CHAPTER 14: Cultural Competency

As Patients' Rights Advocates, you may encounter people from a variety of cultures, languages, classes, races, ethnic backgrounds, and religions. We must recognize that a person's community and/or cultural background can be important factors in the recovery process as well as a source of support from peers, family, friends, and spiritual leaders.

WHAT IS CULTURAL COMPETENCY?

Being culturally competent means being able to interact with people from diverse populations in a manner which recognizes, affirms, values, and respects the worth and dignity of all individuals, families, and the communities they represent.

In order to truly achieve cultural competence, one must first recognize the limitations to achieving this objective. Limitations to cultural competency exist when professionals believe themselves to be culturally competent after learning some generalizations of a particular culture. Therefore, before one can strive towards cultural competency, one must first learn cultural humility.

CULTURAL HUMILITY

Cultural humility is a humble and respectful attitude toward individuals of other cultures that pushes one to challenge their own cultural biases. Doing this requires self-awareness and self-assessment of your own beliefs, attitudes, emotions and values.

We must realize we cannot possibly know everything there is to know about every other culture. When we do this, we can approach learning about other cultures as a lifelong goal and process. Cultural humility encourages an active participation in order to learn about an individual person's personal and cultural experiences.

PEER PERSPECTIVE

Pay particular attention to shared experiences a person has with those they identify as their peers. The people who are identified as peers may or may not include others with a mental illness or mental health diagnosis. Peers can describe others who are willing to publicly identify as a person with a mental illness or as a family member of a person with a mental illness. The term "peer" can also be used to describe someone who is from that same racial or ethnic

community who has had shared experiences related to race and ethnicity as others in that community.

Keep in mind shared experiences with peers can be positive or negative experiences. Examples of shared negative experiences could be generational trauma or being part of a historically underserved population.

UNDERSERVED POPULATIONS

The term “underserved populations” is used to describe groups or communities that currently, or historically, have experienced a disparity in access to community mental health services.

“Underserved populations” could be used to describe people from racial, ethnic, or limited/ non-English speaking communities that have a demonstrated history of disparities in access to mental health services.

Underserved populations could also include people from the lesbian/ gay/ bisexual/ transgender/ questioning/ intersex (LGBTQI+) community, rural communities, people who are homeless, transition-age youth (TAY), older adults/ seniors, and other groups that currently or historically have a demonstrated disparity in access to mental health services.

STIGMA AND DISCRIMINATION

When striving for cultural competency, advocates must also be mindful of stigma. Stigma refers to attitudes and beliefs that a person carries with them in their daily life. Stigma can cause people to fear, reject, and even avoid those they perceive as different from themselves.

Stigma can come in different forms. Institutional stigma exists when an organization's policies or practices reflect negative attitudes and beliefs. While institutional stigma may not always be apparent in organizational policies, it can often by spotted in every day conversational terms and tones used amongst treatment staff.

Self-stigma occurs when an individual buys into society's misconceptions about them or their community. By internalizing negative beliefs, individuals or groups may experience feelings of shame, anger, hopelessness, or despair that keep them from seeking social support, employment, or treatment for their mental health conditions.

Public stigma refers to the attitudes and beliefs of the general public towards people of certain communities. We see this when the media or other members of

the public make assumptions that a person with a mental health diagnosis is unable to contribute to their community, becomes a burden, or is inherently dangerous just because of their diagnosis.

While "stigma" is an attitude or belief, "discrimination" is behavioral because of those attitudes or beliefs. Discrimination occurs when individuals or institutions deprive others of their rights and life opportunities due to stigma. Discrimination may result in the exclusion or devaluing of people and deprive them of their rights, such as access to personal property, opportunities for religious choices, treatment services, and full participation in creating a social structure.

LAWS AGAINST DISCRIMINATION

There are several state and federal laws which protect a person from discrimination based on their being part of a protected class. This includes, but is not limited to, Section 504 of the Rehabilitation Act, which protects qualified individuals from discrimination based on their disability. Individuals with disabilities are defined as persons with a physical or mental impairment that limits one or more major life activities.

Individuals receiving mental health services have the right to file a complaint of discrimination based on any of the following protected categories:

- Race
- Age (40 and over)
- Color
- Marital Status
- Religion
- Disability
- Sex-Sexual Harassment
- Medical Condition
- Gender
- Sexual Orientation
- National Origin
- Political Affiliation or Opinion
- Ancestry
- Retaliation (Reprisal)

Any person who believes he or she has been discriminated against may file a complaint of discrimination on the basis of disability with the Department of Health and Human Services, Office for Civil Rights, 90 7th Street, Suite 4-100, San Francisco, CA 94103; Telephone: (800) 368-1019; TDD: (800) 537-7697, or any agency charged with enforcing laws prohibiting discrimination.

INTERPRETER REQUIREMENTS

An interpreter shall be someone who is fluent in both English and the language used by the patient and his or her legal representative, or who can communicate with a deaf person, if deafness is the communication barrier.

When interpreters are used, documentation shall be placed in the patient's health record indicating the name of the person who acted as the interpreter and his or her relationship to the patient and to the facility. (California Code of Regulations, Title 22, Section 72528)

GENDER IDENTITY

It has been recently recognized that the gender a person identifies with may be different from the sex they were assigned at birth.

Transgender describes a diverse group of individuals who cross or transcend culturally defined categories of gender. Transgender includes individuals who define themselves as transsexual. Transsexual describes individuals who seek to change or who have changed their primary and/ or secondary sex characteristics through feminizing or masculinizing medical interventions (hormones and/or surgery), typically accompanied by a permanent change in gender role.

Gender-Nonconforming is a term used to describe individuals whose gender identity, role, or expression differs from what is normative for their assigned sex in a given culture and historical period.

Gender Dysphoria (GD) is a condition outlined in the DSM-5 and defined by a marked incongruence between a person’s experienced/ expressed gender and assigned gender. This condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

The care and support needed by people who identify as transgender or gender non-conforming may vary greatly between individuals. A person’s care plan should be individualized and created in collaboration between the person who identifies as transgender/ gender non-conforming and their primary care provider.

A care plan could include housing arrangements, restroom use, clothing, and name/ pronoun usage that is consistent with the person's gender identity. A care plan may or may not include medical interventions, and a person may not always feel comfortable disclosing or discussing these interventions.

When working with people who identify as transgender or gender non-conforming, it is important to ask the person what they want to be called or what they feel they need. You should be cautious not to assume you know what a person who is transgender/ gender non-conforming will want or how they will want to be referred to.

For more tips on ways to improve cultural competency and/or reduce stigma, contact COPR. COPRinforequest@disabilityrightsca.org