
# Cultural Competence Handbook

County of San Diego Behavioral Health Services

*July 2020*

COUNTY OF SAN DIEGO
HHSA
HEALTH AND HUMAN SERVICES AGENCY

LIVE WELL
SAN DIEGO

Document Prepared by:

**County of San Diego Behavioral Health Services (SDCBHS)**
**Quality Improvement Unit**
**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.

| | 2010 United States Census Data | 2010 San Diego County Census Data | FY 2018-19 Behavioral Health Services |
|---|---|---|---|
| **White** | 231,040,398 (74.8%) | 1,981,442 (64.0%) | 29,320 (39.2%) |
| **Hispanic** | 50,477,594 (16.4%) | 991,348 (32.0%) | 23,939 (32.0%) |
| **African American** | 42,020,743 (13.6%) | 158,213 (5.1%) | 8,460 (11.3%) |
| **Asian/Pacific Islander** | 17,320,856 (5.6%) | 351,428 (11.4%) | 3,183 (4.3%) |
| **Native American** | 5,220,579 (1.7%) | 26,340 (0.9%) | 657 (0.9%) |
| **LGBTQ+** | 9,083,558* (2.9%) | 300,000** (9.6%) | 3,351 (4.5%) |
| **Veterans** | 26,403,703 (8.5%) | 292,034 (9.4%) | 2,259 (3.0%) |
| **Age 0-17** | 74,181,467 (24.0%) | 821,263 (26.5%) | 14,379 (19.2%) |
| **Age 18-24** | 30,672,088 (9.9%) | 270,750 (8.8%) | 10,898*** (14.6%) |
| **Age 25-59** | 146,806,075 (47.6%) | 1,502,564 (49.0%) | 41,602*** (55.6%) |
| **Age 60+** | 57,085,908 (18.5%) | 500,736 (16.2%) | 7,493 (10.0%) |
| *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 Responsive Integrated Health Solutions (RIHS, formerly BHETA)*
*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.*

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.

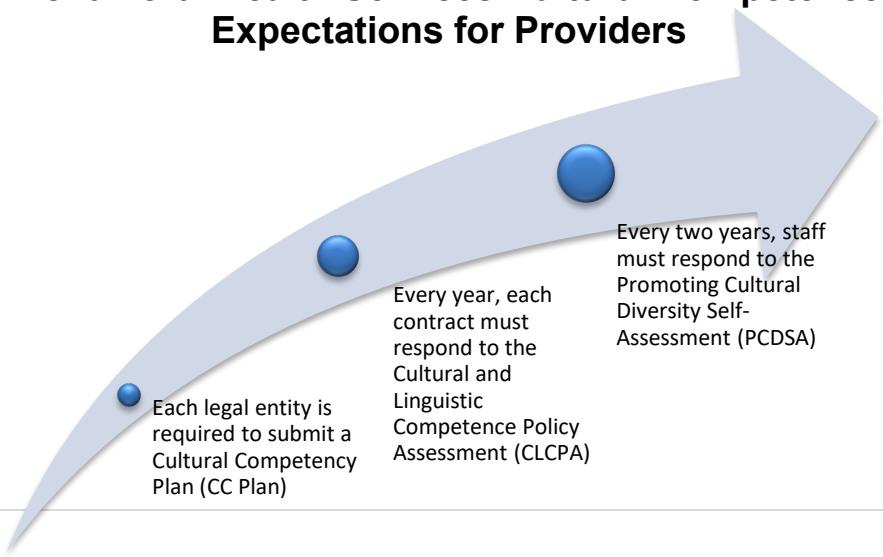
For more details, visit https://nccc.georgetown.edu/foundations/need.php.

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 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*<br><br>*Updates as needed* | |
| Annual | Cultural and Linguistic Competence Policy Assessment (CLCPA) | *February 2019*<br><br>*February 2020*<br><br>*February 2021* | |
| Biennial | Promoting Cultural Diversity Self-Assessment (PCDSA) | *October 2020*<br><br>*October 2022* | |

| Cultural Competence Assessment History | | |
|---|---|---|
| **Cultural Competence Program Annual Self-Evaluation (CC-PAS)** | **California Brief Multicultural Competence Scale (CBMCS)** | **CC Plan** |
| April 2012 (MHS only)<br>April 2013 (MHS only)<br>April 2014 (MHS & SUD)<br>April 2015 (MHS & SUD)<br>April 2016 (MHS & SUD) | October 2011 (MHS only)<br>October 2013 (MHS & SUD)<br>October 2015 (MHS & SUD) | April 2012 (MHS)<br>December 2014 (SUD)<br>September 2019 (MHS & SUD) |
| **Cultural and Linguistic Competence Policy Assessment (CLCPA)** | **Promoting Cultural Diversity Self-Assessment (PCDSA)** | |
| October 2017 (MHS & SUD)<br>February 2019 (MHS & SUD)<br>February 2020 (MHS & 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<br>b) Faith-based services | ☐<br>☐ | | ☐<br>☐ | | | |

# 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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# Promoting Cultural Diversity Self-Assessment

# PCDSA

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# 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](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 | *Native Son* by Richard Wright |
| *Chasing Freedom: The Life Journeys of Harriet Tubman and Susan B. Anthony* by Nikki Grimes (based on true story) | *The Amazing Adventures of Kavalier & Clay* by Michael Chabon |
| *Citizen: An American Lyric* by Claudia Rankine | *The Bluest Eye* by Toni Morrison |
| *I'm Not Dying with You Tonight* by Kimberly Jones and Gilly Segal | *The Hate U Give* by Angie Thomas |
| *Little Bee* by Chris Cleave | *Their Eyes Were Watching God* by Zora Neale Hurston |

| **Non-Fictional Books** | |
|---|---|
| *A Different Mirror: A History of Multicultural America* by Ronald Takaki | *Black Feminist Thought: Knowledge, Consciousness and the Politics of Empowerment* by Patricia Hill Collins |
| *A Piece of Cake: A Memoir* by Cupcake Brown | *Bloods: An Oral History of the Vietnam War by Black Veterans* by Wallace Terry |
| *Allah Made Us: Sexual Outlaws in an Islamic African City* by Rudolf Pell Gaudio | *Covering: The Hidden Assault on Our Civil Rights* by Kenji Yoshino |
| *Always My Child: A Parent's Guide to Understanding your Gay, Lesbian, Bisexual, Transgendered, or Questioning Child* by Kevin Jennings | *Eloquent Rage: A Black Feminist Discovers Her Superpower* by Brittney Cooper |
| *Assessing and Treating Culturally Diverse Clients: A Practical Guide, 4th Edition* by Freddy A. Paniagua | *Fun Home: A Family Tragicomic* by Alison Bechdel |
| *Between the World and Me* by Ta-Nehisi Coates | *GLBTQ: The Survival Guide for Queer and Questioning Teens* by Kelly Huegel |

| | |
|---|---|
| *Heavy: An American Memoir* by Kiese Laymon | *The Bisexual Option* by Fritz Klein |
| *How to Be An Antiracist* by Ibram X. Kendi | *The Fire Next Time* by James Baldwin |
| *I Am Jazz* by Jazz Jennings | *The Life and Times of Frederick Douglass* by Frederick Douglass |
| *I Know Why the Caged Bird Sings* by Maya Angelou | *The New Jim Crow: Mass Incarceration in the Age of Colorblindness* by Michelle Alexander |
| *I'm Still Here: Black Dignity in a World Made for Whiteness* by Austin Channing Brown | *The Next American Revolution Sustainable Activism for the Twenty-First Century* by Grace Lee Boggs |
| *In My Shoes: A Memoir* by Tamara Mellon | *The Night* by Elie Weisel |
| *Just Mercy* by Bryan Stevenson | *The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors, and The Collision of Two Cultures* by Anne Fadiman |
| *Middlesex* by Jeffrey Eugenides | *The Warmth of Other Suns: The Epic Story of America's Great Migration* by Isabel Wilkerson |
| *My Gender Workbook* by Kate Bornstein | *This Bridge Called My Back: Writings by Radical Women of Color* by Cherríe Moraga |
| *On Edge: A Journey Through Anxiety* by Andrea Petersen | *Trauma, War, and Violence: Public Mental Health in Socio-Cultural Context* (edited by Joop De Jong) |
| *Redefining Realness: My Path to Womanhood, Identity, Love & So Much More* by Janet Mock | *We Should All Be Feminists* by Chimamanda Ngozi Adichie |
| *So You Want to Talk About Race* by Ijeoma Oluo | *White Fragility: Why It's So Hard for White People to Talk about Racism* by Robin DiAngelo |
| *The Big Sort: Why the Clustering of Like-Minded America is Tearing Us Apart* by Bill Bishop | *White Like Me: Reflections on Race from a Privileged Son* by Tim Wise |

| **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

http://www.netflix.com/blacklivesmatter

https://tubitv.com/category/black_cinema

## 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

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**<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 _____

*Revised 8/3/2012*

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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.