Magellan Institute of Diversity and Cultural Excellence Resource Kit

When reviewing this material electronically, please click on the table of contents headings below to navigate to the applicable section of the resource kit.

Table of Contents

The Fundamental Principles of Cultural Competency

1. Principle of Cultural Competence

Cultural competence is essential to the provision of effective services and treatment for diverse populations. On the part of the caregiver, cultural competence includes incorporating language, knowledge, skills and attitudes within systems of care that are informed by the specific reality of a client/consumer's cultural circumstances. Truly competent service acknowledges and incorporates cultural variables into the assessment and treatment process.

2. Principle of Client/Consumer-Driven System of Care

A client/consumer-driven system of care promotes the client/consumer, together with the family, as the most important participants in the service-providing process.

3. Principle of Community-Based System of Care

A community-based system of care includes the full continuum of care. There is strong focus on being open to:

- Including recognized, valued community resources from within the environment of the client/consumer's culture;
- Investing in early intervention and prevention efforts; and
- Treating the client/consumer in a language and environment that least restricts healing influences familiar to the client/consumer.

4. Principle of Managed Care

The costs of a public managed healthcare delivery system are best contained through the delivery of truly effective, high-quality services that emphasize outcome-driven systems and positive results. Such systems acknowledge, as essential, the added-value inclusion of both the ethnicity/culture and language of a group as a treatment partner. The system should include an emphasis on managing care, not dollars. It recognizes that dollars will manage themselves if overall care is well managed. It also recognizes that cultural group-specific variables have significant implications for individualized assessment and treatment.

5. Principle of Natural Support

Natural community support and culturally competent practices are viewed as an integral part of a system of care that contributes to desired outcomes in a multicultural environment. Traditional healing practices of particular ethnicities/cultures are used when relevant or possible. Function rather than bloodlines define the family, insofar as individuals from many ethnicities/cultures often conceive of family much more broadly than mainstream individuals.

6. Principle of Sovereign Nation Status

Systems of healthcare that serve Native Americans who are members of sovereign nations shall acknowledge the right of those sovereign nations to participate in the process of defining culturally competent services.

7. Principle of Collaboration and Empowerment

Clients/consumers from all ethnicity/culture groups and their families have the capacity to collaborate with treatment systems and providers in determining the course of treatment. The greater the extent of this collaboration, the better the chance that recovery and long-term functioning will occur and be sustained. Empowering clients/consumer and families enhances their self-esteem and ability to manage their own health.

8. Principle of Holism

Clients/consumers from all ethnicity/culture groups are more likely to respond to managed systems of care, organizations and treatment providers who recognize the value of holistic approaches to healthcare and implement these in their clinical work, policies, and standards. Where holistic approaches are absent, there is a greater risk that clients/consumer will tend to over-utilize services in seeking appropriate outcomes.

9. Principle of Feedback

Legitimate opportunities for feedback and exchange among treatment systems, organizations, and providers will improve the quality of behavioral health services and enhance the desired outcomes of their service delivery to clients/consumer of all ethnicity/culture groups. Where such opportunities for feedback are absent, there is a greater likelihood that the system of services and policies will not be congruent with the needs of client/consumers and will not result in high levels of client/consumer satisfaction. Care systems that implement feedback increase the opportunity of making ongoing culturally specific corrections in their approaches to services while simultaneously decreasing their risks.

10. Principle of Access

In order for clients/consumers from all cultural groups to seek, utilize, and gain from healthcare provided in a system-wide plan, all services, facilities and providers have to be accessible. Where services and facilities are geographically, psychologically, linguistically and culturally accessible, the chances are increased that clients/consumers from all populations will respond positively to treatment and services. Inadequate access to services will result in increased costs, limited benefit to the client/consumer, and a greater probability that services will not result in the desired outcomes.

11. Principle of Universal Coverage

Populations of many ethnicity/culture groups experience higher than average frequencies of unemployment, lower receipt of transfer payments, and less disposable income. Where

healthcare coverage, benefits, and access are based on employment or ability to pay, client/consumers from these groups are more likely to be under-served in health issues. The greater the extent to which healthcare is universally available without regard to income, the greater the likelihood that the health status of these client/consumers will be enhanced.

12. Principle of Integration

Clients/consumers from some ethnicity/culture groups suffer higher than expected frequencies of physical health problems. Integrating primary care medicine, mental health, prevention and substance abuse services in a system-wide plan increases the potential that all clients/consumers will receive comprehensive treatment services and recover more rapidly, with fewer disruptions due to a fragmented system of care.

13. Principle of Quality

The more that emphasis is placed in the behavioral healthcare system on ensuring the continuous quality of culturally competent service to client/consumers of all ethnicity/culture groups, the greater the likelihood that relapse will be prevented, and disorders will be treated appropriately and costs lowered. The less that emphasis is placed on providing culturally competent quality services to all clients/consumers, the greater the chance that costs will increase.

14. Principle of Data-Driven Systems

The quality and skill of culturally appropriate decision-making, service design, and clinical intervention for clients/consumers in a system of healthcare is increased where cultural group-data on prevalence, incidence, admission, discharge, service utilization, and treatment outcomes are used to inform and guide decisions.

15. Principle of Outcomes

Clients/consumers and their families always evaluate services received on the basis of real life outcomes relative to the actual problems that first stimulated them to seek help in a prevention, intervention and treatment environment. The greater the extent to which the system of care employs policies, plans, organizations, and providers that emphasize and measure these outcomes according to the basic expectations of clients/consumers, the greater will be the degree of client/consumer satisfaction.

16. Principle of Prevention

Behavioral health service systems and local provider organizations should offer culturally specific community education programs about the behavioral health system and the risk factors associated with specific disorders. The goal is to increase the capacity of families from all ethnicities/cultures to provide a healthy environment and to identify the early warning signs that indicate when a mental illness or an addictive disorder does exist. Early identification and intervention can prevent exacerbation of the problems and reduce the disabling effects of behavioral health problems.

Adapted with permission from the Connecticut Department of Mental Health and Addiction Services Office of Multicultural Affairs Assessment Guidelines for Developing a Multiculturally Competent Service System for a Program or Organization.

AMCD Multicultural Counseling Competencies

I. Counselor Awareness of Own Cultural Values and Biases

A. Attitudes and Beliefs

1. Culturally skilled counselors believe that cultural self-awareness and sensitivity to one's own cultural heritage is essential.

2. Culturally skilled counselors are aware of how their own cultural background and experiences have influenced attitudes, values, and biases about psychological processes.

3. Culturally skilled counselors are able to recognize the limits of their multicultural competency and expertise.

4. Culturally skilled counselors recognize their sources of discomfort with differences that exist between themselves and clients in terms of race, ethnicity and culture.

B. Knowledge

1. Culturally skilled counselors have specific knowledge about their own racial and cultural heritage and how it personally and professionally affects their definitions and biases of normality/ abnormality and the process of counseling.

2. Culturally skilled counselors possess knowledge and understanding about how oppression, racism, discrimination, and stereotyping affect them personally and in their work. This allows individuals to acknowledge their own racist attitudes, beliefs, and feelings. Although this standard applies to all groups, for Caucasian counselors it may mean that they understand how they may have directly or indirectly benefited from individual, institutional, and cultural racism as outlined in Caucasian identity development models.

3. Culturally skilled counselors possess knowledge about their social impact upon others. They are knowledgeable about communication style differences, how their style may clash with or foster the counseling process with persons of color or others different from themselves based on the A, B and C, Dimensions, and how to anticipate the impact it may have on others.

C. Skills

1. Culturally skilled counselors seek out educational, consultative, and training experiences to improve their understanding and effectiveness in working with culturally different populations. Being able to recognize the limits of their competencies, they (a) seek consultation, (b) seek further training or education, (c) refer out to more qualified individuals or resources, or (d) engage in a combination of these.

2. Culturally skilled counselors are constantly seeking to understand themselves as racial and cultural beings and are actively seeking a non-racist identity.

II. Counselor Awareness of Client's Worldview

A. Attitudes and Beliefs

1. Culturally skilled counselors are aware of their negative and positive emotional reactions toward other racial and ethnic groups that may prove detrimental to the counseling relationship. They are willing to contrast their own beliefs and attitudes with those of their culturally different clients in a nonjudgmental fashion.

2. Culturally skilled counselors are aware of their stereotypes and preconceived notions that they may hold toward other racial and ethnic minority groups.

B. Knowledge

1. Culturally skilled counselors possess specific knowledge and information about the particular group with which they are working. They are aware of the life experiences, cultural heritage, and historical background of their culturally different clients. This particular competency is strongly linked to the "minority identity development models" available in the literature.

2. Culturally skilled counselors understand how race, culture, ethnicity, and so forth may affect personality formation, vocational choices, manifestation of psychological disorders, help-seeking behavior, and the appropriateness or inappropriateness of counseling approaches.

3. Culturally skilled counselors understand and have knowledge about sociopolitical influences that impinge upon the life of racial and ethnic minorities. Immigration issues, poverty, racism, stereotyping, and powerlessness may impact self-esteem and self-concept in the counseling process.

C. Skills

1. Culturally skilled counselors should familiarize themselves with relevant research and the latest findings regarding mental health and mental disorders that affect various ethnic and racial groups. They should actively seek out educational experiences that enrich their knowledge, understanding, and cross-cultural skills for more effective counseling behavior.

2. Culturally skilled counselors become actively involved with minority individuals outside the counseling setting (e.g., community events, social and political functions, celebrations, friendships, neighborhood groups, and so forth) so that their perspective of minorities is more than an academic or helping exercise.

III. Culturally Appropriate Intervention Strategies

A. Beliefs and Attitudes

1. Culturally skilled counselors respect clients' religious and/ or spiritual beliefs and values, including attributions and taboos, because they affect worldview, psychosocial functioning, and expressions of distress.

2. Culturally skilled counselors respect indigenous helping practices and respect helping networks among communities of color.

3. Culturally skilled counselors value bilingualism and do not view another language as an impediment to counseling (monolingualism may be the culprit).

B. Knowledge

1. Culturally skilled counselors have a clear and explicit knowledge and understanding of the generic characteristics of counseling and therapy (culture-bound, class-bound, and monolingual) and how they may clash with the cultural values of various cultural groups.

2. Culturally skilled counselors are aware of institutional barriers that prevent minorities from using mental health services.

3. Culturally skilled counselors have knowledge of the potential bias in assessment instruments and use procedures and interpret findings keeping in mind the cultural and linguistic characteristics of the clients.

4. Culturally skilled counselors have knowledge of family structures, hierarchies, values, and beliefs from various cultural perspectives. They are knowledgeable about the community where a particular cultural group may reside and the resources in the community.

5. Culturally skilled counselors should be aware of relevant discriminatory practices at the social and community level that may be affecting the psychological welfare of the population being served.

C. Skills

1. Culturally skilled counselors are able to engage in a variety of verbal and nonverbal helping responses. They are able to send and receive both verbal and nonverbal messages accurately and appropriately. They are not tied down to only one method or approach to helping, but recognize that helping styles and approaches may be culture-bound. When they sense that their helping style is limited and potentially inappropriate, they can anticipate and modify it.

2. Culturally skilled counselors are able to exercise institutional intervention skills on behalf of their clients. They can help clients determine whether a "problem" stems from racism or bias in others (the concept of healthy paranoia) so that clients do not inappropriately personalize problems.

3. Culturally skilled counselors are not averse to seeking consultation with traditional healers or religious and spiritual leaders and practitioners in the treatment of culturally different clients when appropriate.

4. Culturally skilled counselors take responsibility for interacting in the language requested by the client and, if not feasible, make appropriate referrals. A serious problem arises when the linguistic skills of the counselor do not match the language of the client. This being the case, counselors should (a) seek a translator with cultural knowledge and appropriate professional background or (b) refer to a knowledgeable and competent bilingual counselor.

5. Culturally skilled counselors have training and expertise in the use of traditional assessment and testing instruments. They not only understand the technical aspects of the instruments but are also aware of the cultural limitations. This allows them to use test instruments for the welfare of culturally different clients.

6. Culturally skilled counselors should attend to as well as work to eliminate biases, prejudices, and discriminatory contexts in conducting evaluations and providing interventions, and should develop sensitivity to issues of oppression, sexism, heterosexism, elitism and racism.

7. Culturally skilled counselors take responsibility for educating their clients to the processes of psychological intervention, such as goals, expectations, legal rights, and the counselor's orientation.

Arredondo, P., Toporek, M. S., Brown, S., Jones, J., Locke, D. C., Sanchez, J. and Stadler, H. (1996) *Operationalization of the Multicultural Counseling Competencies.* AMCD: Alexandria, VA.

Key Components of Organizational Cultural Competence

I. Agency (Provider) Demographic Data

A culturally competent agency collects basic demographic information to assess and determine such information as:

- Ratio of staff to clients by race, ethnicity, gender, etc.
- Client performance and outcome pattern
- Composition of the service area by key demographics

II. Policies, Procedures and Governance

A culturally competent agency has:

- A board of directors that represents diverse community populations, and promotes the importance of cultural competence to achieve quality outcomes
- A culturally informed advisory committee or a policy development group that is proportionally representative of the staff, client/consumers and community members

III. Services/Programs

A culturally competent agency offers services that are culturally competent and in a language that ensures client/consumer comprehension.

IV. Care Management

A culturally competent agency ensures that:

- Client services are monitored for clinical and cultural appropriateness
- Supervision of clinicians includes addressing cultural aspects of care
- Referrals consider the cultural appropriateness of the referred agency

V. Continuity of Care:

A culturally competent continuum of care includes services that not only meet criteria for the appropriate level of care, but also includes services that are culturally appropriate and compatible across levels and agencies.

VI. Human Resources Development

A culturally competent agency implements staff training and development in cultural competence at all levels and across all disciplines including for leadership and governing entities, as well as for management, supervisory, treatment and support staff.

VII. Quality Monitoring and Improvement

A culturally competent agency has a quality monitoring and improvement program that:

- Evaluates services in terms of access, retention and engagement and service quality by key client demographics
- Utilizes these data for service planning and improvement purposes

Adapted with permission from the Connecticut Department of Mental Health and Addiction Services Office of Multicultural Affairs Assessment Guidelines for Developing a Multiculturally Competent Service System for a Program or Organization.

Multicultural Competence Service System Assessment Measure

The cultural competence assessment guidelines that follow can help agencies identify cultural competence strengths and expansion areas. The elements presented reflect guidelines developed by organizations nationwide, as well as by accrediting and licensing bodies. Elements in each section of the guidelines offer a basis for program development in the area of cultural competence. The results of your self-assessment can be used in the development of plans and strategies to increase the cultural competence of services delivered by your agency.

Instructions

Rate your organization on each item in Sections I through VIII using the following scale:

1	2	3	4	5
Not at all		**To a moderate degree**		**To a great degree**

Suggested Rating Interpretations:

#1 and #2: **"Priority Concerns"**

#3: **"Needs Improvement"**

#4 and #5: **"Strengths"**

I. Agency Demographic Data (Assessment)

____ Have you identified the demographic composition of the program's service area (from recent census data, local planning documents, statement of need, etc.) which should include ethnicity, race, and primary language spoken as reported by the individuals?

____ Have you identified the demographic composition of the persons served?

____ Have you identified the staff composition (ethnicity, race, language capabilities) in relation to the demographic composition of your service area?

____ Have you compared the demographic composition of the staff with the client demographics?

II. Policies, Procedures and Governance

____ Has your organization appointed executives, managers and administrators who take responsibility for, and have authority over, the development, implementation, and monitoring of the Cultural Competence Plan?

____ Has your organization's director appointed a standing committee to advise management on matters pertaining to multicultural services?

____ Does your organization have a mission statement that commits to cultural competence and reflects compliance with all federal and state statutes, as well as any current state or local discriminatory and affirmative action policies?

____ Does your organization have culturally appropriate policies and procedures communicated orally and/or written in the principle language of the client/consumer to address confidentiality, individual patient rights and grievance procedures, medication fact sheets, legal assistance, etc. as needed and appropriately?

III. Services/Programs:

A. Linguistic and Communication Support

____ Has the program arranged to provide materials and services in the language(s) of limited English-speaking clients/consumers (e.g., bilingual staff, in-house interpreters, or a contract with outside interpreter agency and/or telephone interpreters)?

____ Do medical records indicate the preferred language of service recipients?

____ Is there a protocol to handle client/consumer/family complaints in languages other than English?

____ Are the forms that clients/consumers sign in their preferred language?

____ Are the persons answering the telephones, during and after-hours, able to communicate in the language of the speakers?

____ Does the organization provide information about programs, policies, covered services and procedures for accessing and utilizing services in the primary language(s) of clients/consumers and families?

____ Does the organization have signs regarding language assistance posted at key locations?

____ Are there special protocols for addressing language issues at the emergency room, treatment rooms, intake, etc.?

____ Are cultural and linguistic supports available for clients/consumers throughout different service offerings along the service continuum?

B. Treatment/Rehabilitation Planning

____ Does the program consider the client/consumer's culture, ethnicity and language in treatment planning (assessment of needs, diagnosis, interventions, discharge planning, etc.)?

____ Does the program involve clients/consumers and family members in all phases of treatment, assessment and discharge planning?

____ Has the organization identified community resources (community councils, ethnic/cultural social entities, spiritual leaders, faith communities, voluntary associations, etc.) that can exchange information and services with staff, clients/consumers, and family members?

____ Have you identified natural community healers, spiritual healers, clergy, etc., when appropriate, in the development and/or implementation of the service plan?

____ Have you identified natural supports (relatives, traditional healers, spiritual resources, etc.) for purposes of reintegrating the individual into the community?

____ Have you used community resources and natural supports to re-integrate the individual into the community?

C. Cultural Assessments

____ Is the client/consumer's culture/ethnicity taken into account when formulating a diagnosis or assessment?

____ Are culturally relevant assessment tools utilized to augment the assessment/diagnosis process?

____ Is the client/consumer's level of acculturation identified, described and incorporated as part of a cultural assessment?

____ Is the client/consumer's ethnicity/culture identified, described and incorporated as part of a cultural assessment?

D. Cultural Accommodations

____ Are culturally appropriate educative approaches such as films, slide presentations or video tapes utilized for preparation and orientation of client/consumer family members to your program?

____ Does your program incorporate aspects of each client/consumer's ethnic/cultural heritage into the design of specialized interventions or services?

____ Does your program have ethnic/culture-specific group formats available for engagement, treatment and/or rehabilitation?

____ Is there provider collaboration with natural community healers, spiritual healers, clergy, etc., where appropriate, in the development and/or implementation of the service plan?

E. Program Accessibility

____ Do persons from different cultural and linguistic backgrounds have timely and convenient access to your services?

____ Are services located close to the neighborhoods where persons from different cultures and linguistic backgrounds reside?

____ Are your services readily accessible by public transportation?

____ Do your programs provide needed supports to families of clients/consumers, i.e., meeting rooms for extended families, child support, drop-in services, etc.?

____ Do you have services available during evenings and weekends?

IV. Care Management

____ Does the level and length of care meet the needs for clients/consumers from different cultural backgrounds?

____ Is the type of care for clients/consumers from different backgrounds consistently and effectively managed according to their identified cultural needs?

____ Is the management of the services for people from different groups compatible with their ethnic/cultural background?

V. Continuity of Care

____ Do you have letters of agreement with culturally oriented community services and organizations?

____ Do you have integrated and planned transitional arrangements between one service modality and another?

____ Do you have arrangements, financial or otherwise, for securing concrete services needed by clients/consumers (e.g., housing, income, employment, medical, dental, and other emergency personal support needs?)

VI. Human Resources Development

____ Are the principles of cultural competence (e.g., cultural awareness, language training skills, training in working with diverse populations) included in staff orientation and ongoing training programs?

____ Is the program making use of other programs or organizations that specialize in serving persons with diverse cultural and linguistic backgrounds as a resource for staff education and training?

____ Is the program maximizing recruitment and retention efforts for staff who reflect the cultural and linguistic diversity of populations needing services?

____ Have the staff's training needs in cultural competence been assessed?

____ Have staff attended training programs on cultural competence in the past two years?

Describe: _____

_____

VII. Quality Monitoring and Improvement

____ Does the Quality Improvement (QI) Plan address the cultural/ethnic and language needs?

____ Are clients/consumers and families asked whether ethnicity/culture and language are appropriately addressed in order to receive culturally competent services in the organization?

____ Does the organization maintain copies of minutes, recommendations, and accomplishments of its multicultural advisory committee?

____ Is there a process for continually monitoring, evaluating, and rewarding the cultural competence of staff?

VIII. Information/Management System

____ Does the organization monitor, survey, or otherwise assess the QI utilization patterns, Against Medical Advice (A.M.A.) rates, etc., based on the culture/ethnicity and language?

____ Are client/consumer satisfaction surveys available in different languages in proportion to the demographic data?

____ Are there data collection systems developed and maintained to track clients/ consumers by demographics, utilization and outcomes across levels of care, transfers, referrals, re-admissions, etc.?

Summarizing and Applying Assessment Findings

1. To interpret this instrument, review your responses and note areas that represent your agency's strengths (#4 & #5), improvement needed areas, (# 3) and priority concern areas (#1 & #2).

2. Your pattern of responses provides you with an overall picture of possible intervention areas that can help to enhance your agency's level of cultural and linguistic competence.

3. Findings of this assessment can be used to inform the development of an agency cultural competence plan.

4. To develop a plan based on your assessment findings, use the Cultural Competence Plan Template included in this resource kit. This template outlines goals/objectives, action steps, person/persons responsible, timeframes, outcomes and strategies for measuring progress. Strategies for completing the template and developing an agency cultural competence plan are included with the template. An example of a completed template and an agency cultural competence plan is included in this resource kit.

(Agency/Provider Name) Cultural Competence Plan Template

Goal #					
Objectives	**Steps to Achieve Goal**	**Person/s Responsible**	**Time frame**	**Expected Outcome**	**Strategies for Measuring Progress**

Strategies for Completing the Cultural Competence Plan

- In beginning to consider goals, think about building on organizational or system strengths and assets, as well as growth areas.

- If agency data collection and information systems are a strength, for instance, one goal could be to conduct ongoing analyses of service utilization data by race, ethnicity, gender, age and other key demographic variables to assess for service equity in access, retention and engagement, service quality and outcomes. These findings can then be used for quality assurance and further goal identification purposes.

- In developing an agency cultural competence action plan, a key strategy is to select goals that are realistic. One way to evaluate whether a goal is realistic is to note whether a person or department exists within your agency who can assume responsibility for implementing the goal. If no such person exists, additional planning may be needed to identify or hire such a person. This can become a specific goal for your cultural competence plan.

- An additional key strategy is to develop an incremental timeline for goal completion in which specific and staggered timeframes are selected for identified goals. Thus, in a three-year plan, for example, a manageable set of goals should be selected for each of the three years.

- The number of goals selected per year should coincide with your organization's internal capacity to realistically implement the goals. Again, capacity is impacted by whether individuals are in place to implement the goals, whether individuals or departments identified to implement to goal have the resources and supports needed to implement the goals, whether there are other goals simultaneously occurring, and the overall agency commitment to advancing the goals.

- In selecting goals and objectives, remember to select goals that address the eight components of organizational cultural competence: 1) Agency Demographic Data, 2) Policies, Procedures and Governance, 3) Services and Programs, 4) Care Management, 5) Continuity of Care, 6) Human Resource Development, 7) Quality Monitoring and Improvement, and 8) Information/Management Systems.

Sample Cultural Competence Action Plan

Wellspring Behavioral Health Center
2006-2009 Cultural Competence Action Plan

This document presents the Wellspring Behavioral Health Center's 2006-2009 Cultural Competence Action Plan. The Wellspring 2006-2009 Plan was developed in conjunction with the Center's Cultural Competence Taskforce after a series of meetings in which committee members completed the Multicultural Competence Service System Assessment Measure as a group, discussed findings, and developed this Wellspring cultural competence action plan. Action areas proposed within this plan are strategically staggered such that specific goals and objectives are targeted for each of the three years of the Plan's implementation. Finally, an overarching goal in developing this cultural competence action plan was to propose realistic and manageable interventions given the Center's current and projected fiscal resources.

We begin with a brief description of the Wellspring Behavioral Health Center in terms of services offered, satellite clinics in operation, and overall client and staff demographics for the Center. Next, we briefly discuss cultural competence strength and growth areas as identified by the Multicultural Competence Service System Assessment Measure, and conclude with a presentation of Wellspring's cultural competence goals and objectives for the 2006-2009 fiscal years.

The Wellspring Behavioral Health Center

The Wellspring Mental Health Center is a multi-site, urban community mental health center that has been in operation in Chicago, Illinois since 1976. Wellspring treats individuals who are of low income and experiencing severe and persistent mental illness and/or substance abuse problems. Services are offered at a variety of locations throughout the Chicago area and are easily accessible by public transportation. Wellspring also provides oversight responsibility for 12 community agencies funded by the Illinois Department of Mental Hygiene. These agencies provide services in four categories which include: 1) Clinical and Case Management Services, 2) Psychosocial Rehabilitation Services, 3) Residential Services, and 4) Vocational Rehabilitation Services.

In addition to these 12 community agencies, the Center provides services through three satellite clinics located throughout the Chicago area. Satellite service locations include:

The Hispanic Clinic. Created in 1981, the Hispanic Clinic provides bilingual and bicultural outpatient services to individuals of Latino origin in the Chicago area. Service components of the clinic include the Mental Health Unit, the Substance Abuse Unit and the Prevention Unit. Specific service modalities offered include individual, group, couples, family therapy, in addition to comprehensive evaluation and psychiatric medication services.

The Substance Abuse Treatment Unit (SATU). SATU provides outpatient evaluation, referral, and treatment to individuals who are 18 years and older and who are experiencing problems with drug or alcohol use. Key program components of SATU are the evaluation unit, the brief treatment unit and the Naltrexone program for opiate-dependent individuals.

The North Chicago Clinic. The North Chicago Clinic was established in 1971 and offers a full range of psychological and psycho-pharmacological services to adults, families and children in the North Chicago area. In addition to the provision of the highest quality of outpatient services, the clinic is committed to the goals of research and the provision of training for students in the mental health disciplines.

Agency Demographic Data

Wellspring routinely collects data on client and staff demographics. For the purposes of this cultural competence action plan, and to provide a sense of the racial and ethnic composition of those receiving services at the Center, and those working at the Center, we have compiled the following demographic profile:

	White	Black	Latino**	Native American	Asian Pacific Islander	Other
Wellspring Clients	34%	31%	18%	3%	12%	2%
Wellspring Staff	73%	10%	17%	0%	0%	0%

** May be of any race.

In addition to the above racial and ethnic composition of the Wellspring staff and clients, 55% of services users are female and 45% are male, while 67% of staff members are female and 33% are male. A goal for the current plan is to compare staff and client demographics to population demographics of the Chicago area to obtain a picture of the extent to which the service users and staff reflect the demographic composition of the service area.

Wellspring Strength and Growth Areas

Based on findings of the Multicultural Competence Service System Assessment Measure and discussions of the Cultural Competence Taskforce members, the following cultural competence system strengths have been identified. This list is not comprehensive, but rather includes examples of key strengths identified by Taskforce members:

1. Wellspring is located in the heart of the Chicago area and is easily accessible by public transportation.

2. Service hours are flexible and include night and weekend appointment options. Several 24-hour hotlines are available to individuals in the Chicago area.

3. Wellspring has a fairly well-developed information system in which client demographic and performance data is collected on a regular basis.

4. Wellspring has done fairly well in addressing the linguistic needs of clients of Latino origin in particular. Currently, forms are translated into Spanish, and 17% of Wellspring members are bilingual/bicultural Spanish speaking. In addition, interpreter services are available in Spanish and a variety of other languages spoken by service users. We have done less well with addressing the service and language needs of service users of Haitian origin.

5. Wellspring offers programs that address and support client cultural needs and interests. Clients are encouraged to offer ideas for needed services and supports that reflect their personal interests and lifestyles. For example, Wellspring offers two groups as a result of members' requests for specific programming, and one of these groups (a single fathers support and therapy group) is co-led by a service user.

6. Wellspring has successfully included service users and family members on their Advisory board and on other key committees.

7. Wellspring has succeeded in working collaboratively with other service agencies such as homeless shelters, residential support services, social service agencies, medical facilities, etc.

8. Wellspring staff members have participated in some introductory cultural competency training.

The following represents priority concern growth areas that represent Center goals for the 2006-2009 fiscal years:

1. As a center, the Wellspring staff members are predominately Caucasian and English speaking. A goal for the Center is to increase the staff diversity so that there is a closer match between client and staff racial and ethnic composition.

2. Wellspring staff members have participated in sporadic cultural competence training; however, a goal is for the Center to develop and implement an ongoing cultural competence training and education plan.

3. Wellspring has succeeded in collaborating with a number of community service agencies; however, a goal for the next three years is for Wellspring to continue to develop relationships with key community agencies, members, and natural supports. Community supports or services of interest include, but are not limited to, churches and

faith communities, indigenous healers or spiritualists, community centers, community leaders, and family members.

4. Building on the Wellspring strength of having a strong information system, a concern and goal area is for Wellspring to begin to use staff demographic and performance pattern data for quality assurance and planning purposes to ensure service quality and equity in access, retention and engagement and outcomes.

5. Currently, no formal or informal procedure exists at Wellspring to manage client or staff complaints or grievances. To create an atmosphere of open communication, and respectful resolution of staff or client conflicts and grievances, a goal is for Wellspring to develop a formal process for addressing grievances and conflicts.

Wellspring Behavioral Health Center
Cultural Competence Action Plan
2006-2009

Goal # 1: Continue to diversify Wellspring's administrative, clinical, and support staff in an effort to increase the match between client and staff demographics.					
Objectives	**Steps to Achieve Goal**	**Person/s Responsible**	**Time frame**	**Expected Outcome**	**Strategies for Measuring Progress**
1. Increase the racial/ethnic and gender composition of staff by 25%	1. Hold internal and external focus groups to discuss recruitment and retention issues. 2. Creatively articulate the Wellspring benefits package. 3. Develop a list of stakeholders in the community and nationwide to notify when job openings are available. 4. Widely market employment incentives and benefits of working at Wellspring. 5. Conduct yearly analyses to be able to compare client and staff demographics.	Human Resources Department Workforce Development Subcommittee		1. Increased diversification of Wellspring staff 2. Greater match between staff and client demographics	1. Bi-annual assessments of staff demographics 2. Compare staff and client demographics

			By August 2008		
2. Increase the racial/ethnic and gender diversity of interns by 50%	1. Creatively articulate and market the intern benefits package and position openings. 2. Develop relationships with schools with diverse student populations nationwide and actively recruit students to the clinic. 3. Link hired interns with a supervisor and mentor.	Human Resources Department Workforce Development Subcommittee	By August 2008	1. Increased diversification of Wellspring interns 2. Greater match between staff/student demographics	1. Bi-annual assessments of intern demographics 2. Compare intern demographics

Goal # 2: Ensure that staff across all levels receive ongoing cultural and linguistic competence education and training					
Objectives	**Steps to Achieve Goal**	**Person/s Responsible**	**Time frame**	**Expected Outcome**	**Strategies for Measuring Progress**
1. Create annual plans for staff cultural competence (cc) training across all levels	1. Identify training needs by surveying staff about their training interests.	Human Resources Department Wellspring CC Taskforce	2006-2009	1. Staff across all levels will participate in two formal trainings per year.	1. Percentage of staff who attend trainings are tracked

	2. Review cc and related trainings available throughout the state. 3. Identify potential trainers, their areas of training expertise and costs. 4. Plan for at least two trainings/workshops per year related to cc.			2. Increased cc knowledge, skills and awareness of all staff. 3. Client cultural beliefs, values and worldview respected and incorporated into the treatment process.	2. Staff report increased cc as measured by provider cc surveys. 3. Client reports of their cultural beliefs & values being incorporated in treatment as measured by client satisfaction surveys & consumer measure of provider cc.
2. Convene monthly brown-bag lunches in which community members present on culturally related topic of interest.	1. Survey staff on topic areas of interest for lunch presentations. 2. Identify potential speakers 3. Contact speakers 4. Develop brown-bag lunch schedule 5. Distribute schedule of speakers and topics. 6. Post schedule on key center bulletin boards	Cultural Competence Taskforce	2006-2009	1. Increased staff awareness and discussion of cultural issues. 2. Increased connection and relationship	1. Staff self reports of increased cultural awareness as measured by staff cc measures. 2. The number ongoing relationships

	7. Send reminders to staff several days before and on the day of the lunch.	Center administrative support staff		building with community members and natural supports.	with community members established as a result of lunches.

Goal # 3: Continue to develop ongoing relationships and partnerships with community resources and natural supports					
Objectives	**Steps to Achieve Goal**	**Person/s Responsible**	**Time frame**	**Expected Outcome**	**Strategies for Measuring Progress**
1. Diversify the Wellspring Advisory Board and all relevant committees to include membership from key community stakeholders and natural supports.	1. Identify key community members and natural supports to invite to become advisory board members. 2. Send letters to identified individuals and agencies inviting participation. 3. Schedule face-to-face meetings with community stakeholders and natural supports to discuss possible	Agency Director Cultural Competence Task Force	12/07 - 2009	1. Increased community participation and partnerships. 2. Client reports of cultural relevance or services.	1. Track number of community members participating on an ongoing basis on Advisory Boards and other relevant committees. 2. Client satisfaction survey findings. 3. Assessments of client

	participation in Wellspring Advisory Board and other committees.				perceptions of provider/agency cultural competence.
2. Engage in formal community asset mapping, and relationship building.	1. Convene a subcommittee to engage in asset mapping and relationship building with identified community resources and supports (include community members, consumer and family members, providers, etc.). 2. Conduct focus groups with providers, service users, community members to gather information about community services and supports that have been useful for clients. 3. Develop and disseminate a survey to providers, service users, and community members to gather information about community services and natural supports that	Cultural Competence Taskforce Asset Mapping Subcommittee	12/08-12/09	1. Formation of a diverse network of community assets and supports who are involved in key Center Advisory Boards and Committees. 2. Ongoing input and participation and partnerships with community stakeholders and natural supports. 3. Increase in the cultural relevance and competence of Center services.	1. Network success can be measured by the number and type of community agencies, assets, natural supports, etc. contacted and participating in Center Boards, committees etc. on an ongoing basis. 2. Client reports of satisfaction with services and cultural relevance of services as measured by client satisfaction

	have been or can be useful in addressing client needs. 4. Contact all community agencies, and natural supports, etc., to be included in the resource guide to discuss the asset mapping project and to begin relationship building. 5. Summarize information in a formal guide to be distributed broadly center- and community-wide.			4. Client reports of satisfaction with services. 5. The development and dissemination of a community asset and resources guide.	surveys and consumer measures of provider cc.

Goal # 4: Ensure service quality and equity for all individuals seeking care					
Objectives	**Steps to Achieve Goal**	**Person/s Responsible**	**Time frame**	**Expected Outcome**	**Strategies for Measuring Progress**
1. Develop and implement a Quality Monitoring and Improvement Initiative in which service utilization data is assessed on an ongoing basis for equity in access,	1. Convene a standing QMI Subcommittee to design and implement the initiative. 2. In addition to individuals from the information systems department, include consumers, family	Information Systems Department Quality Monitoring and Improvement Subcommittee	1/07 -2009	1. Refinement of the Wellspring data systems such that needed demographic and other variables are collected to be able to asses for service equity	1. Presence of a data system that includes variables that can be used to assess for equity in access, retention and engagement,

retention and engagement, service quality and outcomes.	members and providers on the subcommittee. 3. Initiative design features are likely to include such activities as: * Develop a list of access, retention and engagement, service quality and outcomes questions of interest to be assessed on an ongoing basis. *Review existing agency data systems to determine if the necessary data points are being collected to be able to conduct the analyses of interest. Make recommendations for data that needs to be collected prospectively to conduct analyses of interest. * Offer recommendations for additional data points that may need to be collected to conduct the analyses of interest.			in access, retention and engagement, service quality and outcomes. 2. Increased service equity and quality as a result of implemented interventions.	service quality and outcomes. 2. The presence of bi-annual reports summarizing service utilization patterns. 3. The development and implementation of specific interventions designed to eliminate any identified disparities. 4. Decrease in any identified disparities.

	*Conduct bi-annual analyses of questions of interest. *Develop recommendations for eliminating any identified disparities. *Develop and implement interventions designed to eliminate disparities. *Conduct analyses of agency service utilization and outcome data on an ongoing basis to assess for equity.				5. Increased reports of client satisfaction with services as measured by client satisfaction surveys. 6.Increase in client access, retention and engagement and service quality.

Goal # 5: Foster an agency environment of open communication, dialogue, and the respectful resolution of staff or client conflict and grievances					
Objectives	**Steps to Achieve Goal**	**Person/s Responsible**	**Time frame**	**Expected Outcome**	**Strategies for Measuring Progress**
1. Develop and implement an internal process for addressing staff or client grievances and conflicts.	1. Convene a committee to develop an internal process for managing conflicts and grievances. 2. Provide needed organizational support for implementing the grievance process developed by the committee. 3. Ensure that grievances or complaints can be handled in the languages of Center service users. 4. Grievance policies and procedures will be disseminated to staff and clients by administrative staff.	Human Resources Department Agency Cultural Competence Taskforce Grievance Management Subcommittee	By 2/2006 By 8/2006	1. Staff and clients feel that their concerns are valued and respected. 2. Use of the grievance procedures as needed. 3. Improved staff relations.	1. Client endorsement of their concerns being formally addressed as measured by agency client satisfaction surveys. 2. Reports of improved staff relations in supervision meetings

Clinician/Service Provider Cultural Competence Measures

CLAS Standards

(Culturally and linguistically Appropriate Services)

Office of Minority Health, U.S. Department of Health and Human Services 6/2014

The National Standards for Culturally and Linguistically Appropriate Services in Health and healthcare (The National CLAS Standards) aim to improve healthcare quality and advance health equity by establishing a framework for organizations to serve the nation's increasingly diverse communities. Last updated 6/2014

Three themes: **Governance, Leadership and Workforce**
Communication and Language Assistance
Engagement, Continuous Improvement and Accountability

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 healthcare 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 organizations' planning and operations.

10) Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into assessment 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.

Standards were based on analytical review of key laws, regulations, contracts and standards currently in use by federal and state agencies, and other national organizations. The standards were developed by a national project advisory panel.

Last Modified: 6/19/2014 2:52:00 PM

Click here for a link to the National CLAS standards:
https://www.thinkculturalhealth.hhs.gov/clas

The Multicultural Awareness-Knowledge-Skills Survey

Below is a list of statements and/or questions on a variety of issues related to the field of multicultural counseling. Please read each statement/question carefully. From the available choices, circle the one that best fits your reaction to each statement/question.

1. Culture is not external but is within the person.

   Strongly Disagree Disagree Agree Strongly Agree

2. One of the potential negative consequences about gaining information concerning specific cultures is that trainees might stereotype members of those cultural groups according to the information they have gained.

   Strongly Disagree Disagree Agree Strongly Agree

3. At this time in your life, how would you rate yourself in terms of understanding how your cultural background has influenced the way you think and act?

   Very Limited Limited Fairly Aware Very Aware

4. At this point in your life, how would you rate your understanding of the impact of the way you think and act when interacting with persons of different cultural backgrounds?

   Very Limited Limited Fairly Aware Very Aware

5. How would you react to the following statement? *While counseling enshrines the concepts of freedom, rational thought, tolerance of new ideas, and equality, it has frequently become a form of oppression to subjugate large groups of people.*

   Strongly Disagree Disagree Agree Strongly Agree

6. In general, how would you rate your level of awareness regarding different cultural institutions and systems?

   Very Limited Limited Fairly Aware Very Aware

7. The human service professions, especially counseling and clinical psychology, have failed to meet the mental health needs of ethnic minorities.

   Strongly Disagree Disagree Agree Strongly Agree

8. At the present time, how would you generally rate yourself in terms of being able to accurately compare your own cultural perspective with that of a person from another culture?

   Very Limited Limited Fairly Aware Very Aware

9. How well do you think you could distinguish “intentional” from “accidental” communication signals in a multicultural counseling situation?

   Very Limited Limited Fairly Aware Very Aware

10. Ambiguity and stress often result from multicultural situations because people are not sure what to expect from each other.

Strongly Disagree Disagree Agree Strongly Agree

11. The effectiveness and legitimacy of the counseling profession would be enhanced if counselors consciously supported universal definitions of normality.

Strongly Disagree Disagree Agree Strongly Agree

12. The criteria of self-awareness, self-fulfillment, and self-discovery are important measures in most counseling sessions.

Strongly Disagree Disagree Agree Strongly Agree

13. Even in multicultural counseling situations, basic implicit concepts, such as "fairness" and "health" are not difficult to understand.

Strongly Disagree Disagree Agree Strongly Agree

14. Promoting a client's sense of psychological independence is usually a safe goal to strive for in most counseling situations.

Strongly Disagree Disagree Agree Strongly Agree

15. While a person's natural support system (i.e., family, friends, etc.) plays an important role during a period of personal crisis, formal counseling services tend to result in more constructive outcomes.

Strongly Disagree Disagree Agree Strongly Agree

16. How would you react to the following statement? In general, counseling services should be directed toward assisting clients to adjust to stressful environmental situations.

Strongly Disagree Disagree Agree Strongly Agree

17. Counselors need to change not just the content of what they think, but also the way they handle this content if they are to accurately account for the complexity in human behavior.

Strongly Disagree Disagree Agree Strongly Agree

18. Psychological problems vary with the culture of the client.

Strongly Disagree Disagree Agree Strongly Agree

19. How would you rate your understanding of the concept of "relativity" in terms of the goals, objectives, and methods of counseling culturally different clients?

Very Limited Limited Good Very Good

20. There are some basic counseling skills that are applicable to create successful outcomes regardless of the client's cultural background.

Strongly Disagree Disagree Agree Strongly Agree

At the present time, how would you rate your own understanding of the following terms:

21. "Culture"

    Very Limited Limited Good Very Good

22. "Ethnicity"

    Very Limited Limited Good Very Good

23. "Racism"

    Very Limited Limited Good Very Good

24. "Mainstreaming"

    Very Limited Limited Good Very Good

25. "Prejudice"

    Very Limited Limited Good Very Good

26. "Multicultural Counseling"

    Very Limited Limited Good Very Good

27. "Ethnocentrism"

    Very Limited Limited Good Very Good

28. "Pluralism"

    Very Limited Limited Good Very Good

29. "Contact Hypothesis"

    Very Limited Limited Good Very Good

30. "Attribution"

    Very Limited Limited Good Very Good

31. "Transcultural"

    Very Limited Limited Good Very Good

32. "Cultural Encapsulation"

    Very Limited Limited Good Very Good

33. What do you think of the following statement? *Witch doctors and psychiatrists use similar techniques.*

    Strongly Disagree Disagree Agree Strongly Agree

34. Differential treatment in the provision of mental health services is not necessarily thought to be discriminatory.

Strongly Disagree Disagree Agree Strongly Agree

35. In the early grades of formal schooling in the United States, the academic achievement of such ethnic minorities as African Americans, Hispanics, and Native Americans is close to parity with the achievement of White mainstream students.

Strongly Disagree Disagree Agree Strongly Agree

36. Research indicates that in the early elementary school grades girls and boys achieve about equally in mathematics and science.

Strongly Disagree Disagree Agree Strongly Agree

37. Most of the immigrant and ethnic groups in Europe, Australia, and Canada face problems similar to those experienced by ethnic groups in the United States.

Strongly Disagree Disagree Agree Strongly Agree

38. In counseling, clients from different ethnic/cultural backgrounds should be given the same treatment that White mainstream clients receive.

Strongly Disagree Disagree Agree Strongly Agree

39. The difficulty with the concept of "integration" is its implicit bias in the favor of the dominant culture.

Strongly Disagree Disagree Agree Strongly Agree

40. Racial and ethnic persons are underrepresented in clinical and counseling psychology.

Strongly Disagree Disagree Agree Strongly Agree

41. How would you rate your ability to conduct an effective counseling interview with a person from a cultural background significantly different from your own?

Very Limited Limited Good Very Good

42. How would you rate your ability to effectively assess the mental health needs of a person from a cultural background significantly different from your own?

Very Limited Limited Good Very Good

43. How well would you rate your ability to distinguish "formal" and "informal "counseling strategies?

Very Limited Limited Good Very Good

44. In general, how would you relate yourself in terms of being able to effectively deal with biases, discrimination, and prejudices directed you by a client in a counseling setting?

Very Limited Limited Good Very Good

45. How well would you rate your ability to accurately identify culturally biased assumptions as they relate to your professional training?

Very Limited Limited Good Very Good

46. How well would you rate your ability to discuss the role of "method" and "context" as they relate to the process of counseling?

Very Limited Limited Good Very Good

47. In general, how would you rate your ability to accurately articulate a client's problem who comes from a cultural group significantly different from your own?

Very Limited Limited Good Very Good

48. How well would you rate your ability to analyze a culture into its component parts?

Very Limited Limited Good Very Good

49. How would you rate your ability to identify the strengths and weaknesses of psychological tests in terms of their use with persons from different cultural/ racial/ ethnic backgrounds?

Very Limited Limited Good Very Good

50. How would you rate your ability to critique multicultural research?

Very Limited Limited Good Very Good

51. In general, how would you rate your skill level in terms of being able to provide appropriate counseling services to culturally different clients?

Very Limited Limited Good Very Good

52. How would you rate your ability to effectively consult with another mental health professional concerning the mental health needs of a client whose cultural background is significantly different from your own?

Very Limited Limited Good Very Good

53. How would you rate your ability to effectively secure information and resources to better serve culturally different clients?

Very Limited Limited Good Very Good

54. How would you rate your ability to accurately assess the mental health needs of women?

Very Limited Limited Good Very Good

55. How would you rate your ability to accurately assess the mental health needs of men?

Very Limited Limited Good Very Good

56. How well would you rate your ability to accurately assess the mental health needs of older adults?

Very Limited Limited Good Very Good

57. How well would you rate your ability to accurately assess the mental health needs of gay men?

Very Limited Limited Good Very Good

58. How well would you rate your ability to accurately assess the mental health needs of gay women?

Very Limited Limited Good Very Good

59. How well would you rate your ability to accurately assess the mental health needs of handicapped persons?

Very Limited Limited Good Very Good

60. How well would you rate your ability to accurately assess the mental health needs of persons who come from very poor socioeconomic backgrounds?

Very Limited Limited Good Very Good

(D'Andrea, M., Daniels, J., Heck, R. (1999). Evaluating the Impact of Multicultural Counseling Training. *Journal of Counseling & Development, 70,* 143-150.)

Cultural Competence Self-Test

This checklist is intended to heighten the awareness and sensitivity of personnel to the importance of cultural and linguistic competence in health and human service settings. It provides concrete examples of the kinds of beliefs, attitudes, values and practices that foster cultural and linguistic competence at the individual or practitioner level. There is no answer key with correct responses. However, if you frequently responded "C," you may not necessarily demonstrate beliefs, attitudes, values and practices that promote cultural and linguistic competence within healthcare delivery programs.

The following self-assessment can assist healthcare service providers in identifying areas in which they might improve the quality of their services to culturally diverse populations.

Promoting Cultural and Linguistic Competency

Self-Assessment Checklist for Personnel Providing Primary Healthcare Services

Directions: Please enter A, B or C for each item listed below.
A = Things I do frequently
B = Things I do occasionally
C = Things I do rarely or never

Physical Environment, Materials & Resources

____ 1. I display pictures, posters, artwork and other decor that reflect the cultures and ethnic backgrounds of clients served by my program or agency.

____ 2. I ensure that magazines, brochures and other printed materials in reception areas are of interest to and reflect the different cultures of individuals and families served by my program or agency.

____ 3. When using videos, films or other media resources for health education, treatment or other interventions, I ensure that they reflect the cultures and ethnic background of individuals and families served by my program or agency.

____ 4. I ensure that printed information disseminated by my agency or program takes into account the average literacy levels of individuals and families receiving services.

Communication Styles

5. When interacting with individuals and families 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.

____ 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.

____ They may or may not be literate in their language of origin or English.

____ 6. I use bilingual-bicultural staff and/or personnel and volunteers skilled or certified in the provision of medical interpretation during treatment, interventions, meetings or other events for individuals and families who need or prefer this level of assistance.

____ 7. For individuals and families 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 assessment, treatment or other interventions.

____ 8. I attempt to determine any familial colloquialisms used by individuals or families that may impact on assessment, treatment or other interventions.

____ 9. When possible, I ensure that all notices and communiqués to individuals and families are written in their language of origin.

____ 10. I understand that it may be necessary to use alternatives to written communications for some individuals and families, as word of mouth may be a preferred method of receiving information.

Values & Attitudes

____ 11. I avoid imposing values that may conflict or be inconsistent with those of cultures or ethnic groups other than my own.

____ 12. I screen books, movies and other media resources for negative cultural, ethnic or racial stereotypes before sharing them with individuals and families served by my program or agency.

____ 13. I intervene in an appropriate manner when I observe other staff or clients within my program or agency engaging in behaviors that show cultural insensitivity, racial biases and prejudice.

____ 14. I recognize and accept that individuals from culturally diverse backgrounds may desire varying degrees of acculturation into the dominant culture.

____ 15. I understand and accept that family is defined differently by different cultures (e.g., extended family members, fictive kin, god-parents).

____ 16. I accept and respect that male-female roles may vary significantly among different cultures and ethnic groups (e.g., who makes major decisions for the family).

____ 17. I understand that age and life-cycle factors must be considered in interactions with individuals and families (e.g., high value placed on the decision of elders, the role of eldest male or female in families, or roles and expectation of children within the family).

____ 18. Even though my professional or moral viewpoints may differ, I accept individuals and families as the ultimate decision makers for services and supports impacting their lives.

____ 19. I recognize that the meaning or value of medical treatment and health education may vary greatly among cultures.

____ 20. I accept that religion and other beliefs may influence how individuals and families respond to illnesses, disease and death.

____ 21. I understand that the perception of health, wellness and preventive health services have different meanings to different cultural or ethnic groups.

____ 22. I recognize and accept that folk and religious beliefs may influence an individual's or family's reaction and approach to a child born with a disability, or later diagnosed with a disability, genetic disorder or special healthcare needs.

____ 23. I understand that grief and bereavement are influenced by culture.

____ 24. I seek information from individuals, families or other key community informants that will assist in service adaptation to respond to the needs and preferences of culturally and ethnically diverse groups served by my program or agency.

____ 25. Before visiting or providing services in the home setting, I seek information on acceptable behaviors, courtesies, customs and expectations that are unique to the culturally and ethnically diverse groups served by my program or agency.

____ 26. I keep abreast of the major health concerns and issues for ethnically and racially diverse client populations residing in the geographic locale served by my program or agency.

____ 27. I am aware of the socioeconomic and environmental risk factors that contribute to the major health problems of culturally, ethnically and racially diverse populations served by my program or agency.

____ 28. I am well versed in the most current and proven practices, treatments and interventions for major health problems among ethnically and racially diverse groups within the geographic locale served by my agency or program.

____ 29. I avail myself to professional development and training to enhance my knowledge and skills in the provision of services and supports to culturally, ethnically, racially and linguistically diverse groups.

____ 30. I advocate for the review of my program or agency's mission statement, goals, policies and procedures to ensure that they incorporate principles and practices that promote cultural and linguistic competence.

Self-assessment developed by Tawara D. Goode, Georgetown University Child Development Center-UAP. Adapted with permission from *Promoting Cultural Competence and Cultural Diversity in Early Intervention and Early Childhood Settings* and *Promoting Cultural Competence and Cultural Diversity for Personnel Providing Services and Supports to Children with Special Health Care Needs and Their Families* (June 1989; latest revision July 2000).

Cultural Competence Information Sheets

Please see the separate link to accompanying cultural competence information sheets. These sheets can be used for training purposes, posted on bulletin boards or disseminated in resource booklets. They are intended as a tool for disseminating concise summaries of cultural competence related information.

Cultural and Linguistic Definitions

Access: Refers to the degree to which services are quickly and readily obtained. It is determined by the extent to which needed services are available, the information provided about these services, the responsiveness of the system to individual cultural and linguistic needs, and the convenience and timeliness with which services are obtained.

Assessment: Activities which determine the current need for culturally competent and linguistically appropriate services and the current availability and quality of such services. Assessment efforts should be data-driven and will include surveys, studies, or evaluations to determine the demographic characteristics of the clients/consumers, the capability of providers and staff, the quality of services, customer and provider satisfaction, and appropriate utilization of the services.

Complementary Resources: Any help that is exchanged beyond treatment services. They are services that are supported, operated, and/or regulated by the public or professional sector. These resources may include religious, social or those of other voluntary organizations; mutual aid or self-help groups; indigenous healers or natural helpers; as well as kin, friends, and neighbors.

Cultural Competence: A set of knowledge, skills, attitudes, policies, practices, and methods that enable care providers and programs to work effectively with culturally diverse client/consumers, families and communities. Culturally competent behavioral healthcare providers have, at a minimum, linguistic competence and also some knowledge about the culture and ethnicity. They should also have the knowledge and skills to use assessment and treatment methods which are appropriate for multicultural client/consumers.

Cultural Competence Plan: A written document that outlines a systematic approach to provide culturally relevant services to individuals served by a particular agency/organization. The Plan is used to direct an agency towards culturally responsive services with demographic information, congruent policies, services/programs, ongoing staff development, and quality improvement strategies that come together to enable behavioral programs to provide culturally competent services.

Culturally Appropriate: The capacity of individuals or organizations to develop compatible health practices and behaviors of target populations. Cultural information is used to design programs, interventions and services that address cultural and language needs in order to deliver appropriate and necessary healthcare services; and to evaluate and contribute to the ongoing improvement of services.

Cultural Humility: Cultural humility is a lifelong process that ensures that professionals learn about other cultures and are sensitive to cultural differences. It is a humble and respectful attitude toward individuals of other cultures that pushes one to challenge their own cultural

biases, realize they cannot possibly know everything about other cultures, and approach learning about other cultures as a lifelong goal and process.

Cultural Relevance: Services that bear "a traceable, significant, logical connection" to the ethnically/culturally-based needs, expectations, desires and existing realities of the individuals to whom the services are directed. This includes a leadership and workforce that is able and willing to obtain the necessary knowledge about the clients/consumers' cultural and socioeconomic background that will enable them to plan and deliver effective therapeutic behavioral health programs.

Culture: Recurrent patterns of thought and behavior that are shared and transmitted by members of a group, including language, ideology, norms and values. Culture shapes personal identity (e.g., race, ethnicity and culture), interpersonal networks, and social institutions. Culture is also a powerful force in diagnosis, treatment, aftercare and other responses to illness and behavioral disorders.

Engagement: The skill and environment to promote a positive personal influence on the quality of the client's commitment to be in treatment.

Interpretation: Putting words of one language into another language. In health services, translation is used when converting written information from English-language medical/psychiatric forms, informational brochures and other health-related materials into the patient/client/consumer's language.

Linguistic Competence: The ability to communicate and provide behavioral healthcare in both English and the primary language of client/consumers and families. A behavioral healthcare organization with linguistic competence offers 24-hours access to staff and/or interpreters who are fluent in the client/consumer's language and in English.

Limited Spoken English or a Limited Proficiency in Speaking English: Persons who have a limited language proficiency in English. This includes those who have limited spoken English who also have difficulty understanding what an English-speaking person is saying, or, who have trouble being understood by an English-speaking person.

Natural Helpers: Individuals who are recognized by persons close to them, and/or by local communities, as being able to advise, help or heal, using medicinal items, symbols, activities, rituals, and social connections that are most meaningful to those seeking support.

Primary Language: Refers to the language in which an individual is most proficient and uses most frequently to communicate with others inside or outside the family system.

Retention: The result of quality service that helps maintain a client in treatment with continued commitment.

Written Material and Orientation: Refers to the availability of written materials and orientation sessions in languages other than English.

Included with permission from the Connecticut Department of Mental Health and Addiction Services Office of Multicultural Affairs Assessment Guidelines for Developing a Multiculturally Competent Service System for a Program or Organization.

Web Resources

American Psychological Association Guidelines on Multicultural Education Training, Research, Practice, and Organizational Change for Psychology
www.apa.org

Becoming a Culturally Competent Health Care Organization, American Hospital Association
http://www.hpoe.org/resources/ahahret-guides/1395

~~CulturedMed Resources for Culturally Competent Care, The State University of New York Institute of Technology (SUNYIT)~~
~~http://culturedmed.sunyit.edu/index.html~~[LT1]

~~Department of Health and Human Services ~ CMS (Centers for Medicare & Medicaid Services)~~

- ~~Providing Oral Linguistic Services: A Guide for Managed Care Plans~~[LT2]
- ~~Planning Culturally and Linguistically Appropriate Services: A Guide For Managed Care Plans~~

Planning Culturally and Linguistically Appropriate Services, Agency for Healthcare Research and Quality
https://www.ahrq.gov/professionals/systems/primary-care/cultural-competence-mco/planclas.html

Institute on Disability Culture
http://www.instituteondisabilityculture.org/

Department of Health and Human Services
Health Resources and Services Administration Study on Measuring Cultural Competence in Health Care Delivery Settings

http://www.hrsa.gov/culturalcompetence/healthdlvr.pdf

Department of Health and Human Services, Office of Minority Health
Cultural and Linguistic Competence Standards
~~https://www.thinkculturalhealth.hhs.gov/content/clas.asp~~[LT3]
https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53

Georgetown University National Center for Cultural Competence
http://nccc.georgetown.edu/

Mental Health: Culture, Race, and Ethnicity, U.S. Surgeon General
~~www.surgeongeneral.gov~~ https://www.ncbi.nlm.nih.gov/pubmed/20669516

National Association of School Psychologists

Cultural Competence Information and Resources
http://www.nasponline.org/resources/culturalcompetence/definingculture.aspx

National Association of Social Workers, Standards for Cultural Competence in Social Work Practice
~~https://www.socialworkers.org/pressroom/features/issue/diversity.asp~~[LT4]
http://www.socialserviceworkforce.org/resources/standards-and-indicators-cultural-competence-social-work-practice

Cultural Competency in Mental Health Peer-Run Programs and Self-Help Groups: A Tool to Assess and Enhance Your Services
https://power2u.org/wp-content/uploads/2017/09/CulturalCompetencyInMentalHealthPeer-runProgramsSelf-helpGroups.pdf
Minority Population Profiles, Office of Minority Health Data and Statistics
http://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=26

~~Substance Abuse and Mental Health Services Administration~~[LT5]
~~Cultural Competence Standards in Managed Care Mental Health Services: Four Underserved/Underrepresented Racial/Ethnic Groups~~
~~The Provider's Guide to Quality and Culture~~Culture, Language, and Health Literacy, HRSA
http://www.hrsa.gov/culturalcompetence/index.html

The Compelling Need for Cultural and Linguistic Competence, National Center for Cultural Competence, Georgetown University ~~Why Is There A Compelling Need For Cultural Competence?~~ https://nccc.georgetown.edu/foundations/need.php

~~www.gucchd.georgetown.edu~~
~~http://nccc.georgetown.edu/foundations/need.html~~

Cultural Competence Related Books

Carter, R. T. (Ed). (2005). *Racial-cultural psychology and counseling: Theory and research, volume 1.* New Jersey: John Wiley & Sons, Inc.

Carter, R. T. (Ed). (2005). *Racial-cultural psychology and counseling: Training and practice, volume 2*. New Jersey: John Wiley & Sons, Inc.

Constantine, M. & Sue, D. W., (Ed). (2005). *Strategies for building multicultural competence in mental health and educational settings.* New Jersey: John Wiley & Sons, Inc.

Cuellar, I. & Paniagua, F. A. (Eds.). (2000). *Handbook of multicultural mental health*. San Diego, CA: Academic Press.

Dana, R. H. (2005). *Multicultural assessment: Principles, applications, and examples.* New Jersey: Lawrence Erlbaum Associates Publishers.

Fadiman, A. (1997). *The spirit catches you and you fall down*. New York: Farrar, Straus, Giroux.

McGoldrick, M., Giordano, J., Garcia-Preto, N. (Eds). (2005). *Ethnicity and family therapy* (3rd ed.). New York: Guilford Press.

Pedersen, P. (Ed). (1999). *Multiculturalism as a forth force.* New York: Hamilton Printing Company.

Pontorotto, J.G.; Casas, J.M.; Suzuki, L.A.; & Alexander, C.M. (Eds.) (2001). *Handbook of multicultural counseling, 2nd Edition*. Thousand Oaks, CA: Sage Publications, Inc.

Pope-Davis, D., Colman, H. L. K, Liu, W. M., & Toporek, R. L. (Eds.). (2003). *Handbook of multicultural competencies: In counseling & psychology.* Thousand Oaks, CA, US: Sage Publications, Inc.

Sue, D. W. (2006). *Multicultural social work practice.* New Jersey: John Wiley & Sons, Inc.

Sue, D. W., Carter, R., Cases, J.M., Fouad, N., Ivey, A. E., Jensen, M. LaFromboise, T., Manese, J. E., Pontorotto, J.G., & Vasquez-Nutall, E. (Eds.). (1998). *Multicultural counseling competencies: Individual and organizational development.* Thousand Oaks, CA: Sage Publications, Inc.

Sue, D. W. & Sue, D. (1999). *Counseling the culturally different: Theory and practice* (3rd ed.). New Jersey: John Wiley & Sons, Inc.

Tseng, W. & Streltzer, J. (Eds.). (2004). *Cultural competence in clinical psychiatry***.** Washington, DC: American Psychiatric Publishing, Inc.