4 Pursuing Organizational Cultural Competence

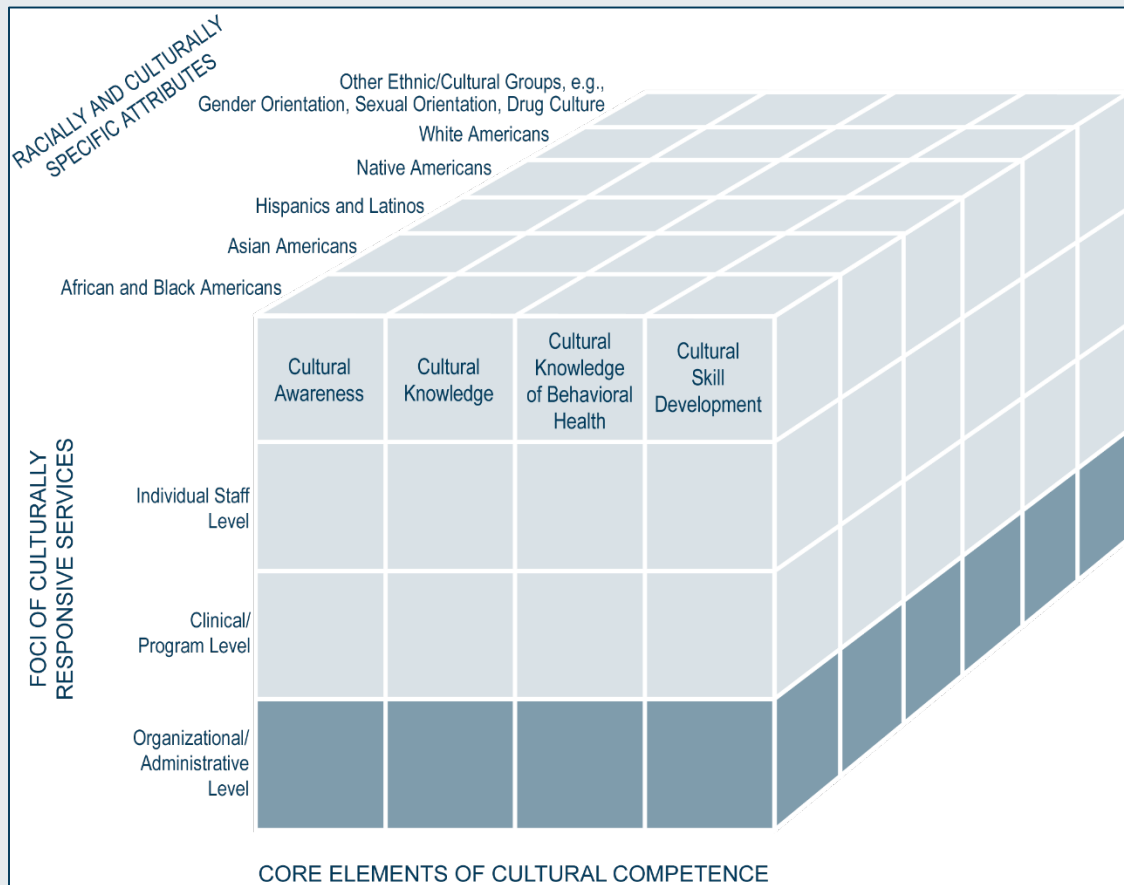Cavin, a 42-year-old African American man, arrived at a well-known private substance abuse treatment center confused and unable to provide his medical history at intake. Referred to the center through his employee assistance program, he was accompanied by his spouse and 14-year-old son. Cavin's wife provided his medical history and recounted her husband's 2-year decline from a promising career as a journalist, researcher, and social commentator to a bitter, often paranoid man who abused cocaine and alcohol. Cavin, she explained, had become increasingly unpredictable.

Upon admission, Cavin was initially cooperative and grateful to his spouse for her efforts, but as withdrawal continued, he became increasingly agitated, insisting that he could detoxify on his own. He resisted any intervention by staff members whom he perceived to be critical or patronizing. On his fourth day in treatment, Cavin began to note the treatment center's "White" environment. There were almost no African American employees—none at the clinical level. He noted how decor reflected only White American culture. Driven in part by his substance use disorder, he was looking for reasons to leave. Later that evening, he checked out.

Cavin was unable to relate to his treatment. He found no cultural cues with which to identify or connect. Therefore, he started searching for reasons to leave—behavior typical in persons who abuse substances. People often leave treatment with the conscious hope of managing their substance abuse themselves and the unconscious drive to relive positive experiences associated with substance use; meanwhile, they all too easily forget the pain imposed by the use of alcohol and other substances. Cavin may have remained in treatment if services had been more culturally responsive. This is an example of how behavioral health programs benefit

Multidimensional Model for Developing Cultural Competence: Organizational/ Administrative Level

RACIALLY AND CULTURALLY SPECIFIC ATTRIBUTES

Other Ethnic/Cultural Groups, e.g., Gender Orientation, Sexual Orientation, Drug Culture

White Americans

Native Americans

Hispanics and Latinos

Asian Americans

African and Black Americans

	Cultural Awareness	Cultural Knowledge	Cultural Knowledge of Behavioral Health	Cultural Skill Development
Individual Staff Level				
Clinical/ Program Level				
Organizational/ Administrative Level				

FOCI OF CULTURALLY RESPONSIVE SERVICES

CORE ELEMENTS OF CULTURAL COMPETENCE

from commitment to culturally responsive services, staffing, and treatment—if they make no such commitment, their services may be underused, unwelcome, and ineffective.

Cultural Competence at the Organizational Level

At the organizational level, cultural competence or responsiveness refers to a set of congruent behaviors, attitudes, and policies that enable a system, agency, or group of professionals to work effectively in multicultural environments (Cross et al. 1989). Organizational cultural responsiveness is a dynamic,

ongoing process; it is not something that is achieved once and is then complete. Organizational structures and components change. The demographics and needs of communities change. Employees and their job descriptions change. Consequently, the commitment to increase cultural competence must also involve a commitment to *maintain* it through periodic reassessments and adjustments. Based on the Cross et al. (1989) definition of the culturally competent organization, Goode (2001) identifies three principal components (Exhibit 4-1) that coincide with Sue's (2001) multidimensional model for developing cultural competence in behavioral health services.

Exhibit 4-1: Requirements for Organizational Cultural Competence

- The organization needs a defined set of values and principles, along with demonstrated behaviors, attitudes, policies, and structures that enable effective work across cultures.
- The organization must value diversity, conduct self-assessment, manage the dynamics of difference, acquire and institutionalize cultural knowledge, and adapt to diversity and the cultural contexts of the communities it serves.
- The organization must incorporate the above in all aspects of policymaking, administration, and service delivery and systematically involve consumers and families.

Source: Goode 2001.

This chapter provides a broad overview of how behavioral health organizations can create an institutional framework for culturally responsive program delivery, staff development, policies and procedures, and administrative practices. Built on the U.S. Department of Health and Human Services' (HHS's) Office of Minority Health (OMH) Enhanced National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (OMH 2013; for review, see Appendix C), this chapter is organized around the Health Resources and Services Administration's (HRSA's) domains of organizational cultural competence: organizational values, governance, planning, evaluation and monitoring, communication (language services), workforce and staff development, and organizational infrastructure (Linkins et al. 2002). (Another domain, services and interventions, is covered in Chapter 3.)

Within each domain, specific organizational tasks are suggested to aid program and administrative staff in developing a culturally responsive clinical, work, and organizational environment (Exhibit 4-2); these domains and

Exhibit 4-2: Creating Culturally Responsive Treatment Environments

Organizational values tasks:
- Commit to cultural competence.
- Review and update vision, mission, and value statements.
- Address cultural competence in strategic planning processes.

Governance tasks:
- Assign a senior manager to oversee the organizational development of culturally responsive practices and services.
- Develop culturally competent governing and advisory boards.
- Create a cultural competence committee.

Planning tasks:
- Engage clients, staff, and community in the planning, development, and implementation of culturally responsive services.
- Develop a cultural competence plan.
- Review and develop policies and procedures to ensure culturally responsive organizational practices.

Evaluation and monitoring tasks:
- Create demographic profiles of the community, clientele, staff, and board.
- Conduct an organizational self-assessment of cultural competence.

Language services tasks:
- Plan for language services proactively.
- Establish practice and training guidelines for the provision of language services.

Workforce and staff development tasks:
- Develop staff recruitment, retention, and promotion strategies that reflect the population(s) served.
- Create training plans and curricula that address cultural competence.
- Give culturally congruent clinical supervision.
- Evaluate staff performance on culturally congruent and complementary attitudes, knowledge, and skills.

Organizational infrastructure:
- Invest in long-range fiscal planning to promote cultural competence.
- Create an environment that reflects the populations served.
- Develop outreach strategies to improve access to care.

Source: Linkins et al. 2002.

tasks are adapted to behavioral health services. Task overlap across domains may require work on several tasks at once. HRSA's organizational cultural competence assessment profile is available online (http://www.hrsa.gov/cultural competence/healthdlvr.pdf; Linkins et al. 2002).

Organizational Values

Journey Mental Health Center (JMHC), a large outpatient mental health and substance abuse treatment clinic in Wisconsin, is an organization that is committed to providing accessible, community-focused, culturally responsive behavioral health services. JMHC offers the following commentary on the importance of clear, culturally responsive organizational values (JMHC 2013, paragraphs 1-3):

> …cultural competence is fundamental to providing quality services that promote individual and family strengths, dignity, and self-reliance. Cultural competence broadens and enriches the delivery of mental health and alcohol and other drug abuse (AODA) services by providing a more holistic, relevant view of the world and the helping process. Cultural competence does not stand apart from, but is intrinsic to good clinical practice. Its threads are woven into the tapestry of effective assessment, treatment planning, intervention, advocacy, and support. In addition, cultural competence is intrinsic to effective staff relationships and business practices.

> Cultural competence promotes relationships based upon understanding and knowledge of how one's own cultural beliefs and values influence the organization of information, perceptions, feelings, experiences, and coping strategies. It involves being able to identify, learn from, and incorporate these into the helping process. When cultural competence is an integral part of personal competence, there is the maximum opportunity to increase the amount and quality of information and the speed with which that information can be shared and processed and to form healthy alliances.

Cultural competence demands an ongoing commitment to openness and learning, taking time and taking risks, sitting with uncertainty and discomfort, and not having quick solutions or easy answers. It involves building trust, mentoring, and developing and nurturing a frame of reference that considers alliances across culture as enriching rather than threatening shared goals.

Task: Commit to Cultural Competence

Counselors are typically a part of a larger organization or system, but the focus on and responsibility for developing culturally responsive services has historically fallen on individual practitioners rather than on organizations. Most literature on cultural competence addresses the cultural awareness, knowledge, and skills of the practitioner, but until recently, it has failed to apply these same concepts to agencies. Cultural competence among counselors is only as effective as their agencies' commitment to and support of cultural competence and ability to value diversity through culturally congruent administrative practices, including—but not limited to—policies and procedures, programming, staffing, and community involvement.

Counselors are unlikely to affect organizational change to the same degree as the agency's overall administration can. Hence, culturally responsive treatment cannot be sustained without an agency's commitment and support. In fact, the organization itself can prevent clients from receiving culturally responsive services or treatment opportunities. Organizations that are unaware of cultural issues can fail to recognize that diverse groups may have difficulty accessing and engaging in treatment. Also, counselors who attempt to use culturally responsive practices—such as the involvement of family members (as defined by the client) and traditional healers—can encounter insurmountable hurdles if their agencies' policies

> Organizations that fail to endorse and make a commitment to cultural competence will more than likely displace the responsibility of cultural competence onto counselors or clients. If the responsibility is on the clients, it is likely that the clients will have to "fit" or change to match the treatment or program rather than treatment services being adapted to fit the needs of clients.

and resources do not support these practices. The system can actually impede efforts made by counselors invested and trained in cultural competence. Thus, the development of cultural competence begins at the top level of the organization, with an initial focus on systemic changes.

Cultural competence does not occur by accident. To maximize its effectiveness in working with diverse groups, the organization must first view diversity as an asset. As importantly, the organization must ensure that its process of developing cultural competence has the genuine, full, and lasting support of the organization's leadership. The chief executive officer (CEO), senior management, and board of directors play critical roles. A strong mandate from the board or CEO, coupled with a commitment to provide resources, can be a good motivator for staff and committees to undertake major organizational change. Support of cultural competence must be made clear throughout the organization and community in meaningful ways, in words and actions.

Leadership can make a difference in the implementation of culturally responsive practices by creating an organizational climate that encourages and supports such practices. This includes a willingness to discuss the importance of cultural competence, try new practices or approaches, tolerate the uncertainty that accompanies transitional periods during which practices and procedures are

evolving, respond to unforeseen barriers, and revise innovations that are not working as intended. It is important that leadership be genuinely committed to the effort and that their support be tangibly apparent in the allocation of relevant resources. A strong commitment to improving organizational cultural competence should include the obligation to monitor procedures after they have been implemented, maintain and reevaluate new practices, and provide resources and opportunities for ongoing training and culturally competent supervision.

Task: Review and Update Vision, Mission, and Value Statements

The organization's mission, vision, and value statements are vitally important in creating a conceptual framework that promotes culturally responsive behavioral health services. Agencies should examine how these statements are developed. Are stakeholders involved in the development process? In what ways does the organization ensure that its values and mission reflect the community and populations that it serves? Does the organization see this task as a singular event, or has it planned for periodic review of its values and mission to ensure continued organizational responsiveness as needs, populations, or environments change?

Initially, the planning committee should determine how the culture of the organization as well as the surrounding community can support achievement of the mission and vision statements. Culturally responsive organizational statements cannot provide a tangible framework unless supported by community, referral, and client demographics; a needs assessment; and an implementation plan. Mission and vision statements need to be operationalized through identified goals as well as measurable indicators to track progress. The Hands Across Cultures Corporation of

northern New Mexico, which serves Native peoples within pueblos (American Indians), the City of Española, Pojoaque Valley, and surrounding communities (predominantly Latino), addresses the importance of the cultural context of its work in its mission and philosophy statements (Exhibit 4-3).

Task: Address Cultural Competence in Strategic Planning Processes

The strategic planning process provides an opportunity to reevaluate an agency's values, mission, and vision regarding cultural competence. A comprehensive process involves evaluating the organization's internal and external environments prior to holding planning meetings; this evaluation involves conducting staff, client, and community assessments. From assessing current needs to evaluating global factors that influence the direction and delivery of services (e.g., funding sources, treatment mandates, changes in health insurance), organizations can begin to gain insight into the demands and challenges of providing culturally responsive services. Moreover, strategic planning is an opportunity to explore and develop short- and long-term goals that focus on incorporating culturally responsive delivery systems while addressing issues of sustainability (i.e., how to provide resources and support the implementation of culturally responsive policies and procedures over time). A formal strategic planning meeting should be held to determine specific goals, objectives, and tasks that will ensure quality improvement in culturally responsive services. The development of timelines and methods to evaluate progress, obstacles, and directions for each goal are equally important. For organizations that do not have a specific cultural competence plan prior to the strategic planning meeting, this process can provide the forum for developing the steps needed to create a formal plan.

Governance

Task: Assign a Senior Manager To Oversee the Development of Culturally Responsive Practices and Services

From the outset, a senior staff member with the authority to implement change should be assigned to oversee the developmental process of planning, evaluating, and implementing culturally responsive administrative and clinical services. Key responsibilities include the ongoing development and facilitation of cultural competence committees and advisory boards, management of evaluative processes, facilitation of the development of a cultural competence plan and its implementation, and oversight of policies and procedures to ensure cultural competence within the organization and among staff. Cultural competence cannot come to fruition with only one voice being heard, but assigning a key person to oversee

---

Exhibit 4-3: Hands Across Cultures Mission Statement

Mission
To improve the health, education and well being of the people of Northern New Mexico through family-centered approaches deeply rooted in the multicultural traditions of their communities.

Philosophy
To believe in culture as the foundation of human growth; spirituality as the strength of the people; each person's need to love and be loved; family preservation; individual responsibility; and the pursuit of human potential.

With a firm commitment to these beliefs, Hands Across Cultures' Board of Directors, staff, and collaborators hold that:

Culture Is the Cure
La Cultura Cura

Source: Hands Across Cultures 2014.

the process will more likely keep top-priority goals and objectives in view.

Task: Develop Culturally Competent Governing and Advisory Boards

Beyond having the foresight to plan for and develop culturally responsive services, it is vital that executive staff members on governing and advisory boards and committees are educated about and invested in the organization's mission and plan. For example, the board's human resources committee may be more invested in developing and reinforcing culturally responsive recruitment and hiring policies and practices if they are involved in the strategic planning process and educated about the organization's mission, values, and vision. At the same time, the organization should seek outside direction. Given that sharing information about the agency's activities with others outside the organization can create some hesitancy or be a potential barrier, the executive staff can frame the planning process as an opportunity for positive development and community involvement as a powerful resource. The organization should establish a community advisory board that includes stakeholders, specialists, and/or experts in multicultural behavioral health services along with key administrators and staff. This advisory board should consist of local community members from whom the organization can solicit valuable advice, input, and potential support for the development of culturally responsive treatment (Minnesota Department of Human Services 2004).

Representation should include clients, alumni, family members, and community-based organizations and institutions (e.g., community centers, faith communities, social service organizations). Developing an inclusive advisory board of community members can enhance and extend use of and referral from other community agencies. Moreover, this board can help identify community leaders and culturally appropriate resources for the client population to supplement treatment activities, such as traditional healing practices (Castro et al. 1999*a*). The advice box on the next page reviews strategies for engaging communities in the development of culturally responsive services.

Task: Establish a Cultural Competence Committee

By creating a committee within the organization to guide the process of becoming culturally competent and responsive, the organization ensures that a core group will provide oversight and direction. This committee should be inclusive not only in terms of the racial and ethnic composition of the population served, but also in terms of drawing from all levels of the organization (Whaley and Longoria 2008). Representatives of the advisory board should also be included. Program administrators should provide direction to the cultural competence committee. The person assigned to take the lead on cultural competence should chair the committee, and the CEO should be noticeably involved.

The cultural competence committee will oversee the organization's self-assessment process while also creating the demographic profile of the organization's community, developing a cultural competence plan, and formulating and monitoring procedures that evaluate the implementation and effectiveness of the organization's plan in developing culturally responsive services and practices. The committee should ensure that the organization's plans are continually updated. To succeed, this team must be empowered to influence, formulate, implement, and enforce initiatives on all levels and throughout every department of the organization (Constantine and Sue 2005; Fung et al. 2012), including, for example,

Advice to Administrators: Strategies To Engage Communities in Developing Culturally Responsive Treatment Services

- Ask board members to help recruit key members of the local community.
- Create a community advisory group to complement the governing boards in assessing and recommending culturally responsive policies, procedures, and practices.
- Develop local community focus groups to discuss key treatment needs, health beliefs, and attitudes and behaviors related to substance use, mental illness, and help-seeking that could be unknown to others outside of the community and in the organization.
- Develop a policy that supports the use of culturally congruent communication modalities and technologies for sharing information with communities.
- Provide inservice training, continuing education, and other professional development activities (e.g., networking events) that focus on strengthening skills for collaboration with culturally and linguistically diverse communities.
- Develop policies and procedures to support community involvement in the treatment setting (e.g., incorporating peer support programs, having a presence at community housing events, developing partnerships with traditional healers).
- Develop local outreach and educational programs in multiple languages (e.g., provide family education on substance use patterns and community issues in Spanish at a community center).
- Participate in community events to raise awareness of services, to develop trust and build relationships, and to gain further knowledge of local cultural groups and community practices.
- Periodically analyze community demographic trends and populations served by the treatment organization; ensure representation of these diverse populations on the advisory board.
- Become knowledgeable about and use available local goods and services.

Sources: Goode 2001; National Center for Cultural Competence 2013; Washington State Department of Social and Health Services 2011.

presenting data and subsequent recommendations to the administration and boards based on employee feedback about their experiences with newly adopted, culturally responsive procedures in the organization. Exhibit 4-4 highlights key issues in behavioral health treatment that must be addressed in providing culturally responsive services.

Planning

Task: Engage Clients, Staff, and the Community in the Planning, Development, and Implementation of Culturally Responsive Services

Organizations can sometimes have the best intentions of creating culturally responsive services but miss the mark by operating in a vacuum. Initially, the vacuum approach can appear less time consuming, complex, and expensive, but it can also represent paternalism whereby organizations or administrators assume that they inherently know what is best for the program, clients, staff, and community. Instead, organizations and the services that

Exhibit 4-4: Critical Treatment Issues To Consider in Providing Culturally Responsive Services

- Access: Degree to which services for clients are quickly and readily available.
- Engagement: Having appropriate skills and an environment that have a positive personal impact on the quality of clients' commitment to treatment.
- Retention: The result of quality services that help maintain clients in treatment with continued commitment.

Source: The Connecticut Department of Children and Families, Office of Multicultural Affairs 2002.

they provide need to be congruent with the specific populations being served; clients and the community should have an opportunity to provide input on how services are delivered and the types of services that are needed. Otherwise, services may be poorly matched to clients, underused by the community, and detrimental to agency financial resources. For example, an agency could decide that family therapy is a culturally appropriate service and proceed to create a multifamily program (treating several families together in a group format) without considering that, for some cultural groups, family shame associated with seeking help can deter the use of such services.

Staff members are likely to have specific knowledge of client needs and to be able to identify potential obstacles or challenges in how an organization attempts to implement culturally responsive policies and procedures. A parallel process that can influence the potential success of staff involvement and commitment to the development of cultural competence is the organizational culture. Suppose, for example, that the staff perceives the organization's new commitment to cultural competence as another expectation of more work without training, adequate clinical supervision, or ongoing support. Maybe staff members have historically experienced frequent announcements, mandates, or excitement generated by the administration that fade quickly. Perhaps the organization arranges committees and meetings, purporting that they want staff input despite the fact that decisions have already been made.

The organizational climate sets the stage for staff responsiveness and motivation in developing cultural competence and in implementing culturally responsive services. Without an organizational history and culture of supporting change across time, staff members will likely resent an increase in expectations with-

out some means of compensating for additional work, perceive themselves as powerless over the proposed changes, or minimize the need to make any immediate changes. For example, staff members may view changes as temporary or a phase and believe that the organization will focus on other issues or new directions once the pressure or attention on this specific issue subsides.

Task: Develop a Cultural Competence Plan

To ensure the delivery of culturally responsive services, it is important to develop a cultural competence plan (see the "Criteria for Developing an Organizational Cultural Competence Plan" advice box on the next page). Using demographic data and an organizational self-assessment (including community and advisory board input), the organization's cultural competence committee can begin writing an organizational plan for improving cultural competence. The committee will need to assign staff members to research and write each component of the plan, which should outline specific objectives, means of achieving these objectives, and recommend timelines and processes for evaluating progress. The plan should contain at least the following components:

- A narrative introduction that covers community demographics and history, organizational self-assessment and other evaluation tools, the rationale for providing culturally responsive services, and the organization's strengths and needs for improvement in providing services that are responsive to client cultural groups; a brief overview of current priorities, goals, and tasks to help the organization develop and improve culturally responsive clinical services and administrative practices is also advisable.

> ### Advice to Administrators: Criteria for Developing an Organizational Cultural Competence Plan
>
> Using the core elements of access, engagement, and retention as criteria in developing a cultural competence plan, the following recommendations are offered:
> - Develop a thorough knowledge and understanding of the social, cultural, and historical experiences of the community of people your agency is serving.
> - Identify and clearly articulate an understanding of the ethnic, cultural, linguistic, and social groups in the area your agency serves.
> - Document, track, and evaluate/assess the reasons why clients are not accepted for services.
> - Know the demographics of clients within the program and their rates of program completion.
> - Keep profiles of clients who do not complete services.
> - Design steps for your agency to take to remove identified barriers that keep clients from using your agency's services.
> - Establish steps your agency will implement or sustain to create a consumer-friendly environment that reflects and respects the diversity of the clients that use your services.
> - Establish internal criteria the agency will use to measure the impact of the services and programs that it offers.
>
> Source: The Connecticut Department of Children and Families, Office of Multicultural Affairs 2002.

- Strategies for recruiting, hiring, retaining, and promoting qualified diverse staff.
- Resources and policies to support language services and culturally responsive services.
- Methods to enhance professional development (e.g., staff education and training, peer consultation, clinical supervision) in culturally responsive treatment services.
- Mechanisms for community involvement, beginning with the development of a community advisory board and cultural competence committee and including community participation in relevant treatment activities or in support of treatment services (e.g., spiritual direction).
- Approaches to amending facility design and operations to present a culturally congruent atmosphere.
- Identification of and recommendations for culturally and linguistically appropriate program materials.
- Programmatic strategies to incorporate culturally congruent clinical and ancillary treatment services.
- Fiscal planning for funding and human resources needed for priority activities (e.g., training, language services, program development, organizational infrastructure).
- Guidelines for implementation that describe roles, responsibilities, timeframes, and specific activities for each step.

The committee must determine how to oversee the plan (e.g., by tracking accomplishments, obstacles, and remediation strategies). Who will develop and revise guidelines for treatment planning, introduce new guidelines to the staff and provide counselor training, and coordinate revisions with the information technology specialist or department?

Task: Develop and Review Policies and Procedures To Ensure Culturally Responsive Organizational Practices

In essence, policies and procedures are the backbone of an organization's implementation of culturally responsive services. By creating, reviewing, and adapting clinical and administrative policies and procedures in response to the ever-changing needs of client populations, the agency is able to provide counselors and

other workers with support and the means to respond in a consistent, yet flexible, manner. Programs are likely to have the foresight to develop relevant policies and procedures through the planning and evaluative processes outlined in this chapter, but it is unlikely that they will anticipate every situation. Thus, ongoing flexibility is paramount.

When putting together an organizational cultural competence plan, providers should be careful to follow the requirements set by state licensing boards, accreditation agencies, and professional organizations that oversee certification and licensing of treatment professionals. Much of the push for cultural competence throughout the healthcare field is in response to the mandates of accrediting agencies, funders, and managed care organizations. These entities have standards and guidelines that state minimum expectations for client rights, program structure, and staffing, along with treatment content and conditions. Behavioral health organizations, including substance abuse treatment programs, must meet these standards to be accredited by national organizations and compensated by funders.

Although many accrediting bodies require a cultural competence plan that is assessed as part of the accreditation process, their requirements can be minimal. Consequently, organizations should go beyond such requirements in their own thinking and planning to ensure that they are responding adequately to the needs of the communities they serve. Above all, are the policies, procedures, and systems of care suited to the served populations? Do policies reflect the organization's commitment to cultural competence in administrative practices? For example, are strategies for professional development, personnel recruitment, and retention of culturally competent staff members reflective of the populations and cultures that they serve?

If an organization fails to develop culturally responsive policies or procedures yet claims to endorse or support culturally responsive services, counselors and staff members will likely carry the entire burden of implementing these services and will face numerous obstacles that could prevent the delivery of responsive services. Take, for example, a counselor from a county-funded program who was directed by her supervisor to complement her counseling approach with the client's traditional healing beliefs and practices. The agency did not provide staff support, have policies or procedures consistent with this request, or exhibit a willingness to adapt current procedures to meet the client's needs. The counselor had difficulty following this direction because of barriers in finding an appropriate traditional practitioner in the local area, coordinating services, establishing and securing confidentiality for the client and with the practitioner (including educating the practitioner about confidentiality), arranging transportation for the client, obtaining a stipend for services, and discerning how and when to incorporate the traditional practice into the treatment milieu.

Counselors who feel that they have been left to go it alone can view implementation of culturally responsive practices as an insurmountable challenge when the agency provides limited support or fails to endorse adaptive policies that are congruent with the needs of the client population. Counselors may have high motivation to incorporate culturally responsive care but find themselves without appropriate agency resources, permission, or infrastructure to implement it. By developing and endorsing culturally responsive policies and procedures, an organization can provide carefully thought-out strategies and processes to help staff members provide real-time responsive services. Well-defined policies and procedures reinforce commitment to and expectations of cultural competence.

Evaluation and Monitoring

To develop a viable cultural competence plan, information must be gathered from all levels of the organization, from clients and community, and from other stakeholders. Beginning with acquiring initial demographic data from the populations that are or could be served by the agency and extending to soliciting feedback from various stakeholders, gathering information prior to plan development helps the organization provide direction and determine priorities. Gathering information also allows ongoing monitoring and feedback regarding the plan's effectiveness and areas in need of improvement. Areas of evaluation and monitoring can include a demographic profile of the client, community, staff, and board constellations; community needs assessment; client, family, and referral feedback; administrative, clinical, medical, and nonclinical staff assessments; and more (American Evaluation Association 2011; LaVeist et al. 2008).

Task: Create a Demographic Profile of the Community, Clientele, Staff, and Board

Intake, admission, and discharge data provide a good starting point for determining the demographics of current populations being served. Programs would likely benefit from developing a demographic summary for each population served, consisting of age, gender, race, ethnic and cultural heritage, religion, socioeconomic status, spoken and written language preferences and capabilities, employment rates, treatment level, and health status (HHS 2003*b*). With adequate resources, the organization can generate reports dating back 5 years to determine program trends.

Agencies should also gather demographic information on groups in the agency's local community (Hernandez et al. 2009). This information can be easily obtained through census data and national centers (e.g., Bureau of Labor Statistics) or through local sources, including the library, city hall, or the county commissioner's office (Whealin and Ruzek 2008). Community demographics can provide a quick benchmark on how well an agency serves the local community and how the community is represented at all levels of the organization. A demographic profile should also summarize information about clinical, medical, and nonclinical staff members as well as board members. Other information can also be helpful for specific agencies, as can hiring a consultant to gather demographic information and conduct the organization's self-assessment of cultural competence to limit bias; however, lack of funding can prohibit this possibility.

Task: Conduct Organizational Self-Assessment of Cultural Competence

An organization must have an awareness of how it functions within the context of a multicultural environment, evaluating operational aspects of the agency as well as staff ability and competence in providing culturally congruent services to racially and ethnically diverse populations. Therefore, an agency should assess how well it currently provides culturally responsive treatment. An honest and thorough organizational self-assessment can serve as a blueprint for the cultural competence plan and as a benchmark to evaluate progress across time (National Center for Cultural Competence 2013). To review a sample assessment guide, refer to Appendix C.

The importance of organizational self-assessment cannot be overstated. Thorough, reliable, valid evaluations can gauge the effectiveness of an agency's services, structure, and practices (e.g., clinical services, governing practices, policy development, staff composition, and professional development) with culturally and racially diverse clients, staff, and

communities. More and more, public and private funding sources—as well as accrediting bodies—use an organization's self-assessment as a means of measuring compliance, effectiveness, or quality improvement practices.

A self-assessment can seem intensive in terms of both labor and capital, but in the long run, it can guide an organization's quality improvement process more efficiently by helping it provide the most relevant services at the right time. Gathering feedback from many internal and external sources gives agencies considerable information needed to effectively evolve as a culturally responsive organization, including data on current performance, areas needing improvement, and development needs. In the initial self-assessment, an organization should obtain demographic information and seek feedback from key stakeholders—including community members, clients, families, and referral sources (e.g., probation and parole offices, family and child services, private practitioners)—and from all levels of the organization, including administrative, managerial, clinical, medical, and support staff. The following steps are recommended to help an agency gain the information necessary to guide and support the development of its cultural competence plan.

Step 1: With the advisory board and cultural competence committee, identify key stakeholders who can provide valuable feedback about current strengths and areas in need of improvement regarding the function of the organization and the needs of its community.

Step 2: Adopt a self-assessment guideline for organizational cultural competence (see Appendix C).

Step 3: Determine the feasibility of using consultants and/or external evaluators to select, analyze, and manage assessment.

For many organizations, hiring outside consultants is financially prohibitive. Nonetheless, the cultural competence committee could recommend hiring outside evaluators and consultants to help them plan, conduct, and assess the results of the organizational self-evaluation. The committee should ensure that consultants understand the population being served by the treatment facility. This means understanding the population's cultural groups across dimensions: language and communication, cultural beliefs and values, history, socioeconomic status, education, gender roles, substance use patterns, spirituality, and other distinctive aspects. Candidates should be able to articulate a clear understanding of cultural competence (American Evaluation Association 2011). If consultants will train staff, they should have specific knowledge and proficiency in training development and delivery.

If financially feasible, it can be useful for the agency to consider using more than one consultant and to invite each prospective consultant to present their qualifications to the board of directors and/or to a cultural competence

---

The Consumer Assessment of Healthcare Providers and Systems Cultural Competence Item Set

This assessment tool evaluates provider cultural competence through client surveys. It helps identify strengths and weaknesses of individual behavioral health service providers and organizations, aids in provider comparisons, and assesses the extent to which client responses differ based on race, ethnicity, or primary language. The surveys are available online through the Agency for Healthcare Research and Quality (https://cahps.ahrq.gov/clinician_group/), as is an overview and instructions (https://cahps.ahrq.gov/surveys-guidance/hp/instructions/index.html).

committee so that the best match can be achieved between the agency's needs and the consultant based on his or her expertise, cost, and consulting style. If a consultant is hired, the organization should establish guidelines for working closely with that person, including reporting requirements to the cultural competence committee. The organization must retain ownership of the process and provide clear oversight and guidance.

Step 4: Select assessment tools suitable for each stakeholder group (e.g., clinical staff, agency referrals, clients). Several self-assessment tools are available, including checklists and surveys, for use in evaluation or as development guides. To date, most instruments available have limited empirical support (Delphin-Rittmon et al. 2012*b*; Shorkey et al. 2009).

More often than not, surveys and feedback questionnaires will need to be individually developed and tailored to the organization and stakeholder group depending upon setting; available resources; racial, ethnic, and cultural backgrounds; language preferences; and community accessibility (e.g., rural versus urban). Appendix C provides standards and lists the items that should be included in evaluating an agency and its services. Additional resources for provider and organizational assessment of cultural competence are available through the National Center for Cultural Competence (http://nccc.georgetown.edu/) and the Hogg Foundation for Mental Health (http://www.hogg.utexas.edu/index.php).

Step 5: Determine distribution, administration, and data collection procedures (e.g., confidentiality, participant selection methods, distribution time frames). Whatever methods are used to gather data for the self-assessment process, it is critical to explain the context of the assessment to all participants. They need to know why the assessment is being conducted and how the information they give will be used. Confidentiality can be a major concern for some respondents, especially staff members and clients, and every effort should be made to address this concern. Ideally, the evaluation

---

Advice to Administrators: **Gathering Feedback From Clients, Community Members, and Referrals**

Agencies should incorporate a client satisfaction survey into the assessment process. This survey should include questions to help determine whether clients believe that the organization relates well to persons of their ethnicity or race and gives them an opportunity to pinpoint problem areas. To review a sample assessment tool for clients, refer to the Iowa Cultural Understanding Assessment–Client Form (White et al. 2009), available in Appendix C. The tool is also available in Spanish.

If desired, external consultants can conduct interviews with a representative sample of clients, family members, and local community members. The key question should be "What can the treatment provider do to be more responsive to community needs?" The survey process can be as simple as a questionnaire, or it can involve interviews or focus groups with key people in touch with community issues. It can also be helpful to obtain a small but representative sample of community members at large to determine their level of awareness of the services available and their perceptions of the treatment agency based on what they have heard. Information from people not in treatment can be revealing and could suggest areas in which publicity is needed to counter misinformation. Likewise, facilitators can develop, from the information gathered, a map that highlights where people go to receive various services (Center for Substance Abuse Prevention 1995). The agency could also ask their sources of referrals, such as faith-based organizations, community agencies, or primary care physicians, whether they are referring clients to the agency, and if not, why. It is important to know who is not walking through the door.

instrument(s) should be administered by an objective third party, such as a consultant or a member of the cultural competence committee. Staff members should be asked about their attitudes toward cultural issues with the understanding that their attitudes are not necessarily indicative of the degree to which the staff mirrors the cultural groups served. In soliciting community feedback, the more credibility the organization has in the community, the higher the return rate will likely be. The lower the credibility, the more the organization needs to reassure respondents that it intends to listen to, and act on, what it hears. If many survey forms are to be distributed, the organization could consider hiring students or community members on a temporary basis to make follow-up or reminder calls.

Step 6: Compile and analyze the data. The process of reviewing and assessing data should be overseen by the cultural competence committee. Basic data analysis procedures should be used to ensure the accuracy of results and credibility of reported information. For most well-designed instruments, there are relatively simple and appropriate ways to present data. All available data should be assembled in a report, along with interpretive comments and recommended action steps. The report should note areas of strength and needed improvement and should offer possible explanations for any shortcomings. For example, if the community is 20 percent African American, but only 2 percent of the agency's clientele are African American, what are some possible explanations for this group's apparent underuse of services? It is also particularly important to share results with those who participated in the assessment process. Findings should be made available to staff, clients, community members, boards, and managers. This increases overall sense of ownership in the assessment and cultural competence development process and in implementing the

changes that will be made based on the findings of and the priorities established through this assessment.

Step 7: Establish priorities for the organization and incorporate these priorities into the cultural competence plan. After obtaining the results of the self-assessment process, the organization—including boards, cultural competence committee, community stakeholders, and staff members—needs to establish realistic priorities based on the current needs of clients and the community. Significant consideration should be given to the level of influence any given priority could have in effecting organizational change that will improve culturally responsive services. Some priorities will require more planning to implement and can involve more financial and staff resources, whereas other priorities will be easier to implement from the outset (e.g., hiring culturally competent counselors who are bilingual versus translating intake and program forms). Therefore, long- and short-range priorities should be established at the same time to maintain the momentum of change in the organization.

Step 8: Develop a system to provide ongoing monitoring and performance improvement strategies. Similar to the clinical assessment process with clients, the organizational self-assessment is only valuable if it provides guidance, determines direction and priorities, and facilitates action. Assessment is not a one-time activity. It is important to continue monitoring to identify barriers that may impede the full implementation of the cultural competence plan, to evaluate progress and performance, and to identify new service needs. Establishing a system to monitor an organization's cultural responsiveness equips it with the information necessary to formulate strategies to meet new demands and to continuously improve quality of services.

Language Services

Task: Plan for Language Services Proactively

An organization must anticipate the need for language services and the resources required to support these services, including funding, staff composition, program materials, and translation services. Assessing the language needs of the population to be served is essential. Upon determination, the foremost task is letting clients with limited English proficiency know that language services are available as a basic right for a client. Treatment providers need to plan for the provision of linguistically appropriate services, beginning with actively recruiting bicultural and bilingual clinical staff, establishing translation services and contracts, and developing treatment materials prior to client contact. Although it is not realistic to anticipate the language needs of all potential clients, it is important to develop a list of available resources and program procedures that staff members can follow when a client's language needs fall outside the organization's usual client demographics (The Joint Commission 2009).

> ### How To Inform Clients About Language Assistance Services
>
> - Use language identification or "I speak…" cards.
> - Post signs in regularly encountered languages at all points of entry.
> - Establish uniform procedures for timely, effective telephone communication between staff members and persons with limited English proficiency.
> - Include statements about the services available and the right to free language assistance services in appropriate non-English languages in brochures, booklets, outreach materials, and other materials that are routinely distributed to the public.
>
> *Source: OMH 2000.*

Planning for language services is crucial, and the need for these services must be assessed by staff members who have initial contact with clients, their family members, and/or other individuals in their support systems (American Psychological Association [APA] 1990, 2002). If frontline administrative and clinical staff members are bilingual, the initial screening and assessment process can begin uninterrupted. If this is not the case, receptionists or frontline clinical staff members should at least be familiar with some rudimentary phrases in the preferred languages of their client base. The conversation can be scripted so that they can convey their limited ability to speak the client's language, obtain contact information and inquire about language service needs, and inform the client that someone who can speak the language more fluently will be made available to facilitate the initial screening process. Most importantly, procedures should be in place to provide pretreatment contact and follow-up in the client's language to bridge the gap between initial contact and subsequent arrangement of language services.

Written and illustrated materials or a video about the program in the languages spoken by the client population should be available to answer frequently asked questions. All materials given to clients, family members, and community members should be available in their primary languages. It is preferable to develop the materials initially in those languages rather than simply translating materials from one language to another. Along with language, one should also consider the level of literacy of the group in question. Some clients may be functionally illiterate even in their native languages. Materials should graphically reflect the population served through pictures or photographs, using ethnic themes and traditional elements familiar to the target audience. Also, materials should be tested with the populations with whom they

will be used, perhaps through focus groups, to ensure that they communicate effectively.

Task: Establish Practice and Training Guidelines for the Provision of Language Services

Key issues to consider in implementing and overseeing language services within an organization include staff monitoring of language proficiencies, selection of translators and interpreters, confidentiality issues, and training needs. First, agencies need to assess language proficiencies among staff members and encourage them to learn a language relevant to the population served. At a minimum, staff members should acquire in the given language some basic terminology and phrases that are commonly used in the treatment setting.

In recruiting and hiring translators and interpreters, administrative staff members should consider experience, motivation, skill level, mastery of English, and fluency in the language in need of interpretation (OMH 2000; American Translators Association 2011). Be aware, however, that there can be considerable variation in dialects and levels of proficiency within the language, and these must be determined in the selection process. To supplement hiring practices, administrative policies should provide a means for determining the credentials of any language services organizations (Appendix F lists American Translators Association credentialing information).

Other important hiring issues revolve around potential ethical dilemmas. In particular, care should be taken in using interpreters from the local community, which can create potential challenges with confidentiality and dual relationships (e.g., the interpreter may also be client's cousin or neighbor). Policies should place the burden on language service providers

to identify and disclose dual relationships to supervisors immediately and on supervisors to assess and determine the appropriateness of using certain translator. Once a selection has been made, a confidentiality agreement should be signed. Organizations need to provide information routinely to clients about their confidentiality rights in using language services. Implementing a procedure for handling client grievances is also recommended.

In planning for the use of language services, organizations should initially provide training for staff on how to incorporate these services and should familiarize translators and interpreters with the clinical setting, terminology, behavioral expectations, and content related to behavioral health (see the "Training Content for Language Service Personnel" advice box on the next page). The language of mental health and substance abuse services requires an additional degree of specialization. Experienced translators and interpreters who are unfamiliar with concepts of addiction, illness, and recovery could convey information adequately from a linguistic perspective but not accurately convey the intent or meaning of clinically oriented information or dialog. Various training approaches can be used, including role-plays mirroring intakes, evaluations, and counseling sessions; indirect exposure to client sessions through audio or video recordings of sessions or viewing from an observation room; direct observation by sitting in on a session, if appropriate; and consultation with other experienced language service providers and clinical staff. Using other experienced translators and interpreters for training and/or for consultations, as well as sharing experiences in a peer support format, can be very beneficial for new language service providers.

Organizations must also create opportunities for translators and interpreters to inquire about and clarify clinical content and meaning. Language service providers often attempt to convey terminology or concepts that do not exactly match the words or meaning of the client's language or culture by becoming more descriptive, taking longer to deliver the message in an effort to match the intent of a specific word or concept in English.

Advice to Clinical Supervisors and Administrators: **Training Content for Language Service Personnel**

Translators and interpreters need additional training to work in a clinical setting. Initial training should include:

- General mental health and substance abuse information.
- Introduction to behavioral health services.
- Familiarity with interviewing and assessment questions, instruments, and formats.
- Legal and ethical issues, including confidentiality and professional boundaries.
- Relevant programmatic policies and procedures.
- Review of program materials, forms, questionnaires, and other written clinical materials that clients receive during the course of treatment.
- Knowledge of technical vocabulary relevant to the behavioral health field.
- Emphasis on the importance of accurate interpretation and translation without additions or omissions.
- Behavioral and professional guidelines on how to manage potential client reactions in and outside the session (e.g., outward displays of anger or hostility; grief reactions; disclosing information to the translator with a request to keep it a secret from clinical staff; discomfort with translator's biological, social, and/or demographic characteristics, such as gender orientation, age, or socioeconomic status).
- Importance of cultural sensitivity in dialog between translator and client, including how questions are asked.
- General guidelines on how to handle personal issues that can be elicited by participation in the intake, assessment, and treatment processes, including identification with similar clinical issues (e.g., substance use patterns, family dynamics, traumatic events, emotional distress).

Workforce and Staff Development

Task: Develop Staff Recruitment, Retention, and Promotion Strategies That Reflect the Populations Served

To determine whether it adequately reflects the population it serves, an organization has to assess its personnel, including counselors, administrators, and board of directors. According to a 10-year study that collected data on treatment admissions, racial and ethnic composition of treatment populations has not significantly changed. Racially diverse groups (excluding non-Latino Whites) represent approximately 40 percent of treatment admissions (Substance Abuse and Mental Health Services Administration [SAMHSA] 2011*c*), yet 80 percent of counselors are non-Latino Whites (Duffy et al. 2004). In striving to improve cultural responsiveness, staff composition should be a major strategic planning consideration. As much as possible, the staff should mirror the client population.

Nevertheless, providers should avoid hiring "ethnic representatives," which means hiring a single person from an ethnic or cultural group and expecting him or her to serve as the cultural resource on that group for the entire staff. This can be burdensome, if not offensive, to that person. Belonging to a group does not ensure cultural responsiveness toward, knowledge of, or skill in working with members of that group, nor does it guarantee that the person culturally identifies with that cultural group or its heritage. Hiring ethnic

> "Improving the workforce to provide competent services to diverse populations goes far beyond merely increasing the number of individuals from each of the respective groups. While this is clearly an important strategy, there is a need not only to increase the numbers but also to improve the quality of training for all clinicians, regardless of their racial, ethnic, cultural, or linguistic background. This also includes the necessity to recruit, train, and support interpreters."
> (Hoge et al. 2007, p. 192).

representatives undermines the expansion of diversity at all organizational levels and the importance of developing opportunities for all staff members to gain awareness and improve their ability to effectively work with clients.

Some organizations struggle to find multicultural staff members that represent the diversity of their communities and clienteles. If recruitment is perceived as an immediate short-term goal, ongoing difficulties are likely in hiring, promoting, and retaining a diverse staff. Instead, recruitment strategies need to embrace a more comprehensive and long-term approach that includes internships, marketing to those interested in the field at an early age, mentoring programs for clinical and administrative roles, support networks, educational assistance, and training opportunities.

Task: Create Training Plans and Curricula That Address Cultural Competence

The primary purpose of training is to increase cultural competence in the delivery of services, beginning with outreach and extending to continuing care services that support behavioral health. Training should increase staff self-awareness and cultural knowledge, review culturally responsive policies and procedures, and improve culturally responsive clinical skills

(Anderson et al. 2003; Brach and Fraser 2000; Lie et al. 2011). The organization should be prepared to offer relevant professional development experiences consistent with counselors' personal goals and assigned responsibilities as well as the organization's goals for culturally responsive services. Board members, volunteers, and interpreters should all receive appropriate training.

A professional development training plan details the frequency, content, and schedule for staff training and continuing education. Because becoming culturally competent is a process, training and support for engaging in culturally responsive services can be more appropriate when delivered across a period of time involving follow-up sessions rather than through a single session. Outcome research that evaluates the effectiveness of cultural competence training materials, format, and content in mental health services, including treatment for substance use disorders (Bhui et al. 2007; Lie et al. 2010), is limited. Nonetheless, numerous resources have suggested that effective cultural training does feature certain qualities (Exhibit 4-5).

Sometimes, staff members will express resistance to participation in training activities aimed at promoting cultural competence—they may feel forced to learn about cultural competence, or they may feel unable to take the time away from their clients to attend the

> "The learning objectives of a professional development program should include awareness- and knowledge-based objectives and skills-based objectives that motivate students to explore personal perspectives and multiple worldviews, understand and embrace culturally competent health promotion strategies, and engage in self-directed competency development."
> (Perez and Luquis 2008, p. 178).

Exhibit 4-5: Qualities of Effective Cultural Competence Training

The qualifications of the trainer, the selection of training strategies, and the use of reputable training curricula are extremely important in developing culturally competent staff and responsive services. The following concepts should be considered in the development and implementation of cultural training:

- Cultural training should begin with educating new staff members about the organization's vision, values, and mission as related to culturally responsive services. Orientation should address the demographic composition of clientele, policies and procedures for cultural and linguistic services, counseling and performance expectations for assessment, treatment planning, and delivery of culturally responsive services.
- Before developing and initiating a training plan for culturally responsive services, ask staff members about their training needs specific to the cultural groups that they serve. Receptivity will likely increase if managers and administrators involve clinical staff in the planning process rather than assuming that they know exactly what staff members need regarding cultural training.
- Training should occur across time, and a training plan should detail how to provide training for new employees. Too often, trainings occur at one time, ignoring the complexity of cultural groups and suggesting that one training session is sufficient to achieve cultural competence. Cultural competence evolves from ongoing professional development.
- Training should incorporate diverse learning strategies, including experiential learning and cultural immersion when appropriate (e.g., participation in community activities, role-plays, case presentations). Training should be experientially based and process oriented, allowing self-reflection as part of the training and assigning self-reflection activities between training sessions (see the how-to box on self-reflection on the next page).
- Training should provide information that is practice- or research-based to ensure that participants see it as reputable and clinically sound.
- Training should create a welcoming, nonjudgmental, and professional atmosphere in which staff members, regardless of race, ethnicity, or cultural group, have the freedom and safety to explore their own beliefs and to learn about other cultural groups. Training efforts should not scapegoat mainstream cultural groups or make general statements about specific racial or ethnic groups without noting that there are many cultural subgroups within a given racial or ethnic group—often characterized by, but not limited to, geographic location, socioeconomic status, or educational levels. Participation guidelines should be clarified for each training.
- Training should be conducted by an interdisciplinary, multicultural training team that is experienced in training and well versed in cultural competence.
- Trainers should allow time for staff members to ask questions and process the presented materials and experiential exercises, and they should use staff questions and exercises to explore and correct misperceptions in a nonjudgmental manner.

Sources: Brach and Fraser 2000; Dixon and Iron 2006; Gilbert 2003; Pack-Brown and Williams 2003; Roysircar 2006; Russell 2009.

trainings. Others might object on the grounds that they treat everyone equally, thus ignoring their own cultural blindness.

The organization's leadership needs to address staff reluctance and concerns regarding training through initial education on the rationale for cultural competence. Assume that staff members are invested in creating the best opportunities for their clients to achieve suc-

cess, and use this premise to introduce the need for training centered on culturally responsive care. Some staff members may respond to incentives or predetermined objectives and criteria reflected in employee performance evaluations. Others may be more motivated by opportunities that arise from the organization's commitment to culturally responsive services or by other factors, such as specialized training and supervision, the

How To Engage in Self-Reflection: A Tool for Counselor Training and Supervision

Ask participants to preselect three clients whom they are currently counseling and will likely continue to counsel prior to the next training or supervision session. Selection should be based on clients' diversity in age, race, gender, ethnicity, socioeconomic status, education, and/or geographic location. After each participant has selected three clients (remind participants not to disclose actual client identity if this is an external training outside of the agency), ask them to keep a self-reflection journal wherein the number of entries coincide with each client session until the next training. Participants should write about their internal process, including reactions such as feelings, thoughts, or behaviors during the session that relate to the influence of culture. For example:

- Identify racial, ethnic, and cultural similarities and differences between you and your client.
- Explain how your cultural and clinical worldviews influence your dialog, treatment planning, and expectations of yourself and your client in the session.
- Describe assumptions that you have learned to make about your client's specific race, ethnicity, or culture(s).
- Even if you think these assumptions, beliefs, or biases do not play a role in your current counseling relationship and approach, discuss how they could influence your counseling. Provide a specific example.
- Describe the feelings that you have about your client. How do these feelings relate to your client's racial, ethnic, or cultural identity?
- Explain the differences and similarities in worldviews between you and your client.
- Discuss how your and your client's beliefs about health, healing, disease, and addiction differ.
- Describe how your client's experience with discrimination, oppression, and prejudice could influence his/her current level of distress, psychological functioning, and response to treatment.
- Explore how you attend to your client's worldview in each session.
- Describe a misunderstanding or erroneous counseling response during a counseling session that appears related to differences in cultural identification, values, or behavior.
- Identify cultural knowledge that you must obtain to gain a better understanding of your client.
- Discuss the most important lessons that you have learned from your client.

desire to be perceived by other staff members as team players, or their roles as agents of change with other staff members.

Opportunities for cultural competence training abound. National organizations, agencies dedicated to multicultural learning, academic institutions, government agencies, and information clearinghouses offer training or have information about training opportunities and

> "It takes time and energy to work through significant changes, whether in the workplace or in our personal lives. Many times, resistance to change is a natural reaction of people trying to understand what is expected of them and how the change will impact their lives."
> (Addiction Technology Transfer Center 2004, p. 28)

curricula on cultural competence on their Web sites. In addition to OMH guidelines on staff education and training (Exhibit 4-6), guidelines are available from psychological and counseling associations (APA 2002). To review sample training modules, see *Cultural Competence for Health Administration and Public Health* (Rose 2011).

Task: Provide Culturally Congruent Clinical Supervision

Little research is available that measures cultural competence among clinical supervisors or evaluates the effects of supervision on cultural competence among counselors (Colistra and Brown-Rice 2011; Constantine and Sue 2005). Not much is known about the effectiveness of clinical supervision in enhancing culturally competent behavior among counselors,

---

Exhibit 4-6: OMH Staff Education and Training Guidelines

Only general agreement exists as to what constitutes an acceptable cultural competence curriculum. OMH (2000) recommends tailoring curriculum topics to the roles and responsibilities of trainees and the specific needs of populations served over time but suggests that training should at least address:

- The effects of cultural differences between counselors and clients/consumers on clinical and other workforce encounters, such as the therapeutic alliance.
- The elements of effective communication among staff members and clients/consumers from diverse cultural groups who use different languages, including how to work with interpreters and telephone language services.
- Strategies for resolving racial, ethnic, or cultural conflicts between staff members and clients.
- The organization's policies and procedures for written language access, including how to gain access to interpreters and translated written materials.
- Parts of the Civil Rights Act of 1964 that address services for clients with limited English proficiency.
- The organization's complaint or grievance procedures.
- The effects of cultural differences on health promotion and disease prevention, diagnosis and treatment, and supportive care.
- The impact of poverty and socioeconomic status, race and racism, ethnicity, and sociocultural factors on access to care, service use, quality of care, and health outcomes.
- Differences in the clinical management of diseases and conditions indicated by differences in the race or ethnicity of clients.
- The effects of cultural differences among clients/consumers and staff members on health outcomes, client satisfaction, and treatment planning.

Source: OMH 2000. Adapted from material in the public domain.

---

although some research with a multicultural focus has measured counselor self-efficacy after receiving supervision and has examined the dynamics of supervisee–supervisor relationships. Even though educational institutions have developed curricula and standards to reinforce the need for a multicultural perspective in training, many clinical supervisors lack sufficient training in this area (e.g., avoid cultural topics in supervision, have difficulty giving culturally appropriate consultations or direction, fail to guide/reinforce timely implementation of policies or procedures that support culturally responsive services with their supervisees). This can significantly impede organizations attempting to introduce or improve culturally responsive clinical services.

It is essential for organizations to provide counselors with clinical supervisors who are culturally aware, have engaged in multicultural training, and model culturally competent behaviors in clinical supervision sessions (e.g., allowing or engaging in discussions centered on race, ethnicity, and cultural groups in the session). Clinical supervision is the glue that

---

Advice to Clinical Supervisors: **Culturally Competent Clinical Supervision**

Supported by a review of research on multicultural clinical supervision, Miville et al. (2005) suggest that clinical supervisors gain awareness of and assess:

- Their own racial, ethnic, and cultural identities and attitudes and those of their supervisees.
- Their own knowledge base, strengths, and weaknesses and those of their supervisees.
- Racial, ethnic, and cultural issues that generate reactions in supervisors and in supervisees.
- Current engagement in professional development activities that support culturally responsive practices (see the professional development advice box on the next page).

How To Discuss Professional Development in Multicultural Counseling

This tool facilitates supervisee–supervisor discussions surrounding professional development activities that promote cultural competence. Supervisors can ask supervisees to review the list and check off activities that they have engaged in recently or in the past several months. Supervisors can then use the completed exercise as a starting point for gaining more specific information on activities endorsed by supervisees. Even if supervisees check off no items, reviewing the list reinforces activities that build cultural competence.

Materials needed: A printed copy of the checklist and a pen or pencil.

Instructions: Mark off the activities you have engaged in during the past month and/or 6 months.

Past month	Past 6 months	
____	____	I recognized a prejudice I have about certain people.
____	____	I talked to a colleague about a cultural issue.
____	____	I sought guidance about a cultural issue that arose in therapy.
____	____	I attended a multicultural training seminar.
____	____	I attended a cultural event.
____	____	I attended an event in which most other people weren't of my race.
____	____	I reflected on my racial identity and how it affects my work with clients.
____	____	I read a chapter or an article about multicultural issues.
____	____	I read a novel about a racial group other than my own.
____	____	I sought consultation or supervision about multicultural issues.
____	____	I talked to a friend/associate about how our racial differences affect our relationship.
____	____	I challenged a racist remark—my own or someone else's.

Source: Pack-Brown and Williams 2003, p. 136. Used with permission.

reinforces culturally competent behavior, and it is often the only avenue of ongoing clinical training and follow-up after specific workshops or trainings are offered by the organization.

Clinical supervisors should adopt a multicultural framework to guide the supervision process (e.g., Sue's [2001] multidimensional model for developing cultural competence). Endorsement of a model for developing and enhancing cultural competence helps both supervisors and supervisees understand how to address cultural issues in supervision and pursue personal and professional development that supports culturally responsive clinical services. (For a specific example, see Field and colleagues' [2010] Latina–Latino multicultural developmental supervisory model.) The model guides supervision and reinforces the premise that cultural variables influence each aspect of supervision: the relationship between supervisors and supervisees, the supervisors' and supervisees' perceptions and assessments of clients' presenting issues, the interactions between supervisees and their clients, and the treatment recommendations and directions that evolve from supervision.

Task: Evaluate Staff Performance on Culturally Congruent and Complementary Attitudes, Knowledge, and Skills

Organizations committed to endorsing and implementing culturally responsive services need policies and procedures that reflect this commitment in job descriptions and staff evaluations across all levels of the organization. By incorporating specific goals,

> *Advice to Administrators and Clinical Supervisors:* **Culturally Responsive Performance Evaluation Criteria**
>
> Cultural competence is measured by the degree to which counselors, administrators, and other staff members engage in observable actions and attitudes that reflect cultural responsiveness. Following are examples of descriptive evaluation criteria that address a few aspects of culturally responsive behavior:
> - Engages in ongoing self-analysis to identify and address personal and cultural biases.
> - Actively seeks to view life through the eyes of others and, through doing so, develops a greater level of sensitivity for the values and life challenges of other groups.
> - Participates in hands-on training opportunities and seeks practice and feedback that build toward mastery of responsive needs assessment techniques.
> - Seeks opportunities to engage in cross-cultural activities and interactions.

expectations, and tasks into performance evaluations, staff members will receive an important and consistent message from the organization that culturally competent behavior and responsive services are valued and rewarded.

Organizational Infrastructure

Task: Plan Long-Range Fiscal Support of Cultural Competence

An organization's commitment to providing culturally responsive treatment services will only succeed if resources are consistently dedicated to supporting the plan. Realistically, treatment program funds may be insufficient to initially meet the goals outlined in the organization's self-assessment. More often than not, the committee, executive staff, and board will have to prioritize the specific changes that are financially feasible. However, this necessity does not preclude the organization from soliciting help from the community, finding creative and inexpensive ways to make organizational changes, and using strategic and financial planning to build resources designated for culturally responsive services.

Task: Create an Environment That Reflects the Populations Served

The self-assessment process should include an environmental review of the organization's physical facilities in which barriers to access are examined. The plan should address identified deficits. For example, signage should be written in all primary languages spoken by the clients served; it should be written at an appropriate level of literacy in those languages. When possible, signs should use pictures and graphics to replace written instructions. The design of the facility, including use of space and décor, should be inviting, comfortable, and culturally sensitive. The plan should establish how to make facilities more accessible and culturally appropriate. In addition, the organization should create an environment that reflects the culture(s) of its clients not only within the facility, but through business practices, such as using local and community vendors.

Task: Develop Outreach Strategies To Improve Access to Care

The best-laid plans for providing culturally competent treatment are futile if clients cannot access treatment. Providers should develop outreach plans for diverse ethnic and

Advice to Administrators: **Improving Outreach and Access to Care**

Whenever it is not feasible to provide behavioral health services in the neighborhoods or communities where they are needed, treatment providers should consider the following:

- **Referring clients to community resources:** Ensure that all counselors and referral sources know where to refer individuals for culturally appropriate community services. Individuals should not have to "bounce around" through the system seeking care that is already difficult to access. Have culturally and linguistically appropriate brochures available that describe community services, eligibility, and the referral process.
- **Collaborating with other community services:** Collaboration with other community-based organizations is essential to compensate for the limitations faced by any single agency. Behavioral health service providers can reach larger numbers of underserved populations by teaming with others who have complementary missions and, at times, greater funding, such as other behavioral health agencies and programs dealing with welfare-to-work services, homelessness, or HIV/AIDS. Additional collaboration to increase use includes sending culturally competent counselors to work at another agency or community group on at least a part-time basis, training community members or other agency personnel to provide brief interventions or referral services, and supporting the establishment of mutual-help groups with translated/adapted literature in neighborhood locations.
- **Co-locating community services (creating a one-stop facility):** Co-locating with other agencies is often highly desirable, as it can facilitate connections among various community services that clients need and provide an easy central location to access these services (e.g., a substance abuse intensive outpatient treatment program, a community health service agency, and a community outpatient mental health program offered at one location). For culturally diverse people, the process of accessing services across agencies can be complex because of the need to obtain linguistically and culturally appropriate services and to overcome other barriers, such as economic challenges, issues surrounding eligibility, or the cumbersome repetition of completing forms for each agency. An effective one-stop facility ensures close coordination between each agency that participates while also ensuring client confidentiality. Co-location with a community-based organization that already has solid, positive visibility in the community and a culturally competent workforce can help improve the outreach and treatment efforts of behavioral health organizations that have had difficulty connecting with the communities that they serve.
- **Eliciting support from the community and employing outreach workers:** It is often easier and more persuasive for people who abuse substances or need mental health services to receive information and be encouraged to seek treatment by persons who are ethnically similar to them and speak the same language as they do. This is especially important for new immigrants, who do not yet know their way around the new country and could be unsure of whom they can trust. When possible, outreach workers should be of similar cultural origin as the population being served and should be familiar with the community where they are working. This allows them to explain the advantages of treatment in culturally appropriate ways, speak the appropriate language or dialect, address the concerns of community members, and respect clients' priorities and issues. Outreach efforts can forge connections with important members of the community who encourage people with mental and substance use disorders and their families to seek treatment. These efforts are particularly important with new immigrants who may face legal and language barriers or may have a limited understanding of contemporary medicine and treatment possibilities. For example, lay people trained as *promotores de salud* (promoters of health) have been successful in reaching Latino migrant workers (Azevedo and Bogue 2001).
- **Supplying support services:** Providers can use a variety of means to make treatment accessible to culturally diverse clients. One strategy is to provide transportation from clients' neighborhoods to the provider site. In many areas, people must travel long distances to receive culturally appropriate services. This limits the number of people able to receive treatment, especially

racial communities, particularly those whose members may find it difficult to seek services on their own. For example, see *Community-Defined Solutions for Latino Mental Health Care Disparities* (Aguilar-Gaxiola et al. 2012). From the outset, effective outreach and improved access to care should include formal and informal contacts with community organizations, spiritual leaders, and media. Providers can learn from these contacts about the behavioral health concerns in the community, special considerations for working with members of the community, cultural impediments to treatment, and cultural resources to aid treatment and recovery.

Unfortunately, many providers lack sufficient funding to offer the level of outreach services needed by the communities they serve. Because they are overwhelmed already, the issue of outreach to underserved populations is often seen as a low priority, which can cause these providers to send people in need of treatment away, disappointed and disheartened. However, thoughtful and strategic use of community resources can result in more members of underserved populations receiving the treatment they need and deserve. At minimum, outreach enables providers to offer

accurate information and referral to appropriate mutual-help or community groups.

Regarding fiscal planning and funding opportunities, some HHS initiatives support outreach through integrated care. For example, the Health Resources and Services Administration (HRSA) Center for Integrated Health Solutions (CIHS) promotes the development of integrated primary and behavioral health services to better address the needs of individuals with mental health and substance use concerns. Resources are available to help physicians screen for behavioral health problems and refer individuals to appropriate treatment. SAMHSA's Center for Substance Abuse Treatment has a Targeted Capacity Expansion Program that offers grants in support of outreach to specific populations.

The challenges outlined in this chapter are burdensome but can be overcome. Many organizations have been able to develop cultural competence over time (for a historical perspective of one organization's journey, see Exhibit 4-7). A well-defined and organized plan, coupled with a consistent organizational commitment, will enable organizations to initiate and accomplish the tasks necessary to promote culturally responsive services.

Exhibit 4-7: Cultural Competence Initiative Across Time in One Organization

Late 1980s
- The executive director and board endorse the need to pursue cultural competence and outline agency goals.
- An agency cultural competence committee forms to help develop policies, procedures, and a cultural competence plan. Community and client representation is established.
- A senior staff member is hired to oversee the organization's efforts to diversify staff.

Early 1990s
- The executive director, board of directors, and advisory board endorse the need to pursue culturally competent practices throughout the organization.
- General goals are established and senior management and staff members begin educating the staff on cultural competence.

Mid 1990s
- Culturally competent clinical standards are developed and implemented.
- Initial vision, mission, and value statements are modified to include cultural competence.
- Training for management and clinical supervisors incorporates cultural competence in practice.
- The agency begins a community cultural assessment and introduces a client satisfaction survey to gain feedback on current implementation of culturally responsive practices and to guide future direction and focus.
- Ongoing clinical supervisor training on cultural competence is initiated.
- The cultural competence committee develops recommendations for job descriptions and performance appraisals to reflect cultural competence skills and responsibilities.

Late 1990s
- Individuals and families who receive services are now involved in focus groups, orientations, and trainings.
- Partnerships with other agencies to promote cultural competence throughout the community are more strongly encouraged.
- A curriculum to train all staff members in the foundations of cultural competence is developed and implemented.

2000s
- Across the organization, clinical and administrative programs engage in cultural competence review and goal-setting.
- The mission statement is redefined to formally acknowledge the organization's values of respect for cultural differences, recovery, and advocacy.