Cultural Competence Handbook

County of San Diego Behavioral Health Services
October 2019

COUNTY OF SAN DIEGO
HHSA
HEALTH AND HUMAN SERVICES AGENCY

LIVE WELL
SAN DIEGO

Document Prepared by:

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Quality Improvement Unit
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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.

	2010 United States Census Data	2010 San Diego County Census Data	FY 2017-18 Behavioral Health Services
White	231,040,398 (74.8%)	1,981,442 (64.0%)	26,453 (37.7%)
Hispanic	50,477,594 (16.4%)	991,348 (32.0%)	23,010 (32.8%)
African American	42,020,743 (13.6%)	158,213 (5.1%)	8,038 (11.4%)
Asian/Pacific Islander	17,320,856 (5.6%)	351,428 (11.4%)	3,092 (4.4%)
Native American	5,220,579 (1.7%)	26,340 (0.9%)	550 (0.8%)
LGBTQ+	9,083,558* (2.9%)	300,000** (9.6%)	2,988† (4.3%)
Veterans	26,403,703 (8.5%)	292,034 (9.4%)	2,220 (3.2%)
Age 0-17	74,181,467 (24.0%)	821,263 (26.5%)	15,664 (22.3%)
Age 18-24	30,672,088 (9.9%)	270,750 (8.8%)	10,534*** (15.0%)
Age 25-59	146,806,075 (47.6%)	1,502,564 (49.0%)	37,544*** (53.4%)
Age 60+	57,085,908 (18.5%)	500,736 (16.2%)	6,513 (9.3%)
For additional information on BHS client demographics, visit the BHS Technical Resource Library at http://www.sdcounty.ca.gov/hhsa/programs/bhs/mental_health_services_act/technical_resource_library.html			

**The information on adult LGBTQ+ population in the US was obtained from The Williams Institute, UCLA School of Law.*
***This number is approximate based on the information from Behavioral Health Education and Training Academy*
Note: the percentages are based on the total 2010 US population (308,745,538), 2010 San Diego County (3,095, 313) population, and FY 2017-18 BHS client population (60,106).
****The BHS client age groups are 18-25 and 26-59.*
†This number only includes clients in mental health services.

On July 13, 2010, the County Board of Supervisors took a big step forward in public health policy by adopting an innovative 10-year strategy to improve health in the region, that later became *Live Well San Diego*. This strategy aims to improve the health and well-being of County residents through four key pillars: 1) Building a Better Service Delivery System, 2) Supporting Positive Healthy Choices, 3) Pursuing Policy and Environmental Changes, and 4) Improving the Culture from Within County Government.

In alignment with *Live Well San Diego*, the HHSA Behavioral Health Services (BHS) 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. BHS 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. 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 BHS, providers and community partners can contribute towards the County's vision for a safe, mentally healthy and addiction-free San Diego.

County of San Diego, Health and Human Services Agency

Vision:

Healthy, Safe, and Thriving San Diego Communities

Mission:

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

Strategy:

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

Behavioral Health Services

Vision:

Safe, mentally healthy, addiction-free communities

Mission:

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

Guiding Principles:

1. To foster continuous improvement to maximize efficiency and effectiveness of services.
2. To support activities designed to reduce stigma and raise awareness surrounding mental health, alcohol and other drug problems.
3. To maintain fiscal integrity.
4. To ensure services are: outcome-driven; culturally competent; recovery and client/family centered; innovative and creative; and trauma-informed.
5. To assist County employees to reach their full potential.

The Importance of Cultural Competence

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

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

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

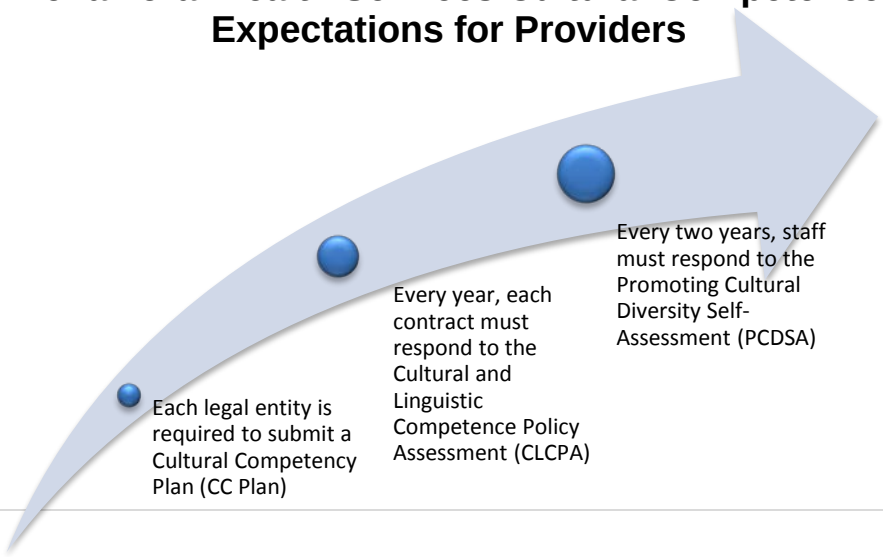
For more details, visit https://nccc.georgetown.edu/foundations/need.php.

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.

Behavioral Health Services Cultural Competence Expectations for Providers



Cultural Competence 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*	
Annual	Cultural and Linguistic Competence Policy Assessment (CLCPA)	*February 2019* *February 2020* *February 2021*	
Biennial	Promoting Cultural Diversity Self-Assessment (PCDSA)	*October 2020* *October 2022*	

Cultural Competence 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 and SUD) April 2015 (MHS and SUD) April 2016 (MHS and SUD)	October 2011 (MHS only) October 2013 (MHS & SUD) October 2015 (MHS & SUD)	April 2012 (MHS) December 2014 (SUD) September 2019 (MHS & SUD)
Cultural and Linguistic Competence Policy Assessment (CLCPA)	**Promoting Cultural Diversity Self-Assessment (PCDSA)**	
October 2017 (MHS and SUD) February 2019 (MHS and SUD)	October 2018 (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 www.thinkculturalhealth.hhs.gov/clas.

Cultural Competence Plan

An outline for the development of a Cultural Competence Plan

Cultural Competence Plan Development Guidelines

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

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

The two checklists on pages 13-15 may serve as a resource for incorporating Cultural Competence Plan components and the CLAS Standards into your policies and procedures. **It is provided for reference only**.

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

Example answer for the development checklist:

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:	
Client outcomes are meaningful to client's social ecological needs.	☐		☒	Client Focus Group	Dec 13	Part of client-focused initiative.

Cultural Competence Plan Development Checklist

SDCBHS recommends the use of this tool

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

Cultural Competence Plan Development Checklist

SDCBHS recommends the use of this tool

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 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.	☐		☐			

Continued on next page.

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:	
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.	☐		☐			

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.

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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

Cultural and Linguistic Competence Policy Assessment

CLCPA

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The Cultural and Linguistic Competence Policy Assessment (CLCPA) was developed by Georgetown University at the request of the Bureau of Primary Health Care (BPHC), Health Resources and Services Administration (HRSA), and the US Department of Health and Human Services (DHHS). The goal of 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. The Assessment is aligned with the National Culturally and Linguistically Appropriate Services (CLAS) Standards.

Before you begin, please identify main cultural groups that your program serves predominantly. Do not limit your groups to solely ethnic cultures. Your groups may be, but are not limited to: LGBTQI, veterans, older adults, Hispanics, African Americans, TAY, homeless, etc. Once you have identified the groups, please refer to them as you answer the CLCPA questions.

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.

1. Is your organization able to identify the culturally diverse communities in your service area?

- ○ Not at all
- ○ Barely
- ○ Somewhat
- ○ Fairly well
- ○ Very well

2. Does your organization's Cultural Competence Plan identify and support the CLAS Standards?

- ○ Yes
- ○ No

3. Is your organization familiar with current and projected demographics for your service area?

- ◯ Not at all
- ◯ Barely
- ◯ Somewhat
- ◯ Fairly well
- ◯ Very well

4. Is your organization able to describe the social strengths (e.g., support networks, family ties, spiritual leadership, etc.) of diverse cultural groups in your service area?

- ◯ Not at all
- ◯ Barely
- ◯ Somewhat
- ◯ Fairly well
- ◯ Very well

5. Is your organization able to describe the social problems (e.g., dispersed families, poverty, unsafe housing, etc.) of diverse cultural groups in your service area?

- ◯ Not at all
- ◯ Barely
- ◯ Somewhat
- ◯ Fairly well
- ◯ Very well

6. Is your organization familiar with health disparities among culturally diverse groups in your service area?

- ◯ Not at all
- ◯ Barely
- ◯ Somewhat
- ◯ Fairly well
- ◯ Very well

7. Is your organization able to identify the languages and dialects used by culturally diverse groups in your service area?

- ◯ Not at all
- ◯ Barely
- ◯ Somewhat
- ◯ Fairly well
- ◯ Very well

8. For the culturally diverse groups in your service area, is your organization familiar with:

The health beliefs, customs, and values?	◯ Not at all	◯ Barely	◯ Somewhat	◯ Fairly well	◯ Very well
The natural networks of support?	◯ Not at all	◯ Barely	◯ Somewhat	◯ Fairly well	◯ Very well

9. For the culturally diverse groups in your service area, can your organization identify:

Help-seeking practices?	◯ Not at all	◯ Barely	◯ Somewhat	◯ Fairly well	◯ Very well
The way illness and health are viewed?	◯ Not at all	◯ Barely	◯ Somewhat	◯ Fairly well	◯ Very well
The way mental health is perceived?	◯ Not at all	◯ Barely	◯ Somewhat	◯ Fairly well	◯ Very well

If you need technical assistance with becoming more familiar with the items in Section 1, please indicate the specific topics (e.g., organizational policy, Cultural Competence Plan, cultural groups in the service area, CLAS Standards, etc).

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.

10. Does your organization have a mission statement that incorporates cultural and linguistic competence in service delivery?

- ◯ Yes
- ◯ No

11. Does your organization support a practice model that incorporates culture in the delivery of services?

- ◯ Not at all
- ◯ Sometimes
- ◯ Often
- ◯ Most of the time
- ◯ All the time

12. Does your organization consider cultural and linguistic differences in developing quality improvement processes?

- ◯ Not at all
- ◯ Sometimes
- ◯ Often
- ◯ Most of the time
- ◯ All the time

13. Does your organization advocate for culturally diverse participants regarding quality of life issues (e.g., employment, housing, education) in your service area?

- ◯ Not at all
- ◯ Sometimes
- ◯ Often
- ◯ Most of the time
- ◯ All the time

14. Does your organization systematically review procedures to ensure that they are relevant to delivery of CULTURALLY competent services?

- ◯ Not at all
- ◯ Sometimes
- ◯ Often
- ◯ Most of the time
- ◯ All the time

15. Does your organization systematically review procedures to ensure that they are relevant to LINGUISTICALLY competent services?

- ◯ Not at all
- ◯ Sometimes
- ◯ Often
- ◯ Most of the time
- ◯ All the time

16. Does your organization help participants get the support they need (e.g., flexible service schedules, childcare, transportation, etc.) to access services?

- ◯ Not at all
- ◯ Sometimes
- ◯ Often
- ◯ Most of the time
- ◯ All the time

17. Are there structures in your program to assure for participant and community participation in:

Program planning?	◯ Not at all	◯ Sometimes	◯ Often	◯ Most of the time	◯ All the time
Service delivery?	◯ Not at all	◯ Sometimes	◯ Often	◯ Most of the time	◯ All the time
Evaluation of services?	◯ Not at all	◯ Sometimes	◯ Often	◯ Most of the time	◯ All the time
Quality improvement?	◯ Not at all	◯ Sometimes	◯ Often	◯ Most of the time	◯ All the time
Customer satisfaction?	◯ Not at all	◯ Sometimes	◯ Often	◯ Most of the time	◯ All the time

18. Does your work environment contain decor reflecting the culturally diverse groups in your service area?

- ◯ None of the decor reflects the culturally diverse groups.
- ◯ Yes, but very little decor reflect culturally diverse groups.
- ◯ Yes, some deco reflects culturally diverse groups.
- ◯ Yes, all done reflects culturally diverse groups.

19. Does your organization post signs and materials in languages other than English?

- ◯ No, only in English
- ◯ Yes, between 1 and 3 other languages
- ◯ Yes, four or more other languages

If you need technical assistance with becoming more familiar with the items in Section 2, please indicate the specific topics (e.g., CLAS Standards, quality improvement processes, beneficiary materials, etc).

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.

20. Does your organization identify opportunities within culturally diverse communities for staff to:

Attend formal cultural or ceremonial functions?	◯ Not at all	◯ Sometimes	◯ Often	◯ Most of the time	◯ All the time
Purchase goods or services from a variety of merchants (either for personal use or job-related activities)?	◯ Not at all	◯ Sometimes	◯ Often	◯ Most of the time	◯ All the time
Subcontract for services from a variety of vendors?	◯ Not at all	◯ Sometimes	◯ Often	◯ Most of the time	◯ All the time
Participate in informal recreational or leisure time activities?	◯ Not at all	◯ Sometimes	◯ Often	◯ Most of the time	◯ All the time
Participate in community education activities?	◯ All the time	◯ Not at all	◯ Sometimes	◯ Often	◯ Most of the time

21. Does your organization identify opportunities for staff to share with colleagues their experiences and knowledge about diverse communities?

◯ Not at all
◯ Sometimes
◯ Often
◯ Most of the time
◯ All the time

If you need technical assistance with becoming more familiar with the items in Section 3, please indicate the specific topics (e.g., CLAS Standards, community events, culturally diverse educational activities, etc).

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.

22. Does your organization collaborate with community-based organizations to address the health and mental health related needs of the culturally and linguistically diverse groups in the service area?

- ◯ Not at all
- ◯ Sometimes
- ◯ Often
- ◯ Most of the time
- ◯ All the time

23. Does your organization work with social or professional contacts (e.g., cultural brokers, liaisons, cultural stakeholders) who help understand health and mental health beliefs and practices of culturally and linguistically diverse groups in the service area?

- ◯ Not at all
- ◯ Sometimes
- ◯ Often
- ◯ Most of the time
- ◯ All the time

24. Does your organization establish formal relationships with these professionals and/or organizations to assist in serving culturally and linguistically diverse groups?

- ◯ Not at all
- ◯ Sometimes
- ◯ Often
- ◯ Most of the time
- ◯ All the time

25. Does your organization use resource materials (including communication technologies) that are culturally and linguistically appropriate to inform diverse groups about whole person wellness?

- ◯ Not at all
- ◯ Sometimes
- ◯ Often

◯ Most of the time

◯ All the time

If you need technical assistance with becoming more familiar with the items in Section 4, please indicate the specific topics (e.g., community resources, CLAS Standards, whole person wellness, etc).

Section 5: Human Resources

This section focuses on the organization's ability to sustain a diverse workforce that is culturally and linguistically competent.

26. Are members of the culturally diverse groups you identified at the beginning of the survey represented on the staff of your organization?

- ◯ No, none of the identified culturally diverse groups are represented.
- ◯ Only some groups are represented.
- ◯ Most groups are represented.
- ◯ The staff is fully representative of the identified culturally diverse groups

27. Does your organization have culturally and linguistically diverse individuals as:

Board members?	◯ None	◯ Very few	◯ Some	◯ Most	◯ All	◯ Not applicable
Program directors?	◯ None	◯ Very few	◯ Some	◯ Most	◯ All	◯ Not applicable
Executive management?	◯ None	◯ Very few	◯ Some	◯ Most	◯ All	◯ Not applicable
Physicians/psychiatrists?	◯ None	◯ Very few	◯ Some	◯ Most	◯ All	◯ Not applicable
Clinical staff?	◯ None	◯ Very few	◯ Some	◯ Most	◯ All	◯ Not applicable
Administrative staff?	◯ None	◯ Very few	◯ Some	◯ Most	◯ All	◯ Not applicable
Clerical staff?	◯ None	◯ Very few	◯ Some	◯ Most	◯ All	◯ Not applicable
Support staff?	◯ None	◯ Very few	◯ Some	◯ Most	◯ All	◯ Not applicable
Peer Support Specialists?	◯ None	◯ Very few	◯ Some	◯ Most	◯ All	◯ Not applicable
Volunteers/students?	◯ None	◯ Very few	◯ Some	◯ Most	◯ All	◯ Not applicable

28. Does your organization have incentives for the improvement of CULTURAL competence throughout the organization?

- ◯ None
- ◯ Very few
- ◯ Some
- ◯ Many

29. Does your organization have incentives for the improvement of LINGUISTIC competence throughout the organization?

- ◯ None
- ◯ Very few
- ◯ Some
- ◯ Many

30. Does your organization have procedures to achieve the goal of a culturally and linguistically competent workforce that includes:

Staff recruitment?	◯ Yes	◯ The agency is in the process of developing the procedures	◯ No
Hiring?	◯ Yes	◯ The agency is in the process of developing the procedures	◯ No
Retention?	◯ Yes	◯ The agency is in the process of developing the procedures	◯ No
Promotion?	◯ Yes	◯ The agency is in the process of developing the procedures	◯ No

31. Are there resources to support regularly scheduled professional development and in-service training for staff at all levels of the organization?

- ◯ None
- ◯ Very few
- ◯ Some
- ◯ Many

32. Are in-service training activities on CULTURALLY competent services (e.g., values, principles, practices, and procedures) conducted for staff at all levels of the organization?

- ◯ None
- ◯ Very few
- ◯ Some
- ◯ Many

33. Are in-service training activities on LINGUISTICALLY competent services (e.g., Title VI, CLAS Standards, ADA mandates) conducted for staff at all levels of the organization?

- ◯ None
- ◯ Very few

◯ Some
◯ Many

If you need technical assistance with becoming more familiar with the items in Section 5, please indicate the specific topics (e.g., CLAS Standards, workforce diversity, etc).

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 (specifically, assessment/diagnosis, interpretation/translation services and use of community-based resources).

34. Does your organization use health assessment or diagnostic protocols that are adapted for culturally diverse groups?

- ◯ Never
- ◯ Seldom
- ◯ Sometimes
- ◯ Regularly
- ◯ Not applicable

35. Does your organization use health promotion, disease prevention, engagement, retention and treatment protocols that are adapted for culturally diverse groups?

- ◯ Never
- ◯ Seldom
- ◯ Sometimes
- ◯ Regularly
- ◯ Not applicable

36. Does your organization connect consumers to natural networks of support to assist with health and mental health care?

- ◯ Never
- ◯ Seldom
- ◯ Sometimes
- ◯ Regularly
- ◯ Not applicable

37. Does your organization differentiate between racial and cultural identity when serving diverse consumers?

- ◯ Never
- ◯ Seldom
- ◯ Sometimes

◯ Regularly

◯ Not applicable

If you need technical assistance with becoming more familiar with the items in Section 6, please indicate the specific topics (e.g., culturally diverse assessments, CLAS Standards, etc).

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 5 through 8.

38. Does your organization inform consumers of their rights to language access services under Title VI of the Civil Rights Act of 1964 - Prohibition Against National Origin Discrimination and as required by the CLAS Standards 5-8 for language access?

- ◯ Never
- ◯ Seldom
- ◯ Sometimes
- ◯ Regularly
- ◯ Not applicable

39. Does your organization use either of the following personnel to provide interpretation services?

Certified medical interpreters?	◯ Never	◯ Seldom	◯ Sometimes	◯ Regularly
Trained medical interpreters?	◯ Never	◯ Seldom	◯ Sometimes	◯ Regularly
Sign language interpreters?	◯ Never	◯ Seldom	◯ Sometimes	◯ Regularly

40. Does your organization:

Translate and use patient consent forms, educational materials, and other information in other languages?	◯ Never	◯ Seldom	◯ Sometimes	◯ Regularly
Ensure materials address the literacy needs of the consumer population?	◯ Never	◯ Seldom	◯ Sometimes	◯ Regularly
Assess the health literacy of consumers?	◯ Never	◯ Seldom	◯ Sometimes	◯ Regularly
Employ specific interventions based on the health literacy levels of consumers?	◯ Never	◯ Seldom	◯ Sometimes	◯ Regularly

41. Does your organization evaluate the quality and effectiveness of interpretation and translation services it either contracts for or provides?

- ◯ Never
- ◯ Seldom

◯ Sometimes

◯ Regularly

If you need technical assistance with becoming more familiar with the items in Section 7, please indicate the specific topics (e.g., CLAS Standards, beneficiary materials, interpretation resources, etc).

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.

42. Does your organization conduct activities tailored to engage culturally diverse communities?
Please reference the culturally diverse groups you identified at the beginning of this survey.

- ◯ Never
- ◯ Seldom
- ◯ Sometimes
- ◯ Regularly

43. What types of activities does your organization conduct that are tailored to engage culturally diverse communities?
Please provide at least one example and specify the cultural group that the activity/activities is/are tailored to.

44. Do organization brochures and other media reflect cultural groups in the service area?

- ◯ Never
- ◯ Seldom
- ◯ Sometimes
- ◯ Regularly

45. Does your organization reach out to and engage the following individuals, groups, or entities in whole person wellness, mental health promotion, and disease prevention initiatives:

A. Places of worship or spiritual wellness, and clergy, ministerial alliances, or indigenous religious or spiritual leaders?	◯ Never	◯ Seldom	◯ Sometimes	◯ Regularly
B. Traditional healers (e.g., medicine men or women, curanderas, espiritistas, promotoras, or herbalists)?	◯ Never	◯ Seldom	◯ Sometimes	◯ Regularly

C. Primary care providers, dentists, chiropractors, or licensed midwives?	◯Never ◯Seldom ◯Sometimes ◯Regularly
D. Providers of complementary and alternative medicine (e.g., homeopaths, acupuncturists, death doulas, or lay midwives)?	◯Never ◯Seldom ◯Sometimes ◯Regularly
E. Ethnic/cultural publishers, radio, cable, or television stations or personalities, or other ethnic media sources?	◯Never ◯Seldom ◯Sometimes ◯Regularly
F. Human service agencies?	◯Never ◯Seldom ◯Sometimes ◯Regularly
G. Tribal, cultural, or recovery advocacy organizations?	◯Never ◯Seldom ◯Sometimes ◯Regularly
H. Local business owners such as barbers/cosmetologists, sports clubs, casinos, salons, and other ethnic/cultural businesses?	◯Never ◯Seldom ◯Sometimes ◯Regularly
I. Social/cultural organizations (e.g., civic/neighborhood associations, sororities, fraternities, ethnic/cultural associations)?	◯Never ◯Seldom ◯Sometimes ◯Regularly

If you need technical assistance with becoming more familiar with the items in Section 8, please indicate the specific topics (e.g., community engagement, CLAS Standards, culturally diverse activities, etc).

Program and Respondent Information

Program name:

What is your program type?

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

Contract number:
You may have more than one. Please complete ONE survey for EACH contract.

What is your program's legal entity?

What role best describes you at your program?

- ◯ Program Director
- ◯ Program Manager
- ◯ Direct/Indirect Services Staff
- ◯ Other

Primary clients at your program:
Please check all that apply.

- ☐ Children and youth
- ☐ Transition Age Youth (TAY)
- ☐ Adults
- ☐ Older adults
- ☐ Other

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Promoting Cultural Diversity Self-Assessment

PCDSA

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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 occasionally
- ◯ 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 occasionally
- ◯ 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 occasionally
- ◯ 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

Suggested process for certifying language competence

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

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

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

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Survey for Clients to Assess a Program's Cultural Competence

Program Name: _____ Date: _____

==========

Client Demographics:

Age: _____

Race/Ethnicity: ☐ Hispanic ☐ African American ☐ White ☐ Native American
☐ Asian/Pacific Islander ☐ Other: _____

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

Please rate this program on the following items:

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Not Applicable
1. In the last six months, the staff listened to me and my family when we talked to them.	☐	☐	☐	☐	☐	☐
2. The services I received here in the last six months really 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 six months, the staff made an effort to understand the experiences and challenges I once experienced.	☐	☐	☐	☐	☐	☐

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Not Applicable
4. The waiting room and/or facility have images or displays that represent people from my cultural group.	☐	☐	☐	☐	☐	☐
5. In the last six months, the staff respected and supported my cultural and religious beliefs.	☐	☐	☐	☐	☐	☐
6. In the last six 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.	☐	☐	☐	☐	☐	☐
7. In the last six 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 six months, there were translators or interpreters easily available to assist me and/or my family if we needed it.	☐	☐	☐	☐	☐	☐
10. In the last six months, the staff made an effort to understand my traditional medicinal practices.	☐	☐	☐	☐	☐	☐

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

Suggested discussion questions for client focus groups to assess the program's cultural competence

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

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?
Examples include, but are not limited to: audio tape, CD, VHS Tape, DVD, etc.

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 societal framework in your preferred language?

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

8) Are clinical staff knowledgeable about how to make culturally appropriate referrals?

9) If you see a program psychiatrist, is s/he familiar with your cultural beliefs surrounding mental illness?

10) If you see a program psychiatrist, has s/he asked about any trauma and or adversity in your past?

11) 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?

Discussion Questions for Community Focus Groups on Program's Cultural Competence

Suggested discussion questions for community focus groups to assess the 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.

Community Focus Group Discussion Questions

Program Name: _____ Date: _____

==========

1) Is this program known within the community?

2) Does the community feel that the services provided by this program are needed?

3) Does the community believe that people who come here for mental health services improve and feel better as a result of the services they receive?

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

5) Is this program trauma informed?

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

7) What are the barriers that people have to coming to this program to receive services?

8) Would you recommend a friend or family to seek services here if they were needed?

9) What else can we do to become an integral part of the community?

Resources

CLAS Standards

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

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

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

Principal Standard:

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

Governance, Leadership, and Workforce:

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.

3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.

4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance:

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.

6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.

7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.

8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement, and Accountability:

9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.

10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.

11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.

12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.

13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.

14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.

15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

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

Context for the Development and Evaluation of Cultural 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 publically or by request to the authors.

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

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

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

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

- Multicultural scales:
  - *Multicultural Awareness-Knowledge-and-Skills Survey* (MAKSS; D'Andrea, Daniels, & Heck, 1991)
  - *Multicultural Counseling Inventory* (MCI; Sodowsky, Taffe, Gutkin, & Wise, 1994)
  - *Multicultural Counseling Knowledge and Awareness Scale* (MCKAS; Ponterotto, Gretchen, Utsey, Rieger, & Austin, 2002)
  - *Multicultural teaching competency scale* (Spanierman et al., 2011)

(Please note that reviews and objective statistical testing of these instruments have been conducted by Constantine & Ladany, (2003), Hays (2008), and 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 Responsive Integrated Health Solutions (RIHS) at https://theacademy.sdsu.edu/programs/rihs/ and through The Knowledge Center (TKC)*.

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.

**TKC is available to County staff only.*

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

Fictional Books	
Behold the Dreamers by Imbolo Mbue	Little Bee by Chris Cleave
Chasing Freedom: the Life Journeys of Harriet Tubman and Susan B. Anthony by Nikki Grimes *Based on true story*	Native Son by Richard Wright
Citizen: An American Lyric by Claudia Rankine	The Amazing Adventures of Kavalier & Clay by Michael Chabon

Non-Fictional Books	
A Different Mirror: A History of Multicultural America by Ronald Takaki	Middlesex by Jeffrey Eugenides
A Piece of Cake: A Memoir by Cupcake Brown	My Gender Workbook by Kate Bornstein
Allah Made Us: Sexual Outlaws in an Islamic African City by Rudolf Pell Gaudio	On Edge: A Journey Through Anxiety by Andrea Petersen
Always My Child: A Parent's Guide to Understanding your Gay, Lesbian, Bisexual, Transgendered, or Questioning Child by Kevin Jennings	The Big Sort: Why the Clustering of Like-Minded America is Tearing Us Apart by Bill Bishop
Assessing and Treating Culturally Diverse Clients: A Practical Guide, 4th Edition by Freddy A. Paniagua	The Bisexual Option by Fritz Klein
Between the World and Me by Ta-Nehisi Coates	The Life and Times of Frederick Douglass by Frederick Douglass
Bloods: An Oral History of the Vietnam War by Black Veterans by Wallace Terry	The Night by Elie Weisel
Covering: The Hidden Assault on Our Civil Rights by Kenji Yoshino	The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors, and The Collision of Two Cultures by Anne Fadiman
Fun Home: A Family Tragicomic by Alison Bechdel	Trauma, War, and Violence: Public Mental Health in Socio-Cultural Context (edited by Joop De Jong)

GLBTQ: The Survival Guide for Queer and Questioning Teens by Kelly Huegel	We Should All Be Feminists by Chimamanda Ngozi Adichie
I am Jazz by Jazz Jennings	White Like Me: Reflections on Race from a Privileged Son by Tim Wise
In My Shoes: A Memoir by Tamara Mellon	

Movies	
12 Angry Men (1957)	La Misma Luna/Under the Moon (2007)
13th (2016, documentary)	Milk (2008)
4 Little Girls (1998, documentary)	Moonlight (2016)
American East (2007)	My name is Khan (2010)
American Violet (2008)	Not Without My Daughter (1991)
Amreeka (2009)	Once Were Warriors (1994)
Bordertown (2016, TV series)	Pariah (2011)
Brother Outsider: The Life of Bayard Rustin (2003)	Powwow Highway (1989)
Chasing Freedom (2004)	Pumpkin (2002)
City of Joy (1992)	Rabbit Proof Fence (2002)
Crash (2004)	Real Boy (2016)
Dead Presidents (1995)	Real Women Have Curves (2002)
Dreamkeeper (2003, TV series)	Running with Scissors (2002)
Eat Drink Man Woman (1994)	Smoke Signals (1998)
Fire (1996)	The Danish Girl (2015)
For the Bible Tells Me So (2007)	The Namesake (2003)
God grew Tired of Us (2006, documentary)	The Year We Thought About Love (2015)
Gun Hill Road (2011)	Thunderheart (1992)
Hidden Figures (2016)	What's Cooking (2000)
In America (2002)	

Web-Based Video and Audio Programs

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

Academic/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 single word, 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.

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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 _____

_____

_____

<u>Participant</u> → 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.

<u>Supervisor</u> → 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

<u>Supervisor to discuss with participant</u> → 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

<u>To be completed by the Supervisor</u>:

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 _____

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Additional Resources

Implementation of CLAS Standards

Think Cultural Health, Office of Minority Health, US Department of Health & Human Services
www.thinkculturalhealth.hhs.gov/Content/clas.asp

Cultural and Linguistic Competence Policy Assessment

National Center for Cultural Competence, Georgetown University, Center for Child and Human Development
www.clcpa.info/

SDCBHS Resources

Cultural Competence Plan 2010 and Executive Summary
www.sdcounty.ca.gov/hhsa/programs/bhs/documents/CulturalCompetencePlan2010.pdf

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

Framework for Eliminating Cultural, Linguistic, Racial and Ethnic Behavioral Health Disparities
www.sdcounty.ca.gov/hhsa/programs/bhs/documents/1_C.pdf

Organizational Provider Operations Handbook (section H)
www.sdcounty.ca.gov/hhsa/programs/bhs/documents/Combined_OPOH_010113_Rev_021214.pdf

Progress Towards Reducing Disparities: A Report for San Diego County Mental Health (Eight Year Comparison: FY 2001-2002, FY 2006-2007, and FY 2009-2010)
www.sdcounty.ca.gov/hhsa/programs/bhs/documents/DisparitiesReport110212.pdf

Trauma-Informed Systems and Services

The National Council for Behavioral Health: Trauma Informed Care
www.thenationalcouncil.org/topics/trauma-informed-care/

The Trauma Informed Project
www.traumainformedcareproject.org/

University of North Carolina Family and Children's Resource Program: Trauma and Behavior – How Trauma Affects the Brain
www.youtube.com/watch?v=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

Druss B.G. & Reisinger Walker E. (2011). Mental disorders and medical comorbidity. *Research Synthesis Report*, No. 21. Princeton, NJ: Robert Wood Johnson Foundation.
www.rwjf.org/files/research/71883.mentalhealth.report.pdf

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 Press.