a framework for psychologists and other mental health professionals to enact the principles of cultural and linguistic competency as individuals, the National CLAS Standards provide a customizable, yet definitive, set of actions for organizations to support their cultural and linguistic competency efforts. The National CLAS Standards can help organizations operationalize cultural and linguistic competency principles and implement them into their overall organizational culture, which better supports the development of cultural and linguistic competency skills by that organization's staff members.

The Standards' applicability across different health and health care sectors also aligns with the increased attention and call for better integration of behavioral and physical health care (Sanchez, Chapa, Ybarra, & Martinez, 2012; Sanchez & Turner, 2003). Widespread adoption and implementation of the National CLAS Standards may help ensure that organizations across disciplines are using similar measures and indicators of culturally and linguistically competent care. Work done by Siegel and colleagues (2000; Siegel, Haugland, & Chambers, 2003) underscores this latter point, as they have used the Standards to benchmark performance indi-

cators for organizational cultural competency in mental health. In addition, while other guidelines such as the APA Guidelines are appropriately designed for use by psychologists and other mental health professionals, they focus on six specific areas that build upon knowledge, skills, and attitudes honed during the training received by mental health professionals. The National CLAS Standards, however, were developed with a much broader, multidisciplinary professional audience in mind, which broadens their applicability to individuals who do not share the same training as mental health professionals. Therefore, this can facilitate communications about and organizational interventions targeting cultural and linguistic competency from everyone from the office receptionist, to the individuals in billing and human resources, to the direct service provider.

Adoption and Implementation of the National CLAS Standards in Mental Health

Despite the availability of the Standards, it is unclear how widespread their adoption and implementation in mental health has been. We note here that by *adoption* we are broadly referring to a mental health agency's decision to try a new program or new innovation, and by *implementation* we are referring to the process of using that new program or innovation (Durlak & DuPre, 2008). Though there are a few case study examples of general health organizations exploring the adoption of the National CLAS Standards (e.g., Diamond et al., 2010; ORC Macro, 2004), there is little empirical research describing the adoption of the Standards in mental health, especially relative to clinical outcomes. To date, only one case study explores the adoption and implementation of the Standards in a New Mexico public mental health system, following its comprehensive behavioral health system reform effort in 2005, which emphasized cultural competency and the adoption of the National CLAS Standards. While results from this study suggest that mental health agencies in New Mexico have some capacity to deliver culturally and linguistically appropriate services as described in the National CLAS Standards, barriers faced include difficulty integrating and using organizational-level data and state and national data on utilization to inform cultural competency efforts, and the lack of knowledge of and technical assistance to implement the National CLAS Standards (Semansky, Altschul, Sommerfeld, Hough, & Willging, 2009). Though some efforts may be underway, to our knowledge there have been no comprehensive case studies or empirical investigations of the adoption, implementation, and evaluation of the National CLAS Standards, either in general health or mental health.

Consistent with implementation and dissemination literature, however, other barriers to the Standards' adoption and implementation likely include the lack of awareness of the compatibility of the Standards to mental health, the lack of adequate leadership support, and the lack of adequate funding and financial resources to support, maintain, and evaluate the Standards' adoption and implementation (Durlak & DuPre, 2008; Greenhalgh, Robert, Macfarlane, Bate, & Kyriakidou, 2004). Such barriers, while not yet empirically established, are among the adoption and implementation characteristics that require additional, empirical study to understand the promise of the Standards in mental health. Thus, while the Standards offer mental health systems promising steps to improve the provision of culturally and linguistically appropriate care, noted implementation barriers and inadequate data on the process and benefits of full-scale adoption and implementation have likely contributed to their limited use.

Implementation Strategies for the National CLAS Standards in Mental Health

The National CLAS Standards aim to help mental health agencies and other health and health care organizations incorporate many of the elements considered critical to delivering culturally and linguistically appropriate practices. For example, the Vista Community Clinic in San Diego County, California developed a Cultural Awareness Program (CAP) in 2001 to facilitate awareness and implementation of the original National CLAS Standards (Martinez, Green, & Sanudo, 2004). Vista Community Clinic's initial approach to implementation via the CAP in this health clinic yielded important implementation recommendations related to CLAS implementation, some of which will be discussed below.

The following sections offer specific implementation strategies for particular Standards of the National CLAS Standards, which are derived from an extensive literature review of organizational change, implementation science, and cultural and linguistic competency literatures.

Strategies for the Standards in Theme 1: Governance, Leadership, and Workforce

The Standards that comprise Theme 1 (Standards 2–4) emphasize the importance of CLAS implementation as a systemic responsibility that requires the investment, support, and training of all individuals within an organization. These action steps help reinforce an organization's value and commitment to diversity. The following specific strategies may be used to help implement the Standards in Theme 1:

- Collaborate with high schools, colleges and universities, and graduate programs—including historically Black colleges and universities (HBCUs)—to build potential workforce capacities and recruit more diverse providers and staff. Evidence shows that there is still cultural and linguistic underrepresentation in the mental health educational pipeline (Holliday et al., 1997). Mental health has been largely unsuccessful in attracting culturally and linguistically diverse individuals (Suinn & Borrayo, 2008). For example, while African Americans comprise approximately 13% of the U.S. population (U.S. Census Bureau, 2011), they constitute 3.1% of psychiatrists and 2% of psychologists (SAMHSA, 2012). Similarly, while Hispanics comprise approximately 16% of the U.S. population (U. S. Census Bureau, 2011), they constitute approximately 4.3% of psychiatrists and 2.3% of psychologists (SAMHSA, 2012). Improved partnerships between academic and mental health agencies can help identify potential recruits already in the educational pipeline and provide them with additional academic support, mentoring, and guidance necessary to enter the field (Smedley, Butler, & Bristow, 2004).

- Provide ongoing in-service training and/or additional employee incentives to complete trainings that meet the unique needs of the population. Training topics may include regular sessions on how and when to access language services for individuals with limited English proficiency (Wilson-Stronks & Galvez, 2007), or delivery of services to particularly underserved populations such as individuals in rural communities, or individuals from various religious backgrounds. Incentives could include offering wage supplements, special work re-

lease time, or certification for those who complete such trainings (Huang, Macbeth, Dodge, & Jacobstein, 2004).

- Ensure that the necessary fiscal and human resources, tools, skills, and knowledge to support and improve culturally competent policies and practices in the agency are available (National Quality Forum, 2009). Through the CAP at Vista Community Clinic, for example, all new employees were trained in cultural and linguistic competency during orientation, all staff were granted access to information via a website and resource manual, a resource library was developed with over 750 books and publications on medical interpretation and cultural competency, and interpreter training was made available (Martinez et al., 2004). Such education and training opportunities may also increase buy-in for cultural and linguistic competency across the agency since it demonstrates a recognition that culture and language play an important role in the provision of care and services (Rose, 2011).

Strategies for the Standards in Theme 2: Communication and Language Assistance

The Standards in Theme 2 (Standards 5–8) highlight the necessary and appropriate steps for supporting the proper exchange of information regardless of differences in culture, language, or communication needs, and address the application of appropriate services to include all communication needs and services, including sign language, braille, oral interpretation, and written translation. The following specific strategies may be used to help implement the Standards in Theme 2:

- Consider employing cultural brokers to facilitate a better understanding of cultural beliefs in treatment, and to bridge differences between the practitioner's cultural frame and the client's cultural frame (e.g., Park, Chesla, Rehm, & Chun, 2011; National Center for Cultural Competence, 2004; Prince Inniss, Nesman, Mowery, Callejas, & Hernandez, 2009; Wilson-Stronks & Galvez, 2007). The provision of mental health care is highly collaborative and participatory, and is shaped by multiple cultures interacting—the culture of the client, the culture of the provider, the culture of mental health, and the culture of the agency. There are often significant consequences when cultural norms are violated, even if the violation is unintentional (Cross et al., 1989). Misunderstandings can occur on both sides of the client−provider interaction, the effects of which include lack of therapeutic alliance, misdiagnosis, poor adherence to treatment plans and recommendations, and ultimately, poorer clinical outcomes (e.g., Cross et al., 1989; Flores, 2006; Kagawa-Singer & Kassim-Lakha, 2003). Use of cultural brokers can help facilitate effective, cross-cultural communication (National Center for Cultural Competence, 2004).

- Ensure that interpreters are qualified and trained (Wilson-Stronks & Galvez, 2007), and that the quality of the language skills used by self-reported bilingual providers and staff using non-English language skills during client−provider interactions is appropriate (Regenstein, Andres, & Wynia, 2013). Research suggests that clinical care is improved when trained interpreters are used (Karliner, Jacobs, Chen, & Mutha, 2007). Leadership at Vista Community Clinic, for example, ensured that language services were provided appropriately by offering interpreter skill development training, translating all written materials into Spanish, developing training curricula for community members to educate them about their rights, and developing internal language proficiency testing for all providers who self-identify as bilingual (Martinez et al., 2004).

- Adopt a multifaceted approach to providing language assistance. For example, agencies can provide language assistance via both trained bilingual staff or dedicated language assistance (e.g., a contract interpreter or video remote interpreting), which can help the agency develop a flexible system to facilitate client−provider communication (National Council on Interpreting in Health Care, 2002). Investing in a shared remote interpreter service, for example, has been found as a low cost adjunct to providing language access services when in-person qualified interpreters are not available (Jacobs, Leos, Rathouz, & Fu, 2011).

Strategies for the Standards in Theme 3: Engagement, Continuous Improvement, and Accountability

The Standards in Theme 3 (Standards 9–15) underscore the importance of establishing individual responsibility in ensuring that CLAS is supported, while highlighting that effective delivery of CLAS demands actions across an organization. These Standards lay the groundwork to identify the needs of the community, develop sustainable policies and procedures that speak to those needs, and maintain an open line of communication between a mental health care agency and community. The following specific strategies may be used to help implement the Standards in Theme 3:

- Use existing cultural and linguistic competency assessment tools to describe structural policies, procedures, and practices. These tools can provide guidance to determine whether the core structures and processes (e.g., management, governance, delivery systems, and customer relation functions) necessary for providing CLAS are in place (USDHHS OMH, 2013). Such assessment activities can include the administration of self-assessments of cultural knowledge and culturally relevant practices that facilitate the identification of factors that enable or impede a mental health agency's effectiveness and performance. Roysircar (2004) argued that such identification fosters increased introspection and intrapersonal awareness of one's own culture, which enables more effective, culturally relevant delivery of mental health services. Self-assessment is also important in planning, implementing, and evaluating the quality of any kind of mental health service.

- Use information and knowledge gained from individual and agency-level assessments and evaluation to create culturally informed and relevant mission, vision, and goals for the agency and tailor services that are relevant to the community served. Cultural self-assessments, whether formal or informal, may focus on clinical competencies, agency resources, and capacity to serve the community, or administrative infrastructures and processes (e.g., governance, policy development, and methods of service delivery) (Rice, 2007).

- Convene regular meetings and retreats to evaluate how goals, objectives, and timelines are responsive to the cultural needs of the community and clients served. During these meetings, also ensure that there are opportunities to discuss cultural and linguistic issues that are arising in everyday clinical encounters (Wilson-Stronks & Galvez, 2007). Such reflective activities are demonstrated, for example, in Vista Community Clinic's efforts to engage leadership and the community. Specifically, the clinic sent letters to and scheduled meetings with the executive management team to discuss how CLAS was being infused in the organization, developed strategic plans, presented a systems change proposal, and updated the organization's policies.

Conclusion and Implications

The HHS Office of Minority Health's National CLAS Standards provide clear action steps through which mental health agencies can become increasingly culturally and linguistically competent, thereby enhancing their ability to address mental health care disparities. The National CLAS Standards can help mental health agencies "develop systematic approaches to address the needs of racial and ethnic minorities" (Shaw-Taylor, 2002, p.213). This paper has attempted to highlight a few concrete strategies that agencies can use to facilitate their implementation of the National CLAS Standards. While implementation of the National CLAS Standards will vary depending upon a number of factors, such as the size of the agency, subpopulations served, and the types of mental health services offered, the goal of their implementation is a resultant service system that "provides effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs" (USDHHS OMH, 2013, p. 46). Ultimately, while mental health agencies may not implement all of the 15 Standards collectively, the Standards can be used as a guide to modify existing policies and procedures to improve the care and services delivered to culturally and linguistically diverse populations, and to advocate for increase funding to support such efforts.

From a broader policy perspective, the National CLAS Standards may equip mental health agencies with a structure to help influence state and federal policies pertaining to mental health and culturally and linguistically diverse populations. This structure can be an especially beneficial clear "voice" in mental health policy-making, which bridges the interests of the mental health system and the culturally diverse clients that are served (Frank & Glied, 2006). Since, arguably, all health policies should be culturally and linguistically appropriate, the National CLAS Standards can be used as a lens through which other policies, policy initiatives, and activities are examined and implemented. This is particularly relevant when considering major health care policies that will inevitably impact health and mental health disparities, such as the Patient Protection and Affordable Care Act (2010), which will require significant monitoring and careful implementation if it is to effectively reduce disparities (Snowden, 2012). Leveraging the National CLAS Standards in this way can help ensure that the development and implementation of policies and services meet the needs of the broadest client populations.

Finally, the National CLAS Standards can help agencies seeking to develop a research agenda in cultural and linguistic competency and mental health outcomes, through using the National CLAS Standards as metrics of culturally and linguistically competent care. Used in this way, the Standards can help to inform and advance both effective practices and efficacy research in a culturally and linguistically appropriate paradigm.

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(*Appendix follows*)

Appendix

National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care

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

Principal Standard

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

Governance, Leadership, and Workforce

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.

3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.

4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.

6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.

7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.

8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement, and Accountability

9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.

10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.

11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.

12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.

13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.

14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.

15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

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