

# Cultural Competence Handbook

San Diego County Behavioral Health Services  
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*Live Well, San Diego!*



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*Live Well, San Diego!*



# Cultural Competence Handbook

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# Cultural Competence Handbook

## Introduction



## **Introduction**

The County's demographic dynamics combined with the recognition that culture is a key factor in service delivery pose an ongoing challenge for mental health care providers. Cultural norms, values, beliefs, customs and behaviors may influence the manifestation of mental health problems, the use of appropriate levels of care/services, the course of treatment and the successful attainment of positive outcomes.

The 2010 United States Census reports that racially and ethnically diverse groups comprised 37% of the total population, with continued growth expected. The demographics for San Diego County reflect that trend. According to Census figures, San Diego has become a "majority minority" county, with no single ethnic/racial group making up the majority of the population. Whites comprise 49% of the County's population, persons of Latino origin 32%, Asians 11%, Blacks 5%, persons reporting two or more races 5%, Native Americans 1%, and Native Hawaiian and other Pacific Islanders 0.5%.

As the diversity of the population continues to increase, the assessment completed for the 2009-2010 Cultural Competence Plan noted minority populations continue to be under-represented among total mental health clients. As part of our goal to reduce disparities for all populations, San Diego County Mental Health presents this Cultural Competence Handbook. The Handbook contains tools that will assist Mental Health Providers to make improvements throughout the system of care.



# Prioritizing Cultural Competence



## Prioritizing 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.

To support the needs of our diverse populations SDCMHS recommends that all MH providers be committed to prioritizing cultural competence.

This goal can be achieved through the following:

1. Incorporating cultural competence 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 and Programs
4. Ensuring that Clinical Practice is based on cultural awareness, knowledge and skills.

This Cultural Competence Handbook provides some guidelines and examples of methods and tools that can be used to assist programs in achieving the goal of reducing disparities.



# Cultural Competence Plan

An outline for the development of a  
Cultural Competence Plan



## **Cultural Competence Plan Development Guidelines**

Goal: To provide guidelines to assist programs to develop a plan to enhance their current capability for providing culturally competent services.

Background: As stated in your contracts, the expectation of San Diego County Mental Health Services (SDCMHS) administration is that all county and contracted providers are providing culturally competent services and are working to continually enhance their current level of cultural competence. One measure of how culturally competent a provider is whether or not they have a plan for enhancing cultural competence for their programs. This mirrors the expectation that the California Department of Mental Health has for each county. The following suggested format for developing a Cultural Competence Plan (CCP) has been developed by San Diego County Mental Health with input from the Cultural Competence Resource Team. If you do not have a CCP in place currently please use the following format. If you do have a CCP in place currently please evaluate if your plan could be improved by adding any of the elements noted in these guidelines.

### Cultural Competence Plan Component Guidelines:

- Current Status of Program
  - Document how the Mission Statements, guiding principles, and policies and procedures support cultural competence
  - Identify how Program Administration prioritizes cultural competence in the delivery of services
  - 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
  - Use of Interpreter Services
  - Service utilization by ethnicity, race, language usage, and cultural groups.
  - Client outcomes
  
- Objectives
  - Goals for improvements
  - Develop processes to assure Cultural Competence (language, culture, training, surveys) is practiced in service delivery.

Please note: Beginning in July of 2011 Cultural Competence Plans shall be required for all contractors.

## San Diego County Mental Health Services Cultural Competence Plan 2010

The San Diego County Mental Health Services Cultural Competence Plan 2010 was sent to the Department of Mental Health, as required. It is available upon request.

An executive summary of the Cultural Competence Plan 2010 is included in this handbook as an addendum.

# 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 Mental Health Services. Evaluations for other areas may be done by using the tools noted or other tools that your program or legal entity have 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



## Culturally Competent Program Annual Self-Evaluation

The Culturally Competent Program Annual Self-Evaluation (CC-PAS) tool has been developed by San Diego County Mental 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 2011 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.



**CC-PAS Protocol:**

1) The program/facility has developed a Cultural Competence Plan. Attach a copy of the Cultural Competence Plan or describe the plan. \_\_\_\_\_

Met: Program has a written Cultural Competence Plan that addresses the specific needs of that program.

Partially Met: Legal Entity has a written Cultural Competence Plan but the specific needs of that program are not identified or there is no written Cultural Competence Plan but there is some other evidence of a plan.

Not met: There is no plan to achieve Cultural Competence for the program.

Note: A suggested format that may be used for developing a Cultural Competence Plan, if one is needed, has been provided on page 15.

\_\_\_\_ Technical Assistance needed

Score = \_\_\_\_

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

Met: The strengths and needs of the community are clearly identified in the Cultural Competence Plan. Community members, Program Advisory Groups, and other stakeholders have participated in the identification of the strengths and needs of the community.

Partially Met: The strengths and needs of the community are not clearly identified in the Cultural Competence Plan, but there is evidence that the program is aware of the strengths and needs of the community

Not met: The program is not aware of the strengths and needs of the community

\_\_\_\_ Technical Assistance needed

Score = \_\_\_\_

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: \_\_\_\_\_

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.

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.

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.

\_\_\_\_ Technical Assistance needed

Score = \_\_\_\_

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: \_\_\_\_\_

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 bilingual 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.

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.

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

Not applicable if program is not a direct service provider.

\_\_\_\_\_ Technical Assistance needed

Score = \_\_\_\_\_

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: \_\_\_\_\_

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 bilingual or who provide interpreter services to ensure that language needs are being met.

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.

Not met: The program has no process for testing the language competence of support services staff who identify themselves as bi or multi-lingual.

\_\_\_\_\_ Technical Assistance needed

Score = \_\_\_\_\_

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

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

Partially Met: There is informal training of direct services staff on the use of interpreters.

Not met: There has been no training for direct services on the use of interpreter services training.

\_\_\_\_\_ Technical Assistance needed

Score = \_\_\_\_\_

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

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

Partially Met: The program occasionally uses language interpreters.

Not met: The program does not use language interpreters and cannot demonstrate the offer of interpreters

\_\_\_\_ Technical Assistance needed

Score = \_\_\_\_

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

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

Partially Met: The program/facility has a process in place for assessing cultural competence of direct/ support services staff

Not met: The program/facility has no process in place for assessing cultural competence of direct services/ support services staff

\_\_\_\_ Technical Assistance needed

Score = \_\_\_\_

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

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

Partially Met: The program encourages staff to complete the CMCBS or a similar tool.

Not met: The program does not support opportunities for staff to complete the CMCBS or a similar tool and has evidence of the results of the those evaluations,

\_\_\_\_ Technical Assistance needed

Score = \_\_\_\_

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

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

Partially Met: The program/facility is using the annual SDCMHS client satisfaction survey to determine if the program is perceived as being culturally competent

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

\_\_\_\_ Technical Assistance needed

Score = \_\_\_\_

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

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

Partially Met: The program/facility uses the annual SDCMHS State survey to determine if the program's clinical services are perceived as being culturally competent

Not met: The program/facility does not use a survey amongst their clients to determine if the program's clinical services are perceived as being culturally competent

\_\_\_\_ Technical Assistance needed

Score = \_\_\_\_

12) The program utilizes the Culturally Competent Clinical Practice Standards.

Describe how the standards are utilized: \_\_\_\_\_

Met: The program utilizes the Culturally Competent Clinical Practice Standards and trains all staff and managers on them at least annually.

Partially Met: The program utilizes the Culturally Competent Clinical Practice Standards but has little or no training.

Not met: The program does not utilize the Culturally Competent Clinical Practice Standards

Not applicable if program is not a direct service provider.

\_\_\_\_ Technical Assistance needed

Score = \_\_\_\_

13) The program/facility supports cultural competence training of *direct services staff*.

Describe the process: \_\_\_\_\_

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.

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

Not met: The program/facility does not support cultural competence training of direct services staff

\_\_\_\_ Technical Assistance needed

Score = \_\_\_\_

14) The program/facility supports cultural competence training of *support services staff*.

Describe the process: \_\_\_\_\_

- 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.
- 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
- Not met: The program/facility does not support cultural competence training of support services staff

\_\_\_\_ Technical Assistance needed

Score = \_\_\_\_

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

- 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.
- Partially Met: Services provided include groups that are targeted to meet the specific community needs.
- Not met: Services provided include do/not include options that are targeted to meet the specific community needs.

\_\_\_\_ Technical Assistance needed

Score = \_\_\_\_

16) The program has implemented the use of any Evidence Based Practices, or best practice guidelines *appropriate for the populations served*. Describe the practices: \_\_\_\_\_

- Met: The program has implemented the use of Evidence Based Practices, or best practice guidelines *appropriate for the populations served*
- Partially Met: The program has implemented the use of any Evidence Based Practices, or best practice guidelines
- Not met: The program has not implemented the use of any Evidence Based Practices, or best practice guidelines
- Not applicable if program is not a direct service provider.

\_\_\_\_ Technical Assistance needed

Score = \_\_\_\_

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

- Met: The program collects client outcomes *appropriate for the populations served*
- Partially Met: The program collects client outcomes
- Not met: The program does not collect client outcomes.

Not applicable if program is not a direct service provider.

\_\_\_\_ Technical Assistance needed

Score = \_\_\_\_

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

Met : The program conducts effective and on-going outreach efforts *appropriate for the populations in the community*.

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

Not met: The program does not conducts outreach efforts.

\_\_\_\_ Technical Assistance needed

Score = \_\_\_\_

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

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

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

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

\_\_\_\_ Technical Assistance needed

Score = \_\_\_\_

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. Examples of commitment: \_\_\_\_\_

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.

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.

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

\_\_\_\_ Technical Assistance needed

Score = \_\_\_\_

After completing all of the items, #'s 1- 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 mental health  
services



## **Description**

The CBMCS is a 21-item scale that measures the self-reported multicultural competence of providers of mental health services. This scale was developed by researchers at the University of La Verne with support from the California Department of Mental Health to identify training needs in the delivery of culturally competent mental health services. It was empirically developed using items from four existing measures of cultural competence: The CCCI-R, MAKSS, MCAS-B, and MCCTS. Participants in the normative sample were 1244 community mental health providers throughout the State of California. The scale is composed of 4 factors: Multicultural Knowledge (5-items), Awareness of Cultural Barriers (6-items), Sensitivity and Responsiveness to Consumers (3-items), and Socio-cultural Diversities (7-items). The names of the factors were somewhat modified to be more descriptive than what appears in the original source.

## **Scoring**

The CBMCS items are rated on a 4-point Likert scale: 1 = Strongly Disagree, 2 = Disagree, 3 = Agree, and 4 = Strongly Agree. Higher numbers indicate higher competence. CBMCS yields one total score and four subscale scores from each factor.

For Training purposes, the four factor scores can be obtained by adding the ratings of the subscale items as follows;

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

## **Administration in San Diego**

The survey will be administered electronically for SDBHS by the UCSD Health Services Research Center (HSRC). 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. There will be a version of the survey for staff in Children's MH programs and another for staff in Adult MH programs.

To gain 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 mental 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 CCRT:

- Legal Entities/programs to establish a panel of expert speakers- minimum of 2 persons.
- 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 mental health, clinical terminology, ability to communicate ideas, concerns and the societal framework, familiarity with designated culture and variant beliefs concerning mental 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 conduct therapy.
- On-going 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



PROPOSED SURVEY FOR CLIENTS TO ASSESS A PROGRAM'S CULTURAL COMPETENCE

Mental Health Program: \_\_\_\_\_

Client Demographics:

Age: \_\_\_\_\_

Gender:  Male  Female  Transgender

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

Other Cultural Group:  Gay/Lesbian/Bisexual/Transgender

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

Please rate this mental program on the following items:

1) The environment of this mental health program is 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.  
 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 clinical staff (if staff are bilingual) is linguistically proficient and is able to communicate ideas, concerns, and rationales in my preferred language.  
 Strongly Agree  Agree  Neutral  Disagree  Strongly Disagree

6) The clinical staff is familiar with my cultural beliefs regarding mental illness.  
 Strongly Agree  Agree  Neutral  Disagree  Strongly Disagree

7) The clinical staff is knowledgeable about culturally appropriate referral resources  
 Strongly Agree  Agree  Neutral  Disagree  Strongly Disagree

8) The physician is familiar with my cultural beliefs regarding mental illness.  
 Strongly Agree  Agree  Neutral  Disagree  Strongly Disagree

9) 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



# Cultural Competence Focus Groups for Program Clients

Suggested format for using focus groups  
for assessing cultural competence



# CLIENT FOCUS GROUPS FORM

Mental Health Program: \_\_\_\_\_ Date: \_\_\_\_\_

=====

Demographics of Client focus group participants:

Age	Gender	Ethnicity	Preferred Language	Other Cultural Notes

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



# Cultural Competence Survey for Program Community

Suggested survey tool for assessing  
cultural competence



# COMMUNITY FOCUS GROUPS FORM

Mental Health Program: \_\_\_\_\_ Date: \_\_\_\_\_

=====

Demographics of Community focus group participants:

Age	Gender	Ethnicity	Preferred Language	Other Cultural Notes

- 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) What are some things we can improve about our program?
- 6) What are the barriers that people have to coming to this program to receive services?
- 7) Would you recommend a friend or family to seek services here if they were needed?
- 8) What else can we do to become an integral part of the community?



# Training Needs Survey

Suggested survey to assess staff training needs regarding cultural competence



# TRAINING NEEDS SURVEY

Mental Health Program: \_\_\_\_\_ Date \_\_\_\_\_

=====

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

a.  Yes  No

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

2) 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)

3) What type of training is needed by your clinical staff to ensure that they are familiar with client cultural beliefs surrounding mental illness? (Please list)

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

1.  Yes  No

5) Do program psychiatrists need training about client cultural beliefs surrounding mental illness?

1.  Yes  No  N/A

6) 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)



# Culturally Competent Clinical Practice Standards

Principles of culturally competent  
clinical practice



## **Culturally Competent Clinical Practice Standards**

The following principles regarding cultural competence are affirmed by SDCMHS as essential in the continued progress toward a mental health system that advocates for and provides multilingual and multicultural services for its diverse populations:

- A comprehensive, competent mental health system provides and integrates relevant linguistic and cultural values and capacities in its service system.
- A culturally competent mental health system seeks to understand, respect, and accept differences of multi-cultural groups.
- A system that is moving towards cultural competence develops standards and criteria to evaluate its performance.

The Culturally Competent Clinical Practice Standards currently utilized by SDCMHS were originally written in 1998. These standards have now been revised by the Cultural Competence Resource Team (CCRT) in order to ensure that the Clinical Practice Standards would: 1) promote and encourage values and approaches that are necessary for the support and development of culturally competent practices; 2) increase and improve knowledge and understanding of concepts and information critical for the development and implementation of culturally competent practice, and; 3) establish goals for the development/improvement of practice skills of all members in the system to ensure that cultural competence is an integral part of service delivery at all levels.

The revised standards are as follows:

- 1) Providers engage in a culturally competent community needs assessment.
- 2) Providers engage in community outreach to diverse communities based on the needs assessment.
- 3) Providers create an environment that is welcoming to diverse communities.
- 4) Staffing at all levels, clinical, clerical, and administrative, shall be representative of the community served.
- 5) There is linguistic capacity and proficiency to communicate effectively with the population served.
- 6) Use of interpreter services is appropriate and staff are able to demonstrate ability to work with interpreters as needed.
- 7) Staff shall demonstrate knowledge of diversity within ethnic and cultural groups in terms of social class, assimilation, and acculturation.
- 8) Staff shall demonstrate knowledge about a) specific cultural features that may be present in various disorders, b) culture-bound syndromes, c) cultural explanations of illness, d) help seeking behaviors, include faith-based, in diverse populations, and e) appreciation for traditional ethnic and cultural healing practices.

- 9) Cultural factors are integrated into the clinical interview and assessment.
- 10) Staff take into consideration the potential bias present in clinical assessment instruments and critically interpret findings within the appropriate cultural, linguistic and life experiences context of the client.
- 11) Culture-specific consideration consistent with the cultural values and life experiences of the client shall be integral in the intervention and shall be reflected in progress notes, treatment planning and discharge planning.
- 12) Psychiatrists consider the role of cultural factors (ethnopsychopharmacology) in providing medication services.
- 13) Providers promote an environment that encourages staff to conduct self-assessment as a learning tool.
- 14) Staff actively seek out educational, consultative and multicultural experiences, including a minimum of 4 hours of cultural competence training annually.

# Addendum

San Diego County  
Mental Health Services  
Executive Summary of the  
Cultural Competence Plan, 2010



# EXECUTIVE SUMMARY



## CULTURAL COMPETENCE PLAN 2010

COUNTY OF SAN DIEGO MENTAL HEALTH SERVICES

**PROGRESS TOWARD CULTURAL COMPETENCE  
CULTURAL COMPETENCE PLAN 2010  
EXECUTIVE SUMMARY**

The County of San Diego has long had a commitment to cultural competence. Sharing a border with Mexico, San Diego has one of the highest immigration rates of all California counties. The need to provide physical and mental health services to persons from many diverse cultures has been acknowledged through all parts of the County's Health and Human Services Agency. San Diego County Behavioral Health Services maintains policies, procedures, cultural competence clinical practice standards, etc. which reflect steps taken to recognize and value racial, ethnic, and cultural diversity. With the advent of Mental Health Services Act funding, the mental health system was able to reach out to diverse cultural groups and tailor new services to the needs of unserved and underserved populations. In planning for these new services the following steps were taken:

- An extensive effort was made to include stakeholders from identified racial, ethnic, cultural and linguistic communities in the planning process. Clients/client family members and other stakeholders were included in ongoing planning councils and committees.
- To be best able to plan for services, San Diego County Mental Health Services has found it more useful and reflective of the County's population to consider the combined needs of the Medi-Cal and indigent populations, since fully 45% of the adult mental health population and 15% of the children's population are uninsured.
- Two major reports were created to foster data-driven decision making. The SDCMHS Gap Analysis and report on "Progress Toward Addressing Disparities: A Five-Year Comparison FY 2001-02 to FY 2006-07" have served as the basis for planning service direction and expansion for MHSA Community Services and Support, Prevention and Early Intervention, Workforce Education and Training, and Innovations programming.
- Program expansion included efforts to strengthen existing community based organizations to broaden access to care.

## DISPARITIES FOUND

### **Racial/Ethnic Disparities**

The Gap Analysis and Progress Toward Addressing Disparities indicated the following race/ethnicity service disparities:

#### Latinos

The gap analysis data pointed to a clear need to increase access to care for Latino children, TAY, adults, and older adults who live in poverty. Latino females, as compared to males, tend to be under-represented in both children and TAY age groups. There is no gender gap among adult Latinos. According to the data, older adult Latino males are under-represented. Latino children who are fully served in the Children's System of Care/Wraparound Services program represent approximately 27% of all fully served youth. Latino fully served adults and older adults in the REACH program represent only 12% of all fully served population of the REACH program. Thirty-one percent of Hispanic adult clients identified Spanish as their preferred language which may contribute to difficulty in engaging adult clients—one-third left after fewer than five visits to outpatient services.

#### Asian/Pacific Islanders

The Asian/Pacific Islander population is under-represented in the public mental health system, comprising 8% of the target population and only 5% of current mental health clients. This population is complex, drawn from numerous countries, and comprised of many linguistically and ethnically diverse groups. The Asian/Pacific Islander umbrella group includes Amerasian, Cambodian, Chinese, Filipino, Hawaiian Native, Hmong, Japanese, Korean, Laotian, Pacific Islander, and Vietnamese. Forty-one percent identified an Asian language as their preferred language. Children in this group had the lowest engagement rates, with 16% having only one visit to mental health services. The need for easily available interpreting services for parents/family may be higher for this group to be able to engage children. Clients are more likely to be female.

#### African Americans

The African-American general population is expected to stay relatively constant at 5-6%, yet they are over represented in acute inpatient care, in the juvenile forensic system and in adult jail mental health services. They are also more likely to receive a diagnosis of schizophrenia and are more likely to be male.

#### Native Americans

While there may not be a substantial difference between Native Americans served and the county's Native American population, San Diego County is home to 17 reservations, composed of numerous tribal groups. Mental health clients are more apt to be female. The SDMHS gap analysis noted that Native American children compose 1% of the children's mental health system, yet have disproportional rates of contact with other systems:

- They represent 1.6% of the mental health clients concurrently receiving Child Welfare Services;
  - 3.2% are concurrently receiving services in Alcohol & Drug Services; and
  - 0.2% of the children concurrently open to Juvenile Forensic Services.
- These data on involvement in other systems may reflect inappropriately served populations that may benefit from mental health services.

## **Age Group Disparities**

- Transitional aged youth (ages 18-24) who are aging out of the children's mental health system and not connecting with the adult system. Transition Age Youth had the lowest access rates among age groups and their access to services declined slightly over time.
  - 31% had three or fewer visits to outpatient services.
  - Were more likely to use inpatient/emergency services (24%) and jail services (26%) and less likely to outpatient services.
- Older adults (ages 60+) who were dealing with transportation barriers to service as well as cultural barriers.
- Very young children (ages 0-5) , especially for early intervention and prevention efforts.
- Outside factors affect children's usage of mental health services
  - 20% of children receiving mental health services were also involved with Child Welfare Services and 36% were receiving Special Education services.
  - 24% of children ages 12-17 used juvenile forensic mental health services only, while 18% of CMHS clients were also open to the Probation System.

## **Special Cultural Group Disparities**

### Veterans

There are a substantial number of veterans who have returned from service in overseas conflicts and are seriously mentally ill, in need of comprehensive mental health services. The MHSA Community Services and Supports programs will include, throughout its service array, all veterans who meet the MHSA and DMH guidelines.

### PEI Special Situational Populations

PEI Services will be targeted at the following groups who are experiencing difficulties as a result of special circumstances:

- African refugees
- Individuals experiencing onset of serious psychiatric illness
- Children/youth in stressed families
- Trauma exposed individuals
- Children/youth at risk of school failure
- Children/youth at risk of experiencing juvenile justice involvement

## **Workforce Disparities Compounding Barriers to Culturally Competent Services**

The Workforce Education and Training Plan notes that the staffing disparities listed below add barriers to the expansion of programming to unserved and underserved populations:

- Unlicensed Direct Staff positions remained vacant primarily as a result of both non-competitive salaries and the unique qualifications needed for these positions; whereas Licensed Direct Staff positions were difficult to fill due to noncompetitive salaries and requirements for bilingual staff, primarily Spanish;
- Qualified clinical supervisor positions were identified as hard-to-fill, especially professionals with LCSW or MFT licensure;
- Hospitals and clinics are struggling from the overall shortage of nurses available in the county;

- Several positions have been vacant for over a year, particularly in rural areas or positions requiring licensed bilingual capability;
- Intense competition exists in the community for bilingual professionals and bilingual clinical positions;
- Latinos and African Americans are under-represented in mental health staffing;
- There is a need for positions designated for individuals with consumer and/or family member experience;
- There is a need for staff language proficiency in the following languages: Spanish, Tagalog, Vietnamese, Arabic, Russian, Cambodian, ASL, Lao, Somali and Swahili.

A long-standing shortage of psychiatrists with linguistic specialties and child psychiatrists have also compounded the problem of providing culturally appropriate services.

## NEW MHSA PROGRAMMING ADDED TO ADDRESS DISPARITIES

### **Community Services and Support (CSS) Plan**

Three basic types of services were established to meet the needs of unserved and underserved:

- 1) Outreach and education to acquaint underserved or unserved groups about mental health problems and services/
- 2) System Development programs to add targeted services to meet the needs of cultural, racial, and ethnic groups;
- 3) Full Service Partnerships for persons with severe, persistent mental health problems to provide a full spectrum of services ranging from housing, therapy and medication, to whatever it takes to support them in the community.

A total of 40 programs were started between 2006 and 2009. The following strategies guided the establishment of CSS programs:

- Conduct outreach to engage and increase access to care for Latinos and Asian/Pacific Islanders, African Americans, and Native Americans in the mental health system.
- Increase penetration and rates of client retention for underserved and unserved clients in age groups and racial/ethnic groups and for females.
- Provide linguistically and culturally appropriate services in settings that are more acceptable to ethnically diverse individuals and have less stigma associated with them, such as primary care clinics and school-based programs.
- Provide culturally competent mental health services in all MHSA programs by educating and training providers on evidence-based and promising clinical practices, interventions and skill sets, including coordination and integration of mental health and primary care, clinical practice guidelines, screening/assessment protocols, chronic disease management and cultural competence.
- Include training on working with interpreters, the deaf and hard of hearing, victims of trauma, and gender and sexual orientations in cultural competence training.
- Require enhancement of the bilingual and bicultural capacity in all programs by recruiting, hiring, retaining and retraining culturally competent staff.

- Address disparities in services for females in all age groups by requiring MHSAs programs to ensure females are assessed for mental illness.
- Increase access to services for all ethnic/racial groups and females by implementing the MHSAs program to provide more mental health services in community clinics.
- Establish relationships with tribal communities for as many of the 17 Native American tribes as possible who have reservations in San Diego County.
- Implement a Breaking the Barriers program, designed to evaluate how to address stigma and increase access for selected underserved communities.

See the Cultural Competence Plan Appendix for a description of the forty programs, their target populations, services offered and program goals.

### **Prevention and Early Intervention (PEI) Plan**

Through the PEI Work Plan, 30 programs were established from 2008-2010. The PEI Work Plan followed the strategies below in developing programming with the goal of reducing service disparities among targeted populations.

- Provide education and outreach campaigns to reduce stigma and discrimination and to aid in suicide prevention for all age groups, race/ethnicities, persons with co-occurring substance abuse disorders, and caregivers.
- Assist in maintaining a safe home and a community safety net for children and in reducing the effects of trauma exposure (including gang experience).
- Promote healthy, effective parenting styles, connecting children with necessary health and other related service, to prevent re-traumatizing children and families already exposed to domestic and/or community violence.
- Increase Native American community involvement and education through services designed and delivered by Native American community members.
- Strengthen the skills of parents, staff, and educators to promote the development, growth, health, and social competence of young children and help reduce their behavioral/emotional problems.
- Reduce the potential negative outcomes associated with mental health issues in the early stages of mental illness.
- Increase access to care for older adults from minority populations.
- Educate caregivers and primary care service providers to increase awareness and understanding of the older adult concerns and create a wellness focus.
- Support caregivers of clients with Alzheimer's, to reduce incidence of caregiver mental health problems.
- Provide outreach and outreach services to the Veterans community to improve their knowledge of and access to mental health services.
- Provide prevention services for clients in rural community clinics to help them address behavioral health issues, addiction, and severe mental illness at an early stage.
- Support persons being treated for substance abuse in dealing with mental health issues through providing integrated services.

See the Cultural Competence Plan Appendix for a description of the PEI programs, their target populations, services offered and program goals.

### **WORKFORCE EDUCATION AND TRAINING (WET) Plan**

In the WET Plan, the strategies, outlined below were adopted to reduce the workforce disparities, discussed previously, so that the County could more effectively provide services for ethnic/racial and cultural populations:

- Address shortages in bilingual staff – Spanish, Vietnamese, Arabic, Tagalog, Russian, Cambodian, ASL, Lao, Somali, and Swahili.
- Implement trainings/educational opportunities to build staff to fill unique qualifications for hard to fill jobs and for clinical supervision.
- Create incentives to encourage nurses, child psychiatrists, etc. to enter public mental health employment and take hard-to-fill positions.
- Increase the numbers of Latino and African American staff.
- Create positions and a career ladder for mental health consumers and/or family members.

Nine programs were begun to implement these strategies, ranging from providing training in core competencies for current staff, to developing career pathways, residency and internship programs, and financial incentive programs. See the Cultural Competence Plan for a fuller description of the nine programs.

### **MONITORING AND OVERSIGHT TO HELP INSURE THE EFFECTIVENESS OF SERVICES**

In order to monitor and measure the effectiveness of MHSA programming in reducing disparities, the SDCMHS updated the following Quality Improvement Plan for FY 10-11:

#### **Quality Improvement Strategies for Addressing Disparities**

The Quality Improvement Plan for addressing cultural disparities in San Diego County involves the following activities:

- 1) Evaluating root causes of disparities in San Diego
- 2) Assessing effectiveness of current strategies and interventions- as part of Cultural Competence Plan when State gives counties guidelines- on hold
- 3) Implementing stigma and discrimination educational campaign through MHSA funding
- 4) Evaluating cultural sensitivity of providers and services-
  - a. Facilitate the implementation of the CMCBS to evaluate staff
  - b. Implement the Culturally Competent Program Annual Self-Evaluation (CC-PAS) for new and re-procured programs
- 5) Improving quality of care by working with ethnically diverse groups
  - a. Complete and distribute Cultural Competence Handbook- QI- Dec 2010
  - b. Identify Culturally Competent EBP, best practices, proven practices- Policy and Practice Committee- will identify 2 new practices by – Dec 2011
  - c. Work with Clinical Standards Committee to ensure interventions are culturally appropriate.

- d. Study results of outcome measure based on age/racial/ethnic groups- Update Disparities for FY 09-10; data available for comparisons in Jan 2011. (Report will be available in Spring 2011.)
- e. Identify community groups that represent age/racial/ethnic/cultural diversity and do focus groups with them to identify areas for improvement- not started yet

The Cultural Competence Resource Team (CCRT)—an advisory board representing an array of stakeholders in the mental health community with a special interest in cultural diversity and the remediation of service disparities is participating in the development and monitoring of MHSA programming. The CCRT and its subcommittees, under the guidance of the Ethnic Services Manager, makes recommendations to Mental Health Administration and the Mental Health Director about issues concerning service disparities and cultural competency development. Accordingly, the CCRT Training and Education Subcommittee has drawn up a list of recommendations for cultural competency courses, requirements, and objectives:

**Cultural Competence Resource Team  
Training and Education Subcommittee  
Recommendations for Cultural Competency Courses Requirements & Objectives  
(culture-specific courses)**

In cultural competency courses, classes shall address the following:

- Some demographics of the country of origin, which may include maps, its location, population makeup, etc.;
- Discussion of language need, especially if high percentage are monolingual in their native language
- A brief history of the population, which may include migration/integration to and within the United States, the unique impact of migration on the population
- Discussion of any historical trauma, if applicable, such as war trauma, migration trauma, etc.
- Overview of the culture with some of these possible topics: values, sociological history, family structure, customs, perceptions of assistance or help, support systems, spirituality, health approaches, complementary healing approaches, cultural resilience, and language
- Access Issues and/or disparities: community support systems and resources; likelihood of group accessing resources
- Perspective on what causes mental illness and perspective on accessing mental health services
- Discussion of culture-bound mental health syndromes, if applicable
- When applicable to population, overview of unique patterns of acculturation
- Identify any specific generational trends with social/emotional/behavioral/mental health challenges, i.e. children, adolescents, TAY, Adults, Older Adults
- If applicable, discuss common health conditions and challenges, i.e. depression, diabetes, substance abuse, problem gambling, etc.

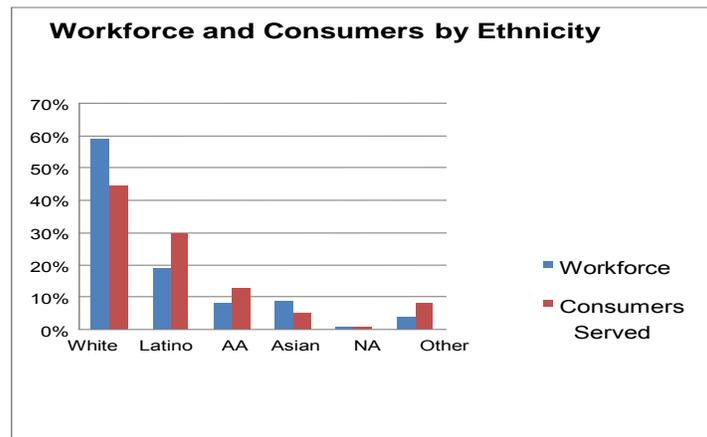
- If applicable the training can also include a quick reference guide with greeting words in the foreign language
- Cover the effects of inter- and intra- cultural racism, stereotypes and myths

If elements listed above are met by the end of the training session, participants should be able to:

- Recognize the need to assess individuals and families based upon a psycho/social/cultural/political/spiritual perspective.
- Recognize the need to understand cultural differences when working with clients/customers
- Articulate client/customer needs that are culturally appropriate
- Identify and utilize community resources on behalf of the client
- Provide services with understanding of cultural differences
- Advocate to reduce racism, stereotypes and myths

**CURRENT CULTURALLY COMPETENT TRAINING ACTIVITIES PROVIDED**

With a current workforce of approximately 2,500 persons working in hundreds of programs, the SDCMHS and its contractors have a major task on their hands to ensure the training in cultural awareness and sensitivity of all staff who work directly with clients. A comparison of the current workforce and mental health system consumers indicates that ethnic/racial groups are under-represented in the workforce.



To develop the cultural awareness and sensitivity of the workforce, the SDCMHS requires that contractors have all staff dealing directly with clients receive four hours of cultural competence training each year. These trainings have been conducted by a broad variety of organizations, but not all provider staff have access to an equal array of programs. To help address the variance in training opportunities, the SDCMHS is providing a 4-prong approach to expanding training for existing staff to enhance their level of cultural competence:

1. Training on cultural specialties will continue to be provided through the County Knowledge Center for County employees at no cost and a small number of providers on a fee basis.
2. Contracted trainings through the Behavioral Health Education and Training Academy (BHETA) are offered free of charge to County and contract BHS staff. Both classroom and some on-line trainings are offered. Expansion of on-line trainings is planned.

3. Cultural Competence Academy Training—a 32-40 hour intensive training program, offered once or twice yearly, on cultural awareness, knowledge, and specific skills development. New contractors and contractors winning a re-procurement will be required to send a portion of staff. Providers with 75% of staff attending the Academy will be able to achieve a certification as a Culturally Competent and Proficient Program.
4. WET Workforce Building Activities includes specialized training modules, creating career pathways, providing financial incentives, and providing fellowships/internships.

#### OTHER CURRENT APPROACHES TO EXPANDING LANGUAGE CAPACITY

- The SDCMHS spends over a million dollars annually to make interpreter services available throughout the outpatient system at no cost to a client or provide help to alleviate the demand for bi-lingual staff temporarily.
- Culturally Competent Clinical Practice Standards mandate that racial/ethnic and cultural factors are integrated into clinical interviews, assessment tools, assessment, medication considerations, etc. Services are to be provided in the client's preferred language. Key points of contact are mandated to have staff or interpretation services available.
- Training for staff on how to best utilize interpreters is being provided.
- Translated forms, documents, signage and client informing materials are provided.

#### ADAPTATION OF SERVICES TO IMPROVE CULTURAL COMPETENCE

##### The Role of Clients Driven/Operated Recovery and Wellness Programs

A valuable part of the SCDMHS services are client driven/operated recovery and wellness programs. Clients working in and attending these programs are able to reach out to others who both share their lived experience and often a common cultural/ethnic/racial heritage; they can also model progress toward recovery in the local communities. The client driven/operated programs range from client-operated clubhouses, warm line services, program advisory groups, Elder Multicultural Access and Support Services, client peer support programs, Roadmap to Recovery, Peer and Family Engagement Project, and Family Youth Roundtable.

##### Current Service Accommodations for Individual Preference

To help accommodate racial, ethnic and cultural preferences, some of the above programs have been adapted to further address the need for cultural/ethnic/racial/ linguistic service diversity:

- The Language Line provides interpreter services for all programs
- The Warm Line and the Adult Peer Support Line have Spanish speaking staff.
- Program Advisory Groups in the South Region (an area with a high Spanish speaking population) are conducted in English and Spanish.
- Roadmap to Recovery groups are facilitated in languages that reflect the population it serves and clients are free to choose among groups.
- Clients are free to change providers to get a more comfortable racial/ethnic or cultural "fit."

### Outreach Efforts to Engage Unserved/Underserved Populations

The SDCMHS realized that traditional efforts to engage unserved and underserved populations were inadequate. Through MHSA funding, outreach services were begun to try to inform diverse communities of the availability of mental health services which could meet their cultural and linguistic needs. Staff on specialized programs such as Breaking Down Barriers, the Union of Pan Asian Communities, Chaldean Middle Eastern Social Services, Survivors of Torture International, and clinics such as Douglas Young and the Heritage Clinic are participating in neighborhood festivals, information fairs, refugee assistance efforts, food distribution services, and substance abuse prevention efforts. Outreach efforts have been made to reach youth and high school students in new ways, through the Internet and at a Youth Summit.

### Location of Mental Health Services in Non-Threatening, Non-Stigmatizing Locations

A major effort has been made to begin to bring services to people where they are. Through MHSA funding, the SDCMHS is working with the Council of Community Clinics to co-locate services and create partnerships with primary care services to bring services to ethnic groups who are more comfortable in getting services at the family doctor's office. The Children's System of Care is now providing mental health services at over 300 community schools. On another level, new programs such as the Integrated Health Care Project, the Physical Health Integration Project, and the East County Integrated Health Access Project are striving to coordinate care to address the physical health and mental health needs of clients.

## CONCLUSION

The SDCMHS has been moving along the road toward achieving cultural competence for over a decade now. Significant progress has been made, especially under MHSA, to tailor programs to meet the cultural, ethnic, racial and linguistic needs of diverse communities. Efforts to reach out to, engage, and retain in services, the underserved and unserved are still not as successful as they need to be. The use of Evidence Based Practices and the development of best practices models are helping point development efforts toward greater effectiveness. Program staff, operating with an awareness of the link between meeting the cultural needs of clients and helping them move toward recovery, are being given a greater array of tools to foster their own cultural competence. Programs are being called upon to conduct a yearly self-assessment of their ability to meet the cultural needs of clients. The course of action chosen by the SDCMHS is broad-based and sound, but there is still much left to do to create true systemwide cultural competence.

*Live Well, San Diego!*

