

Transforming Cultural and Linguistic Theory into Action

A Toolkit for Communities



Providing safe havens and sharing power yields success.

**Michigan Department of Health and Human Services
Behavioral Health and Developmental Disabilities Administration
Office of Recovery Oriented Systems of Care
Recovery Oriented System of Care, Transformation Steering Committee**

Revised March 2016

Table of Contents

Transforming Cultural and Linguistic Theory into Action

Part One

A Toolkit for Communities

Forward.....	1
Fast Forward – Lessons Learned 3-year Update	2
Framework for Cultural and Linguistic Proficiency	3
BSAS Cultural Competency Guidance and Implementation Principles	3
Core Elements	5
Next Steps	7
The Role of Self-Assessment	8
Self-Assessment Framework.....	9
o Tool #1 - ROSC Workgroup Self-Assessment Tool.....	11
o Tool #2 - Guide to Ensure that Selected Values are Incorporated	13
o Tool #3 - Promoting Cultural Diversity and Cultural Competency – Self-Assessment Checklist	15
Basic Cultural Competency Concepts.....	19
References	20

FOREWORD

In this document, we provide a yardstick to help the reader examine his/her own cultural values and evaluate their interpersonal strengths and weaknesses. Being a successful professional requires flexibility, respect for other opinions, and the ability to adapt to different beliefs and lifestyles. These are the building blocks to cultural and linguistic competence. In designing cultural competency guidance, it was important to the Bureau of Substance Abuse and Addiction Services (OROSC) that the subject be regarded as more than another well-articulated, but rarely used definition. Substance abuse and substance use disorders are very sensitive issues and are closely linked to self-image, language nuances, group traditions, religious beliefs, and social mores. These things shape who we are and how we interact with the rest of society. Interaction with others has just as much to do with personal views about health and wellness as with how other people perceive and treat us.

Self-awareness is an important first step because understanding oneself and how personal world views have been shaped can lend insight into biased thinking that we may have unwittingly developed. These biases can lead to assumptions and stereotypes that hinder the way we administer care. Professionally we evolve toward cultural competence the more we are able to link human diversity with what we know about risk and protective factors relevant to substance use behaviors. When equipped with this expertise we understand that, even though race inevitably links us to a group of people; so does age, gender, socio-economic status, profession, politics, religion, and other categorical influences. This awareness allows the practitioner to gain a broader appreciation of people, improves the quality of service, and ultimately leads to better outcomes. There is no single formula for cultural competency. Just as people differ, building cultural knowledge can be achieved in a variety of ways including books, observation and empathetic listening to the client. The latter can help the counselor or educator learn about the client's values and beliefs regarding health and illness. Understanding how group dynamics influence behaviors can lead to providing appropriate service without being patronizing.

A self-evaluation should be ongoing, as we continually adapt and re-evaluate the way things are done. The dynamic nature of our personal growth and surrounding population changes means that this is a living document that will periodically be revised. It is our hope that these guidelines will help you develop policies, practices, and procedures that contribute to delivery of culturally competent care.

I would like to thank Sonia Acosta, Marcia Cameron, Carolyn Foxall, Denise Herbert, and Pamela Pellerito for their untiring work to finalize this document.

Sincerely,

*Deborah J. Hollis, Director
Office of Recovery Oriented Systems of Care*

Fast Forward – Lessons Learned 3-year Update

During the first three-years of using this cultural competency document, the Bureau of Substance Abuse and Addiction Services merged with the Department of Human Services. The name of the entity is now the Michigan Department of Health and Human Services (MDHHS) and we are a division known as the Office of Recovery Oriented Systems of Care (OROSC). Organizations under MDHHS jurisdiction that were formerly called Coordinating Agencies are now incorporated into regional Prepaid Inpatient Health Plans (PIHPs). This merger created the ideal laboratory to test the theories of cultural competency because we had to learn how to work as a complimentary team. There were five primary lessons learned:

1. Becoming culturally competent (CC) is a PROCESS. Having a CC policy is the first step to strategic planning and evolutionary implementation. This is not a “one-in-done” activity that can be checked off your “To Do” list and neatly shelved.
2. There is a rhetorical premise about working with a diverse group that is sometimes countered by reality. Organizations must be FLEXIBLE in implementation. As demographics, economic conditions and social mores change, outreach and programs should adapt to population need.
3. It is important to have a plan when introducing concepts, however, it is EQUALLY IMPORTANT TO LISTEN. Knowledge about cultural competency principles is essential, however, listening with empathy and sensitivity to the target audience is critical to buy-in and ultimately participation.
4. Workforce goals are dynamic. In our hectic day-to-day existence it is easy to disconnect. Avoid boring redundancy, however, REPEAT key points to RECONNECT the audience with the umbrella goal and the activity. Be ready to answer the question, “How is this RELEVANT?”
5. As people learn things about themselves and as leaders discover strengths and interests of the body at large UTILIZE those SKILLS to make the process better. This will help foster ownership and sustainability.

Keeping these things in mind, we have chosen to revisit the original toolkit and augment it’s implementation with revisions that are labeled as “**Caveats**” throughout the document. Finally, we will add an evaluation form for Part One that will help us continue to help you by developing a Part Two.

Thank you.

Sincerely,

Deborah J. Hollis, Director
MDHHS/Office of Recovery Oriented Systems of Care

Framework for Cultural and Linguistic Proficiency

As the single state agency responsible for the Michigan's publicly funded substance abuse service system, the MDHHS/OROSC is committed to developing a culturally competent substance abuse service delivery system. Best practices in the performance of our business (service delivery), regulatory, and clinical functions necessitate responding to our clients, customers, and employees in a culturally appropriate manner.

A person's culture is a combination of the attitudes, policies, and practices that ultimately shape the behaviors of individuals and groups of people. This includes the language, communications, thoughts, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. In the context of substance misuse the goal is to improve the quality of services and health outcomes for all cultural groups and to reduce disparities that occur when a client's culture deviates from the majority or mainstream. Cultural and linguistic competence simply means that an individual and/or an organization possesses the knowledge, skills, and attitude to function effectively within the cultural beliefs, behaviors, and needs presented by clients and their communities. We believe that cultural competence gives consideration to all variables that may be key determinants of a substance use disorder (SUD) that ultimately impact an individual's wellness/illness. This information allows appropriate continuum of care interventions for prevention assessment and treatment.

OROSC, regional Prepaid Inpatient Health Plans (PIHPs), providers, and professionals must work together effectively to serve Michigan's varied population. A diverse service system is reflected in its leadership, community relations, hiring, staffing, outreach, and services. This includes a workforce that is representative, capable, and culturally responsive toward the people it serves. Conversely, not being an eclectic or responsive system decreases effectiveness and wastes our limited resources.

To be clear, race historically and presently plays a major role in health and economic disparities. Economic disparities often contribute to availability and quality of mental health and substance use disorder services. Although race contributes to an assortment of cultural attributes, it is a mistake to assume that it is synonymous with culture. Culture cannot be pigeon-holed in that way. To name just a few, religious, socio-economic, age and gender groups often represent underserved classes of people who are treated differently from majority or mainstream populations. Language or dialect barriers also create schisms within society. The mindset about culture must include the issues of these core cultures in addition to racial and ethnic groups. A good start would be to develop a generic marketing perspective that asks:

- 1) Who is in my service area?
- 2) Who is not being served?
- 3) What are the special needs of this population?
- 4) How can I include them in service decisions and evaluation?

Caveat #1: "Part Two" will provide greater detail on how to implement these four steps.

OROSC Cultural Competency Guidance and Implementation Principles:

Cultural competency:

- is integral to OROSC strategic plan and system expectations
- must be infused into routine business practices and operations
- requires continuous quality improvement (CQI)
- must be data driven
- must be administratively friendly vs. burdensome
- roles and responsibilities need to be identified throughout the system

Six key implementation components to Michigan's substance abuse service delivery system:

- **Inclusion** – Involvement in an open process (planning to implementation) that is personalized and sensitive to all stakeholders.
- **Diversity** – Seek out, embrace, and value differences and similarities among stakeholders. This includes gender, age, race, ethnicity, sexual orientation, mental and physical abilities, and characteristics.
- **Respect** – Accept, acknowledge, value, don't judge, and respond to differences.
- **Excellence** – Strive for quality services and measurable outcomes through clear expectations, best practices, and on-going training and education, and accountability.
- **Relationships** – Partnerships among stakeholders that are productive, have shared goals, trust, and support.
- **Accountability** – OROSC, in partnership with key stakeholders, will provide clear guidance regarding accountability, setting objectives, measuring progress, and further steps to improve quality, service delivery, and outcomes. Outcomes will be meaningful to both the provider and the recipient.

Caveat #2: Following an in-house survey, OROSC staff concluded that when all of these components are in place it breeds an atmosphere of trust. They further concluded that if agencies want people to participate in programming and/or treatment services, trust is key to quality and successful outcomes. Subsequently, employees participated in a series of activities designed to foster "trust" among co-workers. You are welcome to use these or adapt them to your unique organizational characteristic. See Appendix #1 – Organizational Trust Building Activities.

Michigan's population estimate is 9,883,640 (2010) and its demographics are constantly changing. In the next 35 years it is estimated that people of color will account for 50% of the state's population (currently it's 20%). In our substance abuse treatment delivery system, Hispanic admissions have remained relatively stable at 3%, yet the Hispanic population in Michigan has increased from 3.9% in 2007 to 4.4% in 2010. In 2005, the National Survey of Drug Use and Health (NSDUH) estimated that 14.3% of Michigan's Hispanic population (56,460 persons) is in need of treatment. Seniors, who by nature experience human loss, failing health and increased prescription drug use, account for 13% of our population. According to the American Community Survey (2010), Michigan unemployment hovers at 9.4% and persons below poverty total 16.8%. Current job demands, increased foreclosures, and economic conditions create daily stressors that often become high risk causal factors to use. Layoffs and business cutbacks are compelling Michigan residents with substance use disorders to seek public services. In addition, our system must continue to serve those with language barriers (8.4% of

Michigan residents in 2005 [over 850,000]), physical disabilities (Michigan residents ages 5 and older with disabilities totaled 1,711,231 in 2000), and various religious affiliations that affect belief systems about use and recovery.

All of these issues set the stage for businesses and clinicians to work internally and collaboratively as a “village” of support for our citizenry. A rationale for each of these institutions follows.

Regulatory Case:

National accrediting agencies recognize the value in understanding and serving the needs of a client base in their quality assurance process. State agencies and provider organizations should be purposeful in increasing systemic standard protocols to ensure cultural competency. Those interested in doing so could follow the guidance adapted from the Michigan 2008 "*Color Me Healthy*" report:

- Emphasize behavioral risk-reduction and prevention
- Promote healthy norms
- Identify and require interventions of evidence-based strategies
- Ensure on-going efforts to increase knowledge
- Develop infrastructure and capacity of state and community organizations
- Monitor and participate in web-based technical assistance

The focus of cultural competency should be to improve the quality of prevention, treatment, and recovery services, and to reduce the rate of morbidity by implementing professional guidelines.

Business Case:

As stated earlier, Michigan’s population is changing. Also, current economic conditions are compelling Michigan residents with SUDs to seek public services. A culturally competent community should have a distinct look. The SUD system should provide:

- Easy access to products and services of various ethnic origins.
- Seamless, natural, harmonious interaction.
- People working together through participation and collaboration.
- A safe welcoming atmosphere.
- A feeling of equality among people.

The West Michigan Chamber Coalition contends, “Within a city, there is a sense of vibrancy and energy as well as a variety of ages, arts and entertainment, products and services, restaurants, and languages spoken.” Businesses are inclined to invest in such a community.

Clinical Case:

As client norms, language, values, behaviors, and practices become more diverse and changing; the goal of prevention, treatment, and recovery should be to make our services culturally sensitive and germane to grassroots needs. Culture should not be used to profile and stereotype recipients, but rather as a tool to build understanding, teach respect, foster trust, and reduce disparities. To better serve our recipients, we need a system that welcomes, engages, and retains clients to help achieve positive outcomes. Healthy citizens are productive contributors to the workforce and society.

Core Elements:

The following tables identify core elements at a systems level for which OROSC, PIHPs, providers, and staff each have a role in ensuring state, regional, and community “buy in” and implementation:

Provide Leadership

OROSC	<ul style="list-style-type: none"> - Share data/information/policies, outcomes (NOMS, PIs) - Provide training on best practices - Seek effectiveness in end result - Integrate cultural competency, or provide guidelines on how to integrate - Maintain Prevention <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Treatment Continuum - Develop standards for ongoing education
PIHPs	<ul style="list-style-type: none"> - Establish reporting requirements - Balance guidance with OROSC directives with community needs - Assess effectiveness within communities for prevention (outreach) and recovery rates; and integrate into policies, practices, and contracts with providers - Educate boards on policy developments - Reflect community cultural composition in PIHP board and staff - Make cultural competency policy a pre-condition of funding - Promote staff training
Substance abuse service providers	<ul style="list-style-type: none"> - Enforce or follow PIHP policy - Model staffing via cultural composition (when possible) or cultural awareness - Provide community education, and demographic outreach to underserved populations about the value of seeking formal treatment service resources when necessary - Train staff to develop individual treatment plans that build upon the individual client’s diversity, strength, and community - Include cultural competency in staff recipient rights training

Address Workforce Capability

OROSC	<ul style="list-style-type: none"> - Survey attitudes about cultural competency - Incorporate client/consumer suggestions - Determine what works and do more of it - Evaluate priority resource allocations - Assess cultural and linguistic competence or representation - Clarify cultural diversity needs - Periodically assess welcoming practices or atmosphere
PIHPs	<ul style="list-style-type: none"> - Gather baseline data of all providers credentials and skills - Assess experience with cultural competency - Construct a socio-economic picture of region/communities - Develop strategic training and technical assistance plan

Substance abuse service providers	<ul style="list-style-type: none"> - Provide baseline data of staff credentials and skills to PIHP - Assess staff understanding of populations in service area - Determine if there are outreach gaps and staff ability to address them - Educate treatment personnel about cultural competency, cultural diversity, and how to harness a client's unique cultural strengths as a lever to build successful prevention/treatment outcomes and sustain results
--	---

Address Disparities

OROSC	<ul style="list-style-type: none"> - Gather data at both state and regional levels - Compare variety and quality of prevention and treatment services across populations - Profile level of service by race, gender, age, ethnicity, and other cultural aspects - Review treatment outcomes among priority populations - Assess factors have most negative impact: recovery, engagement, affordability, access - Strategically prioritize which disparity to address - Brainstorm: money/funding
PIHPs	<ul style="list-style-type: none"> - Compile information from providers regarding cultural competency - Provide services based on data
Substance abuse service providers	<ul style="list-style-type: none"> - Balance provider panels with cultural variety - Determine gaps and strategize how to address them via inclusive think tank process

Improve Community Involvement

OROSC	<ul style="list-style-type: none"> - Connect with health systems, insurance providers, faith-based organizations, schools - "Educate communities" <ul style="list-style-type: none"> - capitalize on existing media campaigns - build on successes - Update stakeholders with a “newsy” newsletter - Provide community friendly data presentations – PSAs, TV - Answer, “How does substance abuse impact on me?” with relevant information
PIHPs	<ul style="list-style-type: none"> - Recruit community members, recovery communities, boards - Validate volunteers – tap into passion [What does community care about? Begin there.]
Substance abuse service providers	<ul style="list-style-type: none"> - Recruit community members, recovery communities, boards - Validate volunteers – tap into passion - Make concerted outreach to minority populations by recruiting staff who are representative of local clients - Develop a system that makes it easier for diverse neighborhoods to access treatment services, and feel comfortable in retaining those services

Colleges and universities	<ul style="list-style-type: none"> - Determine patterns of health disparities and underserved populations - Engage resource persons and Greek organizations - Involve target groups in activities - Provide coalition internships - Encourage fun
----------------------------------	--

Next Steps:

In order to begin taking steps to transform our current system into a system where cultural competency is infused throughout, OROSC is working with its partners to implement the following activities:

- Continue Cultural Competency Workgroup.
 1. Establish charge.
 2. Disseminate framework.
 3. Include key members in planning workgroup.
- Draft cultural competency technical advisory.
- Address cultural competency in all of its current policy and technical advisories.
- Establish baseline data by PIHP for retention and penetration rates using fiscal year 2005 data.
- Establish performance indicators.
- Monitor PIHP plans and implementation during site visits.
- Report and evaluate progress.

To operationalize cultural competency, OROSC recognizes and accepts:

- Current regulatory and accreditation requirements.
- Current individual, agency, and PIHP efforts to address cultural competency.
- Local agency definitions of cultural competency.
- Different stages of cultural competency implementation at all system levels.

Caveat #3: See “Part Two”, for core elements and next step planning.

The Role of Self-Assessment

In Achieving Cultural and Linguistic Competence within a Michigan ROSC

The following three Self-Assessment Tools were identified to help the process of becoming a recovery oriented system of care (ROSC) that is inclusive and welcoming of the different “cultures” within communities throughout the state.

The first tool, “**ROSC Workgroup Self-Assessment Tool**,” is designed to ensure that workgroup members and field staff are selected to bring diverse points of view and perspectives to the design and implementation of culturally relevant practices. We see this as the first step in trying to model a system where cultural competence is permeated throughout the process and to ensure that Cultural Competence is thought of as something more than racial and ethnic diversity.

The goal is to help agencies value the diversity of their population as relevant to age, language, disability, race, ethnicity, gender, religion and other unique group aspects that may lead to service disparities. Each community can focus on the group(s) represented in their demographic profile and can adapt the toolkit to meet their needs.

After ensuring that leaders can speak to the different “cultures” that they want to outreach, they can also utilize the documents that have been developed by the National Center for Cultural Competence. More of these tools are available on their website at www.nccc.georgetown.edu.

The second tool entitled “**Guide to Ensure that Selected Values are Incorporated into Workgroup Strategies Moving Toward Cultural Competency**,” is an evaluation tool. It is designed to help workgroups determine if they are progressively moving toward full implementation of cultural competence strategies that lead to trusting environments.

The third tool entitled “**Promoting Cultural Diversity and Cultural Competency: Self-Assessment Checklist for Personnel Providing Behavioral Health Services and Supports to Children, Youth, and their Families**,” provides some practical examples of how to implement cultural outreach. This coincides with guidance in the ROSC Implementation Plan. The package provides practical examples of cultural outreach.

We hope you find this package useful as you strive to offer culturally competent care to the various social structures within your catchment area.

The ROSC Cultural Competency Workgroup

Self-Assessment Framework For Improving Michigan's ROSC Cultural Competency

The Premise for Cultural Competency

Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. 'Culture' refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. 'Competence' implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities (Adapted from Cross et.al., 1989, as cited in National Center for Cultural Competence, 2012a).

Guiding Principles

Cultural Competency . . .

- Must be infused into routine business practices and operations.
- Requires continuous quality improvement.
- Must be data driven.
- Must be administratively friendly vs. burdensome.
- Roles and responsibilities must be identified throughout the system.

Framework Ideals

Strategies and practices are aimed at factors that shape the broader community by improving the quality of services and behavioral health outcomes while reducing disparities. The systems-level strategies and practices recommended include efforts to:

- **Promote coordination, collaboration, and partnerships** to build relationships and trust, allow for pooling and leveraging of resources, expertise and talent, and foster synergies that benefit all involved parties.
- **Foster and ensure leadership and commitment**, including the development and implementation of strategic plans that provide vision and direction, set priorities and coordinate, and target resources. Strategic plans for addressing minority health and health disparities should draw on existing data on minority groups, incorporate input and feedback from community partners, build upon the best of existing and emerging evidence of successful strategies and practices, structure activities around expected outcomes and impacts tied to goal-setting processes (e.g. Healthy People 2010) at the state and federal levels, and employ performance assessment and evaluation results for continuous improvement.
- **Establish, increase, and strengthen system components and resources**, such as infrastructure, staffing, and funding to ensure specific attention to potential barriers and

health disparities among racial/ethnic minority groups and other special populations (e.g. LGBT, military, and disabled) representative of a particular community.

- **Promote user-centered design to address racial/ethnic minority needs** to improve racial/ethnic bias or discrimination, cultural and linguistic barriers, lack of access and lack of trustworthiness. Strategies and practices should include community-based participation by increased participation of racial/ethnic minorities in planning, implementation, monitoring, and evaluation of programs and initiatives.
- **Improve knowledge about successful strategies and practices** through increased and enhanced research, demonstrations, and evaluation (RD&E) – translating research into practice and policy.

Implementing the ROSC Workgroup Self-Assessment Tool Checklist

The overall intent of this tool is to build an infrastructure that helps guide, organize and coordinate system planning, implementation and evaluation efforts within Michigan's ROSC system. The process will ensure accountability and build transparent, trusting relationships with key community stakeholders. The tool should be performed semi-annually by each Transformation Steering Committee (TSC) member in combination with other TSC evaluation measures as a means of discerning the level of infusion of cultural competence elements within Michigan's ROSC.

ROSC Workgroup Self-Assessment Tool

Date of Self-Assessment: _____ [To be compared with future dates.]*

Individuals are asked to rank items from 1-4 (1 = not true at all, 4 = very true).

Workgroup Name:		Not at All True	Slightly True	Moderately True	Very True
1	Workgroup currently represents the diversity of our community with respect to: a. race b. gender c. geography d. ethnicity e. age f. sexual orientation g. <u>disability</u> h. other special populations	1 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	2 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	3 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	4 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
2	Workgroup has a documented plan to recruit and retain diverse membership that is demographically representative of the service area.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
3	Workgroup uses a needs assessment to accurately plan for and implement (workgroup) strategies responsive to the cultural and linguistic characteristics of the service area.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
4	Workgroup accepts, seeks out, embraces, and values differences among stakeholders and helps them feel welcomed.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
5	Workgroup ensures proposed strategies of the ROSC Implementation Plan are culturally competent by measuring against the Cultural Competency Toolkit.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
6	Workgroup ensures members receive ongoing education and training in culturally and linguistically appropriate service delivery inclusive of all special groups represented.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
7	Workgroup has developed, implemented, and promoted a written strategic plan that outlines clear goals, policies, operational plans, and accountability/oversight mechanisms to provide culturally and linguistically appropriate services.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4

Workgroup Name:		Not at All True	Slightly True	Moderately True	Very True	
8	Workgroup has integrated cultural and linguistic competence-related measures into routine business practices and operations.	1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>
9	Workgroup has developed participatory, collaborative partnerships with communities and utilizes a variety of formal and informal mechanisms to facilitate community and consumer involvement in designing and implementing (workgroup) strategic plan activities.	1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>

10 Are there unique characteristics of your workgroup that makes the infusion of cultural competency difficult?

11 Are there unique characteristics of your workgroup that makes the infusion of linguistic competency difficult?

12 Additional comments:

*** This tool is a self-assessment measurement to allow goal setting over time and to help your group determine its strengths/weaknesses/opportunities/threats.**

NOTE: After completing this workgroup self-assessment, it is recommended that members conduct a self-assessment of their own agency/organization to determine where they are in determining if they are culturally and linguistically competent. Emphasize to sub-recipients that “cultural” also includes all other special groups and not just ethnic background or race.

Guide to Ensure that Selected Values are Incorporated Into Workgroup Strategies Moving Toward Cultural Competency

See next page for detailed explanation of rankings.

PERCEPTION: Selected Values 1 – 4	<i>Not at all True</i> – Blindness/ Denial 1	<i>Slightly True</i> – Pre- competence/ Awareness 2	<i>Moderately True</i> – Competency/ Understanding 3	<i>Very True</i> – Proficiency/ Action/Seek 4
Inclusion: Involvement in an open process that is personalized and sensitive to all stakeholders.				
Diversity: Seek out, embrace, and value differences and similarities among stakeholders. This includes gender, age, race, ethnicity, sexual orientation, mental and physical abilities, and characteristics.				
Respect: Accept, acknowledge, value, don't judge, and respond to differences.				
Excellence: Strive for quality services and measurable outcomes through clear expectations, best practices, and on-going training and education, and accountability.				
Relationships: Partnerships among stakeholders that are productive, have shared goals, trust, and support.				
Accountability: OROSC, in partnership with key stakeholders, will provide clear guidance regarding accountability, setting objectives, measuring progress, and further steps to improve quality, service delivery, and outcomes.				
Safety and Trust: Stakeholders and members feel safe and in control, feel staff is trying to understand them and their values; balance of power is evident.				
Welcoming: Workgroup accepts, seeks out, embraces, and values differences among stakeholders and helps them feel welcomed. There is no "in group." Materials developed and meeting procedures respect differences, needs, and languages.				
Healthy: Health outcomes for individuals are culturally-based and related directly to individual values. Workgroup strategies strive to reduce health disparities.				
Equal Accessibility: Workgroup members ensure that all representatives are able to access full participation in workgroup activities; barriers to engagement and participation are removed. Members strive to ensure that consumers are able to enter, navigate, and exit appropriate services and supports as needed. Membership, participation, and services are geographically, psychologically, linguistically, and culturally accessible. Outreach efforts reflect responsiveness to cultural groups.				

PERCEPTION: Selected Values 1 – 4	<i>Not at all True</i> – Blindness/ Denial 1	<i>Slightly True</i> – Pre- competence/ Awareness 2	<i>Moderately True</i> – Competency/ Understanding 3	<i>Very True</i> – Proficiency/ Action/Seek 4
Equal Opportunities: Multiple avenues for expression of viewpoints, feedback, and needs (e.g. focus groups, peer committees) are an integral part of workgroup processes. Services and supports are in sufficient range and capacity to meet the needs of the populations they serve. Resources reflect representative cultural beliefs, needs, and languages.				
Fair Treatment: It is evident that there are no “preferred” groups or membership; balance of power is evident; accommodations are made to ensure all members and stakeholders are provided engagement and highest quality service. A framework is in place for eliminating bias; nondiscrimination policies and practices are based on law and regulations, and are addressed.				

Definitions of Scale Ratings:

Not at all True - Blindness/Denial: Group thinks they are doing fine but review shows areas overlooked; “stuck” in belief that it is too difficult to move further; not recognizing that differences exist among and between different cultural groups; thinks all people are the same and should be treated the same.

Slightly True - Pre-competence/Awareness: Awareness of limitations of workgroup when interacting with communities or providing services/programming; begin to diversify membership; desire to provide quality work driven by commitment to cultural competency and diversity; tendency to view issues of diversity as being about “the other;” increased awareness but lack systems change.

Moderately True - Competency/Understanding: Ongoing commitment to the recognition, understanding, and acceptance of differences and impact of differences; understanding how one’s own identity and cultural background influences relationships across differences; continuous expansion of cultural knowledge, resources and commitment to outreach, engagement, program content and delivery; understand the interplay between policy and practice, and support change that enhances services to diverse individuals and communities.

Very True - Proficiency/Action/Seek: Holding culture and the impact of differences in high esteem; seek to add to the knowledge base of culturally competent practices, procedures, policies, and outreach; commitment to continuous process that prioritizes importance of culture, inclusion, and equity; committed to action and working for change.

Promoting Cultural Diversity and Cultural Competency

Self-Assessment Checklist for Personnel Providing Behavioral Health Services and Supports to Children, Youth, and their Families

Directions: Please select A, B, or C for each item listed below.

A = Things I do frequently, or statement applies to me to a great degree.

B = Things I do occasionally, or statement applies to me to a moderate degree.

C = Things I do rarely or never, or statement applies to me to a minimal degree or not at all.

How to use this checklist

This checklist is intended to heighten the awareness and sensitivity of personnel to the importance of cultural diversity and cultural competence in human service settings. It provides concrete examples of the kinds of values and practices that foster such an environment.

PHYSICAL ENVIRONMENT, MATERIALS, AND RESOURCES

- _____ 1. I display pictures, posters and other materials that reflect the cultures and ethnic backgrounds of children, youth, and families served by my program or agency.
- _____ 2. I insure that magazines, brochures, and other printed materials in reception areas are of interest to and reflect the different cultures of children, youth, and families served by my program or agency.
- _____ 3. When using videos, films, CDs, DVDs, or other media resources for substance abuse and mental health prevention, treatment or other interventions, I insure that they reflect the cultures of children, youth, and families served by my program or agency.
- _____ 4. When using food during an assessment, I insure that meals provided include foods that are unique to the cultural and ethnic backgrounds of children, youth, and families served by my program or agency.
- _____ 5. I insure that toys and other play accessories in reception areas and those, which are used during assessment, are representative of the various cultural and ethnic groups within the local community and the society in general.

COMMUNICATION STYLES

- _____ 6. For children and youth 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.
- _____ 7. I attempt to determine any familial colloquialisms used by children, youth, and families that may impact on assessment, treatment, or other interventions.

- _____ 8. I use visual aids, gestures, and physical prompts in my interactions with children and youth who have limited English proficiency.
- _____ 9. I use bilingual or multilingual staff or trained/certified interpreters for assessment, treatment, and other interventions with children and youth who have limited English proficiency.
- _____ 10. I use bilingual staff or multilingual trained/certified interpreters during assessments, treatment sessions, meetings, and for other events for families who would require this level of assistance.
11. When interacting with parents 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.
- _____ 12. When possible, I insure that all notices and communiqués to parents, families, and caregivers are written in their language of origin.
- _____ 13. I understand that it may be necessary to use alternatives to written communications for some families, as word of mouth may be a preferred method of receiving information.
14. I understand the principles and practices of linguistic competency, and:
- _____ • apply them within my program or agency.
- _____ • advocate for them within my program or agency.
- _____ 15. I understand the implications of behavioral health literacy within the context of my roles and responsibilities.

VALUES AND ATTITUDES

- _____ 16. I use alternative formats and varied approaches to communicate and share information with children, youth, and/or their family members who experience disability.
- _____ 17. I avoid imposing values that may conflict or be inconsistent with those of cultures or ethnic groups other than my own.
- _____ 18. In group or treatment situations, I discourage children and youth from using racial and ethnic slurs by helping them understand that certain words can hurt others.

- _____ 19. I screen books, movies, and other media resources for negative cultural, ethnic, or racial stereotypes before sharing them with children, youth, and their parents served by my program or agency.
- _____ 20. I intervene in an appropriate manner when I observe other staff or parents within my program or agency engaging in behaviors that show cultural insensitivity, bias, or prejudice.
- _____ 21. I understand and accept that family is defined differently by different cultures (e.g. extended family members, fictive kin, godparents).
- _____ 22. I recognize and accept that individuals from culturally diverse backgrounds may desire varying degrees of acculturation into the dominant or mainstream culture.
- _____ 23. I accept and respect that male-female roles in families may vary significantly among different cultures (e.g. who makes major decisions for the family, play and social interactions expected of male and female children).
- _____ 24. I understand that age and life cycle factors must be considered in interactions with individuals and families (e.g. high value placed on the decisions of elders or the role of the eldest male in families).
- _____ 25. Even though my professional or moral viewpoints may differ, I accept the family/parents as the ultimate decision makers for services and supports for their children.
- _____ 26. I recognize that the meaning or value of behavioral health prevention, intervention, and treatment may vary greatly among cultures.
- _____ 27. I recognize and understand that beliefs and concepts of emotional well-being vary significantly from culture to culture.
- _____ 28. I understand that beliefs about substance use disorders, mental or physical illnesses, disease, disability, and death are culturally-based. I accept that responses to these conditions and related treatment/interventions are heavily influenced by culture.
- _____ 29. I understand the impact of stigma associated with behavioral health services within culturally diverse communities.
- _____ 30. I accept that religion, spirituality, and other beliefs may influence how families respond to substance use disorders, mental or physical illnesses, disease, disability, and death.
- _____ 31. I recognize and accept that folk and religious beliefs may influence a family's reaction and approach to a child born with a disability or later diagnosed with alcohol and drug-related birth defects, physical/emotional disability, or special health care needs.

- _____ 32. I understand that traditional approaches to disciplining children are influenced by culture.
- _____ 33. I understand that families from different cultures will have different expectations of their children for acquiring self-help, social, emotional, cognitive, and communication skills.
- _____ 34. I accept and respect that customs and beliefs about food, its value, preparation, and use are different from culture to culture.
- _____ 35. Before visiting or providing services in the home setting, I seek information on acceptable behaviors, courtesies, customs, and expectations that are unique to families of specific cultures and ethnic groups served by my program or agency.
- _____ 36. I seek information from family members or other key community informants that will assist in service adaptation to respond to the needs and preferences of culturally and ethnically diverse children, youth, and families served by my program or agency.
- _____ 37. I advocate for the review of my program's or agency's mission statement, goals, policies, and procedures to insure that they incorporate principles and practices that promote cultural diversity, and cultural and linguistic competence.
- _____ 38. I keep abreast of new developments in pharmacology particularly as they relate to racially and ethnically diverse groups.
- _____ 39. I either contribute to and/or examine current research related to ethnic and racial disparities in behavioral health, and quality improvement.
- _____ 40. I accept that many evidence-based prevention and intervention approaches will require adaptation to be effective with children, youth, and their families from culturally and linguistically diverse groups.

Footnote about this checklist:

There is no answer key with correct responses. However, if you frequently responded "C," you may not necessarily demonstrate values and engage in practices that promote a culturally diverse and culturally competent service delivery system for children and youth who require behavioral health services and their families.

Reference:

Goode, Tawara D. (Revised 2009). Adapted from *Promoting Cultural Competence and Cultural Diversity in Early Intervention and Early Childhood Settings*, June 1989. National Center for Cultural Competence, Georgetown University Center for Child & Human Development, University Center for Excellence in Developmental Disabilities Education, Research & Service.

Basic Cultural Competency Terms

Behavioral Health: A state of mental/emotional well-being and/or choices and actions that affect wellness. Substance abuse and misuse are one set of behavioral health problems. Others include (but not limited to) serious psychological distress, suicide, and mental illness as well as the presence of positive characteristics, such as the ability to manage stress, demonstrate flexibility under changing conditions, and bounce back from adverse situations. (SAMHSA, 2011 taken from the *Leading Change* document and *A Behavioral Health Lens for Prevention*”).

Culture: Refers to norms and practices of a particular group that are learned and shared and guide thinking, decisions, and actions.

Cultural values: The individual's desirable or preferred way of acting or knowing something that is sustained over a period of time and which governs actions or decisions.

Culturally diverse care: An optimal mode of health care delivery; refers to the variability of approaches needed to provide culturally appropriate care that incorporates an individual's cultural values, beliefs, and practices including sensitivity to the environment from which the individual comes and to which the individual may ultimately return (Leininger, 1985).

Ethnocentrism: The perception that one's own way is best when viewing the world (Geiger & Davidhizar, 1991). [i.e. *Our perspective is the standard by which all other perspectives are measured and held to scrutiny.*]

Ethnic: Relates to large groups of people classified according to common traits or customs.

Race: Though many definitions exist, there appears to be no established agreement on any scientific definition of race. Race is a cultural term used to describe a person's ancestry and physical characteristics, and that unfortunately brings with it many misconceptions and erroneous biological connotations. The popular tendency to attribute a general inferiority or superiority to a particular race, based on these biological differences, fails to notice that these differences in humans are not only genetic but also influenced by environmental factors.

Linguistic competence: The capacity of an organization and its personnel to communicate effectively, and convey information in a manner that is easily understood by diverse audiences including persons of limited English proficiency, those who have low literacy skills or are not literate, individuals with disabilities, and those who are deaf or hard of hearing.

References:

- Geiger, J.N. & Davidhizar, R.E. (1991). *Transcultural nursing: assessment in intervention*. St. Louis: Mosby-Year Book.
- Leininger, M. (1991). Transcultural nursing: the study and practice field. *Imprint*, 38(2), 55-66.
- Leininger, M. (1985). *Qualitative research methods in nursing*. New York: Grune & Straton.
- Tripp-Reimer, T. & Dougherty, M.C. (1985). Cross cultural nursing research. *Annual Review of Nursing Research*, 3, 77-104.
- Copyright © 1997-2008 culturediversity.org. All Rights Reserved.

Direct all comments or questions to webmaster@culturediversity.org.

References

- Cross, T., Bazron, B., Dennis, K., & Isaacs, M., (1989). *Towards A Culturally Competent System of Care, Volume I*. Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center.
- Geiger, J.N. & Davidhizar, R.E. (1991). *Transcultural nursing: assessment in intervention*. St. Louis: Mosby-Year Book.
- Goode, Tawara D. (Revised 2009). Adapted from *Promoting Cultural Competence and Cultural Diversity in Early Intervention and Early Childhood Settings*, June 1989. National Center for Cultural Competence, Georgetown University Center for Child & Human Development, University Center for Excellence in Developmental Disabilities Education, Research & Service.
- Leininger, M. (1985). *Qualitative research methods in nursing*. New York: Grune & Straton.
- Leininger, M. (1991). Transcultural nursing: the study and practice field. *Imprint*, 38(2), 55-66.
- Michigan Department of Community Health. (2008). *Color Me Healthy*.
- National Center for Cultural Competence. (2012). *Curricula Enhancement Module Series. Definitions of Cultural Competence*. Retrieved from <http://www.ncccurricula.info/culturalcompetence.html>.
- National Center for Cultural Competence. (2012). *Self-Assessments*. Retrieved from <http://nccc.georgetown.edu/resources/assessments.html>.
- Tripp-Reimer, T. & Dougherty, M.C. (1985). Cross cultural nursing research. *Annual Review of Nursing Research*, 3, 77-104.
- U.S. Department of Health and Human Services. (2001). *Healthy People 2010*.