

Technical Assistance Document 5

Considerations for Embedding Cultural Competency

Purpose:

Cultural Competency continues to be a critical component for all mental health programs and policies. Now, the Mental Health Services Act (MHSA) provides an opportunity to develop a transformed culturally competent mental health system. This concept is embodied in the Vision Statement and Guiding Principles for DMH Implementation of the Mental Health Services Act, “DMH will dedicate its resources and energies to work with stakeholders to create a state-of-the-art, culturally competent system...” This document offers operational strategies for embedding Cultural Competency in the Community Services and Supports component of the MHSA. The operational strategies in this document, however, are not meant to be exhaustive. Rather, it is recommended that the counties and stakeholders use these strategies as a compliment to their own materials and the expertise gained through their on-going Cultural Competence activities, pursuant to the Medi-Cal Specialty Mental Health Services–Cultural Competence Plan Requirements (DMH Information Notice No. 02-03). The strategies to achieve a culturally competent mental health system and thereby eliminate the existing disparities in the current system have been discussed over the years in a variety of documents. Many of these documents are available on the DMH Website at: www.dmh.ca.gov.

Cultural Competence is defined as a set of congruent practice skills, knowledge, behaviors, attitudes, and policies that come together in a system, agency, or among consumer providers, family members, and professionals that enables that system, agency, or those professionals and consumers, and family member providers to work effectively in cross-cultural situations (adapted from Cross, et al., 1989; cited in DMH Information Notice No.: 02-03).

Background:

Rapidly changing demographics in the United States (U.S.) and California, and the increasing numbers of Californians without health care have accelerated the need to change the system. Presently, the non-Hispanic white population in California stands at 47%, making ethnic, racial, linguistic, and multiracial groups the majority of the State’s population.

Racial and ethnic populations are a growing segment of the U.S. population and are currently either underserved, and/or inappropriately served in the metal health system (Rice, 1996). In California, County Mental Health Plans have been required to submit Cultural Competency Plans since 1998. These plans include population and utilization

DMH DRAFT – MAY 23, 2005

data. The data clearly document the disparities that exist among ethnic and racial groups.

Collectively, the ethnically, racially, and linguistically diverse populations experience greater disability from emotional and behavioral disorders than do white populations (Mental Health: Culture, Race and Ethnicity, A Supplement to the Surgeon General's Report, 2001). The higher burden is partially attributed to receiving less access to care, and poorer quality of care rather than from disorders being inherently more severe or increased prevalence in racially, ethnically, linguistically diverse populations. In general, mental health disparities among ethnically, racially, and linguistically diverse populations have been attributed to inadequate funding of the public mental health system and its inability to understand and value the need to adapt the service delivery process to the histories, traditions, beliefs, languages and values of diverse groups. This inability results in misdiagnoses, mistrust, and poor utilization of services by ethnically, racially, and linguistically diverse populations seeking services. These groups also experience more stressful environments due to poverty, violence, discrimination and racism.

Developing effective and efficient culturally competent organizations, access, and programs is fiscally prudent. The lack of these components in a mental health system results in inappropriate and inefficient services leading to higher levels of care for clients and higher costs. It is estimated that the general cost of untreated or poor treatment of mental illness costs the government, business, and families \$113 billion a year (Rice, 1996).

Additionally, the mental health system has to comply with federal and state legislation when delivering services to persons who are limited English-proficient. Title VI of the Civil Rights Act of 1964 (U.S. Congress, 1964) mandates meaningful and equal access to health and social services. California counties started to work towards this goal among a myriad of rules, regulations, and limitations. The MHSA allows California counties to advance the mental health system into a transformed culturally competent mental health system for those ethnically, racially, and linguistically diverse groups who are unserved and underserved

A culturally competent service delivery system accomplishes the following efficiency elements:

- ◆ Improved service access, including early intervention
- ◆ Accuracy of diagnosis
- ◆ Appropriate and individualized service planning and delivery
- ◆ Effective integration of the client's family (including extended family members) into services
- ◆ Use of relevant community supports
- ◆ External resources in client services
- ◆ Financial efficiencies – cost-avoidance and cost-effectiveness

Considerations for Embedding Cultural Competency in Organizations

Recommendation for Counties/Organizations	Recommended Action	Resources
<p>1. Counties/organizations to identify values, principles, and commitment to Cultural Competency</p>	<p>It is recommended for counties/organizations to have:</p> <ul style="list-style-type: none"> • Written policies and procedures that clearly identify Cultural Competence principles and values • Written policies and procedures that acknowledge Cultural Competency as developmental and continuous 	<p>"Many Voices, One Direction: Building a Common Agenda for Cultural Competence in Mental Health: A Report to the Community," February 6-8, 2002</p>
<p>2. Counties/organizations include Cultural Competency in vision statements, speeches, and public communications</p>	<p>It is recommended that mental health directors and senior staff advocate for/institutionalize Cultural Competence in the broader mental health community and in the stakeholder process</p>	<ul style="list-style-type: none"> • Ethnic Services Managers (ESM) • "Many Voices, One Direction: Building a Common Agenda for Cultural Competence in Mental Health: A Report to the Community," February 6-8, 2002 • "Mental Health: Culture, Race, and Ethnicity, A Supplement to Mental Health: A Report of the Surgeon General," 2001
<p>3. County mental health directors establish expectations and objectives for senior management staff to promote Cultural Competency</p>	<p>It is recommended that directors:</p> <ul style="list-style-type: none"> • Develop performance objectives • Communicate expectations/objectives through all the mental health system/organization/structure 	

DMH DRAFT – MAY 23, 2005

Recommendation for Counties/Organizations	Recommended Action	Resources
<p>4. Counties/organizations dedicate a position responsible for providing leadership in multicultural/ethnic services which has the responsibility to review the major policies and agency products to ensure that Cultural Competence is included or addressed</p>	<p>It is recommended that counties/organizations establish policies and procedures that ensure the review of policies by the person who has been entrusted with leadership responsibilities for ethnic services</p>	
<p>5. Counties/organizations conduct a system-wide self-assessment related to Cultural Competence annually</p>	<p>It is recommended that counties/organizations:</p> <ul style="list-style-type: none"> • Conduct self-assessments as part of the counties'/organizations' Quality Improvement Plan • Conduct self assessment at multiple levels of administration, middle management, direct service providers, contract agencies, and clients/family members • Use a strength-based model • Develop dissemination formats that reflect the needs of stakeholder groups, i.e., translation of information, regional meetings, etc • Disseminate results of self-assessment to all internal and external stakeholders 	<ul style="list-style-type: none"> • Cultural Competence Plans • Georgetown Cultural Competence Organizational Assessment Tools • Cultural Competency Methodological and Data Strategies to Assess the Quality of Service in Mental Health Systems of Care," Carol Siegel, G. Haugland, E. Davis, Center for the Study of Issues in Public Mental Health

DMH DRAFT – MAY 23, 2005

Recommendation for Counties/Organizations	Recommended Action	Resources
<p>6. Counties/oranizations conduct a baseline needs assessment that includes a profile of racially, ethnically, and linguistically diverse groups currently being served</p>	<p>It is recommended that counties/organizations:</p> <ul style="list-style-type: none"> • Review the 2003-04 cultural competence population, utilization, organizational, and provider data and update data • Review data per MHSA plan requirements • Analyze current levels of disparities to county population • Set strategies and objectives to eliminate identified disparities in county, regional, or service areas 	<ul style="list-style-type: none"> • DMH Information Notice No.: 02-03, Medi-Cal Specialty Mental Health Services—Cultural Competence Plan Requirements • Georgetown Cultural Competency Organizational Assessment tools • Carol Siegel Organizational Assessment
<p>7. Counties/organizations have developed a strategic plan for Cultural Competency, pursuant to DMH Information Notice No.: 02-03, Medi-Cal Specialty Mental Health Services—Cultural Competence Plan Requirements</p>	<p>It is recommended that counties/organizations:</p> <ul style="list-style-type: none"> • Utilize self-assessment tools and the Cultural Competency Plans as a starting point to begin a strategic planning process for the MHSA • Ensure stakeholder process includes multicultural community groups and client/family members 	<p>Each county's Cultural Competence Plan, pursuant to DMH Information Notice No.: 02-03, Medi-Cal Specialty Mental Health Services—Cultural Competence Plan Requirements</p>
<p>8. Counties/organizations have a process to assess language, access, capacities, and needs in the county</p>	<p>It is recommended that counties/organizations:</p> <ul style="list-style-type: none"> • Monitor county language access needs, and set objectives to meet need • Develop strategies to hire bilingual staff and trained interpreters 	<p>National Standards for Cultural and Linguistically Appropriate Service (CLAS) in Health Care, U.S. HHS, OMS, Final Report, 2001</p>

DMH DRAFT – MAY 23, 2005

Recommendation for Counties/Organizations	Recommended Action	Resources
<p>9. County mental health programs have an accountability system that monitors and assesses the following on an ongoing basis, and it is inclusive of the components of the MHSA: 1) increasing its culturally competent programs and 2) elimination of disparities</p>	<p>It is recommended that the:</p> <ul style="list-style-type: none"> • Data collected to assess programs' outcomes is by race and ethnicity • Data be reviewed annually and that it reflects the Cultural Competence Plan objectives and outcomes • Review evidence of embedding cultural and linguistic competency factors in new and existing programs 	<ul style="list-style-type: none"> • Cultural Competence Standards in Managed Mental Health Care Services, U.S. HHS, 2000 • "Cultural Competency Methodological and Data Strategies to Assess the Quality of Service in Mental Health Systems of Care," Carol Siegel, G. Haugland, E. Davis, Center for the Study of Issues in Public Mental Health
<p>10. Counties/organizations ensure that Cultural Competence and strategies to eliminate and prevent disparities in the planning and implementation of the MHSA are embedded in all MHSA efforts</p>	<p>It is recommended that the county mental health planning and implementation of the MHSA utilizes leaders in ethnic services to assist in efforts to identify and include the perspective of multicultural client/family member community and ensures that cultural competence factors are embedded in each of the six components of the MHSA as they are being developed</p>	

DMH DRAFT – MAY 23, 2005

Recommendation for Counties/Organizations	Recommended Action	Resources
<p>11. County's/ organization's dedicated budget is established for activities to address underserved and racial/ethnic groups</p>	<p>It is recommended that counties/organizations develop budgets that include the following:</p> <ul style="list-style-type: none"> • Outreach activities to multicultural groups • Translation of materials • Purchase of interpreter devices • Hiring of multicultural and bilingual clients and family members • Training and certification of interpreters • Hiring of cultural brokers • Hiring of Culturally Competent consultants 	<ul style="list-style-type: none"> • National Technical Assistance Center (NTAC) for State Mental Health Planning www.nasmhpd.org/ntac • Cultural Competence Standards In Managed Mental Health Care Services: Four Underserved/Underrepresented Racial/Ethnic Groups • National Standards for Cultural and Linguistically Appropriate Service (CLAS) in Health Care, U.S. HHS, OMS, Final Report, 2001
<p>12. Counties/organizations execute contracts/agreements with agencies that support the counties'/ organizations' commitment to Cultural Competency</p>	<p>It is recommended that in the contracts/agreements the counties/organizations include language requiring agencies/contractors:</p> <ul style="list-style-type: none"> • To report activities that promote and sustain Cultural Competency • To include quality improvement activities and projects 	<ul style="list-style-type: none"> • National Technical Assistance Center (NTAC) for State Mental Health Planning www.nasmhpd.org/ntac • Cultural Competence Standards In Managed Mental Health Care Services: Four Underserved/Underrepresented Racial/Ethnic Groups • National Standards for Cultural and Linguistically Appropriate Service (CLAS) in Health Care, U.S. HHS, OMS, Final Report, 2001

DMH DRAFT – MAY 23, 2005

Recommendation for Counties/Organizations	Recommended Action	Resources
<p>13. Counties/organizations administratively monitor accessibility for all regions and areas</p>	<p>It is recommended that counties/organizations establish location of services and hours of operation to ensure maximum accessibility</p>	
<p>14. Counties/organizations develop recruitment, hiring, and retention plans that are reflective of the counties'/ organizations' ethnic, racial, and linguistic populations</p>	<p>It is recommended that counties/organizations:</p> <ul style="list-style-type: none"> • Dedicate a staff to be responsible for overseeing the plan • Link the plan to Cultural Competence Plan, pursuant to the Medi-Cal Specialty Mental Health Services—Cultural Competency Plan Requirements and Program Improvement Projects (PIPs), pursuant to federal Medicaid Managed Care regulations • Expand access studies to include other underserved populations as the required Latino access studies • Disseminate plan to all internal and external stakeholders 	<ul style="list-style-type: none"> • “Promoting Cultural Competence in Children’s Mental Health Services.” M. Hernandez, M. Isaacs, J. Romero, p. 81, Ch. 5 • Recruitment, Retention, Training, and Supervision of Mental Health Staff • California Mental Health Planning Council—Human Resources Project • Summit Workshop Report “Multilingual & Multicultural Pipeline,” 2000
<p>15. Counties/organizations have members from ethnically/racially/linguistically diverse communities participating on advisory boards/committees</p>	<p>It is recommended that counties/organizations:</p> <ul style="list-style-type: none"> • Develop policies and procedures which outline counties’ plans for ongoing recruitment, mentoring of community participants • Support the principle of communities defining their challenges and solutions 	

DMH DRAFT – MAY 23, 2005

Recommendation for Counties/Organizations	Recommended Action	Resources
<p>16. The county's Cultural Competence Committee (CCC) meets regularly and is representative of the county's multicultural/race/ethnicity/linguistic populations</p>	<p>It is recommended that CCC:</p> <ul style="list-style-type: none"> • Establish written procedures which ensure a process for membership that reflects the multicultural/race/ethnicity/linguistic populations of the county • Provides for interpreters, interpreter aids, translated materials to allow for full participation of multicultural members, especially those members who are limited English-proficient • Conducts pre-meetings with clients and family members to provide an opportunity for questions and answers and an education process • Conducts meetings with community leaders within multicultural groups 	
<p>17. The county's CCC is a part of, or has a communication/reporting link to the county's Quality Improvement Committee</p>	<p>It is recommended that the:</p> <ul style="list-style-type: none"> • CCC's policies and procedures outline the communication process to and from the Quality Improvement Committee • Quality Improvement Committee has members of the CCC as part of their membership 	

DMH DRAFT – MAY 23, 2005

Recommendation for Counties/Organizations	Recommended Action	Resources
<p>18. Activities and recommendations of the CCC are distributed system-wide</p>	<p>It is recommended that managers and supervisors:</p> <ul style="list-style-type: none"> • Communicate information from the CCC to direct services staff and establish communication link back to the CCC with staff input • Train staff on policies, procedures, and new recommendations <p>It is recommended that:</p> <ul style="list-style-type: none"> • Policies and procedures related to the CCC be developed and clearly delineate the CCC's purpose and responsibilities • County administration reports back to the CCC the status of its recommendations 	<p>"Towards a Culturally Competent Systems of Care," Georgetown, Vols. I and II</p>
<p>19. The CCC is responsible for reviewing policies and making recommendations related to Cultural Competence</p>	<p>It is recommended that the Quality Improvement Committee:</p> <ul style="list-style-type: none"> • Establishes written procedures that ensure a process for membership that reflects the multicultural/linguistic populations in the county • Provides for interpreters, interpreter aids, translated materials to allow for full participation of multicultural and limited English-proficient members • Conducts pre-meetings with clients and family members to provide an opportunity for questions and answers and an education process 	
<p>20. The Quality Improvement Committee meets regularly and is representative of the county's multicultural/linguistic populations</p>		

DMH DRAFT – MAY 23, 2005

Recommendation for Counties/Organizations	Recommended Action	Resources
21. Outcome measures and quality indicators are based on culturally competent criteria	It is recommended that the county develop an accountability system to assess progress in eliminating disparities	

Considerations for Culturally Competent Client, Family Member, and Community Engagement

California's mental health system will be well on its way to transformation when it successfully engages clients, family members, and extended families of the ethnically, racially, and linguistically diverse groups that comprise 53% of California's population. Engaging these groups is vital to developing a responsive mental health system that will meet their needs and lessen their marginal status. The planning process for engaging ethnically, racially, and linguistically diverse communities will call upon counties to have informed discussions with those cultural brokers, consultants, and community stakeholders who have expertise in working with multicultural populations. Also, county leadership will be called upon to develop different avenues and methods to reach these historically underserved and unserved populations. The successful engagement might result in new and different community partners with whom county mental health systems collaborate.

California's mental health system has a responsibility to respond to community needs regarding access to services, delivery systems, and culturally and linguistically proficient services. Culturally competent systems include the community as well as families and extended families in determining how these responsibilities will be met. It includes the community in setting system goals and outcomes. It is a system that recognizes the different help-seeking behaviors, communication styles, parenting styles, culturally based treatments and cultural healers of its populations. A culturally competent system adapts its operating procedures to meet community needs as opposed to expecting that the various ethnically, racially, and linguistically diverse communities adapt to the system.

Soliciting the participation of ethnically, racially, and linguistically diverse groups is challenging (especially in rural areas) but achievable. It is achievable by adopting various existing models such as the "Promotora" program models. The *Promotora* program is a program that uses culturally and linguistically proficient health educators/advocates who go into communities to deliver services using the community's structures rather than an agency structure. The *Promotora* programs have long been used in Latino communities in the physical health care system with much success.

Another model is the increasing use of telehealth, which provides an opportunity to engage rural communities in a much expanded dialogue in addition to providing services for populations who lack access to care.

It is imperative that the planners of the service delivery system understand the complexities of the mental health needs of the various ethnically, racially, and linguistically diverse groups as well as acknowledge the value of their strengths and expertise through their participation.

Client/Family Member/Community Engagement

<p>Recommendation for Counties/Organizations</p>	<p>Recommended Action</p>
<p>1. Counties/organizations adopt an organizational commitment to eliminate disparities to racial and ethnically underserved and unserved populations and assign leadership for operationalizing the commitment</p>	<p>It is recommended that the leadership:</p> <ul style="list-style-type: none"> • Be knowledgeable and familiar with concepts of Cultural Competency • Have working knowledge of mental health system's values, philosophy, and guiding principles • Have experience working with multicultural communities • Be familiar with disparities in access to and the effectiveness of mental health services among multicultural communities • Work with client and families of multicultural communities
<p>2. Counties/organizations identify a team of multicultural and bilingual staff, clients, and family members who are hired to assist in addressing elimination of disparities to underserved and unserved racial/ethnic clients and family members</p>	<p>It is recommended that members of the team:</p> <p>Be knowledgeable of the barriers specific to targeted racial ethnic groups for whom county is trying to increase access and appropriateness of care</p> <ul style="list-style-type: none"> • Have knowledge of how to engage the gatekeepers of multicultural groups/communities • Encourage the leadership of clients and family members of these diverse groups. Leadership among racial/ethnic clients and family members is needed to give voices to these relatively unheard stakeholders • Include those who are bilingual to help address monolingual and bilingual clients who experience barriers to access to care • Help to create and imbed cultural and linguistically appropriate services in collaboration with other county client-run programs, such as peer support programs, etc.

<p>Recommendation for Counties/Organizations</p>	<p>Recommended Action</p>
<p>3. Counties/organizations develop an outreach plan that maximizes input and involvement of multicultural communities in the planning process</p>	<p>The outreach plan must include all regions of the county—rural and urban</p> <p>Outreach activities should occur where the population lives and or gathers. For example outreach efforts should:</p> <ul style="list-style-type: none"> • Take place in juvenile halls. Two thirds of incarcerated youth are persons of color. A focus group could be held in juvenile hall to get input from youth. • Occur when people are available: Community meetings could be held on Sundays, after church, or temples, or places of worship. • Include the expertise and involvement of clients and family members from the groups that are targeted by county to increase/improve access to care. <p>In addition, outreach efforts should also:</p> <ul style="list-style-type: none"> • Include ethnic-specific activities. Examples of ethnically appropriate activities include Discussion and Dinner (Platicas y Comida) at neighborhood community centers, Healthy Start Centers, ethnic fairs, etc. • Include stipends for clients and family members providing expertise and input • Provide transportation and child care • Emphasize and encourage immediate and or extended family members to attend outreach activities • Include interpreter services with staff that are trained in the skills and ethics of interpreting • Use of culturally competent telehealth programs to reach rural communities and use of telehealth consultants to assist in the planning

DMH DRAFT – MAY 23, 2005

Recommendation for Counties/Organizations	Recommended Action
<p>4. Client-run programs must be culturally and linguistically competent</p>	<p>DMH recognizes that the client and family member movements have made progress to be more inclusive of multicultural and bilingual clients and family members. It is important to include the voice of multicultural client and family members, including monolingual and bilingual clients and family members in the expansion of client-run programs. MHSA client-run expansion programs should include the voices of new refugees and immigrant communities.</p>
<p>5. Counties/organizations develop language access plans to include interpreter services in stakeholder planning process</p>	<ul style="list-style-type: none"> • It is critical that the voices of monolingual or limited English-speaking clients and family members be included in the early and ongoing planning process. Consider working with county leadership staff, client and family members for ideas on creative strategies for inclusion of limited English-speaking clients and family members in the planning. • Consider hiring interpreters for clients at planning meetings. "Nothing about us without us" should also include the many voices of limited English-speaking clients and their families.
<p>6. Counties/organizations identify ethnic-based community groups outside of the mental health system to involve in stakeholder process</p>	<ul style="list-style-type: none"> • Examples include faith based organizations, churches, temples • Ethnic-specific civic groups, e.g., ethnic-specific Chambers of Commerce • Ethnic-specific social clubs
<p>7. Counties/organizations collaborate with primary health provider partners including rural health clinics, urban health clinics, private health care providers, etc.</p>	<p>Establish and formalize collaborative relationships with health care providers – approximately 50% of ethnic groups access mental health services through primary care</p>

DMH DRAFT – MAY 23, 2005

Recommendation for Counties/Organizations	Recommended Action
8. Counties/organizations collaborate with current client groups in county to include a more multicultural client voice	Work with client and family member groups to address expansion of services/inclusion to underserved racial ethnic groups. Help resolve barriers to their participation including, but not limited to language, and other program and participation barriers.
9. Counties/organizations collaborate with non-mental health community groups/agencies which serve multicultural groups	<ul style="list-style-type: none"> • Identify non-mental health community groups/agencies e.g., schools, YMCA, YWCA, and conduct focus groups with staff • Involve appropriate staff as cultural brokers in communicating with the multicultural groups they serve
10. Value and respect the role of natural healers in multicultural client communities	<ul style="list-style-type: none"> • Acknowledge the client choice of a culturally based healer (“alternative” describes the opinion of the mental health system) • Actively seek cultural healers in the design of services
11. Counties/organizations apply Cultural Competence values, philosophy, and guiding principles to high-risk youth populations—homeless, foster care and incarcerated	Develop training module for staff working with high-risk youth on Cultural Competency, the impact of culture, family and extended family systems
12. Counties/organizations develop outreach/access plan for ethnic and racial groups living in rural geographic areas	<ul style="list-style-type: none"> • Use of telecommunications to facilitate participation in system program design, goal setting • Encourage the use of <i>Promotora</i>-type models • Train outreach staff in use of telecommunications

Recommendation for Counties/Organizations	Recommended Action
13. Counties/organizations reduce disparity in multicultural client participation by developing client leadership training with added emphases on racial ethnic clients and family members	Racial ethnic and monolingual and bilingual clients and family member voices need to be supported to include their input and serve as new leaders in client focus involvement. Consider replicating the San Francisco "Asian Client Leadership Team" training programs to expand involvement of diverse clients and family members.

Considerations for Culturally Competent System Transformation

The MHSA addresses the need that exists to evaluate, develop, and implement a mental health system for all the communities of California. Leaders of California's mental health system are acutely aware of the critical needs that exist in ethnically, racially, and linguistically diverse communities. A myriad of documents give evidence to these needs and reinforce the call for action. Studies that clearly define data regarding mental health treatment in these communities are much less available. The perspective of these communities is often not represented in treatment studies, position papers regarding changes in practice, and quality improvement standards. A special analysis performed for the Surgeon General's Office, entitled, "Mental Health: Culture, Race, and Ethnicity, A Supplement to Mental Health: A Report of the Surgeon General" reveals that controlled clinical trials used to generate professional treatment guidelines do not conduct specific analysis for any racial/ethnic groups. This exclusion hampers the efforts to develop values-based and evidence-based treatments, and therefore guidelines and treatment protocols for practitioners working with these populations. Culturally and linguistically proficient mental health providers (both individual and agency level) struggle to provide appropriate treatment within frameworks that may not "fit" the majority of the population to be served. The concept of "family" as perceived by the system is an example that illustrates this point. Currently, services are organized in youth, adult, and older adult segments throughout the system, frequently having different providers and provider locations by age group. Ethnic/racial/linguistic populations operate as an integrated system. More often than not, these populations live in multi-generation households. In a transformed system, services would be delivered to families within a community setting, not individuals by age group.

There is an increased focus on providing culturally responsive mental health services to vulnerable populations in which ethnic and racial groups are over-represented—homeless, foster care, incarcerated youth, refugees, etc. Counties can use these models and the data generated from them and add the participation of multicultural stakeholders to develop their service delivery systems.

Considerations for Culturally Competent System Transformation

Recommendation for Counties/Organizations	Recommended Action	Resources
<p>1. Counties/organizations conduct training on the use of DSM IV R-cultural formulation in assessment of racial ethnic populations</p>	<ul style="list-style-type: none"> • Develop process for continuous training of staff to maintain standards as work force changes occur • Monitor staff use in individualized treatment planning documents 	<ul style="list-style-type: none"> • DSM IV R • Culture of Emotions Video: A Cultural Competence and Diversity Training Program (Harriet Koskoff, 2002)
<p>2. Counties/organizations conduct Cultural Competence training needs assessed for county and contract providers</p>	<ul style="list-style-type: none"> • Use well-established tools to assess training needs for Cultural Competency for providers • Practitioners and other service providers need tools that are appropriate for or can be modified to address needs of increasingly diverse populations 	<ul style="list-style-type: none"> • CA Brief Multicultural Competence Scale and Training Program • California Mental Health Planning Council's Mental Health Master Plan • Cultural Competence Training Plans
<p>3. Counties/organizations collaborate and consult with other programs/agencies engaged in ethnic/racial-specific services</p>	<ul style="list-style-type: none"> • Modify and adapt existing evidence-based practices to meet needs • Collect best and promising practices, demographic, and outcome data on all programs 	<p>"Mental Health: Culture, Race, and Ethnicity, A Supplement to Mental Health: A Report of the Surgeon General," 2001</p>

Recommendation for Counties/Organizations	Recommended Action	Resources
<p>4. Counties/organizations provide training in understanding the dynamics of race, culture, and ethnicity in mental health treatment for practitioners</p>	<ul style="list-style-type: none"> • Maximize use of county staff who have expertise in areas as trainers • Actively seek partnerships with educational institutions who may provide classes/expertise • Use available training resources • Provide training in the use of cultural brokers 	<ul style="list-style-type: none"> • "Mental Health: Culture, Race, and Ethnicity, A Supplement to Mental Health: A Report of the Surgeon General," 2001 • Cultural Competence Standards in Managed Mental Health Care Services, U.S. HHS, 2000 • National Standards for Cultural and Linguistically Appropriate Services in Health Care, US HHS, OMS, 2001 • California Mental Health Planning Council's Mental Health Master Plan

DMH DRAFT – MAY 23, 2005

Recommendation for Counties/Organizations	Recommended Action	Resources
<p>5. Counties/organizations develop programs to address the needs of youth in the juvenile justice system by gender, and race/ethnicity. Counties/organizations acknowledge and address disproportionate confinement to these groups and address mental health treatment needs</p>	<ul style="list-style-type: none"> • Specialized family group input for this population • Establish/strengthen school linkages with program for transition planning • Establish mentoring programs in partnership with ethnic-specific community groups • Develop specific strategies for ethnic/cultural youth in the juvenile justice system program 	<p>Recommendations for Juvenile Justice Reform, American Academy of Child and Adolescent Psychiatry Task Force on Juvenile Justice Reform, October, 1999-2001</p>
<p>6. Counties/organizations develop and support evidence-based practices that are congruent with ethnic/racial/linguistic group belief systems, cultural values, help-seeking behaviors</p>	<ul style="list-style-type: none"> • Collect sufficient data to begin establishing evidence-based treatments • Links to Quality Improvement Committee 	<p>Review research documentation and other evidence of treatment interventions beneficial for racial ethnic groups</p>
<p>7. Counties/organizations allow for the inclusion of natural healers in the community</p>	<ul style="list-style-type: none"> • System can consult with natural healers to add to knowledge base • Included on treatment team at request of client/family members 	

DMH DRAFT – MAY 23, 2005

Recommendation for Counties/Organizations	Recommended Action	Resources
<p>8. Counties/organizations train providers on cultural values and world views and beliefs as they relate to the role of an older adult, their place in the family and care-giving expectations</p>	<p>County and contract providers adopt/develop practice standards for older adult populations within ethnic/racial/linguistic groups</p>	<p>Older Adult System of Care Framework, California Mental Health Directors Association, 2001</p>
<p>9. Counties/organizations train providers on cultural values, beliefs, parenting styles, regarding children</p>	<p>County and contract providers adopt/develop practice standards for children and youth, including transition age within ethnic, racial, and linguistic groups</p>	
<p>10. Counties/organizations provide training in ethno-psycho-pharmacological concepts and management for medical staff</p>	<ul style="list-style-type: none"> • Hire specialists/consultants to conduct training • Collaborate with other counties to establish peer-to-peer physician training to provide for exposure to treatment with different ethnic, racial, linguistic groups 	
<p>11. Counties/organizations explore the use of telehealth to create access to services in rural/small counties</p>	<p>Identify regions within counties impacted by underserved/unserved</p>	

DMH DRAFT – MAY 23, 2005

Recommendation for Counties/Organizations	Recommended Action	Resources
<p>12. Counties/organizations develop transformative mental health service interventions. Expand the growth of new treatment/service interventions for underserved or underserved racial/ethnic groups and document evidence of successful specific alternative treatment interventions</p>	<p>Work with racial ethnic clients and family members and other multicultural experts to develop and or try new mental health services interventions for underserved and underserved groups, for children, youth, adults and older adults. Include Quality Improvement Committee or research assistance to document new intervention and outcomes</p>	