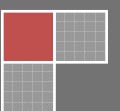


2007

Cultural Competency and Workforce Development for Mental Health Professionals

Maryland's Mental Health Transformation Project



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Introduction

“It is difficult to overstate the magnitude of the workforce crisis in behavioral health. There is substantial and alarming evidence that the current workforce lacks adequate support to function effectively and is largely unable to deliver care of proven effectiveness in partnership with the people who need services. There is equally compelling evidence of an anemic pipeline of new recruits to meet the complex behavioral health needs of the growing and increasingly diverse population in this country. ... Urgent attention to this crisis is essential.”

The above statement taken from a report published in 2007 entitled *An Action Plan for Behavioral Workforce Development* (The Annapolis Coalition of the Behavioral Health Workforce), summarizes the workforce situation of our nation’s behavioral health care system. Across the United States there is a high degree of concern about the state of the behavioral health workforce and pessimism about its future. Workforce problems have an impact on almost every aspect of prevention and treatment across all sectors of the diverse behavioral health field. The issues encompass difficulties in the following;

- recruiting and retaining staff;
- the absence of career ladders for employees;
- marginal wages and benefits;
- limited access to relevant and effective training;
- the erosion of supervision;
- a vacuum with respect to future leaders; and
- financing systems that place enormous burdens on the workforce to meet high levels of demand with inadequate resources.

Most critically, there are significant concerns about the capability of the workforce to provide quality care. The majority of the workforce is uninformed about and unengaged in health promotion and prevention activities. Too much of the workforce also lacks familiarity with resilience and recovery-oriented practices and is generally reluctant to engage children, youth, and adults and their families, in collaborative relationships that involve shared decision-making

about treatment options. Training and education programs have largely ignored the need to alter their curricula to address this problem and, thus, the nation continues to prepare new members of the workforce who simply are unprepared from the moment they complete their training.

In addition, the workforce lacks the racial diversity of the populations it serves and is far too often insensitive to the needs of individuals affected by ethnicity, culture, and language. There is overwhelming evidence that the behavioral health workforce is not equipped in skills or in numbers to respond adequately to the changing needs of the American population. In summary, there are a host of issues influencing the recruitment, training and retention of our nation's behavioral health workforce. However, this report will focus primarily on race, ethnic, and linguistic issues.

Recognizing the changing face of Maryland and the importance of providing relevant and culturally appropriate services and treatments to the growing ethnic and culturally diverse population, the Maryland General Assembly enacted House Bill 524 (HB524) in 2007. This bill requires the formation of a Workgroup to assess:

- Barriers to access to appropriate mental health services provided by health care professionals who are culturally competent to address the needs of the State's diverse population;
- Barriers to licensure or certification of foreign-born and foreign-trained mental health professionals;
- Initiatives from other states for the facilitation of licensure or certification of foreign-born and foreign trained mental health professionals;
- Mental health workforce shortages and potential strategies to use foreign-born and foreign-trained mental health professionals to alleviate shortages; and
- Options for enhancing the cultural competency of licensed and certified mental health professionals.

Specifically the Workgroup shall develop recommendations regarding:

- The availability of specific options to facilitate the licensure or certification of foreign-born or foreign-trained mental health professionals within the limitations of State and federal law;
- The development of training programs to assist foreign-born and foreign-trained mental health professionals to prepare for and pass required, licensure or certification examinations;
- The development of specific training and educational materials and programs to enhance the cultural competency of all mental health professionals;
- The advantages and disadvantages of changing the current licensing and certification requirements for relevant professional licensing boards; and
- Any other initiatives that will accomplish enhanced access to culturally sensitive and competent mental health services.

Rationale for Developing a Culturally Competent System

The need to adopt and implement a range of culturally and linguistically appropriate workforce and service policies and practices is beyond question. The momentum for addressing these issues was spurred by the Surgeon General's Report on Mental Health: *Culture, Race and Ethnicity* (2001), the Institute of Medicine's *Unequal Treatment: Confronting Racial and Ethnic Disparities* (2002), and the President's New Freedom Commission on Mental Health: *Achieving the Promise: Transforming Mental Health Care in America* (2003). These reports proclaim a public health imperative to meet the needs of diverse communities in the United States.

The issue is not only one of access but also, in many cases, of a profound lack of culturally and linguistically competent care because of the dearth of providers who are grounded in diverse languages and cultures. The consequences of having health care provided by individuals who are inadequately prepared and trained can include misdiagnosis, inadequate or inappropriate treatment, and premature treatment termination, all of which can compound potential and existing behavioral and mental health problems.

Research concerning the prevalence of mental health problems of racial or ethnic groups shows little difference in rates of disorders, but there are differences in referral patterns, problem

manifestation, applicability of assessment protocols and diagnoses (Coard and Hodlen, 1998; Yeh, McCabe, Hurlburt, Hough, Hazen, Culver, Garland, and Landsverk, 2002). Having too few competent providers or having providers who lack proper training in and sensitivity to cultural issues can also result in the misdirection and unintended displacement of culturally diverse individuals into other social systems, such as the criminal justice system. This is particularly true for African Americans, who make up 12% of the total adult population but 40% of all jail inmates (U.S. Department of Justice, 2002). Data from other ethnic groups reflects similar concerns suggesting disparities. For example, 75% of all deaths for American Indians and Alaskan Natives are due to violent causes, including unintentional injury, homicide, or suicide (Resnick, et al., 1997). In studies involving refugees, up to 40% of Southeast Asians suffer from depression, 35% from anxiety, and 14% from post-traumatic stress disorder (Nicholson, 1997). The uninsured rate among Latinos is more than three times higher than that of non-Hispanic whites.

The Surgeon General's Report (2001) indicated that consumers from ethnic or cultural groups are underrepresented and underserved in the U.S. mental health system. This report also revealed that persons from ethnic and cultural groups who did receive services felt ill-at-ease and did not fare well in the mental health system. This report documented the existence of the disparities between racial and ethnic minorities and whites. Communities of ethnic and cultural minorities experience less:

- availability of, and access to, mental health services;
- access to prevention and early intervention;
- access to providers of color;
- utilization of cultural parameters in assessment of service design;
- information about mental health disorders/services;
- access to trained interpreters;
- access to more effective psychopharmacologic interventions;
- probability of recovery;
- quality of mental health care; and
- representation in mental health research.

And more

- frequency of inaccurate diagnosis;
- findings of severe mental disorders;
- delays in help-seeking;
- use of inpatient hospitalization and longer lengths of stay;
- involvement in the criminal justice system; and
- mortality rates (higher primary health problems).

To eliminate disparities among ethnic and cultural groups, mental health systems must be culturally competent and encompass sensitivity to, respect for and understanding and knowledge of the beliefs and values related to economic status; spirituality and religion; cognitive, emotional and physical abilities; gender; language, race, ethnicity and culture; and age and sexual orientation of consumers and family members. In addition, the mental health workforce must have an appreciation for the political, social and physical trauma which many ethnic and cultural groups, particularly recent immigrants, have faced. A keen understanding of the historical realities of ethnic, cultural and race relations, and the resulting stereotyping, discrimination and stigma, is also necessary.

The workforce must not assume that cultural and ethnic groups are homogeneous. The heterogeneity of a cultural or ethnic group is complex and deserves an understanding that goes beyond the phenotypic identification and assignment of what is believed to be “African-Americans”; “Latino/Hispanic Americans”; “Asian Pacific/Islanders”; Native American/Alaskan Natives; or other cultural groupings (Bell and Williamson, 2006).

The ability to communicate and establish a meaningful, interactive relationship is critical to the successful recovery process for consumers and families. Even when individuals speak the same language, there are barriers to communication. One of the special challenges in developing a broadly responsive workforce involves grappling with variations in terminology used by stakeholders representing the highly diverse areas in this field. The selection and use of language is an extremely important issue. However, there is a lack of consensus on terms that are broadly applicable and acceptable to all of the individuals, organizations, interests, and issues that constitute the field. For example, individuals receiving care are referred to as patients,

consumers, recipients, individuals suffering from a mental illness, the mentally ill, and survivors. In addition, training of the workforce is often done within specific workforce disciplinary silos, thus creating different terms for similar practices.

Finding a means to communicate is essential when it is understood that many ethnic and cultural groups describe psychiatric symptoms in physical terms. Often symptoms are expressed as fatigue, dizziness, heart pain or headache. For some ethnic and cultural groups, there is no word for illnesses such as depression.

Consequently, the mental health system must acknowledge and incorporate the importance of culture, race, ethnicity and language within the workforce and treatment arenas to provide optimal access to quality services. The recognition of culture, race and ethnicity has a profound influence on the behavior and thinking of service recipients and providers. These perspectives must be understood to increase access and quality of services.

A foundational definition of culture is: a set of congruent behaviors, attitudes and policies that come together in a system or agency or among professionals and enables that system or agency or these professionals to work effectively in cross-cultural situations (Cross, Bazron, Dennis and Isaacs, 1988). The mental health workforce should be clinically culturally competent. This encompasses the willingness, commitment, effort and ability to understand, appreciate and accept the cultural differences of others with whom one comes in contact, and to use this knowledge to improve effective services based on cultural identity. A clinically culturally competent mental health workforce will improve treatment outcomes and provide cost effective, quality care.

As stated in the 2001 Surgeon General's report that in regards to mental health, "culture counts".

Implications for Behavioral Health Systems

The current growth of ethnic populations and the demographic projections for the future clearly indicate the need for increased understanding and strategic preparation for addressing the mental health needs of consumers/families from racial/ethnic groups. Because of the generally low income level of immigrants, this dramatic increase of ethnic groups will have a significant impact for public sector programs. It is also important to understand that within broadly identified categories (i.e., Native American, Asian, African American and Latino/Hispanic), there are numerous subgroups with distinct cultural attitudes, patterns and behaviors. These attitudes and behaviors have not been addressed adequately, resulting in less access to and poor quality of care.

Given the lack of providers from the Asian, Native American, Latino/Hispanic and African American cultures and the growth of ethnic populations in the U.S., it is crucial that clinicians of all ethnic backgrounds become more culturally aware and competent. It is unlikely that sufficient numbers of ethnic providers will become available at a pace commensurate with the growth of persons from ethnic groups needing mental health care. Therefore, practitioners of all ethnic backgrounds need to fill gaps when individuals are unable to self-select providers whom they feel would best match their needs from a cultural or ethnic perspective. This situation will be especially pertinent for rural and frontier areas.

At the agency level, evaluation of the current system is crucial for the purpose of assessing the organizational strengths and weaknesses and areas for training and/or improvement. This assessment should result in a comprehensive cultural competency plan that includes demographic information, training strategies, workforce analysis, hiring and retention strategies, measuring effectiveness and outcomes. Implications at the staff level include assessing cultural sensitivity, awareness, knowledge, skills and ability to effectively serve diverse populations.

Sometimes a major hurdle is the reluctance of staff to view cultural values or differences as important to the treatment process. For example, reluctance to consider spirituality, family involvement and folk healing practices can be serious barriers to rendering effective mental health services. Often, because of their position or ethnic background, some providers may feel that they do not need to become culturally competent. Also, being a member of an ethnic group

does not inherently make one culturally competent with all cultures, and not necessarily with all aspects of one's own culture. Cultural competency is an on-going process that will require continual reassessment.

Clinical and Provider Barriers to Utilization of Mental Health Services

African Americans

African Americans with mental health problems are more likely to seek help from their primary care doctor and make extensive use of alternative treatments. Expressing emotional distress through somatic symptoms is more common among African Americans (15%) than among white Americans (9%) (Robins & Reiger, 1991). Recent studies reveal that only 16% of African Americans with a diagnosable mood disorder saw a mental health specialist and less than one third consulted a health care provider of any kind. Members of this ethnic group are more likely to delay seeking professional mental health treatment or only seek help in severe crisis situations or when legally forced to do so. This practice contributes to the high rate of utilization of inpatient and emergency services experienced by African Americans. When outpatient treatment is utilized, African Americans are more likely than whites to terminate treatment prematurely (Sue, et al., 1994). However, studies indicate that higher retention rates are experienced when treatment is received from an African American provider (Snowden, et al., 1995).

Latino/Hispanic Americans

Recent studies reveal that members of the Latino/Hispanic communities feel that they are treated badly because of their race or ethnicity. Compared to 1 percent of whites, 15 percent of Latinos/Hispanics felt that they were treated with disrespect and unfairly because of their racial background (Brown, et al., 1999). In another study, compared to 5 percent of whites, 28 percent of Latinos/Hispanics felt that they were treated badly because of their ethnic background. Misdiagnosis with schizophrenia has also contributed to mistrust (Mukherjee, et al., 1983), which may be due to linguistic factors.

Language plays a very important role with regard to seeking and using mental health services. In 1990, 40% of the Spanish-speaking Latinos/Hispanics reported that they either could not speak

English or did not speak it well. The lack of Spanish-speaking mental health practitioners clearly presents a barrier to utilization of services by Latinos/Hispanic Americans.

Native Americans

Studies reveal extensive use of alternative treatment among Native American/Alaskan Native populations. Many use native healers and remedies on a regular basis to address health concerns. Often, it is only when these remedies don't work or a crisis occurs that members of this group utilize mental health practitioners. Generally, when involved in outpatient treatment, Native Americans experience higher non-return rates than African Americans, Asians, Latino/Hispanics and whites and are more likely than whites or African Americans to terminate treatment prematurely (Sue, 1977; O' Sullivan, et al., 1989). Delaying treatment and premature termination contribute to a higher rate of inpatient or emergency services admissions for people from this ethnic group.

Asian Americans/Pacific Islanders

Almost 50% of the Asian American/Pacific Islanders lack the ability to use the mental health system due to limited English proficiency and a shortage of providers with appropriate language skills. In the late 1990s there were only 70 Asian American providers available for every 100,000 Asian Americans in the U.S. (Mandersheid & Henderson, 1998). Also about 21% of this population lacks health insurance and some are hesitant to secure Medicaid because of mistaken concerns among immigrants about how enrollment in Medicaid could negatively affect their application for citizenship.

The Color of Health Care: Clinical Bias

Although racism and discrimination have diminished in the United States, there are still overt signs of discrimination manifested in medical practices, diagnosis, treatment, medication prescribing practices and referrals. For example, a recent study conducted by researchers at Massachusetts General Hospital and institutions affiliated with Harvard University provides empirical data that bias is the central problem in determining the proper diagnosis and treatment for certain illnesses affecting ethnic and cultural groups (Washington Post, 2007). The study suggested that one can measure unconscious bias among physicians and show it has an impact on treatment decisions. Rather than harboring deliberate will, physicians internalize racial stereotypes and these attitudes influence their medical judgment without their realizing it.

Race appears to matter and still appears to adversely pervade the clinical encounter whether consciously or not. Race, when coupled with lack of understanding of cultural beliefs by a mental health practitioner or one who does not have the same experience, may lead to the misinterpretation of symptoms. This results in mistrust, fear, and ineffective treatment with negative consequences. For example, paranoia among some ethnic groups may be considered by some as “healthy” based on their lived experience and how they perceive society. Others would see this as unhealthy and establish a treatment protocol inconsistent with the real symptoms and needs.

Linguistic incompetence can also contribute to ineffective outcomes. For example, during the winter, a hospitalized individual who had shown improvement but still had limited access to the outdoors entered her therapist’s office, looked out the window and stated that the “hawk is really flying high today.” Based upon this comment, the therapist concluded that the individual was delusional, showed no signs of improvement and needed continued stay. This incident happened on several other occasions. The therapist by chance described this behavior to a colleague who quickly responded by saying that “hawk” is a slang term for the wind. The therapist realized the individual was simply commenting on the weather, was not delusional and had been hospitalized based on this comment unnecessarily.

These examples validate the need for developing a network of culturally competent providers from all cultures to assure a culturally competent multicultural workforce.

The Changing Face of America

A significant rationale for cultural competence is the rapidly changing demographic makeup of the U.S. In 2000, persons from the following ethnic groups made up 31% of the U.S. population as follows:

- African Americans, 36.4 million (13%)
- Latino/Hispanic Americans, 35.5 million (12.5%)
- Asian/Pacific Islanders, 11 million (4%)
- Native American/Alaskan Natives, 4.1 million (1.5%)

It is estimated that by 2020, persons of color will make up 40% of the U.S. population. While the percentage of whites and African Americans is projected to decrease to 64.3% and 12.9% respectively, significant increases are projected for Asian and Hispanic populations.

The Asian population is the fastest growing population by percentage in the U.S. - increasing by 95% between 1980 and 1990 and another 44% between 1990 and 2000. It is projected that by 2020, Asians will comprise 6% of the U.S. population.

The fastest growing group by numbers is the Latino/Hispanic American population. By 2050, it is projected that this group will increase from 35 million to 97 million and will constitute nearly 25% of the U.S. population. In addition, it is predicted that by 2050, nearly 33% of youth under the age of 19 years will be Latino/Hispanic American.

The Changing Face of Maryland

According to 2005 Maryland Vital Statistics, more than 40 percent of Maryland's population is comprised of ethnic and racial minority groups: Black – 29%; Hispanic – 5.7%; Asian American/Pacific Islander- 5.1 %; and American Indian - 0.4 %. A growing percentage of Maryland's ethnic population is foreign-born. In 2005 the state's foreign-born population had increased to 12 percent (Maryland Plan to Eliminate Minority Health Disparities, 2006).

Racial/Ethnic Provider Availability & Workforce Shortage

The most compelling reason for a more diverse health professional workforce is that it will lead to improvements in public health. In a report entitled *The Rationale for Diversity in the Health Professions: A Review of the Evidence* (U.S. Department of Health and Human Resources, Health Resources and Services Administration, 2006), researchers examined the literature to address this contention and determined the following:

- Health professionals from ethnic groups, particularly physicians, disproportionately serve minority and other medically underserved populations;
- Minority patients tend to receive better interpersonal care from practitioners of their own race, culture or ethnicity, particularly in primary care and mental health settings;
- Non-English speaking patients experience better interpersonal care, greater medical comprehension, and greater likelihood of keeping follow-up appointments when they see a language-concordant practitioner, particularly in mental health care; and
- Insufficient evidence exists as to whether greater health professional diversity leads to greater trust in health care or greater advocacy for disadvantaged populations. (Only two studies were noted in the literature at the time this report was written).

These findings indicate that greater health professional diversity will likely lead to improved public health by increasing access to care for underserved populations and by increasing opportunities for individuals to see practitioners with whom they share a common culture, race, ethnicity or language. Culture, race, ethnicity, and language concordance, which are associated with better patient-practitioner relationships and communication, may increase patients' likelihood of receiving and accepting appropriate medical care.

Despite the evidence, the document entitled *Mental Health, United States, 2002* (Manderscheid & Henderson, 2004) describes the relative homogeneity of the current workforce in terms of race and ethnicity. The vast majority of professionals in the traditional mental health disciplines are non-Hispanic whites. The specific percentage by discipline is as follows:

- 75.7% of psychiatrists;

- 94.7% of psychologists;
- 85.1% of social workers;
- 80% of counselors;
- 91.5% of marriage and family therapists;
- 69.8% of psychosocial rehabilitation providers;
- 95.1% of school psychologists; and
- 83.8% of pastoral counselors (Duffy et al., 2004).

These figures stand in contrast to the diversity of the current U.S. population, in which 74.7% of residents are non- Hispanic whites; 14.5% are Latino; 12.1% are African American; and 4.3% are Asian.

The problem will be increasingly exacerbated; the U.S. growth rate among Latinos from 2002 to 2005, at 46.2%, was more than double the 21.6% growth rate among non-Hispanic Whites.

National and Maryland Initiatives Regarding Improving Cultural Competency and Workforce Development for Mental Health Professionals

National

From the literature it appears that all States recognize the need to accommodate an increasingly diverse constituency for mental health services. Doing so will reduce inappropriate diagnoses, increase the utilization of mental health services, change perceived negative encounters between ethnic and cultural population groups, and improve treatment from a system that often does not provide culturally sensitive and competent services.

Generally, state efforts have included but are not limited to: (1) developing and disseminating information and providing technical assistance on best practices in culturally competent services; (2) providing forums for state dialogues on the need for and effective provision of culturally competent mental health services; and (3) in some instances cooperating with other states and

national organizations to develop research, education, training and performance-based initiatives to ensure the provision of culturally competent mental health services. However, there is no agreed upon national approach to addressing this issue.

Recognizing the need to develop a common agenda and corresponding strategies geared toward improving cultural competency within the nation's mental health workforce, the U. S.

Department of Health and Human Resources, Substance Abuse and Mental Health Services Administration commissioned a report entitled *An Action Plan for Behavioral Health Workforce Development* (The Annapolis Coalition of the Behavioral Health Workforce, 2007). Ida and Morgan, the authors of the chapter entitled *Cultural Competency and Disparities Issues in the Behavioral Health Workforce* obtained input from individuals and organizations from around the country who have been addressing cultural competence in the mental health field for 30 years or more. They concluded that much has been written and much is known, but there is not an overarching national goal coupled with specific recommendations, nor the political will to ensure that the unique cultural and linguistic needs of diverse populations are met. To that end a single national goal: "reduce and eliminate disparities in the health care of ethnic and cultural communities through the development of a culturally competent workforce" was presented to the Substance Abuse and Mental Health Services Administration.

The goal was accompanied by four recommendations. The recommendations are separate and distinct. However, they form a cohesive plan that will help ensure a more culturally and linguistically competent behavioral health workforce. The following recommendations were suggested:

Recommendation 1: Increase the recruitment and retention of people of color in the workforce, which, in addition to the conventional workforce of bachelor's-prepared, pre-doctoral, and doctoral individuals, includes the use of non-degreed professionals, consumers, family members, natural healers, and trained interpreters.

The authors recommend that recruitment begin at the high school level or earlier to help guide individuals to consider a career in behavioral health. In an effort to reduce stigma and

discrimination against people with mental health and substance use disorders, recruitment strategies should include a forceful public campaign to educate communities about mental health from a culturally responsive perspective. In addition to paraprofessionals, consumers and family members could add much to the workforce by contributing their personal knowledge and experiences. Incorporating them in greater numbers in the workforce would ensure that a consumer and family driven model is implemented that guarantees inclusion at all levels of the service delivery system.

Recommendation 2: Identify, develop, implement, and evaluate culturally competent training curricula for pre-professional trainees, service providers, consumers, family members, and non-degreed professionals, including traditional/indigenous healers and interpreters.

Merely increasing the number of culturally and ethnically diverse providers does not necessarily translate into a workforce that is culturally competent. Regional cultural competence training centers could be established to work with community-based organizations and institutions of higher education to provide:

- training and support for faculty, administrators, and staff on cultural competence;
- technical assistance in creating culturally competent programs;
- a venue for faculty, administrators, and staff of different programs to discuss teaching methods;
- ways in which students can work with culturally diverse populations;
- evaluation and feedback to staff, students, and faculty on cultural competency skills;
- programs for the credentialing of paraprofessionals, interpreters, and consumer and family assisted mental health providers;
- training programs that integrate health and mental health as cultural paradigms for communities; and
- feedback to academic and community agencies that adds to the field's ability to grow culturally.

Recommendation 3: Make cultural competency training a requirement for licensure and certification of professionals and interpreters.

It is critical to institutionalize cultural competency into the behavioral health workforce by requiring a working knowledge of cultural competency for certification and licensing. Caution must be exercised to avoid a training model that reinforces stereotypes. The core competencies should be based on standards that have been developed by recognized groups, including the Culturally and Linguistically Appropriate Services Standards for Cultural and Linguistic Appropriate Services (DHHS, 2001), the Cultural Competency Standards in Managed Care (DHHS, 1998) developed by Western Interstate Commission for Higher Education and Substance Abuse and Mental Health Services Administration and the Outline for Cultural Formulation found in the *DSM-IV-TR*. To date, these standards have not been applied consistently. They must be integrated into existing training programs that teach core competencies and skills.

Recommendation 4: Establish appropriate rates of reimbursement for use of trained, culturally competent professionals, non-degreed professionals, and interpreters.

Reimbursement rates from Medicaid and third party payers must reflect the costs of using properly trained, certified professionals, non-degreed professionals, and interpreters. Providers should be properly compensated for their expertise without these costs being passed on to agencies, which cannot absorb the extra financial burden. Many agencies currently forgo using qualified personnel because of financial constraints. Too often, this practice results in substandard care that negates the efforts put into recruiting, training, credentialing, and licensing a culturally competent workforce. Pay-for-performance initiatives should require a workforce to meet certain standards in cultural competency to qualify for reimbursement.

Maryland

A review of initiatives undertaken in Maryland gives credence to that state's commitment to eliminate health care disparities by providing culturally and linguistically competent services. Selected accomplishments are as follows:

Recommendation 1: Increase the recruitment and retention of people of color in the workforce, which, in addition to the conventional workforce of bachelor's-prepared, pre-doctoral, and doctoral individuals, includes the use of non-degreed professionals, consumers, family members, natural healers, and trained interpreters.

- The Mental Hygiene Administration, in conjunction with Coppin State University (CSU), identified two major needs of the public mental health system: (1) a shortage of African American clinicians who can provide culturally relevant clinical services and (2) the lack of trained clinicians available to meet the needs of seriously emotionally disturbed children, adolescents and their families. To this end, in 1996, The Maxie Collier Scholars Program was initiated as a professional training model to provide a supportive, challenging learning environment to students pursuing careers in psychiatric nursing, pre-med, psychology and social work. Students receive an enriched, career focused academic background, financial support, graduate school preparation and internship experience. The project has increased curriculum offerings at CSU related to mental health topics and promotes a college wide interest in mental health issues. It has increased community awareness of resources to assist people who are interested in a career in the field of mental health.
- The Maryland fee for service mental health system introduced in 1997 (HB 1159) increased the number (from approximately 200 to over 4,000) and the geographic distribution of providers, resulting in a dramatic increase in the availability of culturally and ethnically diverse providers.
- The Board of Professional Counselors and Therapists was authorized by legislation enacted in 1998 to include individuals who provide services involving the application of counseling principles and methods in the diagnosis, prevention, treatment, and amelioration of psychological problems, emotional conditions, or mental conditions. The requirements for licensure include instruction in social and cultural foundations of counseling (aging, ethnicity, gender, psycho-sexual orientation, and the impact of culture on human development and counseling relations).
- Maryland has established a statewide network of consumer-run peer support services. Within the consumer arena, Maryland also established the Anti-Stigma Project which has

gained national recognition for its efforts to reduce stigma within the Public Mental Health System.

Recommendation 2: Identify, develop, implement, and evaluate culturally competent training curricula for pre-professional trainees, service providers, consumers, family members, and non-degreed professionals, including traditional/indigenous healers and interpreters.

Besides House Bill 524 (2007) for which this report is being written, the following activities have also been undertaken to increase cultural competence in the health care system. While they are not specific for mental health, they have obvious implications for the workforce shortage challenges experienced in the mental health system.

- House Bill 883 (2003) encourages courses or seminars that identify and eliminate health care disparities of minority populations.
- House Bill 1445 (2006), requires the Department of Health and Mental Hygiene (DHMH) to implement a pilot program that addresses: (1) cultural competency training of health care providers with an emphasis on community based providers: and (2) health outcomes by tracking indicators related to the specific health care needs of the population in a specific area.
- House Bill 1127 (2006) and Senate Bill 230/House Bill 322 (2006) address the lack of minorities in the health care workforce and provide assistance to attract and retain minorities as practicing nurses or faculty in the state, respectively.

Recommendation 3: Make cultural competency training a requirement for licensure and certification of professionals and interpreters.

- In 2006 the state formed a workgroup consisting of representatives of each health occupations board to develop specified recommendations for requiring cultural competency instruction as part of an individual's licensure or renewal process.
- Since 1997, the Mental Hygiene Administration has incorporated cultural competency into all of its training and conferences and has offered continuing education credits.

Recommendation 4. Establish appropriate rates of reimbursement for use of trained, culturally competent professionals, non-degreed professionals and interpreters.

- The Maryland fee for service system provides for reimbursement of licensed faith based healers/practitioners.
- The Maryland Mental Hygiene Administration provides for reimbursement of interpreters for individuals who are deaf and hard of hearing.

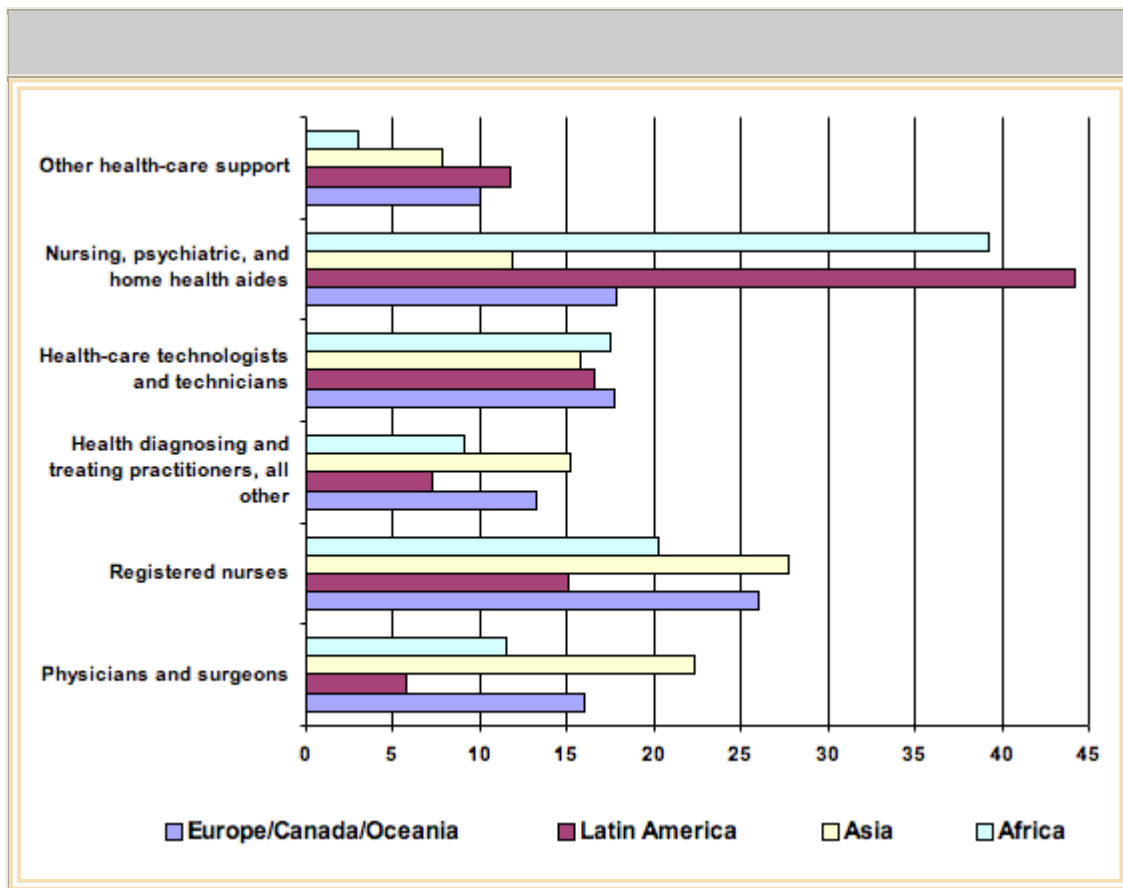
Licensure of Foreign-Born and Foreign-Trained Mental Health Professionals

Congress has set immigration requirements for physicians, nurses, and "health care workers." Organizations such as the Commission on Graduates of Foreign Nursing Schools, the National Board for Certification in Occupational Therapy, the Foreign Credentialing Commission on Physical Therapy and the Educational Commission for Foreign Medical Graduates are recognized national regulatory bodies for comparative evaluation of the level of medical knowledge of graduates from international schools. United States psychology regulating authorities do not recognize the validity of the usual qualifications required to obtain a license to practice psychology in countries which do not have a United State's school system. According to the Migration Policy Institute, the characteristics pertaining to foreign-born and foreign-trained individuals who have been successful in fulfilling the necessary requirements to work in the United States are as follows:

- In 2005, 15 percent of all U.S. health care workers were foreign-born.
- About 44 percent of the foreign-born workers in health care occupations arrived in the United States in 1990 or later.
- One in four doctors (physicians and surgeons) was born abroad.
- Foreign-born health care workers, regardless of gender, were more likely to be physicians and surgeons.
- Women accounted for more than 70 percent of the foreign-born health care occupations.
- In 2005 three-quarters of the foreign-born health care workers were employed in city centers.

- In 2005 Asia accounted for 39.9 percent of all foreign-born health care workers, followed by Latin America (34.4 percent); Europe, Canada and Oceania (16.8 percent); and Africa (8.9 percent).

Table 1: Migration Region of Birth of Foreign-Born Health Care Workers



Migration Policy Institute, Washington DC

Despite the success of some individuals in obtaining the necessary credentials to work in the United States, foreign-born and foreign-trained individuals with professional qualifications face unique challenges. This is ironic given the continued demand for foreign-trained individuals to assist in meeting the U. S. health care worker shortage. This shortage occurs in part from an aging workforce, high turnovers of existing health care workers, the increasingly ethnic and culturally diverse population and the U. S. educational system not keeping up with demand.

During the last decade Minnesota experienced a significant increase in the number of individuals from sub-Saharan and East African countries. In addressing the health care needs of these new Americans, Minnesota officials realized that many had a wide range of medical education and training. However, 80% of those who had such qualifications were working in entry level medical positions and as taxi drivers or parking lot attendants (Holder and Omondi, 2006).

Committed to utilizing the skills and talents of its foreign- born and foreign-trained citizens, Minnesota conducted a survey and found the following barriers impeded the ability of individuals to obtain their license to practice:

- Lack of access to institutional information from foreign colleges that is required by the accreditation entities;
- Institutional disregard for past professional health care experience resulting in requirements for retraining or externships;
- Lack of a central location for information about the licensure process in the United States;
- Transportation problems stemming from lack of driver's license or money to afford a car;
- Communication barriers that prevent applicants from understanding information that is provided;
- High cost associated with licensure process; and
- The need to study basic material again for licensure exams.

To overcome these barriers, the following strategies were recommended by the Minnesota study group:

- Form support groups with other professionals pursuing licensure;
- Establish a scholarship fund to assist with licensure fees and study costs;
- Allow international medical graduates to complete rotations at American hospitals to provide exposure to the U. S. medical system;
- Allow international medical graduates to have audit privileges at American universities for classes that can help prepare them for licensing exams;

- Identify ways the international community can become involved in bodies that oversee licensing activities;
- Create a one-stop website with links to all available resources for foreign-trained health care professionals seeking licensure within the State; and
- Provide a mechanism to assess the knowledge and skills of foreign-trained health care professionals to enable temporary eligibility or access to appropriate jobs while they complete licensure requirements.

To implement the above recommendations, Minnesota passed House Bill 378 that appropriated \$450,000 to create a public/private partnership to assist foreign-born and foreign-trained health professionals to obtain licensure.

Initiatives in other states include the funding of three programs in California known as Welcome Back Centers funded by the California Endowment. Similar to the Minnesota initiative, these centers were developed to build a bridge between the pool of internationally trained health workers living in California and the need for linguistically and culturally competent health services in underserved communities. In other words, the goal of this exciting program is to assist health professionals from all over the world who have come to the United States and have not been able to exercise their professions. (San Francisco Welcome Back Center). A Welcome Back Center has also been developed in Boston.

The service provided by these centers incorporates individual case management, career counseling services, curricula development, identification of advanced standing programs, and group interventions to meet the needs of internationally trained health workers. The expected outcome is to identify viable pathways that will enable internationally trained health workers to return to providing health services to communities in need.

Florida is the only state that has legislatively approved a state-specific licensure exam for foreign-trained physicians. This exam was designed especially for doctors trained in Cuba and Nicaragua. This permissive legislation is not without controversy. It eliminated internships and hospital residency as preconditions for licensing. Of those that took the test, 90 percent failed in

their first attempt. The state rewrote the test and translated it into Spanish. Again, more than 90 percent failed (Miami Herald, 2000) (New York Times, 2000).

In 2003, New Jersey became the first state to pass legislation (Senate Bill 144) requiring doctors to receive cultural competency training before they can obtain a state medical license or be re-licensed. Other states have considered such legislation but have met opposition due primarily to the mandatory requirements and associated financial costs.

Conclusion

The recruitment, retention and development of a health care workforce with cultural and linguistic skills are a global rather than a Maryland-specific issue. Countries such as Canada, France, and Germany have experienced an increase in their respective immigration population and are attempting to address this issue. As stated earlier, the Department of Health and Human Services has recognized the increasing need to have a culturally and linguistically competent mental health workforce. They also recognize that the workforce shortage in America is a critical issue that must be attended to in order to eliminate health care disparities.

Maryland has taken valiant steps toward developing a culturally and linguistically competent workforce, as evidenced by legislative directives, programs and policies of the Mental Hygiene Administration, actions undertaken by the Office of Mental Health Transformation and initiatives in progress or proposed by the Office of Minority Health and Disparities in conjunction with policymakers, professional licensure boards, providers, consumers, advocacy groups and the public. Many of these efforts are focused on increasing the number and cultural competency of overall health care workforce. In addition to addressing the means by which to make Maryland's mental health system more culturally competent, House Bill 524 contemplated how to use the skills of foreign-born and foreign-trained behavioral health practitioners in addressing Maryland's workforce shortage. In regard to the specific charge of the House Bill 524, the Workgroup developed the following set of recommendations:

Recommendations for Increasing the Number of Foreign-born and Foreign-Trained Behavioral Health Professionals

Recommendations	Lead Party	Start Time
Encourage the licensure boards to provide timely feedback to applicants regarding the status of application.	<ul style="list-style-type: none"> • Health Occupations Boards (HOB) 	October 2007
Develop an information packet which includes information about cultural competence for mental health professionals that will be given to prospective mentors.	<ul style="list-style-type: none"> • The Mental Health Transformation Office 	April 2008
<p>Establish a program whereby current mental health professionals who have been approved by the HOB, can receive continuing education units (CEUs) in exchange for mentoring foreign-born and foreign-trained practitioners who are seeking licensure in Maryland.</p> <p>Encourage foreign-born and foreign-trained individuals, who have already received their license to participate as mentors.</p>	<ul style="list-style-type: none"> • HOB 	July 2008
Provide technical assistance	<ul style="list-style-type: none"> • The Mental Health 	July 2008

<p>to mental health organization on how to recruit and retain foreign-born and foreign-trained mental health professionals</p>	<p>Transformation Office</p>	
<p>Establish a program whereby licensed mental health practitioners can receive CEUs in exchange for:</p> <p>1) mentoring college students who are currently enrolled in mental health programs and;</p> <p>2) mentoring individuals including those in middle school interested in pursuing a mental health profession.</p> <p>This would apply to all students regardless of immigration status.</p>	<ul style="list-style-type: none"> • HOB 	<p>July 2008</p>
<p>Create a web page, that list the universal requirements and processes for securing licensure and certification of foreign-born and foreign-trained behavioral health professionals. This site should be linked to the individual licensure boards and commission for specific information and requirements.</p>	<ul style="list-style-type: none"> • The Mental Health Transformation Office 	<p>July 2008</p>

Increase the number of ethnic and culturally diverse individuals serving on licensure boards and commissions.	<ul style="list-style-type: none"> Health Occupation Boards and Commissions 	July 2008
Create a pilot program that incorporates the elements of the Minnesota and California models for assisting foreign-born and foreign-trained mental health professionals to become licensed in Maryland.	<ul style="list-style-type: none"> The Mental Health Transformation Office 	September 2008

Recommendations for Providing Cultural Competency and Training to Behavioral Health Professionals.

Recommendations	Lead Party	Start Time
Develop and make available by web, a database that delineates cultural and linguistic capabilities of behavioral health providers within each Maryland jurisdiction.	<ul style="list-style-type: none"> The Mental Health Transformation Office 	October 2007
Develop an interactive website that identifies cutting edge organizations, individuals and programs within Maryland that are implementing and sustaining cultural competency efforts. Highlight and reward such	<ul style="list-style-type: none"> The Mental Health Transformation Office 	November 2007

<p>programs at conferences and seminars.</p>		
<p>Review nationally developed standards and best practices and use these to develop a training package for provider organizations to analyze its organizations' cultural competency and to develop a work plan to increase their cultural competence.</p>	<ul style="list-style-type: none"> • The Mental Health Transformation Office 	<p>November 2007</p>
<p>Establish a group comprised of representatives of the various licensing-certification boards as well as from the relevant educational institutions that will:</p> <p>(1) create a process to generate agreement within the State regarding the sources that should/could be consulted in creating culturally competency training modules.</p> <p>(2) investigate and analyze cultural competency training modules currently in use nationally in the various fields with critical analysis of their pros and cons; and</p> <p>(3) draft proposed models of cultural competence training for voluntary</p>	<ul style="list-style-type: none"> • The Mental Health Transformation Office 	<p>Ongoing</p>

adoption.		
In conjunction with the Mental Hygiene Administration and the Mental Health Transformation Office, plan to host an annual Healthcare Disparities Summit, which incorporates cultural competency training and provides CEU s for participants.	<ul style="list-style-type: none"> The Office of Minority Health and Health Disparities 	January 2008
Develop a website that identifies individuals/organizations that can serve as medical mental health translators (who can translate documents) and interpreters (who can speak foreign languages.)	<ul style="list-style-type: none"> The Mental Health Transformation Office 	October 2008

The Workgroup suggest that the lead party should work with other appropriate stakeholders such as but not limited to, the Foreign-Born Information and Referral Network (FIRN), the Governor’s Commissions, the Maryland Cultural Competence and Mental Health Committee and the Maryland Office of New Americans in moving forward with these recommendations.

The Workgroup also addressed the advantages and disadvantages of the above recommendations. The overarching advantage to actively pursuing the recommendations is that many individuals from ethnic and cultural groups prefer to seek care from providers of their own race, ethnicity, or language group, and that such concordance appeared to have a positive impact on appropriate service utilization, treatment participation, and receipt of some services. In addition, select recommendation would make a significant contribution to reducing the work

force shortage in Maryland. The only disadvantage the group saw in reference to recommendations would be the possible focus of limited resources on matters pertaining to the recruitment and retention of foreign-born foreign-trained individuals in lieu of a building a concerted, coordinated effort within Maryland to assure its overall mental health work force is culturally and linguistically competent.

It appears that the greatest challenge for Maryland is to weave these distinct initiatives into a comprehensive action plan with a fixed point of accountability for implementation and evaluation. This would eliminate duplicative and competing efforts and ensure efficient use of scarce resources.

References

Arthur Thomas E., (2000). “*Issues in Culturally Competent Mental Health Services for People of Color*”, *Psychiatric Rehabilitation Skills*, Vol. 4, No. 3, University of Illinois at Chicago.

American Psychiatric Association (1973). “*Homosexuality and Sexual Orientation Disturbance: Proposed Change in DSM-II*”, 6th Printing and Position Statement (Retired). APA Document Reference No. 730608.

American Psychological Association (2007).” *Guidelines for Psychotherapy with Lesbian, Gay and Bisexual Clients*”, APA Online.

Ball, Susan K., (2001).” *Homosexuality and the Mental Health Profession: The Impact of Bias*”. Psychosomatics, the Academy of Psychosomatics.

Bell, C., Williamson, J., (2006). Gift from within – “*Challenges and Obstacles in Treating Mentally Ill African American Patient*” As found on website: www.giftfromwithin.org

Brown, C., Shear, M.K., Schulberg, H.C. & Madonia, M.J. (1999). “*Anxiety Disorders Among African-American and White Primary Medical Care Patients*”. *Psychiatric Services*, 50.

Clark, L. (2000). *Migrant MDs of Two Countries Fail Specially Created Exam*. *Miami Herald*.

Coard, S.I., Holden, E.W. (1998). “*The Effect of Racial and Ethnic Diversity on the Delivery of Mental Health Services in Pediatric Primary Care*”. *Journal of Clinical Psychology in Medical Settings*.

Cross, T.L., Bazron, B.J., Dennis, K.W., & Isaacs, M. R. (1988).” *Towards a Culturally Competent System of Care: A Monograph on Effective Services for Minority Children who are Severely Emotionally Disturbed*”. Washington, DC: Child and Adolescent Service System Program (CASSP), CASSP Technical Assistance Center, Georgetown University Child Development Center.

Duffy, F. F., West, J. C., Wilk, J., Narrow, W. E., Hales, D., Thompson, J., et al. (2004). “*Mental Health Practitioners and Trainees*” In R. W. Manderscheid & M. J. Henderson (Eds.), *Mental health, United States, 2002* (pp. 327-368; DHHS Publication No. SMA 04-3938). Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.

Holder, W., Omondi, N. (2007). “*Needs Assessment of Foreign Trained Healthcare Professionals in Minnesota*”. CURA Reporter, Center for Urban and Regional Affairs, University of Minnesota, Winter Issue.

Institute of Medicine (2003). *“Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care”*. Brian D. Smedley, Adrienne Y. Stith, and Alan R. Nelson, Editors, Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care Washington, DC: National Academies Press.

Kilborn, Peter (2000).” *Dispute Flares in Florida over Licensing of Cuban Doctor”s*, New York Times

Manderscheid, R.W., & Henderson, M.J. (Eds.) (1998).” *Mental Health, United States: 1998”*. Rockville, MD: Center for Mental Health Services.

Maryland Office of Minority Health and Health Disparities (2006).”*Maryland Plan to Eliminate Minority Health Disparities”*, Maryland Department of Health and Mental Hygiene, Office of Minority Health and Disparities.

Migration Policy Institute. As found on website: www.migrationinformation.org

Mukherjee, S., Shukla, S., Woodie, J., Rosen, A.M., & Olarte, S. (1983). *“Misdiagnosis of Schizophrenia in Bipolar Patients: A Multiethnic Comparison”*. American Journal of Psychiatry, 140.

New Freedom Commission on Mental Health (2003). *Achieving the Promise: Transforming Mental Health Care in America. Final Report* (DHHS Pub. No. SMA-03-3832). Rockville, MD.

Nicholson, B. L. (1997).” *The Influence of Pre-immigration and Post Migration Stressors on Mental Health: A Study of Southeast Asian refugees”*. Social Work Research.

O’Sullivan, M.J., Peterson, P.D., Cox, G.B., & Kirkeby, J. (1989), *“Racial Matching and Service Utilization Among Seriously Mentally Ill Consumers,”* Community Mental Health Journal.

Resnick, M. D., Bearman, P. S., Blum, R. W., Bauman, K. E., Harris, K. M., Jones, J., et al. (1997). *“Protecting Adolescents from Harm: Findings from the National Longitudinal Study on Adolescent Health”* .Journal of the American Medical Association.

Robbins, L. & Reiger, D.A. (1991) *Psychiatric Disorders in America; The Epidemic Catchment Area Study*. New York: The Free Press.

San Francisco Welcome Back Center Home page: www.e-welcomeback.org

Snowden, L.R., Takeuchi, D.T., Sue, S and Yeh (1995) *“Outpatient Service Use in Minority-Service Mental Health Programs”*, Administration and Policy in Mental Health.

Somnath S., Portland VA Medical Center and Oregon Health & Science University, Shipman, S., (2006). *“The Rationale for the Diversity in the Health Professions: A Review of the Evidence”*. Contract No. 03-0285P for the U.S. Department of Health and Human Services, Health Resources and Services.

Sue, S., & Sue, D.W. (1974) “*MMPI Comparisons Between Asian and Non-Asian American Students Utilizing a University Psychiatric Clinic*”. *Journal of Counseling Psychology*, 31.

The Annapolis Coalition on Behavioral Health Workforce Building a National Strategic Plan for Behavioral Health Workforce Development. As found of website: www.annapoliscoaliton.org

U.S. Department of Health and Human Services (1999.) “*Mental Health: A Report of the Surgeon General—Executive Summary*”. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999

U.S. Department of Health and Human Services (1998). “*Cultural Competence Standards in Managed Mental Health Care Services: Four Underserved/Underrepresented Racial/Ethnic Groups*”. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.

U.S. Department of Health and Human Services (2001b). “*National Standards for Culturally and Linguistically Appropriate Services in Health Care: Final report*”, (Federal Register, 65(247), 80865-80879).Rockville, MD: Office of Minority Health.

U.S. Department of Justice. (2002). “*Sourcebook of Criminal Justice Statistics 2002*”, Washington, DC: Bureau of Justice Statistics.

U.S. Department of Justice. (2002). “*Sourcebook of Criminal Justice Statistics 2002*”, Washington, DC: Bureau of Justice Statistics.

Vedantan, S (2007) “*The Color of Health Care: Diagnosing Bias in Doctors*”. Washington Post.

Yeh, M., McCabe K., Hurlbert, M., Hough, R., Hazen, A., Culver, S., Garland, A., and Landsverk, J. (2002)” *Referral Sources, Diagnosis and Service Types of Youth in Public Outpatient Mental Healthcare: A Focus on Ethnic Minorities*”, *Journal of Behavioral Health Services and Research*.

Appendix

CHAPTER 412

(House Bill 524)

AN ACT concerning

Workgroup on Cultural Competency and Workforce Development for Mental Health Professionals

FOR the purpose of requiring the Mental Health Transformation Working Group, in collaboration with the Mental Hygiene Administration and the Office of Minority Health and Health Disparities, to convene a Workgroup on Cultural Competency and Workforce Development for Mental Health Professionals; requiring the Workgroup to include representatives from certain groups; providing for the purpose and goals of the Workgroup; requiring the Workgroup to develop certain recommendations; requiring the Workgroup to submit a certain report to the Governor, the General Assembly, and a certain committee on or before a certain date; providing for the termination of this Act; and generally relating to the Workgroup on Cultural Competency and Workforce Development for Mental Health Professionals.

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That:

(a) The Mental Health Transformation Working Group, in collaboration with the Mental Hygiene Administration and the Office of Minority Health and Health Disparities in the Department of Health and Mental Hygiene, shall convene a Workgroup on Cultural Competency and Workforce Development for Mental Health Professionals.

(b) The Workgroup shall include representatives from:

- (1) the Senate of Maryland and House of Delegates of Maryland;
- (2) the relevant professional licensing boards;
- (3) mental health care provider groups;
- (4) consumer groups with knowledge or experience with mental health care issues or health care for minority populations;
- (5) advocacy groups with knowledge or experience with mental health care issues or health care for minority populations; and
- (6) any interest group or stakeholder with knowledge or involvement

in the issues addressed by the Workgroup;

(7) the Statewide Commission on the Shortage in the Healthcare Workforce;

(8) the Governor's Workforce Investment Board or other groups working on health workforce shortage issues; and

(9) State and other organizations that represent minority health professionals.

(c) The purposes and goals of the Workgroup shall be to examine:

(1) barriers to access to appropriate mental health services provided by health care professionals who are culturally competent to address the needs of the State's diverse population;

(2) barriers to licensure or certification of foreign-born and foreign-trained mental health professionals;

(3) initiatives from other states for the facilitation of licensure or certification of foreign-born and foreign-trained mental health professionals;

(4) mental health workforce shortages and potential strategies to use foreign-born and foreign-trained mental health professionals to alleviate shortages; and

(5) options for enhancing the cultural competency of currently licensed and certified mental health professionals.

(d) The Workgroup shall develop recommendations regarding:

(1) the availability of specific options to facilitate the licensure or certification of foreign-born and foreign-trained mental health professionals within the limitations of State and federal law;

(2) the development of training programs to assist foreign-born and foreign-trained mental health professionals to prepare for and pass required licensure or certification examinations;

(3) the development of specific training and educational materials and programs to enhance the cultural competency of all mental health professionals;

(4) changes to the advantages and disadvantages of changing the current licensing and certification requirements for relevant professional licensing boards; and

(5) any other initiatives that will accomplish enhanced access to culturally sensitive and competent mental health services.

(e) The Workgroup shall report its findings and recommendations to the Governor and, in accordance with § 2-1246 of the State Government Article, the General Assembly and the Joint Committee on Access to Mental Health Services, on or before November 1, 2007.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect July 1, 2007. It shall remain effective for a period of 1 year and, at the end of June 30, 2008, with no further action required by the General Assembly, this Act shall be abrogated and of no further force and effect.

Approved by the Governor, May 8, 2007.

MARYLAND HEALTH WORKFORCE RELATED ORGANIZATIONS AND PROGRAMS

1. Baltimore Alliance for Careers in Healthcare

- Career Coaching and Mapping
- Pre-allied Health Bridge Program
- Jobs to Careers

<http://www.baltimorealliance.org>

2. Community Foundation of the Eastern Shore

- Partners in Nursing -- a regional mentoring program specifically to address three issues: Retention of new nurses; Creation of a nursing leadership network; and Development of a career path to increase the number of nurse faculty.
- Partners in Nursing Steering Committee

www.cfes.org

3. Maryland Addiction Directors' Council

- Workforce Development Committee

<http://www.mdaddictiondirectors.com>

4. Maryland Area Health Education Center

- Baltimore Area Health Education Center
 - Eastern Shore Area Health Education Center
 - Western Maryland Area Health Education Center
- Youth Health Service Corps: health professions recruitment program that trains and places high school students as volunteers in health care agencies.
- Exploring Careers in Health Occupations -- a summer pipeline program.

<http://health.allconet.org/>

<http://ahec.umaryland.edu/overview.asp>

5. Maryland Association for Community Services (MACS) for Persons with Developmental Disabilities, Inc.

<http://www.macsonline.org>

6. Maryland Association of Deans and Directors of Nursing Programs

- Nurse Faculty Recruitment Fair

<http://www.marylandhealthcareers.org>

7. Maryland Department of Health and Mental Hygiene

- Maryland Statewide Commission on the Shortage in the Health Care Workforce
<http://www.dhmh.maryland.gov/mscshw/>

8. Maryland Department of Health and Mental Hygiene: Family Health Administration

- Maryland Primary Care Organization (PCO) – designations for Health Professional Shortage Areas and Medically Underserved Areas
- Maryland Loan Assistance Repayment Program (LARP) Physicians only
- Maryland Conrad 30 (J-1 Visa waiver) Program
- National Health Services Corps (coordination with the federal government)
<http://www.fha.state.md.us/ohpp>
- State Office of Rural Health: 3R Net
<http://www.3rnet.org/>
- Maryland Dent-Care Loan Assistance Repayment Program
<http://www.fha.state.md.us/oralhealth/>

9. Maryland Department of Health and Mental Hygiene (DHMH): Mental Hygiene Administration

- DHMH Mental Hygiene Administration Subcommittee on Children's Mental Health Workforce Development.
- Maryland Mental Health Transformation Grant: subcommittee - Mental Health Workforce
- Workgroup on Cultural Competency and Workforce Development for the Mental Health Professionals -- administered by DHMH Office of Minority Health and Health Disparities
<http://www.dhmh.state.md.us/mha/>

10. Maryland Department of Health and Mental Hygiene: Maryland Health Professional Boards and Commissions

<http://www.dhmh.state.md.us/html/org-board&comm.htm>

11. Maryland Department of Health and Mental Hygiene: Office of Minority Health and Health Disparities

- Workforce Diversity Initiative funded by the United States Health and Human Services, Office of Minority Health
<http://www.dhmh.state.md.us/hd/websites.htm>

12. Maryland Department of Labor, Licensing & Regulation, Governor's Workforce Investment Board

- Center for Health Industry
- Health Care Steering Committee
<http://www.mdworkforce.com/>

13. Maryland Health Services and Cost Review Commission (HSCRC)

- Nurse Support Program I – supports staff development and education for health careers, as well as retention programs.
- Nurse Support Program II - sponsored by Health Services and Cost Review Commission (HSCRC) and administered by Maryland Higher Education Commission (MHEC) -- supports nursing education and faculty development
<http://www.hscrc.state.md.us/>

14. Maryland Higher Education Commission

- Janet Hoffman Programs
- Maryland Scholarships and Loan Repayment Programs
<http://www.mhec.state.md.us/>

15. Maryland Hospital Association

- Health Care Faculty Shortage Work Group
- Business Case Work Group
<http://www.mdhospitals.org>

16. Maryland Nursing Workforce Commission, Maryland Board of Nursing (MBON)

- Maryland Commission on the Nursing Workforce (MBON) – subcommittees include recruitment, retention, nursing education, technology applications
<http://www.mbon.org/main.php>

17. Maryland State Department of Education

- Academy of Health Professions
- Project Lead the Way Biomedical Sciences
<http://www.msde.md.gov/msde/>

18. The Annapolis Coalition on the Behavior Health Workforce

- Children’s Workforce Issues
- Innovation in Workforce Education
- Cultural Competency and Disparities in Access to Quality Services
- Rural Workforce Issues
<http://www.annapoliscoalition.org/>

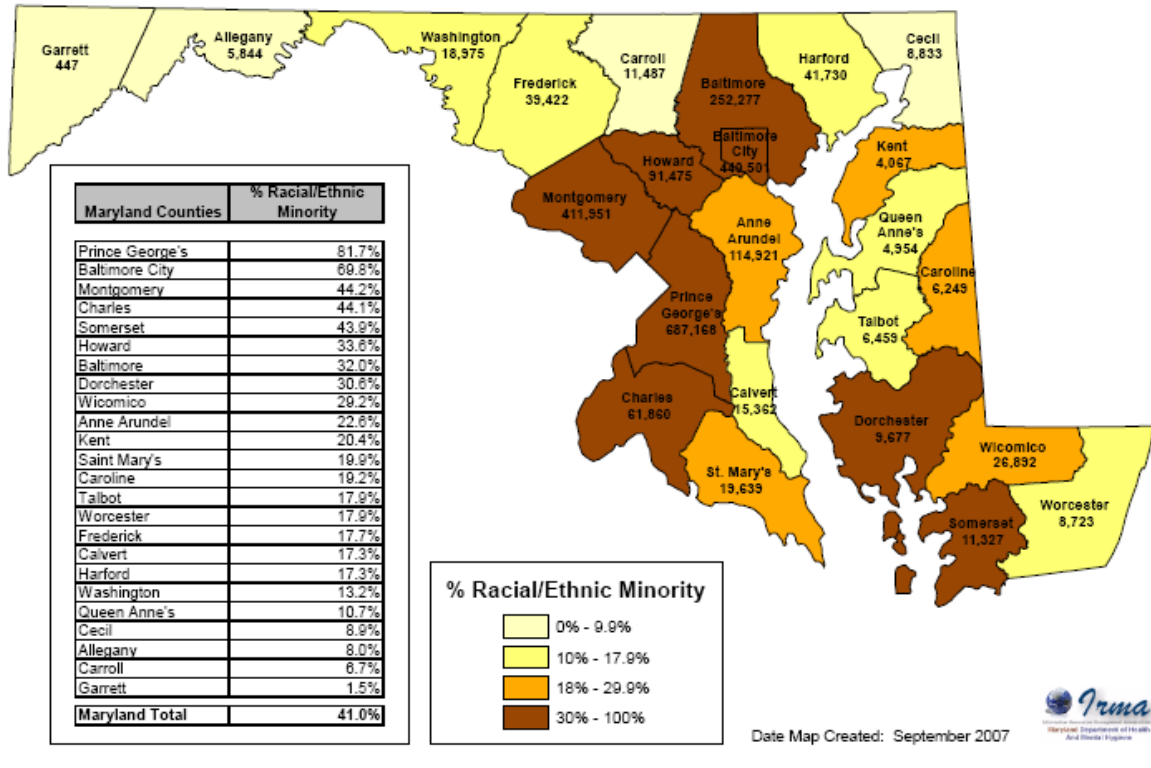
19. Towson University School of Nursing

- Nightingale Scholars Program -- a "grow your own" program for faculty development
EMT to RN transition program developed by Community College of Baltimore County.
<http://www.towson.edu/>

20. University of Maryland Baltimore

- Center for Health Workforce Development
<http://www.umaryland.edu/healthworkforce/>

Racial or Ethnic Minority Population (Number and Percent), by Jurisdiction, Maryland 2006



**House Bill 524 Workgroup on Cultural Competency and Workforce Development for
Mental Health Professionals**

Committee Member List

<p>Lynn Albizo, Executive Director NAMI- Maryland 1804 Landmark Drive, Suite 122 Glen Burnie, Maryland 21061 (410) 863-0470 Lalbizo@nami.org</p>	<p>Lillian Bowie, Consultant Cultural Competency Initiative 218 Dorchester Street La Plata, Maryland 20646</p>
<p>Mohammas Akhter, MD Executive Director National Medical Association 1012 Tenth Street, NW Washington, DC 20001 (202) 347-1895 jfreeman@nmanet.org</p>	<p>Keith Colston, Executive Director MD Commission on Indian Affairs 311 W. Saratoga Street Baltimore, Maryland 21201 (410) 767-3643 kcolston@dhr.state.md.us</p>
<p>Thomas Arthur, Consultant Thomas E. Arthur and Associates 98 Dewey Drive Annapolis, Maryland 21401 (410) 269-5263 arthurhome@annapolis.net</p>	<p>Janet Cornick Senior Education Policy Analyst Maryland Higher Education Analyst 839 Bestgate Road, Suite 400 Annapolis, Maryland 21401 (410) 260-4544 jcornick@mhec.state.md.us</p>
<p>Cyntrice Bellamy, Administrator of Behavioral Health Programs Mental Hygiene Administration 55 Wade Avenue Catonsville, Maryland 21228 (410) 402-8489 cbellamy@dhmh.state.md.us</p>	<p>Antoinette Coward, Health Planning and Development Administrator Family Health Administration 201 W. Preston Street Baltimore, Maryland 21201 (410) 767-5602 CowardA@dhmh.state.md.us</p>
<p>Jennifer Blake Executive Director (FIRN) Foreign-Born Information and Referral Network 5999 Harpers Farm Road Suite 200 Columbia, Maryland 21044 info@firnonline.org</p>	<p>Herb Cromwell, Director Community Behavioral Health Association of Maryland 18 Egges Lane Catonsville, Maryland 21228 (410) 788-1865 mcbcbh@verizon.net</p>
<p>Sharon Bloom, Executive Assistant DHMH- Health Workforce 4201 Patterson Avenue Baltimore, Maryland 21215 (410) 764-4680 Sbloom@dhmh.state.md.us</p>	<p>Delegate Addie Eckardt House of Delegates Eastern Shore Hospital Center P. O. Box 800 5262 Woods Road Cambridge, Maryland 21201 Delegate.A.Eckardt@house.state.md.us</p>

<p>Mariana Falconier , PhD, LCMFT Regional Director- Horizon Region Vesta, Inc. 8737 Colesville Rd, Suite 700 Silver Spring, MD 20910 (301) 588 8881 (X824) marianaf@vesta.org</p>	<p>Paula Lafferty, Consumer Affairs Specialist DHMH-Mental Health Transformation Office 55 Wade Avenue, Dix Building Catonsville, Maryland 21228 (410) 402-8345 plafferty@dhhm.state.md.us</p>
<p>Heidi Holland, Deputy Director Training and Workforce Development Maryland Association of Resources for Youth and Families 1517 Ritchie Highway Arnold, Maryland 21012 (410) 974-4901, ext 6 hholland@marfy.org</p>	<p>Christine McKee, Director of Public Education Mental Health Association of Maryland 711 W. 40th Street Suite 460 Baltimore, Maryland 21211 (410) 235-1178, ext 203 cmckee@mhamd.org</p>
<p>Paula Hollinger, Director DHMH- Health Workforce 4201 Patterson Avenue Baltimore, Maryland 21215 (410) 764-4682 phollinger@dhhm.state.md.us</p>	<p>Ilana Mittman, Workforce Diversity Director Office of Minority Health and Health Disparities 201 W. Preston Street room 500 Baltimore, Maryland 21201 (410) 767-6539 imittman@dhhm.state.md.us</p>
<p>Carlessia Hussien, Director Office of Minority Health and Health Disparities 201 W. Preston Street, Room 500 Baltimore, Maryland 21201 (410) 767-7117 hussainC@dhhm.state.md.us</p>	<p>Oscar Morgan, Vice President Health Management Consultants, LLC 8835 Columbia 100 Parkway Suite A Columbia, Maryland 21045 (410) 715-0011 oscar@hmconsultant.com</p>
<p>Iyan John Health Policy Analyst Office of Minority Health and Health Disparities 201 W. Preston Street, Room 500 Baltimore, Maryland 21201 410-767-6526 ijohn@dhhm.state.md.us</p>	<p>Madge Pat Mosby MD Coalition of Families for Children’s Mental Health 10632 Little Patuxent Parkway, Suite 119 Columbia, Maryland 21044 410-730-8267 pmosby@mdcoalition.org</p>
<p>Senator Delores Kelley Linda Forsyth, Liason Maryland House of Representatives 11 Bladen Street Annapolis, MD 21401 410-841-3606 lforsyth@senate.state.md.us</p>	<p>Sabitri Morris, Consultant Cultural Competency Initiative (410) 238-7979 sabitrिमorr@aol.com</p>

<p>Delegate Shirley Nathan-Pulliam Maryland House of Delegates House Office Building 309 6 Bladen Street Annapolis, Maryland 21401 (410) 841-3358 Shirley.nathan.pulliam@house.state.md.us</p>	<p>Kakoli Ray, Regional Director International Rescue Committee of Baltimore 3516 Eastern Avenue Baltimore, Maryland 21224 (410) 327-1885 Kakoli.ray@their.org</p>
<p>Martha Nathanson, VP Government Relations and Advocacy Lifebridge Health 2401 W. Belvedere Avenue Baltimore, Maryland 21215 (410) 601- 8645 mnathans@lifebridgehealth.org</p>	<p>Iris Reeves, Multicultural Coordinator DHMH- Mental Hygiene Administration 55 Wade Avenue, Mitchell Bldg Catonsville, Maryland 21228 (410) 402-8326 ireeves@dhms.state.md.us</p>
<p>Kaliz Oaks, Liaison for Maryland State Counselor Licensure Loyola College of Maryland Columbia, Maryland (410) 617- 7631 koakes@loyola.edu</p>	<p>Mary Russell, Assessment Director Office of Minority Health and Health Disparities 201 W. Preston Street, Room 500 Baltimore, Maryland 21201 (410) 767-2131 mrussell@dhhm.state.md.us</p>
<p>Tricia O'Neill, Senior Advisor Academic Affairs University of Maryland (410) 706-1850 tdoneill@umaryland.edu</p>	<p>Art Taguding, Director Governor's Workforce Investment Board 1100 N. Eutaw Street Room 108 Baltimore, Maryland 21201 (410) 767-2131 ataguding@dllr.state.md.us</p>
<p>Malinda B. Orlin Vice President, Academic Affairs and Dean, Graduate School University of Maryland Baltimore mborlin@umaryland.edu (410) 706-1850</p>	<p>Delegate Shawn Tarrant Maryland House of Delegates House Office Building Room 316 6 Bladen Street Annapolis, Maryland 21401 (410) 841-3800 (410) 728-0361, District Office Shawnztarrant@aol.com</p>
<p>Linda Raines Mental Health Association of Maryland 711 W. 40th Street Suite 460 Baltimore, Maryland 21211 (410) 235- 1178, ext 204 lraines@mhamd.org</p>	<p>Keisha Tatum Health Policy Analyst Mental Health Transformation Office 55 Wade Avenue Catonsville, Maryland 21228 (410) 402-8347 ktatum@dhhm.state.md.us</p>

<p>Cynthia Vice Maryland Cultural Competency and Mental Health Committee 18858 York Road Parkton, Maryland 21120 Myclouds2@aol.com</p>
<p>Melissa Vice, Consultant Cultural Competency Initiative (410) 961-4975 Myvice99@yahoo.com</p>
<p>Joseph Weiss, Consultant 1 E. Chase Street Suite 8 Baltimore, Maryland 21201 (240) 498-0353 josephmweiss@yahoo.com</p>
<p>Donna Wells, Executive Director Maryland Association of Core Service Agencies 22 S. Market Street Suite 8 Fredrick, Maryland 21701 (301) 682-9754 wells@hcmha.org</p>
<p>Tony Wright, Executive Director On Our Own of Maryland, Baltimore City 6301 Harford Road Baltimore, Maryland 21214 (410) 444-4500 Tonyw21214@aol.com</p>

