



Decreasing Disparities in the Treatment of Depression: Enhancing Cultural Competency

Content based in part on a satellite symposium presented Wednesday, August 9, 2006, at the National Medical Association 2006 Annual Convention and Scientific Assembly.

NMA FAX BLAST NEWSLETTER #2



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Program Overview

There are striking disparities in mental health care for members of ethnic and racial minorities, particularly those with depression—as many as 10% of patients seen in primary care settings. Multiple issues must be addressed to resolve these disparities and enhance outcomes for minority patients with depression. Improving cultural competence skills will allow physicians to communicate more effectively with their patients, and consequently, will facilitate appropriate detection, diagnosis, treatment, and follow-up of depression.

Target Audience

This activity has been designed to meet the educational needs of primary care physicians who treat adults with depression.

Estimated Time to Completion

This activity should take approximately one-half hour to complete.

Educational Objective

Upon completion of this activity, participants should be better able to describe cultural competence skills useful in addressing disparities in depression.

Accreditation Statement

This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education (ACCME) through the co-sponsorship of Vanderbilt University School of Medicine and the University of Alabama School of Medicine and the joint sponsorship of Vanderbilt School of Medicine and Indicia Medical Education, LLC. Vanderbilt University School of Medicine is accredited by the ACCME to provide continuing medical education for physicians.

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Decreasing Disparities in the Treatment of Depression is a series of 3 newsletters, based on a symposium at the National Medical Association 2006 Annual Convention and Scientific Assembly, that seeks to educate physicians about disparities in the diagnosis and treatment of depression in ethnic and minority populations. Major depression is prominent in racial and ethnic minorities and is frequently misdiagnosed or untreated in these populations. Moreover, the significant morbidity and mortality associated with depression exacerbate comorbid illnesses that commonly occur in minority patients. Compounding this issue are the multiple factors experienced by racial and ethnic minorities—socioeconomic factors, cultural issues, poor access to care, and biases among patients and health care providers—that contribute to disparities in care for these patients. The primary care setting is often the initial point of contact for many patients who suffer from depression. Primary care physicians thus require an awareness of screening tools as reliable markers for detecting depression, an understanding of the emerging and accepted best practice standards for treating depression, and the acumen for cultural competence and how depression may manifest within a specific racial or cultural context.

Each of the 3 newsletters contains a short learning module followed by a post-test. The first issue in this series discussed best practices in diagnosing and treating depression. This issue will focus on enhancing cultural competence skills, and Issue 3 will discuss closing the gaps in the diagnosis and treatment of depression in minorities.

Introduction

Divisions of race, ethnicity, and culture continue to be sharply drawn in terms of health care in the United States. Despite recent progress in improving the health status of persons living in this country, there are continuing disparities in disease, disability, and death among racial and ethnic groups. Racial and ethnic disparities in mental health are as prevalent as the disparities that exist in other areas of health. The presentation of symptoms of depressive illness varies by ethnic/racial group and is highly influenced by cultural norms. Moreover, minority individuals are often reluctant to admit to or reveal symptoms of emotional distress and depression. Because primary care physicians are frequently the first point of contact for patients with symptoms of depression, enhancing cultural competency by possessing knowledge, awareness, and respect for other cultures will facilitate better care for patients from ethnic and racial minority populations and help eliminate diagnostic and treatment disparities.

The Relevance of Cultural Competence in Patient-Provider Encounters

The incorporation of cultural competence is a proven approach in the goal to eliminate racial and ethnic health care disparities, both in physical and mental health care. Cultural competence—a developmental process that evolves over time—requires that organizations have a clearly defined, congruent set of values and principles, and demonstrate behaviors, attitudes, policies, structures, and practices that enable them to work effectively cross-culturally.²

According to the Surgeon General's Report on Mental Health in 1999, "The cultures that patients come from shape their mental health and affect the types of mental health services they use. Likewise, the cultures of the clinician and the service system affect diagnosis, treatment, and the organization and financing of services."³ The incorporation within primary

Credit Designation

Vanderbilt School of Medicine designates this educational activity for a maximum of 0.5 *AMA PRA Category 1 Credit™*. Physicians should only claim credit commensurate with the extent of their participation in the activity.

Method of Participation

This is a CME enduring material. It consists of a newsletter and a CME quiz. There are no fees for participating and receiving credit for this activity. To receive your CME credit in the period from November 2006 through November 27, 2007, you must 1) read the newsletter, including the learning objectives and disclosure information, 2) go to https://www.cme.vanderbilt.edu/online/onlinequiz/user/user_exam_view.php?COURSE_EX=PS2006P3501, 3) follow the instructions to log in, and 4) complete the CME quiz. If you answer 80 percent of the questions correctly, you will be prompted to print your certificate.

Disclosures

Commercial Support

Vanderbilt University School of Medicine, the University of Alabama School of Medicine, and Indicia Medical Education, LLC, express appreciation to Wyeth Pharmaceuticals for generous support of this activity through an unrestricted educational grant.

Conflicts of Interest

As an accredited provider of CME, Vanderbilt University School of Medicine follows ACCME requirements regarding industry support of continuing medical education and provides the following information:

Tawara D. Goode, MA disclosed that she has no financial relationships related to the content of her presentation to disclose.

Planning Committee

Donald E. Moore, Jr., PhD, Vanderbilt University, disclosed that he has received a grant from Wyeth Pharmaceuticals. Vanderbilt CME has determined that there are no conflicts of interest between this financial relationship and the content of this symposium.

Robert E. Kristofco, MSW, University of Alabama School of Medicine, disclosed that he has no financial relationships to disclose related to the content of this symposium.

Karen M. Overstreet, EdD, RPh, FACME, Indicia Medical Education, LLC, disclosed that she has no financial relationships to disclose related to the content of this symposium.

Disclosure of Unlabeled Use

Ms. Goode does not reference an unapproved, unlabeled, or investigational use of a therapeutic agent or biomedical device in this presentation.

Release date: November 2006

Expiration date: November 27, 2007

care systems of culturally competent approaches to manage ethnic and minority patients with depressive illness remains a challenge as primary care providers struggle to respond effectively to the needs of individuals and families from these diverse groups. Numerous reasons justify the need for cultural competence at the patient-provider level, including but not limited to the following:⁴

- Perception of disease and mental illness and its causes vary by culture
- Belief systems related to health, healing, and well-being are rooted in culture
- Culture influences help-seeking behaviors and attitudes toward health care providers
- Culture influences acceptance of and approaches to treatments, therapies, and interventions
- Patients must overcome personal experiences of bias or discrimination within the health care delivery system

A review of the evidence base for the impact of cultural and linguistic competence in health and mental health care supports the hypothesis that these competencies are critical components of quality and effective care in relation to health outcomes.⁵ Further, an analysis of the interplay among cultural competence, quality, and racial/ethnic disparities in health care suggests that

quality improvement efforts will need to integrate components of cultural competence to truly achieve equity in health care delivery.⁶ The challenge lies in determining which aspects of cultural competence and which quality improvement interventions will contribute to equity in health care. Cultural competence and quality cannot achieve equity in care alone—there are too many other factors beyond these two efforts.

Convergence of Cultural Contexts in Health Care

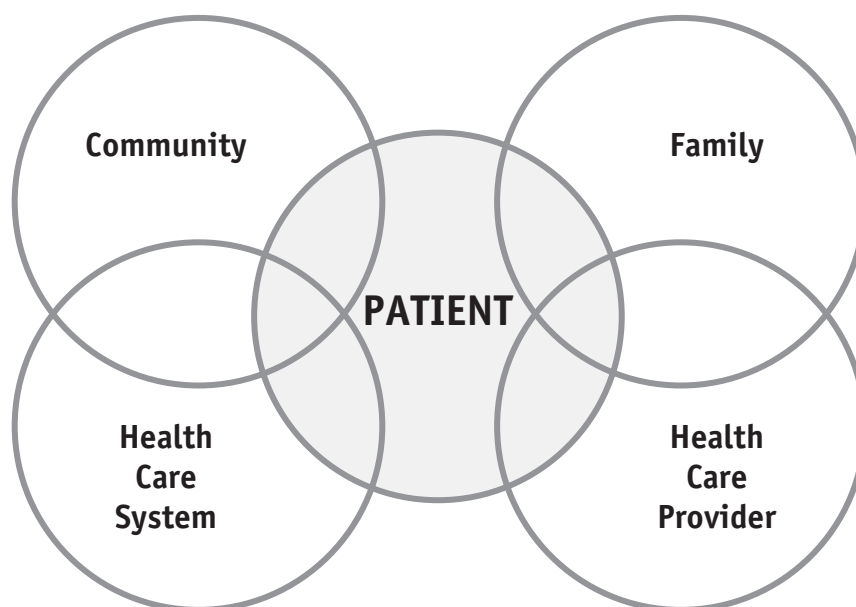
Numerous cultural contexts converge in health care delivery. **Figure 1** illustrates a model that includes five key elements of cultural contexts in health care.

Specific components of these five elements are as follows:

Patient—racial, ethnic, and cultural identity; nationality, immigration status; age; gender; sexual identity and orientation; health beliefs and practices; education; socioeconomic status/class; literacy and health literacy; perception of physical and mental health status

Family—marital status; partner/significant other, children and dependents, health care decision making, financial resources, family support, residence/living environment, religious/spiritual beliefs and affiliations, family history of disease and mental illness,

Figure 1. Convergence of cultural contexts in health care.



knowledge and experience with health care, racial and ethnic identification, socioeconomic status/class, immigration status

Health Care Provider—racial-ethnic concordance or discordance; language concordance or discordance; cross-cultural communication skills; experience providing care to racial-ethnic populations; knowledge of health beliefs and practices; knowledge of family, community, and economic resources; unconscious stereotyping or bias; cultural awareness; cultural competency knowledge and skill sets; advocacy with and on behalf of underserved and vulnerable populations

Health Care System—accessibility and location of facilities, workforce diversity, institutional reputation within the community (bias, discrimination, racism, community asset and advocate), history of providing care to racial-ethnic populations, culturally and linguistically competent workforce, health disparities research portfolio, community partnerships and advocacy, accepted insurance plans (eg, Medicaid)

Community—community demographics and economics; neighborhood and community resources; natural networks of support; community awareness of health and mental health disparities; community perception of mental illness (including stigma); accessible public transportation systems; initiatives to address health disparities; safe and accessible areas for physical activity; accessibility of grocery and food stores; community health promotion and education; role of faith-based and spiritual organizations, business community and employers, and universities and colleges

Table 1 lists the 5 elements of cultural competence at the practitioner level.²

Cultural Competence and the Importance of Self-assessment

An essential element in developing cultural competence is provider capacity to engage in

Table 1. Elements of Cultural Competence for Health Care Providers

- Acknowledge cultural differences
- Understand your own culture
- Engage in self-assessment
- Acquire cultural knowledge and skills
- View behavior within a cultural context

self-assessment. The process of cultural competence assessment benefits practitioners by heightening awareness, influencing attitudes toward practice, and encouraging the development of knowledge and skills.⁷ The Cultural Competence Health Practitioner Assessment (CCHPA), which was developed at the request of the US Department of Health and Human Services, Health Resources and Services Administration, and Bureau of Primary Health Care, is intended to promote cultural competence as an essential approach for practitioners in the elimination of health disparities among racial and ethnic groups.³ The CCHPA is based on 3 assumptions:

- Cultural competence is a developmental process at both the individual and organizational levels
- With appropriate support, individuals can enhance their cultural awareness, knowledge, and skills over time
- Cultural strengths exist within organizations or networks of professionals but often go unnoticed and untapped

The CCHPA measures knowledge and practice using the following 6 subscales:⁷

Value and Belief Systems—Concerns practitioners’ knowledge of the values and belief systems of diverse cultural groups and their impact on health care access and utilization; explores perspectives of health, illness, well-being, care-seeking behaviors, traditional health practices, spirituality, and family/community dynamics

Cultural Aspects of Epidemiology—Concerns practitioners’ knowledge of cultural, environmental, and related etiologic factors that contribute to disease and probes health disparity and risk and protective factors for underserved groups and communities

Clinical Decision Making—Concerns practitioners’ knowledge of culturally defined health beliefs and practices, and the ability to integrate this knowledge in approaches to health care delivery; addresses intake, assessment/diagnosis, treatment/discharge planning, and use of community-based resources

Life-cycle Events—Concerns practitioners’ knowledge of the cultural implications of various stages of life and life-cycle events, and the ability to address them in approaches to health care delivery

Cross-cultural Communication—Involves practitioners’ knowledge and skills in communicating with culturally and linguistically diverse groups as they relate to health care access and utilization; explores capacity for cross-cultural communication, utilization of different modes of communication, and the provision of interpretation/translation services

Empowerment and Health Management—Involves practitioners’ role in providing information that enables individuals to intervene on their own behalf, advocate, and build community capacity for improved health.

Conclusions

Culture influences the way in which care is delivered by physicians, health care practices/organizations, and systems. Culture also influences how patients seek care; their acceptance, adherence, and satisfaction with care; and their health outcomes. There are wide variations in symptoms and expression of depression among diverse patient populations. Cultivation of cultural competence in the primary care setting helps ensure that gaps are reduced in the diagnosis and treatment of depression. Culturally competent care is sound medicine—it is satisfying for the patient and their families and likely to facilitate beneficial clinical outcomes. Among other things, cultural competence requires that individuals and organizations value diversity, acquire cultural knowledge, and manage the dynamics of cultural differences. Self-assessment is an essential element of cultural competence that helps clinicians determine attitudes and biases they may hold that serve as barriers to providing optimal care to culturally diverse groups. Self-assessment is an effective vehicle for self-reflection and facilitates changes in practice; it enables providers to identify strengths as well as areas that require continued professional growth. Self-assessment can also serve as a catalyst for acquiring new knowledge and skill sets that enhance physicians’ capacity to provide care to diverse patient populations.

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Additional Recommended Resources

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