Adoption of the National CLAS Standards by State Mental Health Agencies: A Nationwide Policy Analysis

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Objective: This study reports the extent to which states have adopted the national culturally and linguistically appropriate services (CLAS) standards.

Methods: Officials from public mental health agencies in the 50 states, Washington, D.C., and Puerto Rico were contacted between January and June 2016 to obtain information about adoption of CLAS standards in current policies. Each policy was coded through thematic analysis to determine its correspondence with any of the 14 national CLAS standards, which are grouped into three domains.

Results: Officials from 47 states and territories (90%) responded. Eight states (17%) reported adopting all national CLAS standards. Ten (23%) had adopted no CLAS policies, five (12%) had adopted policies under one domain, three (7%) under two domains, and 25 (58%) under all three domains.

Conclusions: Most states do not have policies that meet all CLAS standards, raising questions about how CLAS standards should be adopted.

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Government and professional bodies have recommended cultural and linguistic competence training for mental health clinicians and organizations. These recommendations are based on hundreds of studies documenting disparities in the initiation, continuation, and completion of treatment among members of racial-ethnic minority groups compared with non-Hispanic whites (1,2). The causes of disparities include low patient literacy, clinician biases, a lack of language-matched services for non–English-speaking clients, and the unequal geographical distribution of health resources (3). Of these four causes, the unequal geographical distribution of health resources justifies government-led public mental health policies in disparity reduction because the government provides safety-net health services for all populations who need them.

In 2001, the U.S. Department of Health and Human Services' Office of Minority Health (OMH) released 14 national standards for culturally and linguistically appropriate services (CLAS) for clinicians, organizations, accreditation bodies, and state agencies (4). The standards encouraged the development of clinician services compatible with patient cultural beliefs, practices, and languages; an organizational workforce representing the demographic diversity in local communities; culturally and linguistically competent services; and ongoing self-assessments for accountability (4). In 2013, OMH released 15 enhanced national CLAS standards with one overarching principal standard and 14 specific standards under three domains: governance, leadership, and workforce; communication and language assistance; and engagement, continuous improvement, and accountability (5). The enhancements include a new definition for cultural identities beyond race and ethnicity (such as sexual orientation), an organizational blueprint of exemplary practices, and recommendations calling for public health organizations to adopt the standards (5). As in 2000, OMH urgently advocated for but did not mandate adoption of all standards because of a lack of research proving that any single standard reduces disparities (4,5). To address this research gap, in 2014 the Assistant Secretary for Health encouraged study of the adoption of national CLAS standards in various contexts, including state mental health agencies (6).

In June 2016, OMH found that 32 states undertook 172 CLAS-type activities in 2014–2015, from holding conferences and creating CLAS-related media to incorporating standards within strategic planning; only nine states adopted CLAS-specific policies, procedures, and regulations (7). The report's methodology consisted of searches on Web sites and research databases for mentions of any type of CLAS activity by agencies concerned with general medical and mental health. CLAS adherence was defined as adoption of all standards wholesale (7). We wanted to understand the extent to which mental health agencies across all states, Washington, D.C., and Puerto Rico have adopted policies that reflect the national CLAS standards. We undertook a more recent investigation, hypothesizing that policies could be better identified by contacting state officials than by consulting Web sites and research articles, which may be outdated.

METHODS

We sought to answer two interrelated questions: Which states have adopted all national CLAS standards? For states that have adopted some but not all standards, under what CLAS domains would their disparity-reduction policies fall? A list of each state agency administering public mental health services in the 50 states, Washington, D.C., and Puerto Rico was compiled by searching Google. Among the 16 U.S. territories, only Washington, D.C., and Puerto Rico were included because Congress has granted them rights over local self-government (8). Hence, all 50 states, Washington, D.C., and Puerto Rico can formulate policies independently from the federal government, permitting study of local adoption of national CLAS standards. Because states and territories differ over whether a single agency provides mental health services—for example, some states, such as New York, have separate agencies overseeing services for patients with certain disorders, such as autism spectrum disorder—we included only the agency responsible for general adult services to ensure sample consistency.

We contacted the official listed on each Web site to obtain information about cultural-competence and disparity-reduction policies. We made up to two phone calls and sent up to five e-mails. We introduced ourselves, sought information about specific policies on disparity reduction, and checked the accuracy of the information on each agency's Web site. We used a standard script: "Is this the most accurate and up-to-date information for your state? If not, could you direct me to a more current Web site or send us the state's policies?" Institutional review board approval was exempted because the analysis involved state agencies, not human beings.

We compared all policies on Web sites with descriptions of policies by officials. The first two authors analyzed all verified policies through thematic analysis (9), a widely used practice in mental health services research (10). We relied on OMH's own assumption that state policies are valid data in examining national CLAS standards adoption (5,7). Each policy was uploaded into NVivo and coded deductively by the first two authors by identifying text corresponding to the CLAS standards. Because only nine states adopted CLAS-related policies in 2016 (7), any policy corresponding to the CLAS standards was defined as fulfilling a broader domain. The first two authors coded policies for ten states (approximately 25% of the entire sample) independently to achieve an interrater reliability of 80% before coding all remaining policies jointly. Two rounds of coding were required to meet this benchmark. To ensure reliability, we drafted analytical memos on coding differences and thematic patterns. Peer checking and debriefing meetings were held weekly during the project.

RESULTS

State officials in 52 states and territories (one per state or territory) were contacted. Officials from Delaware, Hawaii, Kansas, Maine, and Puerto Rico (N=5) did not respond; these states were excluded because we could not verify policies on their Web sites. Officials from 46 states and Washington, D.C. (N=47, 90%) responded. Of these 47, officials from Colorado, Georgia, Kentucky, and New Jersey (N=4) reported that the states had no CLAS policies but that policies were in development at the time of study; these states were excluded from further analysis. For 43 states and territories, we were able to verify the existence of current CLAS policies, available either on Web sites or in written form. [Examples of policies coded according to CLAS domain are available in an online supplement to this report.]

Ten (23%) of the 43 states and territories reported no policies corresponding to any of the three national CLAS standard domains, five (12%) reported policies for one domain, three (7%) for two domains, and 25 (58%) for all three domains. Of these 25, eight states (17%) reported adopting all 15 CLAS standards.

States adopted policies under each domain about equally. Thirty states adopted policies under the domain of governance, leadership, and workforce; 30 under the domain of communication and language assistance; and 28 under the domain of engagement, continuous improvement, and accountability.

No respondent refused to provide information, and all were familiar with the national CLAS standards. Respondents held various positions, ranging from chief community relations officer to director of the division of behavioral health. Officials forwarded our e-mails to others if they did not know the agencies' policies. Officials from 22 states (47%) confirmed that policies on Web sites were current, and officials from 25 states (53%) noted differences between current policies and state Web sites, given that some Web sites were outdated and current policies were not always available online.

DISCUSSION AND CONCLUSIONS

This is the first nationwide study to examine how mental health agencies have adopted the enhanced national CLAS standards by obtaining information about policies from officials. As of June 2016, agencies in most states have taken an all-or-nothing approach. About a third have adopted all standards or policies under all CLAS domains. The remaining two-thirds had no policies or had policies under all three domains. Most agencies still had not adopted the national CLAS standards three years after the standards' release.

Our study also reveals methodological challenges in examining CLAS adoption. Relying predominantly on Web sites to collect information about CLAS policies, as OMH did in 2016, would have produced inaccurate data in almost half of our sample. Our method of contacting state officials was more comprehensive, yet some did not respond, raising questions around how best to obtain this information. To study disparity reduction, some researchers differentiate policy adoption from service implementation (11). Instead of assuming that all national CLAS standards must be adopted wholesale, an alternative approach could explore why states adopt certain policies over others. This framework can generate research evidence through case studies. Case studies on states with no policies can illuminate barriers to incorporating CLAS standards within

policy making. Similarly, research on states with CLAS-related policies could identify facilitators and examine policy implementation within service settings to assess patient, provider, and organizational outcomes. We have focused on state mental health agencies, but methodological problems may also exist among agencies administering general medical services. The CLAS standards also pertain to private for-profit and nonprofit entities (5) for which independent researchers may have limited access to information. Future work could recommend methodological best practices in these contexts.

The differentiation between adoption and implementation of policy has emerged in the few studies on disparity reduction in public mental health settings. Clinicians and administrators may resist disparity-reduction policies because of perceived costs associated with spending time asking patients "cultural" questions or hiring interpreters (12). Private and nonprofit clinicians and organizations look to public systems to implement reimbursable practices, and state agencies have historically pioneered cultural-competence training practices (13). Hence, state mental health agencies can model national CLAS standards adoption.

Our work had limitations. First, our data were valid for the period of investigation, and adoption status may have changed, although that is unlikely for the 43 states and territories that provided policies. Second, our data may be restricted, given that states may have policies beyond the agency contacted, although it is unlikely that states would adopt CLAS-related policies in some mental health agencies but not others.

Third, discrepancies between OMH's study and ours may be due to methodology. We focused on mental health agencies rather than on all medical agencies, and our study occurred in 2016 compared with the OMH study (7), which ended in early 2015. Both studies defined adoption differently, and we found that whereas only eight states adopted all national CLAS standards, 33 had policies under at least one CLAS domain. To give states the benefit of the doubt, we focused on adoption by domain, which prevented us from detecting differences in adoption for each standard within the domain, a focus for future work. Finally, some officials may have neglected to mention pertinent policies, especially given that states like New Jersey have long engaged in cultural competence initiatives (14).

Nonetheless, our study provides the first nationwide analysis comparing state disparity-reduction policies with the national CLAS standards. OMH has repeatedly recommended adoption of these standards (4,5). Most states have not followed this approach, and current scholarship is limited. Instead, studies of how state officials adopt and implement the standards within policies to close disparities may generate greater evidence. Treating the national CLAS standards as an innovation meriting study through formal implementation and dissemination frameworks could organize future research (15). Such studies may help determine the efficacy of specific policies. For example, it is unknown whether certain policies are more effective than others in reducing disparities and whether states that adopt a specific number or specific types of standards are better positioned than others to reduce disparities. Finally, future work could study for whom policies are intended—state personnel, county agencies and providers, or independent contractors receiving state funding—and the mechanisms states can draw on to enforce policy implementation.

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