

Cultural Competence Handbook

San Diego County Behavioral Health Services
March 2016



LIVE WELL
SAN DIEGO

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Cultural Competence Handbook

Introduction

The County of San Diego is richly diverse, beyond ethnicity; cultures are dynamic and unique. We celebrate the wealth of diversity and the demographics below are just one indication of our cultural wealth. The Agency, providers, and community partners face a unique opportunity when engaging culture sensitivity. One way is our recent integration of trauma-informed systems. Being trauma-informed is a philosophy, a component of cultural competence; an approach to engage all people we serve, all staff and those we encounter whilst conducting business. Cultural norms, values, beliefs, customs, and behaviors may influence behavioral health and medical issues, so authentic engagement and developing relationships with those we serve will guide our work with positive outcomes as the intent. On July 13, 2010, the County Board of Supervisors took a bold and innovative leap forward in the area of health policy by adopting a 10-year health strategy agenda to improve the health of our region. This highly innovative strategy agenda aims to improve the health and well-being of county residents through four key pillars: 1) Building a Better Service Delivery System, 2) Supporting Positive Healthy Choices, 3) Pursuing Policy and Environmental Changes, and 4) Improving the Culture from Within County Government.

	2010 United States Census Data	2010 San Diego County Census Data	FY 2014-15 Behavioral Health Services
White	231,040,398 (74.8%)	1,981,442 (64.0%)	22,615 (36.4%)
Hispanic	50,477,594 (16.4%)	991,348 (32.0%)	19,877 (32.0%)
African American	42,020,743 (13.6%)	158,213 (5.1%)	7,171 (11.5%)
Asian/Pacific Islander	17,320,856 (5.6%)	351,428 (11.4%)	2,722 (4.4%)
Native American	5,220,579 (1.7%)	26,340 (0.9%)	424 (0.7%)
LGBTQI	9,083,558* (2.9%)	300,000** (9.6%)	1,786*** (2.8%)
Veterans	26,403,703 (8.5%)	292,034 (9.4%)	1,672*** (3.8%)
Age 0-17	74,181,467 (24.0%)	821,263 (26.5%)	17,308 (27.9%)
Age 18-24	30,672,088 (9.9%)	270,750 (8.8%)	8,492 (13.7%)
Age 25-59	146,806,075 (47.6%)	1,502,564 (49.0%)	30,826 (49.6%)
Age 60+	57,085,908 (18.5%)	500,736 (16.2%)	5,471 (8.8%)
For additional information on BHS client demographics, go to the HHSA, BHS Technical Resource Library: http://www.sdcounty.ca.gov/hhsa/programs/bhs/mental_health_services_act/technical_resource_library.html			

**The information on adult LGBT population in the US was obtained from The Williams Institute, UCLA School of Law.*

***This number is approximate based on the information from Behavioral Health Education and Training Academy*

Note: the percentages are based on the total 2010 US population (308,745,538), 2010 San Diego County (3,095, 313) population, and FY 2012-13 BHS population (59,462).

****Information is based on FY 2013-14 BHS client population. Proportion of veterans is based on A/OA client count.*

In alignment with “Live Well, San Diego!”, the Health and Human Services Agency Behavioral Health Services Division (BHS) continually works toward the complete integration of systems and services. Within this integration process, BHS is working to fully incorporate the recognition of the personal experiences within cultural diversity and sees the creation of an integrated culturally competent and trauma-informed Behavioral Health system as a developmental process. BHS has demonstrated commitment to cultural competence and trauma-informed systems; continually enhancing strategies and efforts for enhancing wellness and reducing all disparities; cultural competence evaluation and training activities; the continued development of a multicultural workforce; and continued integration of systems and services. As part of our goal to enhance well-being and reduce disparities for all populations, SDCBHS presents this Cultural Competence Handbook. The Handbook contains tools that will assist Behavioral Health providers in making improvements throughout the system of care.

County of San Diego, Health and Human Services Agency

Vision:

Healthy, Safe, and Thriving San Diego Communities

Mission:

To make people's lives healthier, safer, and self-sufficient by delivering essential services.

Strategy:

1. **Building a Better System** focuses on systems and how the County delivers services. How it can further strengthen partnerships to support better health and wellbeing. For example, being trauma-informed is a component of cultural competency therefore the County is integrating physical and mental health given the bi-directional connectivity and making the systems and services easier to access.
2. **Supporting Healthy Choices** provides information and educates residents so they are aware of how their choices may impact their health. The plan highlights chronic diseases because these are largely preventable and we can make a difference through awareness and education.
3. **Pursuing Policy Changes for a Healthy Environment** is about creating policies and community changes to support recommended healthy choices.
4. **Improving the Culture from Within.** As an employer, the County has a responsibility to educate and support its workforce so employees "walk the talk." Simply said, change starts with the County as we practice what we teach.

Behavioral Health Services

Vision:

Safe, mentally healthy, addiction-free communities

Mission:

In partnership with our communities, work to make people's lives safe, healthy and self-sufficient by providing quality behavioral health services.

Guiding Principles:

1. Support activities designed to reduce stigma and raise awareness surrounding mental health, alcohol and other drug problems, and problem gambling.
2. Ensure services are outcome driven, culturally competent, recovery and client/family centered, and innovative and creative.
3. Foster continuous improvement to maximize efficiency and effectiveness of services.
4. Maintain fiscal integrity.
5. Assist employees to reach their full potential.

The Importance of Cultural Competence

Cultural Competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among consumer providers, family member providers, and professionals that enables that system, agency or those professionals, consumer, and family member providers to work effectively in cross-cultural situations.

The National Center for Cultural Competence has identified six salient reasons to incorporate cultural competence into organizational policy:

1. To respond to current and projected demographic changes in the United States.
2. To eliminate long-standing disparities in the health status of people of diverse racial, ethnic and cultural backgrounds.
3. To improve the quality of services and health outcomes.
4. To meet legislative, regulatory and accreditation mandates.
5. To gain a competitive edge in the market place.
6. To decrease the likelihood of liability/malpractice claims.

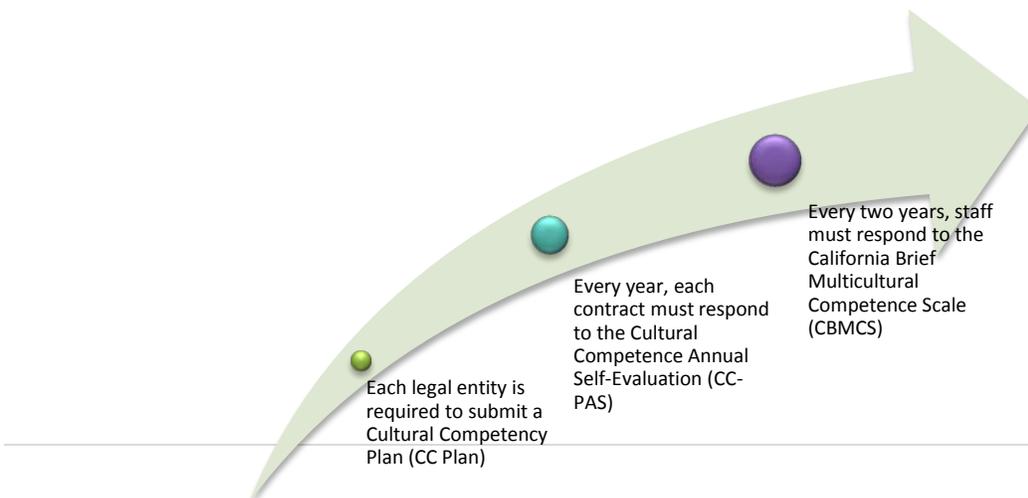
For more details go to: <http://nccc.georgetown.edu/foundations/need.html>.

To support the needs of our diverse populations SDCBHS recommends that all providers be committed to prioritizing cultural competence. This goal can be achieved through the following:

1. Incorporating trauma-informed and cultural competencies throughout the provider's:
 - i. Mission Statements
 - ii. Guiding Principles
 - iii. Policies and Procedures
2. Development or enhancement of a Cultural Competence Plan.
3. Periodic evaluation of staff, programs and clients.
4. Ensuring that the clinical practice is based on trauma-informed care, cultural awareness, and life-long enhancement of knowledge and skills.

This Cultural Competence Handbook provides timelines, guidelines, and examples of methods and tools that are recommended and can be used to guide programs in achieving the goal of enhancing wellness and reducing disparities.

Behavioral Health Services Cultural Competency Expectations for Providers



Cultural Competency Rollout			
When	What	Who	
		Alcohol and Drug Services (ADS)	Mental Health Services (MHS)
1 Time	Cultural Competency Plan (CC Plan)	<i>Required for all Legal Entities as of December 2013</i> <i>Updates as needed</i>	
Annual	Cultural Competence Program Annual Self-Evaluation (CC-PAS)	<i>April 2016</i>	
		<i>April 2017</i>	
		<i>April 2018</i>	
2 Years	The California Brief Multicultural Competence Scale (CBMCS)	<i>October 2017</i>	
		<i>October 2019</i>	

Cultural Competency History		
CC-PAS	CBMCS	CC Plan
Year 1: April 2012 (MHS only) Year 2: April 2013 (MHS only) Year 3: April 2014 (MHS and ADS) Year 4: April 2015 (MHS and ADS)	October 2011 (MHS only) October 2013 (MHS and ADS) October 2015 (MHS and ADS)	April 2012 (MHS) December 2014 (ADS)

The enhanced National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS Standards) were developed by the Health and Human Services Office of Minority Health and are intended to advance health equity, improve quality, and help eliminate health care disparities (see the Resources section). Implementing strategies to improve and ensure cultural and linguistic competency in the behavioral health care systems using the CLAS standards is a powerful way to address disparities and ensure all populations have equal access to services and supports. In addition to the new requirements in each programs' Statements of Work for adhering to CLAS standards, the following chart shows how CLAS Standards are already embedded into cultural competence evaluation tools provided in the Handbook.

CLAS Standards	CC-PAS	CBMCS	CC Plan
Principal Standard:			
1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.	•	•	•
Governance, Leadership, and Workforce:			
2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.	•		•
3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.	•	•	•
4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.	•		•
Communication and Language Assistance:			
5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.	•		•
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.			•
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.	•		•
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.			•
Engagement, Continuous Improvement, and Accountability:			
9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.	•		•
10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.	•	•	•
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.	•		•
12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.	•		•
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.	•		•
14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.			•
15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.	•		•

Source: Think Cultural Health, Office of Minority Health, U.S. Department of Health and Human Services
 For more information and to access CLAS standards visit www.thinkculturalhealth.hhs.gov/Content/clas.asp.

Cultural Competence Plan

An outline for the development of a
Cultural Competence Plan

Cultural Competence Plan Development Guidelines

Goal: To provide guidelines to assist and guide programs to develop a plan that enhances their current capability for providing trauma-informed and culturally competent systems and services.

Background: As stated in all SDCBHS contracts, it is an expectation that the organizations develop and provide trauma-informed and culturally competent systems and services, and work to continually enhance levels of cultural competence. This complements the expectation that the California Department of Health Care Services (DHCS) has for each county. The guidelines below, developed by SDCBHS with input from the Cultural Competence Resource Team (CCRT), can be used as a tool as your organization works to assess the current cultural competence and integrate the plan components into the system of care. If you do not have a Cultural Competence Plan in place currently, please ensure the following components are addressed. If you already have a Cultural Competence Plan in place, please evaluate to determine adding any of the elements noted in these guidelines could enhance your plan.

Cultural Competence Plan Component Guidelines:

- Current Status of Program
 - Document how the mission statements, guiding principles, and policies and procedures support trauma-informed cultural competence.
 - Identify how program administration prioritizes cultural competence in the delivery of services.
 - Agency training, supervision, and coaching incorporate trauma-informed systems and service components.
 - Goals accomplished regarding reducing health care disparities.
 - Identify barriers to quality improvement.
- Service Assessment Update and Data Analysis
 - Assessment of ethnic, racial, linguistic, and cultural strengths and needs of the community.
 - Comparison of staff to diversity in community.
 - A universal awareness of trauma is held within Agency. Trauma is discussed and assessed when needed and relevant to client/target population needs.
 - Use of interpreter services.
 - Service utilization by ethnicity, race, language usage, and cultural groups.
 - Client outcomes are meaningful to client's social ecological needs.
- Objectives
 - Goals for improvements.
 - Develop processes to assure cultural competence (language, culture, training, surveys) is developed in systems and practiced in service delivery.
 - Trauma-informed principles and concepts integrated
 - Faith-based services

The checklist on page 13 may serve as a resource for incorporating Cultural Competence Plan components into your policies and procedures. **It's provided for reference only.**

Please note: As of December 2013, Cultural Competence Plans are required for all legal entities for both mental health and alcohol and drug services. For legal entities with multiple programs, please consider a Cultural Competence Plan per program.

Cultural Competence Plan Implementation Checklist

SDCBHS recommends the use of this tool

CULTURAL COMPETENCE PLAN COMPONENTS:	COMPONENT IMPLEMENTATION					In response to what data or information was the change/innovation/improvement made?
	In Progress:	Approx. Impl. Date:	Met:	Resources Used:	Date Met:	
Current Status of Program						
Document how the mission statements, guiding principles, and policies and procedures support trauma-informed cultural competence.	<input type="checkbox"/>		<input type="checkbox"/>			
Identify how program administration prioritizes cultural competence in the delivery of services.	<input type="checkbox"/>		<input type="checkbox"/>			
Agency training, supervision, and coaching incorporate trauma-informed systems and service components.	<input type="checkbox"/>		<input type="checkbox"/>			
Goals accomplished regarding reducing health care disparities.	<input type="checkbox"/>		<input type="checkbox"/>			
Identify barriers to quality improvement.	<input type="checkbox"/>		<input type="checkbox"/>			
Service Assessment Update and Data Analysis						
Assessment of ethnic, racial, linguistic, and cultural strengths and needs of the community.	<input type="checkbox"/>		<input type="checkbox"/>			
Comparison of staff to diversity in community.	<input type="checkbox"/>		<input type="checkbox"/>			
A universal awareness of trauma is held within Agency. Trauma is discussed and assessed when needed and relevant to client/target population needs.	<input type="checkbox"/>		<input type="checkbox"/>			
Use of interpreter services.	<input type="checkbox"/>		<input type="checkbox"/>			
Service utilization by ethnicity, race, language usage, and cultural groups.	<input type="checkbox"/>		<input type="checkbox"/>			
Client outcomes are meaningful to client's social ecological needs.	<input type="checkbox"/>		<input type="checkbox"/>			
Objectives						
Goals for improvements.	<input type="checkbox"/>		<input type="checkbox"/>			
Develop processes to assure cultural competence (language, culture, training, surveys) is developed in systems and practiced in service delivery.	<input type="checkbox"/>		<input type="checkbox"/>			
a) Trauma-informed principles and concepts integrated	<input type="checkbox"/>		<input type="checkbox"/>			
b) Faith-based services	<input type="checkbox"/>		<input type="checkbox"/>			

Example:

Client outcomes are meaningful to client's social ecological needs.	<input type="checkbox"/>		<input checked="" type="checkbox"/>	Client Focus Group	Dec 13	Part of client-focused initiative.
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CLAS standards offer a strong framework to provide culturally and linguistically appropriate services, and because they are already embedded into cultural competence evaluation tools in the Handbook, the programs will be adhering to the Standards by utilizing the tools, following the established Cultural Competence Plan, and completing regularly scheduled evaluations as noted in the Rollout on page 9.

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Evaluating Cultural Competence

Evaluation

Included in this handbook are the following tools for evaluating program and staff in regards to cultural competence. Programs are required to use the CC-PAS and CBMCS as directed by San Diego County Behavioral Health Services. Evaluations for other areas may be done by using the tools noted or other tools that your program or legal entity has identified that meet the same criteria.

- Cultural Competence – Program Annual Self-Evaluation (CC-PAS)
- California Brief Multicultural Competence Scale (CBMCS)
- Certification of Language Competence
- Assessing Cultural Competence – Client Survey
- Assessing Cultural Competence – Client Focus Groups
- Assessing Cultural Competence – Community Survey
- Training Needs Assessment

Culturally Competent Program Annual Self-Evaluation

CC-PAS
(Clinical and non-clinical)

Culturally Competent Program Annual Self-Evaluation

The Culturally Competent Program Annual Self-Evaluation (CC-PAS) tool has been developed by San Diego County Behavioral Health to be used by programs to rate themselves as to their current capability for providing culturally competent services. The CC-PAS Protocol is based on expectations and standards recommended by the Cultural Competence Resource Team (CCRT) and endorsed by the Quality Review Council (QRC). Once the CC-PAS has been completed, programs should use the space at the end of the CC-PAS to develop new or revised goals and objectives/targets for their program's Cultural Competence Plan that will lead to ratings indicating a higher level of cultural competence in subsequent years.

Directions for scoring for CC-PAS Protocol:

- Review each item and fill out the description as to the status for your program. Add attachments as possible to support your position.
- Determine if your program has Met, Partially Met or Not Met the stated standard using the description of the standard noted for each category.
- Tally the score in each category using the following scale:
 - 5 points for Met Standard
 - 3 points for Partially Met Standard
 - 1 point for Standard Not Met
- Determine the total score.
- If your program needs technical assistance on certain topics, you can note that by checking at the end of any question:
___ Technical Assistance needed.
- The annual evaluation will serve as a baseline for your program. Keep a record of the results of the CC-PAS to use to evaluate your progress over time.
- Repeat the CC-PAS annually.
- Some items may not be applicable if program is not a direct service provider.

CLINICAL CC-PAS Protocol

- 1) The program/facility has developed a Cultural Competence Plan (CCP). Attach a copy of the CCP or describe the plan.**
-
-

STANDARD MET

Program has a written CCP that addresses the specific needs of the program.

STANDARD PARTIALLY MET

Legal Entity has a written CCP but the specific needs of that program are not identified, or there is no written CCP but there is some other evidence of a plan.

STANDARD NOT MET

There is no plan to achieve cultural competence for the program.

Score = _____ Technical Assistance Needed

Note: A suggested format and checklist that may be used for developing a CCP, if needed, have been provided on pages 11-12.

- 2) The program/facility has assessed the strengths and needs for services in its community. Describe the strengths and need for services:**
-
-

STANDARD MET

The strengths and needs of the community are clearly identified in the CCP. Community members, program advisory groups, and other stakeholders have participated in the identification of the strengths and needs of the community.

STANDARD PARTIALLY MET

The strengths and needs of the community are not clearly identified in the CCP, but there is evidence that the program is aware of the strengths and needs of the community.

STANDARD NOT MET

The program is not aware of the strengths and needs of the community.

Score = _____ Technical Assistance Needed

- 3) The staff in the program/facility reflects the diversity within the community. Attach a report that delineates staff diversity and compares the composition of the staff to the community, or describe:**
-
-

STANDARD MET

The diversity of staff in the program closely matches the demographics in the community, and there is evidence that this is a goal the program is working to achieve.

STANDARD PARTIALLY MET

The diversity of staff in the program somewhat matches the demographics in the community, and there is evidence that this is a goal the program is working to achieve.

STANDARD NOT MET

The staff in the program does not closely match the demographics in the community, and there is no evidence that this is a goal the program is working to achieve.

Score = _____ Technical Assistance Needed

4) The program/facility has a process in place for ensuring language competence of *DIRECT SERVICES STAFF* who identify themselves as bi- or multi-lingual. Attach or describe the process:

STANDARD MET

The program has a policy or written process for testing the language competence of **direct services staff** who identify themselves as bi- or multi-lingual. There is training available for any staff who are bi-lingual or who provide interpreter services to ensure that language needs are being met. The program also surveys clients and family members to assure language competence.

STANDARD PARTIALLY MET

The program has an informal process for testing the language competence of **direct services staff** who identify themselves as bi- or multi-lingual.

STANDARD NOT MET

The program does not have a process for testing the language competence of **direct services staff** who identify themselves as bi- or multi-lingual.

Score = _____ Technical Assistance Needed

5) The program/facility has a process in place for ensuring language competence of *SUPPORT SERVICES STAFF* who identify themselves as bi- or multi-lingual. Describe the process:

STANDARD MET

The program has a policy or written process for testing the language competence of **support services staff** who identify themselves as bi- or multi-lingual. There is training available for any staff who are bi-lingual or who provide interpreter services to ensure that language needs are being met.

STANDARD PARTIALLY MET

The program has an informal process for testing the language competence of **support services staff** who identify themselves as bi- or multi-lingual.

STANDARD NOT MET

The program does not have a process for testing the language competence of **support services staff** who identify themselves as bi or multi-lingual.

Score = _____ Technical Assistance Needed

6) The program/facility supports/provides direct and indirect services staff training on the use of interpreters. Describe the process:

STANDARD MET

The program has evidence that demonstrates direct and indirect services staff training on the use of language interpreters.

STANDARD PARTIALLY MET

There is informal training of direct and indirect services staff on the use of language interpreters.

STANDARD NOT MET

There has been no direct or indirect services staff training on the use of interpreters.

Score = _____ Technical Assistance Needed

7) The program/facility uses language interpreters as needed. Describe the use of language interpreters and languages used:

STANDARD MET

The program frequently uses language interpreters, and can consistently demonstrate the offer of interpreters in progress notes.

STANDARD PARTIALLY MET

The program occasionally uses language interpreters.

STANDARD NOT MET

The program does not use language interpreters and cannot demonstrate the offer of interpreters.

Score = _____ Technical Assistance Needed

8) The program/facility has a process in place for assessing cultural competence of direct and support services staff. Describe the process:

STANDARD MET

The program/facility has a written/formal process in place for assessing cultural competence of direct and support services staff and can demonstrate the results of those assessments. Additionally, the process includes input from clients and family members.

STANDARD PARTIALLY MET

The program/facility has a process in place for assessing cultural competence of direct and support services staff.

STANDARD NOT MET

The program/facility does not have a process in place for assessing cultural competence of direct and support services staff.

Score = _____ Technical Assistance Needed

9) The program/facility has a process and a tool in place for direct and support services staff to self-assess cultural competence (e.g. California Brief Multicultural Competence Scale – CBMCS). Describe the process and give the tool name:

STANDARD MET

The program has a requirement at the time staff are hired, and then periodically after hire, for all staff to complete the CBMCS or a similar tool and has evidence of the results of those evaluations. The program uses the evaluation to identify training needs.

STANDARD PARTIALLY MET

The program encourages staff to complete the CBMCS or a similar tool.

STANDARD NOT MET

The program does not support opportunities for staff to complete the CBMCS or a similar tool and does not have evidence of the results of those evaluations.

Score = _____ Technical Assistance Needed

10) The program/facility has conducted a survey amongst its clients to determine if the program is perceived as being culturally competent. Summarize the results of the survey:

STANDARD MET

The program/facility has conducted a survey amongst its clients and their family members to determine if the program is perceived as being culturally competent.

STANDARD PARTIALLY MET

The program/facility is using the annual San Diego County Behavioral Health Services (SDCBHS) client satisfaction survey to determine if the program is perceived as being culturally competent.

STANDARD NOT MET

The program/facility is not using any type of survey to determine if the program is perceived as being culturally competent.

Score = _____ Technical Assistance Needed

11) The program/facility conducted a survey amongst its clients to determine if the program's CLINICAL SERVICES are perceived as being culturally competent. Summarize the results of the survey:

STANDARD MET

The program/facility has conducted a survey amongst its clients to determine if the program's **clinical services** are perceived as being culturally competent.

STANDARD PARTIALLY MET

The program/facility uses the annual SDCBHS state survey to determine if the program's **clinical services** are perceived as being culturally competent.

STANDARD NOT MET

The program/facility does not use a survey amongst its clients to determine if the program's **clinical services** are perceived as being culturally competent.

Score = _____ Technical Assistance Needed

12) The program utilizes the Culturally and Linguistically Appropriate Services (CLAS) Standards. Describe how the standards are utilized:

STANDARD MET

The program utilizes the CLAS Standards and trains all staff and managers on them at least annually.

STANDARD PARTIALLY MET

The program utilizes the CLAS Standards but has little or no training.

STANDARD NOT MET

The program does not utilize the CLAS Standards.

Score = _____ Technical Assistance Needed

13) The program/facility supports cultural competence training of DIRECT SERVICES STAFF. Describe the process:

STANDARD MET

The program/facility supports cultural competence training of **direct services staff**, and 80-100% of staff have attended at least 4 hours of training.

STANDARD PARTIALLY MET

The program/facility supports cultural competence training of **direct services staff**, and 50-79% of staff have attended at least 4 hours of training.

STANDARD NOT MET

The program/facility does not support cultural competence training of **direct services staff**.

Score = _____ Technical Assistance Needed

14) The program/facility supports cultural competence training of *SUPPORT SERVICES STAFF*. Describe the process:

STANDARD MET

The program/facility supports cultural competence training of **support services staff**, and 80-100% of staff have attended at least 4 hours of training.

STANDARD PARTIALLY MET

The program/facility supports cultural competence training of **support services staff**, and 50-79% of staff have attended at least 4 hours of training.

STANDARD NOT MET

The program/facility does not support cultural competence training of **support services staff**.

Score = _____ Technical Assistance Needed

15) Services provided are designed to meet the needs of the community. Describe how the services meet the needs of the community:

STANDARD MET

Services provided include additional after-hours or weekend services, child care, transportation, or other options that are targeted to meet the specific community needs.

STANDARD PARTIALLY MET

Services provided include groups that are targeted to meet the specific community needs.

STANDARD NOT MET

Services provided do not include options that are targeted to meet the specific community needs.

Score = _____ Technical Assistance Needed

16) The program has implemented the use of any evidence-based practices or best practice guidelines *appropriate for the populations served*. Describe the practices:

STANDARD MET

The program has implemented the use of evidence-based practices or best practice guidelines *appropriate for the populations served*.

STANDARD PARTIALLY MET

The program has implemented the use of any evidence-based practices or best practice guidelines.

STANDARD NOT MET

The program has not implemented the use of any evidence-based practices or best practice guidelines.

Score = _____ Technical Assistance Needed

17) The program collects client outcomes *appropriate for the populations served*. Describe the client outcomes that are collected and how the information is used:

STANDARD MET

The program collects client outcomes *appropriate for the populations served*.

STANDARD PARTIALLY MET

The program collects client outcomes.

STANDARD NOT MET

The program does not collect client outcomes.

Score = _____ Technical Assistance Needed

18) The program conducts outreach efforts *appropriate for the populations in the community*. Describe the outreach efforts:

STANDARD MET

The program conducts effective and ongoing outreach efforts *appropriate for the populations in the community*.

STANDARD PARTIALLY MET

The program conducts occasional outreach efforts *appropriate for the populations in the community*.

STANDARD NOT MET

The program does not conduct outreach efforts.

Score = _____ Technical Assistance Needed

19) The program is responsive to the variety of stressors that may impact the communities served. Examples of responsiveness:

STANDARD MET

The program is responsive to the variety of stressors that may impact the communities served and can demonstrate responsiveness.

STANDARD PARTIALLY MET

The program is aware of the variety of stressors that may impact the communities served.

STANDARD NOT MET

The program is not aware of stressors that may have an impact on the communities served.

Score = _____ Technical Assistance Needed

20) The program reflects its commitment to cultural and linguistic competence in all policy and practice documents including its mission statement, strategic plan, and budgeting practices:

STANDARD MET

The program reflects its commitment to cultural and linguistic competence in **all** policy and practice documents including its mission statement, strategic plan, and budgeting practices.

STANDARD PARTIALLY MET

The program reflects its commitment to cultural and linguistic competence in **some** policy and practice documents including its mission statement, strategic plan, and budgeting practices.

STANDARD NOT MET

The program does not reflect its commitment to cultural and linguistic competence in all policy and practice documents including its mission statement, strategic plan, and budgeting practices.

Score = _____ Technical Assistance Needed

After completing all of the items 1 through 20 above, add all the individual scores together to come up with a CC-PAS rating for the program.

TOTAL SCORE = _____

New or revised objectives for the programs Cultural Competence Plan:

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NON-CLINICAL CC-PAS Protocol

- 1) The program/facility has developed a Cultural Competence Plan (CCP). Attach a copy of the CCP or describe the plan.**
-
-

STANDARD MET

Program has a written CCP that addresses the specific needs of the program.

STANDARD PARTIALLY MET

Legal Entity has a written CCP but the specific needs of that program are not identified, or there is no written CCP but there is some other evidence of a plan.

STANDARD NOT MET

There is no plan to achieve cultural competence for the program.

Score = _____ Technical Assistance Needed

Note: A suggested format and checklist that may be used for developing a CCP, if needed, have been provided on pages 11-12.

- 2) The program/facility has assessed the strengths and needs for services in its community. Describe the strengths and need for services:**
-
-

STANDARD MET

The strengths and needs of the community are clearly identified in the CCP. Community members, program advisory groups, and other stakeholders have participated in the identification of the strengths and needs of the community.

STANDARD PARTIALLY MET

The strengths and needs of the community are not clearly identified in the CCP, but there is evidence that the program is aware of the strengths and needs of the community.

STANDARD NOT MET

The program is not aware of the strengths and needs of the community.

Score = _____ Technical Assistance Needed

- 3) The staff in the program/facility reflects the diversity within the community. Attach a report that delineates staff diversity and compares the composition of the staff to the community, or describe:**
-
-

STANDARD MET

The diversity of staff in the program closely matches the demographics in the community, and there is evidence that this is a goal the program is working to achieve.

STANDARD PARTIALLY MET

The diversity of staff in the program somewhat matches the demographics in the community, and there is evidence that this is a goal the program is working to achieve.

STANDARD NOT MET

The staff in the program does not closely match the demographics in the community, and there is no evidence that this is a goal the program is working to achieve.

Score = _____ Technical Assistance Needed

4) The program/facility has a process in place for ensuring language competence of *ADMINISTRATIVE SERVICES STAFF* who identify themselves as bi- or multi-lingual. Attach or describe the process:

STANDARD MET

The program has a policy or written process for testing the language competence of **administrative services staff** who identify themselves as bi- or multi-lingual. There is training available for any staff who are bi-lingual or who provide interpreter services to ensure that language needs are being met. The program also surveys clients and family members to assure language competence.

STANDARD PARTIALLY MET

The program has an informal process for testing the language competence of **administrative services staff** who identify themselves as bi- or multi-lingual.

STANDARD NOT MET

The program does not have a process for testing the language competence of **administrative services staff** who identify themselves as bi- or multi-lingual.

Score = _____ Technical Assistance Needed

5) The program/facility has a process in place for ensuring language competence of *SUPPORT SERVICES STAFF* who identify themselves as bi- or multi-lingual. Describe the process:

STANDARD MET

The program has a policy or written process for testing the language competence of **support services staff** who identify themselves as bi- or multi-lingual. There is training available for any staff who are bi-lingual or who provide interpreter services to ensure that language needs are being met.

STANDARD PARTIALLY MET

The program has an informal process for testing the language competence of **support services staff** who identify themselves as bi- or multi-lingual.

STANDARD NOT MET

The program does not have a process for testing the language competence of **support services staff** who identify themselves as bi or multi-lingual.

Score = _____ Technical Assistance Needed

6) The program/facility supports/provides ALL staff training on the use of interpreters. Describe the process:

STANDARD MET

The program has evidence that demonstrates all staff training on the use of language interpreters.

STANDARD PARTIALLY MET

There is informal training of all staff on the use of language interpreters.

STANDARD NOT MET

There has been no staff training on the use of interpreters.

Score = _____ Technical Assistance Needed

7) The program/facility uses language interpreters as needed. Describe the use of language interpreters and languages used:

STANDARD MET

The program frequently uses language interpreters, and can consistently demonstrate the offer of interpreters in progress notes.

STANDARD PARTIALLY MET

The program occasionally uses language interpreters.

STANDARD NOT MET

The program does not use language interpreters and cannot demonstrate the offer of interpreters.

Score = _____ Technical Assistance Needed

8) The program/facility has a process in place for assessing cultural competence of ALL staff. Describe the process:

STANDARD MET

The program/facility has a written/formal process in place for assessing cultural competence of all staff and can demonstrate the results of those assessments. Additionally, the process includes input from clients and family members.

STANDARD PARTIALLY MET

The program/facility has a process in place for assessing cultural competence of all staff.

STANDARD NOT MET

The program/facility does not have a process in place for assessing cultural competence of staff.

Score = _____ Technical Assistance Needed

9) The program/facility has a process and a tool in place for ALL staff to self-assess cultural competence (e.g. California Brief Multicultural Competence Scale – CBMCS). Describe the process and give the tool name:

STANDARD MET

The program has a requirement at the time staff are hired, and then periodically after hire, for all staff to complete the CBMCS or a similar tool and has evidence of the results of those evaluations. The program uses the evaluation to identify training needs.

STANDARD PARTIALLY MET

The program encourages staff to complete the CBMCS or a similar tool.

STANDARD NOT MET

The program does not support opportunities for staff to complete the CBMCS or a similar tool and does not have evidence of the results of those evaluations.

Score = _____ Technical Assistance Needed

10) The program/facility has conducted a survey amongst its clients/target population to determine if the program is perceived as being culturally competent. Summarize the results of the survey:

STANDARD MET

The program/facility has conducted a survey amongst its clients and their family members to determine if the program is perceived as being culturally competent.

STANDARD PARTIALLY MET

The program/facility is using the annual San Diego County Behavioral Health Services (SDCBHS) client satisfaction survey to determine if the program is perceived as being culturally competent.

STANDARD NOT MET

The program/facility is not using any type of survey to determine if the program is perceived as being culturally competent.

Score = _____ Technical Assistance Needed

11) The program/facility conducted a survey amongst its clients/target population to determine if the program's services are perceived as being culturally competent. Summarize the results of the survey:

STANDARD MET

The program/facility has conducted a survey amongst its clients to determine if the program's services are perceived as being culturally competent.

STANDARD PARTIALLY MET

The program/facility uses the annual SDCBHS state survey to determine if the program's services are perceived as being culturally competent.

STANDARD NOT MET

The program/facility does not use a survey amongst its clients to determine if the program's services are perceived as being culturally competent.

Score = _____ Technical Assistance Needed

12) The program utilizes the Culturally and Linguistically Appropriate Services (CLAS) Standards. Describe how the standards are utilized:

STANDARD MET

The program utilizes the CLAS Standards and trains all staff and managers on them at least annually.

STANDARD PARTIALLY MET

The program utilizes the CLAS Standards but has little or no training.

STANDARD NOT MET

The program does not utilize the CLAS Standards.

Score = _____ Technical Assistance Needed

13) The program/facility supports cultural competence training of *ADMINISTRATIVE SERVICES STAFF*. Describe the process:

STANDARD MET

The program/facility supports cultural competence training of **administrative services staff**, and 80-100% of staff have attended at least 4 hours of training.

STANDARD PARTIALLY MET

The program/facility supports cultural competence training of **administrative services staff**, and 50-79% of staff have attended at least 4 hours of training.

STANDARD NOT MET

The program/facility does not support cultural competence training of **administrative services staff**.

Score = _____ Technical Assistance Needed

14) The program/facility supports cultural competence training of *SUPPORT SERVICES STAFF*. Describe the process:

STANDARD MET

The program/facility supports cultural competence training of **support services staff**, and 80-100% of staff have attended at least 4 hours of training.

STANDARD PARTIALLY MET

The program/facility supports cultural competence training of **support services staff**, and 50-79% of staff have attended at least 4 hours of training.

STANDARD NOT MET

The program/facility does not support cultural competence training of **support services staff**.

Score = _____ Technical Assistance Needed

15) Services provided are designed to meet the needs of the community. Describe how the services meet the needs of the community:

STANDARD MET

Services provided include additional after-hours or weekend services, child care, transportation, or other options that are targeted to meet the specific community needs.

STANDARD PARTIALLY MET

Services provided include groups that are targeted to meet the specific community needs.

STANDARD NOT MET

Services provided do not include options that are targeted to meet the specific community needs.

Score = _____ Technical Assistance Needed

16) The program has implemented the use of any evidence-based practices or best practice guidelines *appropriate for the target populations served*. Describe the practices:

STANDARD MET

The program has implemented the use of evidence-based practices or best practice guidelines *appropriate for the target populations served*.

STANDARD PARTIALLY MET

The program has implemented the use of any evidence-based practices or best practice guidelines.

STANDARD NOT MET

The program has not implemented the use of any evidence-based practices or best practice guidelines.

Score = _____ Technical Assistance Needed

17) The program collects client outcomes *appropriate for the populations served*.

Describe the client outcomes that are collected and how the information is used:

STANDARD MET

The program collects client outcomes *appropriate for the populations served*.

STANDARD PARTIALLY MET

The program collects client outcomes.

STANDARD NOT MET

The program does not collect client outcomes.

Not applicable (the program is not a direct service provider)

Score = _____ Technical Assistance Needed

18) The program conducts outreach efforts *appropriate for the populations in the community*. Describe the outreach efforts:

STANDARD MET

The program conducts effective and ongoing outreach efforts *appropriate for the populations in the community*.

STANDARD PARTIALLY MET

The program conducts occasional outreach efforts *appropriate for the populations in the community*.

STANDARD NOT MET

The program does not conduct outreach efforts.

Score = _____ Technical Assistance Needed

19) The program is responsive to the variety of stressors that may impact the communities served. Examples of responsiveness:

STANDARD MET

The program is responsive to the variety of stressors that may impact the communities served and can demonstrate responsiveness.

STANDARD PARTIALLY MET

The program is aware of the variety of stressors that may impact the communities served.

STANDARD NOT MET

The program is not aware of stressors that may have an impact on the communities served.

Score = _____ Technical Assistance Needed

20) The program reflects its commitment to cultural and linguistic competence in all policy and practice documents including its mission statement, strategic plan, and budgeting practices:

STANDARD MET

The program reflects its commitment to cultural and linguistic competence in **all** policy and practice documents including its mission statement, strategic plan, and budgeting practices.

STANDARD PARTIALLY MET

The program reflects its commitment to cultural and linguistic competence in **some** policy and practice documents including its mission statement, strategic plan, and budgeting practices.

STANDARD NOT MET

The program does not reflect its commitment to cultural and linguistic competence in all policy and practice documents including its mission statement, strategic plan, and budgeting practices.

Score = _____ Technical Assistance Needed

After completing all of the items 1 through 20 above, add all the individual scores together to come up with a CC-PAS rating for the program.

TOTAL SCORE = _____

New or revised objectives for the programs Cultural Competence Plan:

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California Brief Multicultural Competence Scale

(CBMCS)

Scoring Guide and Administration Packet

A tool for self-evaluation of multicultural
competence of providers of behavioral health
services

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Description

The CBMCS is an evidence-based, replicable 21-item scale that was developed by researchers at the University of La Verne in response to the request of the California Mental Health Directors Association for a standardized cultural competency assessment tool. It measures individual, self-reported multi-cultural competency and training needs of behavioral health staff in the following four areas: Multicultural Knowledge (5 items); Awareness of Cultural Barriers (6 items); Sensitivity and Responsiveness to Consumers (3 items); and Socio-cultural Diversities (7 items).

The areas of the CBMCS survey measure the following aspects of cultural competence:

Multicultural Knowledge	Includes recognizing deficiencies in research conducted on minorities; psychosocial factors to consider when providing services to a culturally diverse consumer population; providing a culturally competent mental health assessment; diagnosis and understanding; and evaluating wellness, recovery, and resilience.
Awareness of Cultural Barriers	Includes awareness of self (cultural self-awareness, worldview, racial/ethnic identity) and awareness of others (oppression, racism, privilege, gender differences, sexual orientation).
Sensitivity & Responsiveness to Consumers	Includes acknowledgement and understanding of divergent social values; communication styles; and ability to understand consumers' experiences of racism, oppression and discrimination.
Socio-cultural Diversities	Includes knowledge of socio-cultural groups in which ethnicity may not be the major or immediate focus of professional attention (i.e., age, gender, sexual orientation, social class, physical-mental intactness, and disability status); awareness of bias, oppression and discrimination experienced by members of socio-cultural groups; and knowledge about best practices and treatment considerations for members of socio-cultural groups.

The names of the areas were somewhat modified to be more descriptive than what appears in the original source.

Scoring

The answers to each of the 21 survey questions are assigned a number based on a Likert scale (1=Strongly Disagree, 2=Disagree, 3=Agree, and 4=Strongly Agree) and totaled according to the pre-determined areas of cultural competence. The scores are then analyzed based on thresholds to identify proficiency levels and training needs. CBMCS yields four individual scores from each area of cultural competence.

For training purposes, the four individual area scores can be obtained by adding the ratings of the items as follows:

1. **Multicultural Knowledge** items are 7, 12, 15, 17, and 19
2. **Awareness of Cultural Barriers** items are 1, 8, 10, 11, 14, and 16
3. **Sensitivity and Responsiveness to Consumers** items are 2, 4, and 9
4. **Socio-cultural Diversities** items are 3, 5, 6, 13, 18, 20, and 21

Administration in San Diego

The survey will be administered electronically for SDCBHS by the Quality Improvement Performance Improvement Team. Staff will be asked to fill in all the subunits for which they work. Each staff member will only have to fill out the survey once, and the data will be incorporated into each of their designated subunit's returns.

To obtain information on the demographics of staff, questions on the following areas have been included:

- Gender:
- Race and ethnicity
- County of origin
- Languages spoken
- Highest Degree or Diploma
- Years of experience in the field of behavioral health since highest degree

Questions on staff training will include:

- Course work on multicultural counseling while in school
- Skill training skills desired
- Training needed in cultural competence content areas
- Training needed on specific ethnic and racial groups
- Training needed by age group

California Brief Multicultural Competence Scale (CBMCS)

Below is a list of statements dealing with multicultural issues within a mental health context. Please indicate the degree to which you agree with each statement by circling the appropriate number.

	Strongly Disagree	Disagree	Agree	Strongly Agree
1. I am aware that being born a minority in this society brings with it certain challenges that White people do not have to face.	1	2	3	4
2. I am aware of how my own values might affect my client.	1	2	3	4
3. I have an excellent ability to assess, accurately, the mental health needs of persons with disabilities.	1	2	3	4
4. I am aware of institutional barriers that affect the client.	1	2	3	4
5. I have an excellent ability to assess, accurately, the mental health needs of lesbians.	1	2	3	4
6. I have an excellent ability to assess, accurately, the mental health needs of older adults.	1	2	3	4
7. I have an excellent ability to identify the strengths and weaknesses of psychological tests in terms of their use with persons from different cultural, racial and/or ethnic backgrounds.	1	2	3	4
8. I am aware that counselors frequently impose their own cultural values upon minority clients.	1	2	3	4
9. My communication skills are appropriate for my clients.	1	2	3	4
10. I am aware that being born a White person in this society carries with it certain advantages.	1	2	3	4
11. I am aware of how my cultural background and experiences have influenced my attitudes about psychological processes.	1	2	3	4
12. I have an excellent ability to critique multicultural research.	1	2	3	4
13. I have an excellent ability to assess, accurately, the mental health needs of men.	1	2	3	4
14. I am aware of institutional barriers that may inhibit minorities from using mental health services.	1	2	3	4
15. I can discuss, within a group, the differences among ethnic groups (e.g. low socioeconomic status (SES), Puerto Rican client vs. high SES Puerto Rican client).	1	2	3	4
16. I can identify my reactions that are based on stereotypical beliefs about different ethnic groups.	1	2	3	4
17. I can discuss research regarding mental health issues and culturally different populations.	1	2	3	4
18. I have an excellent ability to assess, accurately, the mental health needs of gay men.	1	2	3	4
19. I am knowledgeable of acculturation models for various ethnic minority groups.	1	2	3	4

- | | | | | |
|--|---|---|---|---|
| 20. I have an excellent ability to assess, accurately, the mental health needs of women. | 1 | 2 | 3 | 4 |
| 21. I have an excellent ability to assess, accurately, the mental health needs of persons who come from very poor socioeconomic backgrounds. | 1 | 2 | 3 | 4 |

Gamst, G., Dana, R. H., Der-Karabetian, A., Aragon, M., Arellano, L., Morrow, G., & Martenson, L. (2004). Cultural competency Revised: The California Brief Multicultural Competency Scale. *Measurement and Evaluation in Counseling and Development, 37*, 3, 163-187.

Certification of Language Competence

Suggested process for certifying language
competence

Proposed Process for Certification of Language Competence

In order to establish a process for certifying the ability of bi-lingual staff or interpreters the following is proposed for the consideration of providers:

- Legal Entities/programs to establish a panel of expert speakers – minimum of 2 persons whenever possible.
- Certification process to be conducted by the panel and contain a minimum 30 minutes worth of material to be reviewed in the designated language.
- Material must cover knowledge of behavioral health, clinical terminology, ability to communicate ideas, concerns and the societal framework, familiarity with designated culture and variant beliefs concerning behavioral illness.
- Written and verbal language assessment:
 - Some language – able to provide basic information.
 - Conversational – able to communicate and provide information and support services.
 - Fluent – written and verbal. Ability to communicate and converse. Ability to discuss behavioral health terminology, and conduct therapy, if applicable.
- Ongoing supervision of each language’s certification process by native speaker of language.

Cultural Competence Survey for Program Clients To Complete

Suggested survey tool for clients
to assess the cultural competence
of the program

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Proposed Survey for Clients to Assess a Program's Cultural Competence

**This survey language may not be applicable to all programs and age groups.
Please adjust to be culturally sensitive to your specific population served.**

Behavioral Health Program Name: _____

Client Demographics:

Age: _____ **Gender:** Male Female Transgender Choose not to disclose

Race/Ethnicity: Hispanic Asian/Pacific Islander African-American
 American Indian White Other: _____

Other Cultural Group: Gay/Lesbian/Bisexual/Transgender Other: _____

Language Preference: Spanish Vietnamese Tagalog English
 Chinese Japanese Laotian Cambodian Farsi Arabic

Please rate this behavioral health program on the following items:

Please note that "trauma informed" means that the program and the staff recognize that people have many different types of trauma in their lives, and are understanding, compassionate, and supportive of the experience of every individual.

- 1) **The environment of this program is trauma informed and culturally welcoming.**
 Strongly Agree Agree Neutral Disagree Strongly Disagree
- 2) **There are written materials available in a language or format (large print/tape) I can understand.**
 Strongly Agree Agree Neutral Disagree Strongly Disagree
- 3) **The staff at the front desk are welcoming and respectful (e.g., they address me by my name).**
 Strongly Agree Agree Neutral Disagree Strongly Disagree
- 4) **Services are provided in my language of choice.**
 Strongly Agree Agree Neutral Disagree Strongly Disagree
- 5) **The services provided are trauma informed.**
 Strongly Agree Agree Neutral Disagree Strongly Disagree
- 6) **The clinical staff (if staff are bilingual) are linguistically proficient and is able to communicate ideas, concerns, and rationales in my preferred language.**
 Strongly Agree Agree Neutral Disagree Strongly Disagree
- 7) **The clinical staff are familiar with my cultural beliefs regarding mental illness.**
 Strongly Agree Agree Neutral Disagree Strongly Disagree
- 8) **The clinical staff are knowledgeable about culturally appropriate referral resources.**
 Strongly Agree Agree Neutral Disagree Strongly Disagree

9) **The clinical staff are knowledgeable about trauma and practice trauma-informed care.**

Strongly Agree Agree Neutral Disagree Strongly Disagree

10) **The physician is familiar with my cultural beliefs regarding mental illness.**

Strongly Agree Agree Neutral Disagree Strongly Disagree

11) **The physician is knowledgeable about trauma and practices trauma-informed care.**

Strongly Agree Agree Neutral Disagree Strongly Disagree

12) **The interpreter (if one was used) is linguistically proficient and is able to communicate ideas, concerns, and rationales in my preferred language.**

Strongly Agree Agree Neutral Disagree Strongly Disagree

13) **The interpreter (if one was used) is professional and understanding of my ethical, cultural, and personal beliefs.**

Strongly Agree Agree Neutral Disagree Strongly Disagree

14) **All staff are trauma informed and knowledgeable about my culture.**

Strongly Agree Agree Neutral Disagree Strongly Disagree

Cultural Competence Focus Groups for Program Clients

Suggested format for using focus groups for assessing cultural competence

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CLIENT FOCUS GROUPS FORM

**This survey language may not be applicable to all programs and age groups.
Please adjust to be culturally sensitive to your specific population served.**

Behavioral Health Program: _____ Date: _____

Demographics of client focus group participants:

Age	Gender	Ethnicity	Preferred Language	Other Cultural Notes

Please note that “trauma informed” means that the program and the staff recognize that people have many different types of trauma in their lives, and are understanding, compassionate, and supportive of the experience of every individual.

- 1) Does this program offer a culturally welcoming, comfortable setting to be in?
- 2) Does the program support and offer trauma-informed practices, policies, language, and environment?
- 3) Does this program provide you with written materials available in a language or format (large print, color, spacing, etc.) that you can understand?
- 4) What other materials would you like to have available? For example: audio tape, CD, VHS Tape, DVD, etc.
- 5) Does this program provide you with services in your language of choice?
- 6) Does this program practice trauma-informed care with you?
- 7) Are bilingual, clinical staff linguistically proficient and able to communicate ideas, concerns and the societal framework in your preferred language?
- 8) Are clinical staff familiar with your cultural beliefs surrounding mental illness?
- 9) Are clinical staff knowledgeable about how to make culturally appropriate referrals?
- 10) If you see a program psychiatrist, is s/he familiar with your cultural beliefs surrounding mental illness?
- 11) If you see a program psychiatrist, has s/he asked about any trauma and or adversity in your past?
- 12) If you need to use an interpreter provided by the program, is s/he linguistically proficient and able to communicate ideas, concerns and rationales in your language of choice?

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Cultural Competence Survey for Program Community

Suggested survey tool for assessing
cultural competence

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Community Focus Groups Form

**This survey language may not be applicable to all programs and age groups.
Please adjust to be culturally sensitive to your specific population served.**

Behavioral Health Program: _____ Date: _____

=====

Demographics of Community focus group participants:

Age	Gender	Ethnicity	Preferred Language	Other Cultural Notes

Please note that “trauma informed” means that the program and the staff recognize that people have many different types of trauma in their lives, and are understanding, compassionate, and supportive of the experience of every individual.

- 1) Is this program known within the community?
- 2) Does the community feel that the services provided by this program are needed?
- 3) Does the community believe that people who come here for mental health services improve and feel better as a result of the services they receive?
- 4) Does this program offer a culturally welcoming, comfortable setting to be in?
- 5) Is this program trauma informed?
- 6) What are some things we can improve about our program?
- 7) What are the barriers that people have to coming to this program to receive services?
- 8) Would you recommend a friend or family to seek services here if they were needed?
- 9) What else can we do to become an integral part of the community?

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Training Needs Survey

Suggested survey to assess staff training needs regarding cultural competence

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Training Needs Survey

Behavioral Health Program: _____

Date: _____

=====

1) Does your program provide services to different cultural groups?

Yes

No

If yes, what cultural groups does your program provide services to? (Please list)

2) Does your program provide services to individuals who have experienced trauma?

Yes

No

3) What type of training is needed by all your staff to ensure they are linguistically proficient and able to communicate ideas, concerns and rationales in languages other than English? (Please list)

4) What type of training is needed by all staff to ensure they are trauma informed? (Please list)

5) What type of training is needed by your clinical staff to ensure that they are familiar with client cultural beliefs surrounding behavioral health issues that often co-occur with other health and wellbeing-related issues? (Please list)

6) What type of training is needed by clinical staff to be trauma informed and provide integrated care?

7) Does your staff need training on how to make culturally appropriate referrals?

Yes

No

8) Does your staff need training on trauma-informed systems and services?

Yes

No

9) Do program psychiatrists need training about client cultural beliefs surrounding behavioral health issues that often co-occur with other health and wellbeing-related issues?

Yes

No

N/A

10) Do program psychiatrists need training on trauma-informed systems and services?

Yes

No

N/A

11) What type of training is needed for interpreters used by your staff to ensure that they are linguistically proficient and able to communicate ideas, concerns, and rationales in the client's language of choice? (Please list)

Resources

CLAS Standards

National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care

The National CLAS Standards were developed by the Health and Human Services Office of Minority Health in 2000 and further enhanced in 2010-2013 to address the importance of cultural and linguistic competency at every point of contact throughout the health care and health services continuum.

The following CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for individuals as well as health and health care organizations to implement culturally and linguistically appropriate services.

Principal Standard:

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

Governance, Leadership, and Workforce:

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance:

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement, and Accountability:

9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.
10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

Source: Think Cultural Health, Office of Minority Health, U.S. Department of Health and Human Services
For more information and to access a Blueprint for Advancing and Sustaining CLAS Policy and Practice visit www.thinkculturalhealth.hhs.gov/Content/clas.asp.

Context for the Development and Evaluation of Cultural Competencies

Summary of the plethora of cultural competence assessments available

(These resources have not been reviewed or approved by the County of San Diego or CCRT and are for additional reference as a supplement to tools in the Handbook)

As background, most of the available assessment scales fall into four broad areas:

- 1) Multicultural knowledge, self-awareness, and skills for working across cultures;
- 2) Intercultural skills in working across international borders (i.e., flexibility, sensitivity, open-mindedness, perceptual acuity, personal autonomy, empathy, and respect);
- 3) Behavioral assessments; and
- 4) Vignette assessments.

The assessments in the first two categories are primarily self-report scales relying on an individual to report on their personal perceptions of their own competency. The latter two categories attempt to sidestep the limitations of self-report. Many of the multicultural assessments (category #1) are publicly available. Unfortunately, however, most of the intercultural scales (category #2) have been “privatized” and are sold at a fee, with access to a summary report only (rather than item-by-item responses). Assessments in categories #3 and #4 are available either publically or by request to the authors.

Researchers have evaluated the statistical properties of these multicultural and intercultural instruments (categories #1 and #2), so that consumers can have confidence that the questions generate reliable patterns of responses when asked to large numbers of people. Naturally, some of the assessments are more reliable in this respect than others. Whether statistically validated or not, any instrument that relies on people reporting their perceptions of their own cultural competence, the scores can be significantly biased by the respondent’s desire to (a) appear better than they are, or (b) by the respondent’s lack of insight on where they need to improve. The multicultural and intercultural instruments have also been critiqued for their lack of scope, in that they do not cover the skills needed to work with the more complex issues of (a) power/privilege, and (b) complexities of identity associated when individuals are marginalized by race as well as by sexual orientation, socioeconomic status, religion, gender, body size, immigration status, health, disability, and other dimensions. The *Alliant Intercultural Competency Scale* (AICS) discussed below attempts to overcome this latter critique.

Also, it is important to keep in mind that the quality of any individual’s “culturally competent skills” will vary by the context. That is, one may be far more culturally competent with Native American girls in the school setting than with Asian American professional men and women in the hospital setting, solely as a result of where they have done their training. Thus, many organizations may try to overcome this contextual issue by designing their own hybrid scale by selecting individual items from the other previously validated instruments. The *California Brief Multicultural Competence Scale* (CBMCS: Gamst, et al., 2004) is an example of this approach.

Recently scholars have brought forth broader concept of *cultural intelligence*, which refers to an individual’s ability to function effectively and fluidly among people of different cultures, in different settings, with the sensitivity to avoid causing the “cultural ruptures” that others with less cultural intelligence will stumble into quickly; the analogy of course is emotional intelligence. Scales assessing Cultural Intelligence may be available. Similarly, the concept of “negotiated space” has also emerged in the literature, which refers to someone’s capacity to “share culture” in meetings such that decision-making and problem-solving can be conducted in a milieu were all cultures are present are weighted equally. “Negotiated space” is a concept of full participation where maintaining culturally respectful relationships is as important as the issues being worked through. The AICS is designed to evaluate skills in “negotiated space”.

In a manuscript in press, Dr. Sheila Henderson and additional co-authors wrote a brief review of various measures available in the fields of psychology, education, and business. The scales found and discussed were:

- Multicultural scales:
 - *Multicultural Awareness-Knowledge-and-Skills Survey* (MAKSS; D’Andrea, Daniels, & Heck, 1991)
 - *Multicultural Counseling Inventory* (MCI; Sodowsky, Taffe, Gutkin, & Wise, 1994)

- *Multicultural Counseling Knowledge and Awareness Scale* (MCKAS; Ponterotto, Gretchen, Utsey, Rieger, & Austin, 2002)
- *Multicultural teaching competency scale* (Spanierman et al., 2011)

(Please note that reviews and objective statistical testing of these instruments have been conducted by Constantine & Ladany, (2003), Hays (2008), and Ponterotto, Rieger, Barrett, & Sparks (1994).)

- Intercultural scales:
 - *Assessment of Intercultural Competence* (AIC: Fantini, 2007)
 - *Intercultural Development Inventory* (IDI; Hammer, Bennett, & Wiseman, 1993)
 - *Global Competency and Intercultural Sensitivity Index* (ISI; Olson & Kroeger, 2001)
 - *Intercultural Sensitivity Inventory* (ICSI: Bhawuk & Brislin, 1992)
 - *Cross-Cultural Adaptability Inventory* (CCAI: Kelley & Meyers, 1995)

Alliant International University, concerned about training professionals across business, forensics, education, law, and psychology for both local and global careers has recently developed a scale that spans both the multicultural and international arena with promising statistical properties in initial testing. This instrument is called:

- *Alliant Intercultural Competency Scale* (AICS; 2014)

For available reviews and statistical evaluations of these two categories of scales, see Constantine, Gloria, & Ladany (2002); Constantine & Ladany (2002); Hays (2008); Olebe & Koester (1989); Ponterotto, Reiger, Barrett, & Sparks (1994); Pope-Davis, Coleman, Liu, & Toporek (2003); Sinicrope et al. (2008); and Worthington, Mobley, Franks, & Tan (2000).

There are another two instrument categories—behavioral and vignette assessments—that try to surmount the “self-report” problem referred to above:

- Behavioral assessment instruments:
 - *Multicultural Teaching Competency Scale* (Spanierman et al., 2011)
 - *Missouri Multicultural Counseling Self-Efficacy Scale* (Mobley, Worthington, & Soth, 2006)
 - *Behavioral Assessment Scale for Intercultural Communication* (BASIC: Olebe & Koester, 1989; Ruben, 1976; Ruben & Kealey, 1979)
- Vignette-style measures:
 - *Cross-Cultural Counseling Assessment-Revised* (CCCI-Revised: LaFromboise et al., 1991)
 - *Multicultural Interactive Theatre* (Burgoyne et al., 2007)
 - *Instructor Cultural Competence Questionnaire* (ICCCQ: Roberson, Kulik, & Pepper, 2002)
 - *Cultural incidents in the University Classroom Vignettes* (Henderson, Horton, Saito, Shorter-Gooden (in press))

Additional Resources

Implementation of CLAS Standards

Think Cultural Health, Office of Minority Health, US Department of Health & Human Services

www.thinkculturalhealth.hhs.gov/Content/clas.asp

Cultural and Linguistic Competence Policy Assessment

National Center for Cultural Competence, Georgetown University, Center for Child and Human Development

www.clcpa.info/

SDCBHS Resources

Cultural Competence Plan 2010 and Executive Summary

www.sdcounty.ca.gov/hhsa/programs/bhs/documents/CulturalCompetencePlan2010.pdf

www.sdcounty.ca.gov/hhsa/programs/bhs/documents/CCP2010ExecSumm110111.pdf

Framework for Eliminating Cultural, Linguistic, Racial and Ethnic Behavioral Health Disparities

www.sdcounty.ca.gov/hhsa/programs/bhs/documents/1_C.pdf

Organizational Provider Operations Handbook (section H)

www.sdcounty.ca.gov/hhsa/programs/bhs/documents/Combined_OPOH_010113_Rev_021214.pdf

Progress Towards Reducing Disparities: A Report for San Diego County Mental Health (Eight Year Comparison: FY 2001-2002, FY 2006-2007, and FY 2009-2010)

www.sdcounty.ca.gov/hhsa/programs/bhs/documents/DisparitiesReport110212.pdf

Trauma-Informed Systems and Services

The National Council for Behavioral Health: Trauma Informed Care

www.thenationalcouncil.org/topics/trauma-informed-care/

The Trauma Informed Project

www.traumainformedcareproject.org/

University of North Carolina Family and Children's Resource Program: Trauma and Behavior – How Trauma Affects the Brain

www.youtube.com/watch?v=IPftosmseYE

What Does “Trauma Informed Care” Really Mean? – The Up Center

www.cpe.vt.edu/ocs/sessions/csa-trauma.pdf

Substance Abuse and Mental Health Services Administration (SAMHSA): Trauma-Informed Approach and Trauma-Specific Interventions

beta.samhsa.gov/nctic/trauma-interventions

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www.theannainstitute.org/Damaging%20Consequences.pdf

Van der Kolk, B, McFarlane, A, & Weisaeth, L. (2007). *Traumatic Stress: The Effects of Overwhelming Experience on Mind, Body, and Society*. New York: The Guilford Press.