Cultural Competence Handbook

County of San Diego Behavioral Health Services
Fiscal Year 2024-25

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Population Health Network Quality and Planning
In collaboration with The Cultural Competence Resource Team

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Cultural Competence Handbook

Introduction

The County of San Diego has long had a commitment to cultural competence. With its geographic location, high rates of immigration, and diverse demographics, the County has a unique opportunity to engage with the community with cultural sensitivity. Because cultural norms, values, beliefs, and customs influence the behavioral and medical health of individuals, authentic engagement through cultural competence in the County's Health and Human Services Agency (HHSA) is instrumental in bringing about positive outcomes for the diverse individuals we serve.

Race/Ethnicity	2020 Decennial Census San Diego County	2020 Decennial Census Data United States	Race/Ethnicity	FY 2023-24 Behavioral Health Services
American Indian and Alaska Native	40,968 (1.2 %)	3,727,135 (61.6%)	**White**	24,747 (33.9 %)
Asian	410,752 (12.5%)	19,886,049 (6.0%)	**Hispanic**	28,501 (39.0%)
Black or African American	155,813 (4.7%)	41,104,200 (12.4%)	**Black/African American**	7,304 (10.0%)
Hispanic or Latino	1,119,629 (33.9%)	62,080,044 (18.7 %)	**Asian/Pacific Islander**	2,676 (3.7%)
Non-Hispanic or Latino	2,179,005 (66.1 %)	269,369,237 (81.3%)	**Native American**	476 (0.6%)
Native Hawaiian and Other Pacific Islander	15,286 (0.5 %)	689,96 (0.2%)	**Multiracial**	3,318 (4.5%)
White Alone	1,633,129 (49.5%)	204,277,273 (61.6%)	**Other**	2,793(3.8%)
Some Other Race Alone	520,994 (15.8%)	27,915,715 (8.4%)	**Unknown**	3,217 (4.4%)
Two or More Races	521,692 (15.8%)	33,848,943 (10.2%)	**LGBTQ+ * (2020)** San Diego* 230,000 (8%) United States* 11,300,000	
Veterans (2022) **	San Diego County ** 181,742 (7.3%)	United States** 16,200,322 (6.2%)		

**The information on LGBTQ+ population was obtained from County of San Diego, Health and Human Services Agency, Public Health, Community Health Statistics Unit, 2022* The Adult Lesbian, Gay, Bisexual, and Queer (LGBQ) Population in San Diego County, 2016-2020

***The information on Veteran status was obtained from U.S. Census Bureau (2022).* San Diego County, CA - Profile data - Census Reporter

Note: *the percentages are based on the total 2020 US Decennial Census population (331,449,281), 2020 San Diego County (3,298,634) population, and FY 2017-18 BHS client population (67,221).*

HHSA previously launched a ten-year effort called " Building Better Health Program" to align County services to promote both physical and mental health in collaboration with community partners and businesses. The goals are to build a better system, support healthy choices, and pursue policy changes for a healthy environment. This service has evolved into a greater, long-term Live Well San Diego Vision to improve the health, safety, and quality of life of all County residents. Live Well San Diego is a vision for a region that is Building Better Health, Living Safely, and Thriving.

In alignment with *Live Well San Diego*, the HHSA San Diego County Behavioral Health Services (SDCBHS) continually strives for complete integration of its systems and services. It is working to fully incorporate the recognition of personal experiences in cultural diversity and sees the integration of a culturally competent and trauma-informed Behavioral Health system as a developmental process. Another focus that SDBHS has incorporated is cultural humility to further support the progress toward reducing disparities in mental health services. The term is based on the idea that we must be open to the identities and experiences of others as a primary way of being in the world. SDCBHS continues to deploy strategies and efforts for enhancing wellness and reducing all disparities including cultural competence evaluation and training activities, the continued development of a multicultural workforce, and continued integration of systems and services. In San Diego County the threshold languages are English, Tagalog, Spanish, Arabic, Persian (Farsi and Dari), Somali, Korean, Mandarin (Chinese), and Vietnamese. These recently expanded over the past fiscal year. Translation services are also available in American Sign Language (ASL). With support from the Behavioral Health Advisory Board (BHAB), SDCBHS adopted the CCISC model for designing system changes to improve outcomes for persons living with co-occurring disorders, within the context of existing resources, via a Consensus Document.

These efforts are embodied in the BHS Cultural Competence Handbook. This Handbook contains practical strategies and tools that will assist behavioral health providers in making improvements throughout the system of care. In partnership with SDCBHS, providers and community partners can contribute towards the County's vision for advance equity and accessibility to quality behavioral health supports and care to ensure all San Diego residents can achieve and sustain wellness.

County of San Diego, Health and Human Services Agency

Vision: A region that is building better health, living safely, and thriving to advance a just, sustainable, and resilient future for all.

Mission: To make people's lives healthier, safer, and self-sufficient by delivering essential services in San Diego County.

Values: In recognition that "The noblest motive is the public good", we are dedicated to: Integrity, Equity, Access, Belonging, Excellence, Sustainability**.**

Core Competency: Advancing Opportunities for All San Diegans to Live Well**.**

Strategy:

1. **Sustainability:** Promote a resilient economy, climate, environment, and region for all.
2. **Workforce:** Engaged employees that feel valued, have a sense of belonging and are motivated to work together toward one vision.
3. **Community Engagement:** Strengthen and invigorate communities with opportunities to grow, connect, and thrive.
4. **Equity:** Equitable access to better health, safety, and opportunities to thrive that enhance well-being
5. **Service Delivery Coordination:** Integrated performance excellence framework that delivers ever-improving value and contributes to the Agency's ongoing success.
6. **Systems & Technology:** Innovative information systems with enhanced technical infrastructure and data sharing capabilities.

Behavioral Health Services

Vision: The broad vision of BHS is to achieve a transformational shift from a model of behavioral health care driven by crises, to one driven by chronic or continuous care and prevention through the regional distribution and coordination of resources to keep people connected, stable, and healthy.

Mission: Advance equity and accessibility to quality behavioral health supports and care to ensure all San Diego County residents can achieve and sustain wellness.

BHS embraces Live Well San Diego, the County's vision to promote healthy, safe, and thriving communities countywide.

The Importance of Cultural Competence, Cultural Humility, Diversity, and Inclusion

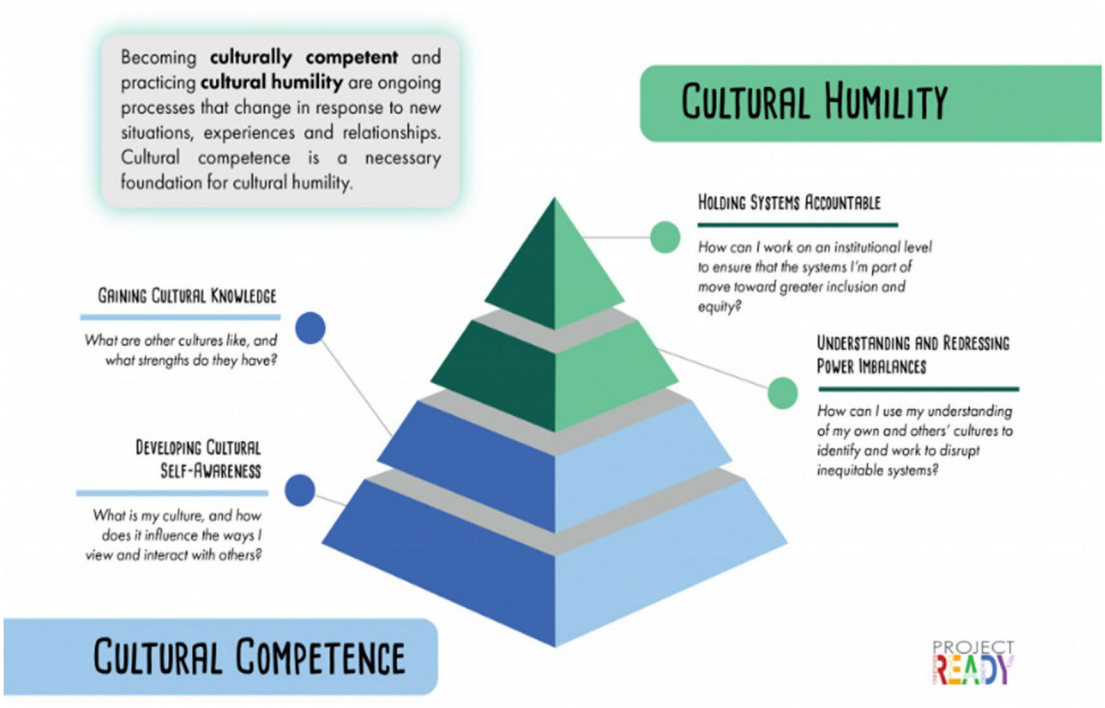
Cultural Competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among consumer providers, family member providers, and professionals that enables that system, agency or those professionals, consumer, and family member providers to work effectively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

Cultural Humility is described in three parts:

• A lifelong commitment to self-evaluation. We are never finished – we never arrive at a point where we are done learning. Therefore, we must be both humble and flexible;

• A desire to fix power imbalances. Each person brings something different to the table. Each person is the expert on their own life, symptoms, and strengths. Both people must collaborate and learn from each other for the best outcomes; and,

• A willingness to develop partnerships with people and groups who advocate for others. We cannot individually commit to self-evaluation and fixing power imbalances without advocating within the larger organizations in which we participate



Difference between Cultural Competence and Cultural Humility: Table - PMC (nih.gov)

Cultural Competence Is A Foundation For Cultural Humility Pyramid. 2020. Image. "Module 8: Cultural Competence & Cultural Humility – Project READY: Reimagining Equity & Access For Diverse Youth". 2021. Ready.Web.Unc.Edu

The Project Ready Equity and Access for Diverse Youth provides an interactive Cultural Competence Self-Evaluation Checklist tool that is designed to help think about your skills knowledge, and awareness in interactions with others and identify areas of strengths and areas that need further development. cultural-competence-self-assessment-checklist.pdf (coloradoedinitiative.org)

The National Center for Cultural Competence has identified five 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 decrease the likelihood of liability/malpractice claims.

For more details, visit https://nccc.georgetown.edu/foundations/need.php.

Diversity and Inclusion:

The County of San Diego has developed the D&I Partnership Model with the focus of Equity, Diversity, & Inclusion. There are six components to support the model. The Human Relations Commission who has 31-members mission is to promote positive human relations, respect and integrity of every individual in the County of San Diego. Second, the Executive D&I Council is a diverse executive leadership creating a culture that keeps diversity and Inclusion at the forefront for leaders throughout the enterprise by guiding the County's diversity and inclusion strategy. Third, the Department of Human Resources: Equity, Diversity & inclusion Division which internally focuses on integrating equity, diversity, and inclusion into the organizational County Culture and specifically supporting the areas of recruitment, hiring, and professional development/advancement. Fourth, the Office of Ethics & Compliance Department is dedicated to fostering a culture of integrity, implementing the Code of Ethics, promoting ethics and compliance through developed policies, programs, and trainings, and reviewing discrimination, fraud, waste, and abuse complaints. Fifth, the Employee Resource Groups (ERGs) there are ten thriving ERGs that play an important role in advancing our commitment to diversity and creating and sustaining an inclusive workplace. ERGs provide employees networking and professional development activities, support County initiatives, and promote culture awareness. Lastly, the Office of Equity & Racial Justice who are devoted to engaging the community to cocreate transformative, enduring, structural and systemic change in San Diego County government.

The Drug Medi-Cal Organized Delivery System (DMC-ODS) was launched in July 2018, specifically designed to serve low -income San Diegans to address the systemic damage that substance abuse inflicts on people, families, and communities. 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. Implementing the National Culturally and Linguistically Competent Services (CLAS) Standards.
4. Periodic evaluation of staff, programs, and clients.
5. 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.

Cultural Competence Assessment Rollout			
When	**What**	**Who**	
		Substance Use Disorder Services (SUD)	***Mental Health Services (MHS)***
1 Time	Cultural Competence Plan (CC Plan)	*Required for all Legal Entities as of December 2013* *Updates as needed*	
Biennial	Cultural and Linguistic Competence Policy Assessment (CLCPA)	*October 2025* *October 2027*	
Biennial	Promoting Cultural Diversity Self-Assessment (PCDSA)	*October 2024* *October 2026*	

Cultural Competence Assessment History		
Cultural Competence Program Annual Self-Evaluation (CC-PAS)	**California Brief Multicultural Competence Scale (CBMCS)**	**CC Plan**
April 2012 (MHS only) April 2013 (MHS only) April 2014 (MHS & SUD) April 2015 (MHS & SUD) April 2016 (MHS & SUD)	October 2011 (MHS only) October 2013 (MHS & SUD) October 2015 (MHS & SUD)	April 2012 (MHS) December 2014 (SUD) September 2019 (MHS & SUD) 2023 (MHS & SUD) 2024 (MHS & SUD)
Cultural and Linguistic Competence Policy Assessment (CLCPA)	**Promoting Cultural Diversity Self-Assessment (PCDSA)**	
October 2017 (MHS & SUD) February 2019 (MHS & SUD) April 2020 (MHS & SUD) June 2022 (MHS & SUD) May 2023 (MHS & SUD)	October 2018 (MHS & SUD) October 2020 (MHS & SUD) October 2022 (MHS & SUD) October 2024 (MHS & SUD)	

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	CLCPA	PCDSA	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:* https://thinkculturalhealth.hhs.gov/assets/pdfs/EnhancedNationalCLASStandards.pdf

Cultural Competence Plan

An outline for the development of a Cultural Competence Plan

Cultural Responsiveness Plan Development Guidelines

Goal: To provide guidelines on how to develop an inclusive and comprehensive plan that enhances their current capability for providing trauma-informed and culturally responsive systems and services.

Background: As of December 2013, Cultural Responsiveness Plans, formerly Cultural Competence Plans are required for all legal entities for both mental health and substance use services. As stated in all County of San Diego Behavioral Health Services (COSDBHS) contracts, it is an expectation that the organizations develop and provide trauma-informed and culturally responsive systems and services, and work to continually enhance levels of cultural responsiveness. Cultural responsiveness is defined as one's ability to know their culture and how it impacts their understanding of other people's culture and way of life, therefore deepening their understanding of other people and recognizing others as individuals. This includes effectively communicating with others based on their individual needs in order to identify and provide culturally appropriate services. This work complements the expectation that the California Department of Health Care Services (DHCS) has for each county. The guidelines developed by COSDBHS with input from the Cultural Competence Resource Team (CCRT), can be used as a tool as your organization works to assess its current cultural responsiveness and integrate the plan's components into the system of care. If you do not have a Cultural Responsiveness Plan in place currently, please ensure that the Culturally and Linguistically Appropriate Services (CLAS) Standards are addressed. In addition, consider inclusion of the other suggested components below. If you already have a Cultural Responsiveness Plan in place, please evaluate and determine if adding any of the elements noted in these guidelines could enhance your plan.

Resources: The two checklists on pages 15-18 may serve as a resource for incorporating Cultural Responsiveness Plan components and the CLAS Standards into your policies and procedures. **It is provided for reference only**. We encourage your organization to review the CLAS standards (provided below) and engaging key stakeholders from across your organization throughout the process.

Please note: For legal entities with multiple programs, please consider a Cultural Responsiveness Plan per program. Consider annual or biannual revisions of this plan to provide relevant updates and/or to demonstrate progress towards goal achievement or revisions of goals.

CLAS Standards: CLAS are comprised of 15 standards which are outlined below. These standard are meant to improve the quality of services that are provided to all individuals, with the intention to help reduce health disparities and achieve health equity. For more information, please visit Culturally and Linguistically Appropriate Services - Think Cultural Health

CLAS STANDARDS:	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:	
Principal Standard						
1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs, 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.	☐		☐			
CLAS STANDARDS:	**COMPONENT IMPLEMENTATION**					**In response to what data or information was the change/innovation/ improvement made?**
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.	☐		☐			

In addition to including the CLAS standards in the Cultural Responsiveness Plan, COSDBHS recommends including the components below. Inclusion of these components can help to strengthen and enhance the incorporation of the CLAS standards in the Cultural Responsiveness Plan (CRP).

Cultural Responsiveness Plan Development Checklist

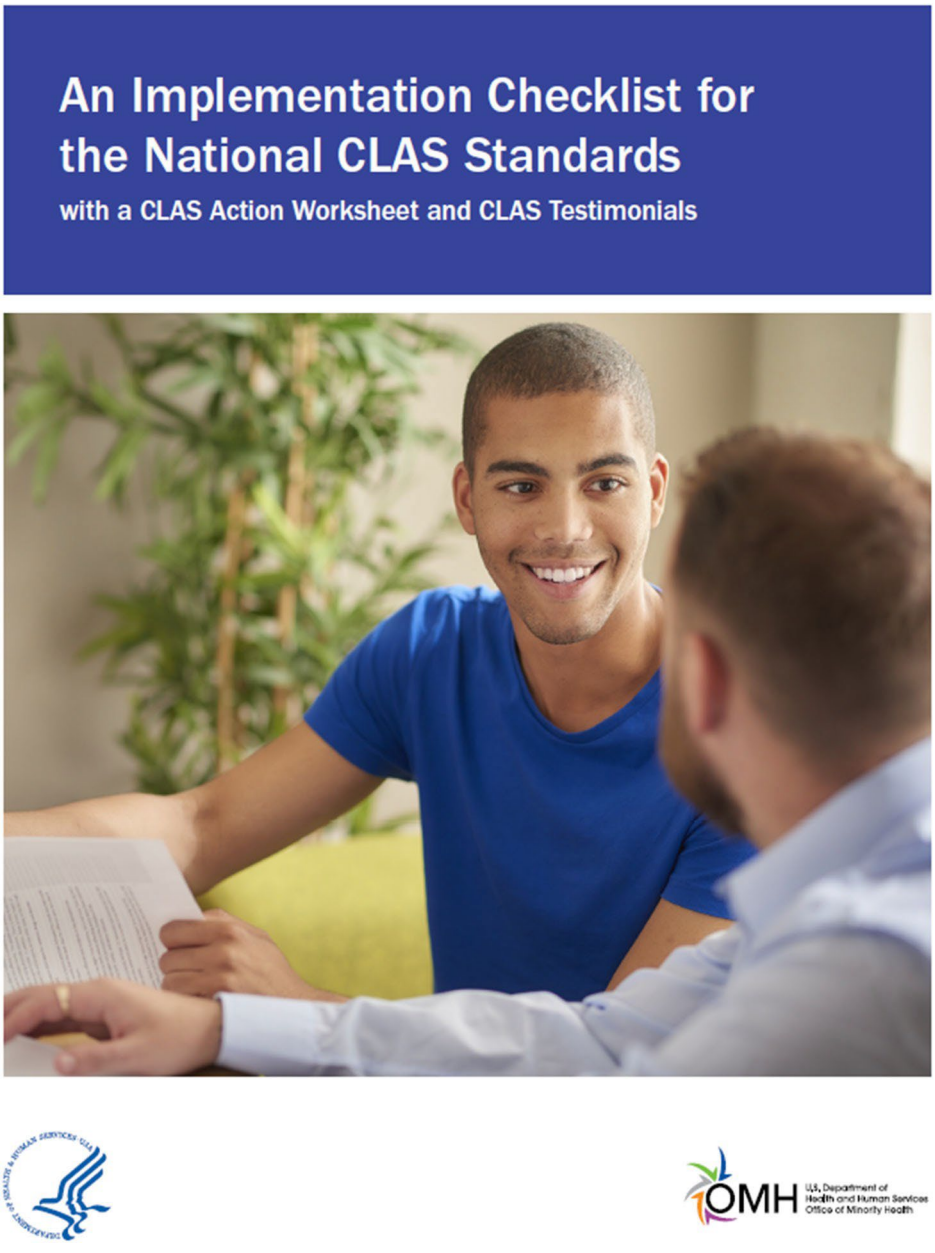
COSDBHS recommends the use of this tool

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 responsiveness .	☐		☐			

Identify how program administration prioritizes cultural responsiveness 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.	☐		☐			
Service utilization by ethnicity, race, language usage, and cultural groups.	☐		☐			
Client outcomes are meaningful to client's social ecological needs.	☐		☐			
Objectives						
Develop processes to assure cultural competence (language, culture, training, surveys) is developed in systems and practiced in service delivery.	☐		☐			

The CLAS Standards offer a strong framework to provide culturally and linguistically appropriate services. As they are already embedded into cultural competence evaluation tools in the Handbook, the programs will adhere to the Standards by utilizing the tools, follow the established Cultural Competence Plan, and complete regularly scheduled evaluations as noted in the Rollout on page 9.

An Implementation Checklist for the National CLAS Standards is a tool that can be used. The Checklist has listed successful CLAS-related organizational activities that were observed across the organizations that were studies. A CLAS action worksheet is provided to be used to plan CLAS activities in your setting. [An Implementation Checklist for the National CLAS Standards (hhs.gov)]



Evaluating
Cultural Competence

Available Tools for Program Evaluation

The following tools are included in the Handbook to assist programs with evaluating their cultural and linguistic competence. Programs are required to use the CLCPA and PCDSA as directed by County of San Diego 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 and Linguistic Competence Policy Assessment (CLCPA)
- Promoting Cultural Diversity Self-Assessment (PCDSA)
- Certification of Language Competence
- Assessing Cultural Competence – Client Survey
- Assessing Cultural Competence – Client Focus Groups
- Assessing Cultural Competence – Community Focus Groups
- Promoting Cultural Diversity and Cultural and Linguistic Competency -Self Assessment Checklist for Personnel Providing Services and Supports to LGBTQ Youth and Their Families.
- Cultural Competence Self-Assessment Checklist
- Self-Assessment Tool on Diversity & Inclusion
- Test Yourself For Hidden Bias

Cultural and Linguistic Competence Policy Assessment (CLCPA)

One of the Quality Improvement strategies in the County of San Diego Behavioral Health Services (BHS) Cultural Competence Plan is to survey all program managers annually to evaluate their perception of their programs' cultural and linguistic competence. The CLCPA was developed by Georgetown University's National Center for Cultural Competence and adapted by SDCBHS to align with the expectations recommended by the Cultural Competence Resource Team (CCRT) and the National Culturally and Linguistically Appropriate Services (CLAS) Standards. The goal of the CLCPA is to enhance the quality of services within culturally diverse and underserved communities; promote cultural and linguistic competence; improve health care access and utilization; and assist programs with developing strategies to eliminate disparities.

Section 1: Knowledge of Diverse Communities The focus of this section is organizational policy that takes into consideration cultural beliefs, strengths, vulnerabilities, community demographics, and contextual realities.
Section 2: Organizational Philosophy This section focuses on the incorporation of cultural competence into the organization's mission statement, structures, practice models, collaboration with clients/participants and community members, and advocacy.
Section 3: Personal Involvement in Diverse Communities This section addresses the extent to which an organization and its staff participate in social and recreational events and purchase goods and services within the communities they serve.
Section 4: Resources and Linkages This section focuses on the ability of the organization and its staff to effectively utilize both formalized and natural networks of support within culturally diverse communities to promote and maintain linkages through structures and resources.
Section 5: Human Resources The focus of this section is on the organization's ability to sustain a diverse workforce that is culturally and linguistically responsive.
Section 6: Clinical Practice This section focuses on the ability of the organization and its staff to adapt approaches to behavioral health care delivery based on cultural and linguistic differences.
Section 7 Language and Interpretation Services Access This section focuses on the ability of the organization and its staff to ensure access to materials in various languages, offer interpretation/translation services, and implement processes to ensure adherence to National CLAS Standards.
Section 8: Engagement of Diverse Communities This section focuses on the organization's and its staff's engagement of diverse communities in health and behavioral health promotion and disease prevention.

Report Located: 2024 CLCPA Report_Final.pdf (sandiegocounty.gov)

Promoting Cultural Diversity Self-Assessment (PCDSA)

Starting in October 2022, the SDCBHS Population Health unit requested each contracted Mental Health Services (MHS) and Substance Use Disorder (SUD) program manager to distribute the survey to their organization and complete the survey. The PCDSA was developed by Georgetown University's National Center for Cultural Competence. The assessment's goal is to heighten the awareness and sensitivity of program staff to the importance of cultural diversity and cultural competence. The PCDSA is administered to all staff of County-operated and County- contracted mental health and substance use disorder programs in October every two years. A Google survey is distributed to all program managers and they are asked to ensure that all program staff receive a copy of the link to complete the survey. The PCDSA results show the providers and their organizations' awareness and understanding of the diverse cultural groups in the County, and may reveal opportunities to provide better communication and access to treatment for diverse populations. The survey data shows that the providers' self-reported values and attitudes are in general, attuned to the diverse populations they serve. The domain that represents the most opportunity for improvement pertains to the program sites' physical environment, materials, and resources. Additional efforts to ensure physical elements in the sites reflect the various cultural and ethnic groups of their clients could be considered as a step towards enhancing cultural competence.

I. **Physical Environment, Materials and Resources**
II. **Communication Styles**
III. **Values and Attitudes**

Report Located: Promoting Cultural Diversity Self-Assessment (PCDSA) Biennial Report: 2024

The Promoting Cultural Diversity Self-Assessment (PCDSA) was developed by Georgetown University, but has been adapted by the County of San Diego Behavioral Health Services in 2017. The PCDSA is intended to heighten the awareness and sensitivity of program staff to the importance of cultural diversity and cultural competence. It assesses the staff's level of understanding around values and practices that promote a culturally diverse and cultural competent service delivery system.
The PCDSA is aligned with the National Culturally and Linguistically Appropriate Services (CLAS) Standards.

I. Physical Environment, Materials & Resources

1. I display pictures, posters, and other materials that reflect the cultures and ethnic backgrounds of communities served by my program or agency.
   - ○ Things I do frequently
   - ○ Things I do occasionally
   - ○ Things I do rarely or never
   - ○ Did not occur to me

2. I ensure that magazines, brochures, and other printed materials in reception areas are of interest to and reflect the different communities served by my program or agency.
   - ○ Things I do frequently
   - ○ Things I do occasionally
   - ○ Things I do rarely or never
   - ○ Did not occur to me

3. When using videos, films, CDs, DVDs, or other media resources for Behavioral Health outreach, prevention, treatment, or other interventions, I ensure that they reflect the cultures of communities served by my program or agency.
   - ○ Things I do frequently
   - ○ Things I do occasionally
   - ○ Things I do rarely or never
   - ○ Did not occur to me

4. When offering food, I ensure that meals provided include foods that are unique to the cultural and ethnic backgrounds of the communities served by my program or agency.
   - ○ Things I do frequently
   - ○ Things I do occasionally
   - ○ Things I do rarely or never
   - ○ Did not occur to me

5. I ensure mediums and modalities in reception areas and those, which are used during program services, are representative of the various cultural and ethnic groups within the local community and the society in general.
   - ○ Things I do frequently
   - ○ Things I do occasionally
   - ○ Things I do rarely or never
   - ○ Did not occur to me

II. Communication Styles

6. For people who speak languages or dialects other than English, I attempt to learn and use key words in their language so that I am better able to communicate with them during interactions.
   - ○ Things I do frequently
   - ○ Things I do occasionally
   - ○ Things I do rarely or never
   - ○ Did not occur to me

7. I attempt to determine any cultural expressions used by communities served that may impact interactions and services.
   - ○ Things I do frequently
   - ○ Things I do occasionally
   - ○ Things I do rarely or never
   - ○ Did not occur to me

8. I use visual aids, gestures, and physical prompts in my interactions with those who have limited English proficiency.
   - ○ Things I do frequently
   - ○ Things I do occasionally
   - ○ Things I do rarely or never
   - ○ Did not occur to me

9. I use trained bilingual or multilingual staff (or appropriate interpreter services) during assessments, treatment sessions, meetings, and for other events for families who would require such level of assistance.
   - ○ Things I do frequently
   - ○ Things I do occasionally

- Things I do rarely or never
- Did not occur to me

10. When interacting with people who have limited English proficiency, I always keep in mind that:

Limitations in English proficiency are in no way a reflection of their level of intellectual functioning.	Things I do frequently	Things I do occasion ally
	Things I do rarely or never	Did not occur to me
Their limited ability to speak the language of the dominant culture has no bearing on their ability to communicate effectively in their language of origin.	Things I do frequently	Things I do occasion ally
	Things I do rarely or never	Did not occur to me
They may or may not be literate in their preferred language or English.	Things I do frequently	Things I do occasion ally
	Things I do rarely or never	Did not occur to me

11. I ensure that all notices and communication to service participants are available in threshold languages.
    - Things I do frequently
    - Things I do occasionally
    - Things I do rarely or never
    - Did not occur to me

12. I understand that it may be necessary to use alternatives to written communications for some communities receiving information.
    - Things I do frequently
    - Things I do occasionally
    - Things I do rarely or never
    - Did not occur to me

13. I understand the value of linguistic competence and promote it within my program or agency.
    - Things I do frequently
    - Things I do occasionally
    - Things I do rarely or never
    - Did not occur to me

14. I understand the implications of health care and behavioral health literacy within the context of my roles and responsibilities.
    - ○ Things I do frequently
    - ○ Things I do occasionally
    - ○ Things I do rarely or never
    - ○ Did not occur to me

III. Values & Attitudes

15. I use alternative formats and varied approaches to communicate and share information with those we serve who experience disability.
    - ○ Things I do frequently
    - ○ Things I do occasionally
    - ○ Things I do rarely or never
    - ○ Did not occur to me

16. I avoid imposing values that may conflict or be inconsistent with those of cultures or ethnic groups other than my own.
    - ○ Things I do frequently
    - ○ Things I do occasionally
    - ○ Things I do rarely or never
    - ○ Did not occur to me

17. In delivering program services, I discourage participants from using derogatory slurs (e.g., racial, ethnic, sexist, homophobic, transphobic, etc.) by helping them understand that certain words can hurt others.
    - ○ Things I do frequently
    - ○ Things I do occasionally
    - ○ Things I do rarely or never
    - ○ Did not occur to me

18. I screen books, movies, and other media resources for negative stereotypes before sharing them with those served by my program or agency.
    - ○ Things I do frequently
    - ○ Things I do occasionally
    - ○ Things I do rarely or never

- Did not occur to me

19. I intervene in an appropriate manner when I observe other staff within my program or agency engaging in behaviors that show cultural insensitivity, bias, or prejudice.
    - Things I do frequently
    - Things I do occasionally
    - Things I do rarely or never
    - Did not occur to me

20. I understand and accept that family is defined differently by different cultures (e.g., extended family members, godparents, family of choice).
    - Things I do frequently
    - Things I do occasionally
    - Things I do rarely or never
    - Did not occur to me

21. I recognize and accept that people from culturally diverse backgrounds may desire varying degrees of acculturation into the dominant or mainstream culture.
    - Things I do frequently
    - Things I do occasionally
    - Things I do rarely or never
    - Did not occur to me

22. I accept and respect that gender roles and expression of gender identity in families may vary significantly among different cultures.
    - Things I do frequently
    - Things I do occasionally
    - Things I do rarely or never
    - Did not occur to me

23. I understand that age and life cycle factors must be considered in interactions with individuals and families (e.g., high value placed on the decisions of elders or the role of the eldest man in families).
    - Things I do frequently
    - Things I do occasionally
    - Things I do rarely or never
    - Did not occur to me

24. Even though my professional or moral viewpoints may differ, I accept the family/parents as the ultimate decision makers for services and supports for their children.
This question is for CYF programs only.
- ○ Things I do frequently
- ○ Things I do occasionally
- ○ Things I do rarely or never
- ○ Did not occur to me
- ○ Not applicable (my program does not serve children, youth, and their families)

25. I recognize that the meaning or value of behavioral health outreach, prevention, intervention, and treatment may vary greatly among cultures.
- ○ Things I do frequently
- ○ Things I do occasionally
- ○ Things I do rarely or never
- ○ Did not occur to me

26. I recognize and understand that beliefs and concepts of emotional well-being vary significantly from culture to culture.
- ○ Things I do frequently
- ○ Things I do occasionally
- ○ Things I do rarely or never
- ○ Did not occur to me

27. I understand that beliefs about mental illness, substance use, and emotional disability are culturally-based. I accept that responses to these conditions and related services are heavily influenced by culture.
- ○ Things I do frequently
- ○ Things I do occasionally
- ○ Things I do rarely or never
- ○ Did not occur to me

28. I understand the impact of stigma associated with mental illness, substance use, and behavioral health services within culturally diverse communities.
- ○ Things I do frequently
- ○ Things I do occasionally
- ○ Things I do rarely or never

- Did not occur to me

29. I accept that religion, spirituality and other beliefs may influence how people respond to mental or physical illnesses, disease, disability, and death.
    - Things I do frequently
    - Things I do occasionally
    - Things I do rarely or never
    - Did not occur to me

30. I recognize and accept that cultural and religious beliefs may influence a family's reaction and approach to a person diagnosed with a physical/emotional disability or special health care needs.
    - Things I do frequently
    - Things I do occasionally
    - Things I do rarely or never
    - Did not occur to me

31. I understand that traditional approaches to disciplining children are influenced by culture.
    - Things I do frequently
    - Things I do occasionally
    - Things I do rarely or never
    - Did not occur to me

32. I understand that people from different cultures will have different expectations for acquiring self-help, social, emotional, cognitive, and communication skills.
    - Things I do frequently
    - Things I do occasionally
    - Things I do rarely or never
    - Did not occur to me

33. I accept and respect that customs and beliefs about food, its value, preparation, and use are different from culture to culture.
    - Things I do frequently
    - Things I do occasionally
    - Things I do rarely or never
    - Did not occur to me

34. Before visiting a home setting, or providing services in the community, I seek information or acceptable behaviors, courtesies, customs, and expectations that are unique to specific cultures and ethnic groups served by my program or agency.
    - ○ Things I do frequently
    - ○ Things I do occasionally
    - ○ Things I do rarely or never
    - ○ Did not occur to me

35. I seek information from family members or other key community leaders that will assist in service adaptation to respond to the needs and preferences of culturally and ethnically diverse community members served by my program or agency.
    - ○ Things I do frequently
    - ○ Things I do occasionally
    - ○ Things I do rarely or never
    - ○ Did not occur to me

36. I promote the review of my program's or agency's mission statement, goals, policies, and procedures to ensure that they incorporate principles and practices that promote cultural diversity and cultural and linguistic competence.
    - ○ Things I do frequently
    - ○ Things I do occasionally
    - ○ Things I do rarely or never
    - ○ Did not occur to me

37. I am aware of cultural specific healing methods, particularly as they pertain to the communities served by my program or agency.
    - ○ Things I do frequently
    - ○ Things I do occasionally
    - ○ Things I do rarely or never
    - ○ Did not occur to me

38. I contribute to and/or review current research related to cultural disparities in behavioral health, health care, and quality improvement.
    - ○ Things I do frequently
    - ○ Things I do occasionally
    - ○ Things I do rarely or never

- ○ Did not occur to me

39. I accept that many evidence-based outreach, prevention, and intervention approaches will require adaptation to be effective with culturally and linguistically diverse groups.
    - ○ Things I do frequently
    - ○ Things I do occasionally
    - ○ Things I do rarely or never
    - ○ Did not occur to me

Program & Respondent Information

Please enter your program reference number from the list provided in the email.
Do not leave it blank. If your program is NOT on the list, please write down the full name below.

What is your program type?

- ○ Mental Health Services (MHS)
- ○ Substance Use Disorder Services (SUD)

Please identify primary clients at your program.
Please check all that apply.

- ☐ Children and youth
- ☐ Transition Age Youth
- ☐ Adults
- ☐ Older Adults

Please select the role that best describes your position.

- ○ Manager/Supervisor
- ○ Direct Service Provider
- ○ Indirect/Support Services
- ○ Peer Support

How many years of experience do you have working in the behavioral health field?

- ○ 0-1 Year
- ○ 2-5 Years
- ○ 6-10 Years

- ○ 10+ Years Ago

Please indicate your gender.

- ○ Male
- ○ Female

Please indicate your race/ethnicity.

- ○ African-American
- ○ Asian/Pacific Islander
- ○ Hispanic
- ○ Native American
- ○ White

Please indicate your country of origin.

Please indicate which languages you speak besides English.
Mark all that apply.

- ☐ Arabic
- ☐ Farsi
- ☐ Spanish
- ☐ Tagalog
- ☐ Vietnamese
- ☐ I do not speak other languages besides English
- ☐ Other

Please indicate your highest degree or diploma.

- ○ High School Diploma
- ○ Associate's Degree
- ○ Bachelor's Degree
- ○ Master's Degree
- ○ Doctorate/MD/PhD/PsyD

Certification of Language 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.

Suggested Process for Certification of Language Competence

In order to establish a process for certifying the ability of bilingual and multilingual 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 health
- 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

Survey for Clients to Assess 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.

SURVEY FOR CLIENTS TO ASSESS A PROGRAM'S CULTURAL COMPETENCE

PROGRAM INFORMATION:

PROGRAM NAME: _____

DATE

MONTH ____ / DAY ____ / YEAR ____

CLIENT DEMOGRAPHICS:

AGE:_____ RACE/ETHNICITY: ○ Hispanic ○ Black ○ White ○ Native American ○ Asian/Pacific Islander ○ Other: _____

LANGUAGE PREFERENCE:

○ English ○ Vietnamese ○ Chinese ○ Laotian ○ Farsi ○ Dari ○ Somali ○ Spanish ○ Tagalog ○ Japanese ○ Cambodian ○ Arabic ○ Korean ○ Other:_____

QUESTIONS:

Please rate this program on the following items:

RATING SCALE:

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Not Applicable
1. In the last 6 months, the staff listened to me and my family when we talked to them.	○	○	○	○	○	○
2. The services I received from this program in the last 6 months has helped me work towards things like:						
A. Getting a Job	○	○	○	○	○	○
B. Taking care of my family.	○	○	○	○	○	○
C. Going to School.	○	○	○	○	○	○
D. Being active with my friends, family, and community.	○	○	○	○	○	○
3. In the last 6 months, the staff made an effort to understand the experiences and challenges I once experienced.	○	○	○	○	○	○
4. The waiting room and/or facility have images or displays that represent people from my cultural group.	○	○	○	○	○	○
5. In the last 6 months, the staff respected and supported my cultural and religious beliefs.	○	○	○	○	○	○
6. In the last 6 months, the staff from this program came to my community to let people like me and others know about the services they offer and how to get them.	○	○	○	○	○	○

SURVEY FOR CLIENTS TO ASSESS A PROGRAM'S CULTRAL COMPETENCE

QUESTIONS:	RATING SCALE:					
Please rate this program on the following items:	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Not Applicable
7. In the last 6 months, the staff treated me and my experiences with respect.	○	○	○	○	○	○
8. Some of the staff are representative of my cultural group.	○	○	○	○	○	○
9. In the last 6 months, there were translators or interpreters easily available to assist me and/or my family if we needed it.	○	○	○	○	○	○
10. In the last 6 months, the staff made an effort to understand my traditional medicinal practices.	○	○	○	○	○	○

Comments or Recommendations:

Discussion Questions for Client Focus Group on Program's Cultural Competence

These questions may not be applicable to all programs and age groups. Please adjust to be culturally sensitive

Client Focus Group Discussion Questions

Program Name: _____ Date: _____

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?

5) Does this program provide you with services in your language of choice?

6) Are bilingual, clinical staff linguistically proficient and able to communicate ideas, concerns and the community framework in your preferred language?

7) Are clinical staff familiar with your cultural beliefs surrounding mental illness?

8) Are clinical staff knowledgeable in making culturally appropriate referrals?

9) If you see a program psychiatrist, are they familiar with your cultural beliefs surrounding mental illness?

10) If you see a program psychiatrist, were you asked about your background history?

11) If you need to use an interpreter provided by the program, are they linguistically proficient and able to communicate ideas, concerns and rationales in your language of choice?

Suggested Discussion Questions for Community Focus Groups to Assess Program's Cultural Competence

This survey language may not be applicable to all programs and age groups. Please adjust to be culturally sensitive to

Community Focus Group Discussion Questions

Program Name:_____ Date: _____

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1) Is the community familiar with the program?

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 because of the services they receive?

4) Does this program offer a culturally welcoming, comfortable setting to be in?

5) Is this program sensitive to the community member's needs?

6) What are some things we can improve about our program?

7) What are some obstacles that people may have when trying to access services in this program?

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 important part of the community?

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* The Blueprint - Think Cultural Health (hhs.gov)

Context for the Development and Evaluation of Cultural Competences

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 publicly 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 Ponterrotto, 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* (ICCQ: Roberson, Kulik, & Pepper, 2002)
  - *Cultural incidents in the University Classroom Vignettes* (Henderson, Horton, Saito, Shorter-Gooden (in press).

Suggestions for Supplemental Cultural Competence Training

The following list of suggestions is a supplement to the core list of trainings, webinars, and classes offered through LMS, BHS, and the Academy of Professional Excellence Professional Trainings

The suggestions are not comprehensive and are designed to offer you additional options in meeting the annual cultural competence training requirement.

The *Supplemental Cultural Competence Training Evaluation Form* must be completed as part of the requirement if you choose this method of meeting the cultural competence training requirement. The completed form should be kept on file for future reference.

Note: *It is important to avoid stereotypes and assumptions regarding any cultural values based on the suggestions listed below.*

SUPPLEMENTAL CULTURAL COMPETENCE TRAINING

FICTIONAL BOOKS	NON-FICTIONAL BOOKS	MOVIES	MOVIES
Behold the Dreamers by Imbolo Mbue	A Different Mirror: A History of Multicultural America by Ronald Takaki	12 Angry Men (1957)	Gun Hill Road (2011)
Chasing Freedom: The Life Journeys of Harriet Tubmanand Susan B. Anthony by Nikki Grimes (based on true story)	A Piece of Cake: A Memoir by Cupcake Brown	13th (2016, documentary)	In America (2002)
Citizen: An American Lyric by Claudia Rankine	Allah Made Us: Sexual Outlaws in an Islamic African City by Rudolf Pell Gaudio	4 Little Girls (1998,documentary)	Pumpkin (2002)
I'm Not Dying with You Tonight by Kimberly Jones and Gilly Segal	Always My Child: A Parent's Guide to Understanding your Gay, Lesbian, Bisexual, Transgendered, or Questioning Child by Kevin Jennings	American East (2007)	Rabbit Proof Fence(2002)
Little Bee by Chris Cleave	Assessing and Treating Culturally Diverse Clients: A Practical Guide, 4th Edition by Freddy A. Paniagua	American Violet (2008)	Real Boy (2016)
The Kite Runner by Khaled Hosseini	Between the World and Me by Ta-Nehisi Coates	Amreeka (2009)	Real Women Have Curves (2002)
A Thousand Splendid Suns by Khaled Hosseini	A Map Is Only One Story by Nicole Chung and Mensah Demary	Bordertown (2016, TV series) Brother Outsider: The Life of Bayard Rustin (2003)	Scissors (2002)
Life of Pi by Yann Martel	Twisted by Emma Dabiri	Antwone Fisher (2002)	Smoke Signals (1998)
Native Son by Richard Wright	Heavy: An American Memoir by Kiese Laymon	La Misma Luna/Under the Moon (2007)	The Namesake (2003)
The Amazing Adventures of Kavalier & Clay by Michael Chabon	How to Be An Antiracist by Ibram X. Kendi	Milk (2008)	Thunderheart (1992)
The Bluest Eye by Toni Morrison	I Am Jazz by Jazz Jennings	Moonlight (2016)	What's Cooking (2000)
The Hate U Give by Angie Thomas	I Know Why the Caged Bird Sings by Maya Angelou	My name is Khan (2010)	Rustin (2023)
Their Eyes Were Watching God by Zora Neale Hurston	I'm Still Here: Black Dignity in a World Made for Whiteness by Austin Channing Brown	Not Without My Daughter (1991)	Barbie (2023)

SUPPLEMENTAL CULTURAL COMPETENCE TRAINING

FICTIONAL BOOKS

The Joy Luck Club by Amy Tan

Down and Rising by Rohith S. Katbamna

The Color Purple by Alice Walker

NON-FICTIONAL BOOKS

Bloods: An Oral History of the Vietnam War by Black Veterans by Wallace Terry

Covering: The Hidden Assaulton Our Civil Rights by Kenji Yoshino

Eloquent Rage: A Black Feminist Discovers Her Superpower by Brittney Cooper

Fun Home: A Family Tragicomic by Alison Bechdel

LGBTQ: The Survival Guide for Queer and Questioning Teens by Kelly Huegel

God-Level Knowledge Darts by Desus Mero

Sigh, Gone by Phuc Tran

My Vanishing Country by Bakari Sellers

The Bisexual Option by Fritz Klein

NON-FICTIONAL BOOKS

In My Shoes: A Memoir by Tamara Mellon

Just Mercy by Bryan Stevenson

Middlesex by Jeffrey Eugenides

My Gender Workbook by Kate Bornstein

On Edge: A Journey Through Anxiety by Andrea Petersen

Redefining Realness: My Path to Womanhood, Identity, Love & So Much More by Janet Mock

So You Want to Talk About Race by Ijeoma Oluo

The Big Sort: Why the Clustering of Like- Minded America is Tearing Us Apart by Bill Bishop

Black Feminist Thought: Knowledge, Consciousness and the Politics of Empowerment by Patricia Hill Collins

The Fire Next Time by James Baldwin

The Life and Times of Frederick Douglass
by Frederick Douglass

The New Jim Crow: Mass Incarceration in the Age of Colorblindness by Michelle Alexander

The Night by Elie Weisel

MOVIES

Once Were Warriors (1994)

Powwow Highway (1989)

Invisible Children (2006)

Chasing Freedom(2004)
City of Joy (1992)

Crash (2004)

Dead Presidents (1995)

Dreamkeeper (2003, TV series)

Eat Drink Man Woman (1994)

For the BibleTells Me So (2007)

God Grew Tired of Us (2006, documentary)

Hidden Figures(2016)

The Year We Thought About Love (2015)

The Danish Girl (2015)

VIDEOS & AUDIOS

http://fenwayhealth.org/the-fenway-institute/publications-presentations/

https://www.hrsa.gov/culturalcompetence/index.html

http://xculture.org/resources/general-resource-guides/cultural-competence-resources/

http://www.npr.org/podcasts/510317/its-been-a-minute-with-sam-sanders

http://www.netflix.com/blacklivesmatter

https://tubitv.com/category/black_cinema

ACADEMICS/ PEER-REVIEWED JOURNALS

Conner, K.O., et al (2010). Mental health treatment seeking among older adults with depression: The impact of stigma and race. The American Journal of Geriatric Psychiatry, 18(6), 531-543.

Malgady, R.G., et al. (1987). Ethnocultural and linguistic bias in mental health evaluation of Hispanics. American Psychologist, 42(3), 228-234.

Saha, S., et al. (2008).Patient centeredness, cultural competence and healthcare quality. Journal of the National Medical Association, 100(11), 1275-1285.

Wurth, K. & Schuster,S. (2017). Some of them shut the door with a singleword, but she was different. A migrant patient's culture, a physician's narrative humility and a researcher's bias. Patient Education and Counseling, 100(9), 1772-1773.

Cultural Competence Training Evaluation Form

The purpose of this checklist is to facilitate a method of tracking cultural competence training that utilizes complementary or adjunct learning courses/materials/activities. This is aligned with the Staffing Requirements of the Organizational Provider Operations Handbook (Mental Health Services): *Require that at a minimum, all provider staff, including support staff dealing with clients or anyone who provides interpreter services, must participate in at least four (4) hours of cultural competence training per year. Training may include but isn't limited to: attending lectures, written coursework, web training, attending a conference, reading a book/article, or watching a movie/online video. These items can count toward the overall cultural competence enhancement. A record of annual minimum four hours of training shall be maintained at the program site.*

Prior to approval of learning event/activity supervisors should make sure the training will result in staff being able to answer the listed questions. Following the training, staff should be able to discuss the questions listed with their supervisor and/or additional staff.

1. How was your worldview impacted by this learning event?

Worldview: The overall way one sees and interprets the world, including one's understanding of self and others.

2. How will you change your work practice as a result of this learning event?

Participant Name _____

Course/Material/Activity _____

_____

_____

Participant Prepare an oral presentation (up to 20 minutes) of the course/material/activity to the supervisor addressing:

- ☑ An 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
- ☑ Effects of inter- and intra- cultural differences, overt/covert racism, generational and gender differences, stereotypes and myths

It is encouraged for the participant to present to other program staff.

Supervisor Did the participant:

- ☑ Address the need to assess individuals and families based upon a psychosocial/cultural/political/ spiritual perspective
- ☑ Identify experiences, perceptions and biases of the culture
- ☑ Address the need to understand and accept cultural differences when working with clients/customers
- ☑ Articulate culturally appropriate responses that are consistent with cultural norms

Supervisor to discuss with participant How do the following help improve cultural sensitivity?

- ☑ Identifying and utilizing community resources on behalf of the client
- ☑ Providing services with understanding of cultural differences
- ☑ Advocating - reducing racism, stereotypes and myths

To be completed by the Supervisor:

Signature confirms that the items listed above were discussed with the participant.

Credited number of cultural competence training hours _____ (max of 4 hours) Fiscal Year _____

Approved by (signature) _____ Date _____

Print Name _____

Revised 8/3/2012

Resources

Implementation of CLAS Standards

Think Cultural Health, Office of Minority Health, US Department of Health & Human Services
An Implementation Checklist for the National CLAS Standards (hhs.gov)
National CLAS Standards (hhs.gov)

Cultural and Linguistic Competence Policy Assessment

National Center for Cultural Competence, Georgetown University, Center for Child and Human Development
NCCC | Self-Assessments (georgetown.edu)

Cultural Humility Toolkit

Division of Equity and Inclusion, University of Oregon
Cultural Humility Toolkit | Equity and Inclusion (uoregon.edu)

Cultural Humility

Division of Equity and Inclusion, University of Oregon,
What is Cultural Humility? The Basics | Equity and Inclusion (uoregon.edu)

Recovery U: Diversity and Cultural Humility Learning Model

Division of Equity and Inclusion, University of Oregon,
RecoveryU: Diversity & Cultural Humility (wisc.edu)

Conversations About Culture: Video and Lesson Plan

School of Social Work, University of Buffalo
Conversations About Culture: Video and Lesson Plan - University at Buffalo School of Social Work - University at Buffalo

Self-Assessment Tool on Diversity & Inclusion-DIGNA

Diversity & Inclusion Group for Networking and Action, CIVICUS
DIGNA (civicus.org)

Test Yourself For Hidden Bias

Test Your Self For Hidden Bias, Learning for Justice
Test Yourself for Hidden Bias | Learning for Justice

Distinguishing Cultural Humility from Cultural Competence

Distinguishing Cultural Humility from Cultural Competence, Division of Equity and Inclusion, University of Oregon
Distinguishing Cultural Humility from Cultural Competence | Equity and Inclusion (uoregon.edu)

SDCBHS Resources

Cultural Competence Plan 2023
Cultural Competency Plan FY 22-23 Final 6.30.23 PDF.pdf (sandiegocounty.gov)

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)
TABLE OF CONTENTS (optumsandiego.com)

SDCBHS Contracted Trainings, BHS Workforce Education and Training
https://www.sandiegocounty.gov/content/sdc/hhsa/programs/bhs/workforce.html

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)
Progress Towards Reducing Disparities in Mental Health Services (sandiegocounty.gov)

City of San Diego

2020 Disparity Study, BBC Research & Consulting, City of San Diego
city_of_san_diego_disparity_study_report_-_final.pdf (sandiego.gov)
Disparity Study | City of San Diego Official Website

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=lPftosmseYE

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

Edwall, G.E. (2012, Spring). Intervening during childhood and adolescence to prevent mental, emotional, and behavioral disorders. *The Register Report*, 38, 8-15.

Felitti V. & Anda, R., (2010). The relationship of adverse childhood experiences to adult medical disease, psychiatric disorders, and sexual behavior: Implications for healthcare, In R. Lanius and E. Vermetten, Eds., *The Hidden Epidemic: The Impact of Early Life Trauma on Health and Disease*. Cambridge University Press. 2010.

Finch, R. A. & Phillips, K. (2005). An employer's guide to behavioral health services. Washington, DC: National Business Group on Health/Center for Prevention and Health Services. www.businessgrouphealth.org/publications/index.cfm

Substance Abuse and Mental Health Services Administration (2011). *Helping Children and Youth Who Have Experienced Traumatic Events.* HHS Publication No. SMA-11-4642.

Substance Abuse and Mental Health Services Administration & National Association of State Mental Health Program Directors. (2004). *The damaging consequences of violence and trauma.* 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 Pres