# Connecticut
# Department Of Mental Health and Addiction Services
# (DMHAS)

# Multicultural Clinical/Rehabilitation Best Practices

**Developed by:**

**The Multicultural Advisory Council**
**Clinical/ Rehabilitation Subcommittee**
**As Part of**
**The Office of Multicultural Affairs Strategic Plan**


**Sub-Committee Members**
**Edna E. Aklin , LCSW**
**Karen Cummings, MSW**
**Efrain Diaz, LCSW**
**Gloria Dzerovych, LCSW**
**Jerilynn Lamb-Pagone, RN, MSN, CS**
**Dianne Stanton, MS, LADC**
**Brenda E. Thorington, RN**

**Laurene Finely, Ph.D.**
**Consultant**
**Temple University**
**Multicultural Training and Research Institute**



**Hartford, Connecticut**
**July 1, 2001**

## Department of Mental Health and Addiction Services

## Multicultural Clinical/Rehabilitation Best Practices and Guidelines

## Introduction

The Department of Mental Health and Addiction Services (DMHAS) established the Multicultural Advisory Council (MCAC) in 1998 to be a change agent in the process of meeting the Department's commitment to culturally-competent services throughout our system of health care. The MCAC spent a year working with consultants from Temple University to develop needed cultural competence skills and the capability to operate as a change agent for the DMHAS system. Among the many accomplishments of the Council is the work of its Multicultural Clinical Standards committee. With ongoing technical assistance provided by Dr. Laurene Finley of Temple University Multicultural Training and Research Institute (MCTRI), the committee enlisted critical input from the MCAC, the DMHAS regional team leaders and the staff of the Office of Multicultural Affairs (OMA). The committee spent long arduous hours to develop a document that could be applicable in both Mental Health Services and Addiction Services.

The original document, *The Multicultural Clinical/Rehabilitation Standards,* was disseminated for provider feedback throughout the Connecticut system of state-operated treatment facilities and contracted services. The process was facilitated by the Interagency Service System (ISS) and the support and technical assistance of the regional team leaders of the DMHAS Division of Community Services and Hospitals.

The DMHAS OMA staff conducted five regional presentations of the committee's working draft of the "*Multicultural Clinical/Rehabilitation Standards*" to introduce the state-operated and contracted providers to the proposed integration of the standards into the health care system. Over 120 agencies responded with both oral and written feedback that suggested improvements in the document and recommendations for its implementation. One recommendation was made to change the title from "*Multicultural Clinical/Rehabilitation Standards*" to "*Multicultural Best Clinical/Rehabilitation Practices*". This title change clarifies the document's function in the system. Providers also offered excellent feedback on the multiple outcomes and measures that were originally included with each standard. That led to the conversion of the document's original outcomes and measures to practical guidelines to assist programs in effective implementation of the *Multicultural Best Clinical/ Rehabilitation Practices.*

The DMHAS Central Quality Council was established to revise and standardize the quality outcomes and measures across the DMHAS system. Their final recommendations on quality outcomes and measures will address the system of care in all the areas of clinical best practices. DMHAS will be able to analyze that outcome data demographically. This demographic analysis will be the basis for assessing quality and effective cultural/ethnic/racial appropriateness of all services. At an appropriate time in the near future, programs will be expected to meet the basic standard contractual outcome measures for each demographic population in the agency's geographic target area. This gradual

process of step-by-step implementation assures the establishment of the *Multicultural Best Clinical/Rehabilitation Practices* with standard measurable outcomes in a user-friendly learning environment.

The DMHAS *Multicultural Clinical/Rehabilitation Best Practices* provide guiding principles for culturally-competent treatment and recovery services to individuals of ethnic/cultural/racial populations living with mental illness and addictive disorders. The *Multicultural Clinical/Rehabilitation Best Practices* reflect the view that multicultural competence is both a value and a set of skills that must be incorporated in every aspect of our system of care. Providers are expected to be sensitive to the cultural values of diverse groups, acknowledge cultural strengths associated with people, their families, significant others, and communities, while recognizing and respecting individual differences. Our prevention, treatment, rehabilitation and recovery services all need to be culturally appropriate for all individuals served. The Department of Mental Health and Addiction Services recognizes that multicultural competence is a developmental process. It occurs along the entire continuum of care and requires the ongoing participation of all stakeholders to bring about a multicultural system of care.

Therefore, this document is intended to serve as the guiding policy for our practice, training and service system development. Implementation of this cultural phase of the Department's overall policy on best clinical practices will stimulate the initiation of service interventions, strategies, policies, and program development necessary to assure a culturally-competent system of care throughout the State of Connecticut. It is a resource that will improve outcomes of direct client services throughout the DMHAS health care system.

"Implementation Guidelines" are provided with each standard to assist every agency in addressing critical areas of clinical operations. The guidelines describe activities intended to assure the quality of care established by a best practice policy. They should be used as an ongoing resource to assist in this effort.

# The DMHAS Multicultural Clinical/Rehabilitation Best Practices

## I. Access and Service Authorization

Access to services shall be made available to persons, their families and/or natural supports (i.e., self-defined family) in a respectful and welcoming manner. Rendered services will be timely, convenient and easily accessible. Bilingual/bicultural providers and interpreters trained in clinical and cultural issues will be available across the service continuum. Service availability and service determination will include integrated and holistic approaches in working with people as well as needed support services. This integration includes psychiatric, rehabilitative, medical, social, behavioral, cultural, spiritual, familial and community support models.

**Implementation Guidelines**

Access to services is culturally appropriate when:

1. Available data establishes the service utilization rates of specific ethnic/culture/racial groups served in the agency. The services delivered across the service continuum to each ethnic/cultural/racial population of the geographic target community are proportionate to the area's actual demographic breakdown.

2. Persons from diverse cultures who have linguistic differences receive appropriate and comparable quality services.

3. Providers disseminate culturally-relevant and linguistically-appropriate information regarding local mental health and addiction services, as well as non-traditional and self-help resources in a wide variety of formats.

4. Staff has and uses an available list of culturally- and linguistically-accessible services within the facilities and throughout the community.

5. The agency's educational materials are made available to individuals served and reflect the language and culture of those persons.

6. Service providers continuously monitor and improve timeliness, access, flexibility of hours, availability of alternative and complementary treatment approaches, engagement and follow-up.

7. A client satisfaction survey for persons served measures satisfaction with timeliness, access, and flexibility of hours and availability of alternative and complementary treatment approaches.

8. The composition of the direct service staff reflects the diversity of the population served.

9. Programs provide, or network to provide for multiculturally and linguistically competent staff to be available 24 hours a day and 7 days per week throughout the service region.

10. The social and physical environment within the agency reflects the diversity and culture of the persons served. Waiting areas and offices display magazines, art, music, etc., reflective of the diversity of persons served.

## II. Cultural Assessment

Cultural assessments shall be conducted as part of the treatment planning process within the context of culture, family and community for each person receiving services. The assessments will incorporate a multidimensional strength-based focus. They will include functional, psychiatric and medical areas of inquiry attentive to cultural, social, discriminatory, social status, and economic stress factors, as well as family support.

### Implementation Guidelines

Assessments as part of the treatment planning process are culturally appropriate when:

**1.** The initial and ongoing assessment includes cultural factors which may affect treatment/rehabilitation services. Bilingual/bicultural staff persons are available to assess individuals both in their preferred language and in the context of their cultural heritage.

**2.** An assessment instrument, which utilizes cultural information and personal preferences, is used to distinguish pathology from cultural factors (e.g., avoiding eye contact with eyes lowered is often a cultural response to respect for the clinician, etc.). Cross-cultural assessment is ongoing throughout the course of treatment and rehabilitation.

**3.** The assessment instrument forms the basis for a culturally-relevant recovery plan resulting from culturally-appropriate diagnoses, and appropriate rehabilitation/ treatment goals.

**4.** Qualified (in both language and culture) interpreters are used when bilingual staff persons are not available.

**5.** There are culturally-valid and reliable assessment and measurement tools that are administered, scored and interpreted by culturally-competent professionals in each discipline that requires assessment.

**6.** Involvement of family members, natural supports and significant community supports in the assessment process are documented in client's clinical file.

**7.** The assessment includes cultural factors that are significant to the treatment process. These may include, but are not limited to, the following:

- Preferred language of the client
- History of immigration or migration
- Description of acculturation and adaptation
- Cultural, social, economic stress factors, discrimination
- Trauma
- Learning and cognitive styles
- Family organizational and relational roles
- Extent of family support
- Social network composition

- Ethnic identity
- Religious/spiritual identity
- Person's perception/belief of presenting problem and explanation of symptoms
- Person's belief systems regarding mental illness/addictive disorder
- Gender identity and sex role orientation in the cultural group
- Sexual identity/sexual preference
- Coping strategies utilized within the identified cultural group
- Help-seeking behaviors
- Previous attempts at relieving symptoms, including healers, etc.

## III. Treatment/Rehabilitation Plan

All persons served are assured a clinically-appropriate treatment plan that incorporates the mutually agreed upon choice of relevant, attainable goals, culturally-compatible treatment/rehabilitation services and alternative treatment/rehabilitation strategies when so determined. Strategies may include use of family, community supports, spiritual leaders and non-traditional healers. Plans will be individualized, client centered, based on individual strengths, developed within the context of family and /or social networks in a treatment / rehabilitation partnership. Plans will be formulated and reviewed during multiculturally-competent supervision of clinicians.

**Implementation Guidelines**

Persons served are assured a culturally-appropriate treatment plan when:

**1.** A comprehensive treatment plan documents the individual's goals and assures that the persons and the families served are satisfied with the goals identified in the treatment plan. Satisfaction with participation in developing the treatment /rehabilitation plan is verified in customer survey documents.

**2.** In consultation with the clients and their families, culturally-relevant goals (related to family, values, work, spiritual, respect, community cultural resources, etc.) are identified and specified in the treatment /rehabilitation plan.

**3.** The treatment plan identifies available culturally-compatible treatment/rehabilitation services and strategies. The plan identifies alternative treatment/rehabilitation strategies and culturally-competent services that can be utilized.

**4.** Persons and their families are satisfied with the degree of participation in developing treatment/rehabilitation plan. Professionals on staff who are multiculturally competent complete or review the plans.

## IV. Communication Styles and Linguistic Support

Culturally-appropriate services in the preferred language of the client will be provided to persons, families and natural supports per their request and offered, when deemed necessary, within available agency resources. Access to services in appropriate communication style will be available at each point of entry into the service continuum and continue throughout the person's course of treatment and rehabilitation. Staff will be knowledgeable in the use of qualified interpreters. Only in crisis situations shall telephone interpreters be utilized. Relevant audio visual, written materials and forms, such as individuals' rights, orientation packets and consents in the person's preferred language shall be the norm for identified populations in the community served and the ideal for individuals from very small populations.

**Implementation Guidelines**

Services in the individual's preferred language is culturally appropriate when:

**1.** Cross-cultural communication supports are identified and utilized at each point of entry along the service continuum and throughout treatment. The persons served and their available natural supports are satisfied with the communication resources provided.

**2.** Staff persons are competent in the communication styles and languages of persons served so as to minimize the use of interpreters.

**3.** Qualified interpreters are available within one hour for crisis situations and within twenty-four hours for routine situations. Information about qualified interpreters is maintained in the agency and the list of such resources is updated at least annually. The clinical staff is trained and knowledgeable about when and how to utilize interpreters across diverse groups.

**4.** Data from client surveys document that persons served express satisfaction that communication support is evident and available.

.

## V. Quality of Life

Quality of life is recognized as a holistic integration of symptom reduction, healthy family relationship ("family" is identified by person served, not limited to nuclear or extended family), community support and spirituality, which can be related to the individual's sense of personal meaning, fulfillment and well being in recovery.

**Implementation Guidelines**

Culturally appropriate quality of life is recognized when:

**1.** The agency has a mechanism to assess the quality of life for all individuals receiving services. Qualitative data is collected on "pre" and "post" instruments and generated reports regarding quality of life. Facilities will utilize quantitative and qualitative data regarding quality of life to evaluate and improve service delivery.

**2.** Assessments, treatment/rehabilitation plans, and other services incorporate the preferences, hopes and wishes of persons served**.**

**3.** Quantitative data (on standard life functions, e.g., employment, socializing, community involvement, etc.) are collected on "pre" and "post" instruments and reports are generated regarding the person's quality of life.

**4.** Persons served report increased satisfaction with the quality of life attained.

## VI. Case Management

Case managers should be familiar with the values, norms and beliefs of persons from various cultures, as well as the resources available to them within each community. As part of a multidisciplinary team, they engage the person, assess need, assist persons in accessing culturally-competent services and community resources. In the absence of such services, case managers should advocate for the development of services or program adaptations to provide culturally-competent services. Case managers facilitate the coordination of culturally competent-services within the person's living environment and cultural communities while assisting in maximizing a person's independence and support from family and social networks.

**Implementation Guidelines**

Case managers facilitate the coordination of culturally-competent services when:

**1.** Case management improves access to a comprehensive array of behavioral health care service systems that are compatible with the cultural needs of persons served. Service utilization data indicate increased access, engagement and retention in treatment of underrepresented populations.

**2.** The agency maintains, as a resource, the descriptions and documentation of culturally-compatible services and resources available to persons served. Identified culturally-competent behavioral health care services are provided system-wide.

**3.** Engagement and retention of persons from under-served and under-represented cultural groups increase.

**4.** Improved role relationships for familial and social networks of the person's culture show that the individuals receive coordinated services within multiple domains, i.e., vocational, social, educational, residential settings, etc.

**5.** Services are developed and/or adapted to be culturally-compatible to meet the needs of persons served. Service plans, program changes, and other service adaptation demonstrate inclusion of appropriate cultural factors.

**6.** Persons achieve a balance between independence and interdependence. The documentation that the person self reports on a prepared instrument indicates the greatest degree of independence possible.

## VII. Performance Indicators Continuum of Service/Discharge Planning

Service/discharge planning begins at all points of entry along the service continuum and is provided by multiculturally competent staff, in cooperation and collaboration with the person, family, community supports, and other social networks and is consistent with the values, norms and beliefs of the persons served. Service/Discharge plans shall relate and incorporate pertinent information from the cultural assessment and include service/discharge factors that are culturally relevant and significant to the person's recovery. The plan identifies personal, familial, living environment, social networks and/or cultural resources in the treatment/rehabilitation environment.

**Implementation Guidelines**

Service/discharge planning is provided by multiculturally competent staff when:

**1.** A culturally-compatible continuum of service and/or culturally-competent discharge plan includes a summary of accomplishments, resources and services utilized by the persons served. This includes clear goals and recommendations for required services in the post discharge continuum of care and the involvement of the persons, their families and social networks when appropriate.

**2.** The values, norms and beliefs of the person are documented in the clinical record. Individuals remain connected to treatment, rehabilitation and recovery services as indicated in the record.

**3.** The description of goals for future treatment and rehabilitation is documented. There is evidence of recommendations regarding personal, familial, living and social networks and cultural resources necessary in the subsequent treatment and rehabilitation setting.

**4.** Staff establishes confirmed referrals with aftercare services and provides follow-up contacts with persons served and services referred to.

## VIII. Recovery and Self-Help

Culturally-compatible recovery, self-help groups and natural supports in the behavioral health service continuum shall be readily available and accessible. These modalities provide an opportunity to engage and support persons and their families in recovery. Recovery, self-help groups and natural supports exist in a variety of community locations including home-based initiatives, community centers, and churches. Multiculturally-competent providers and persons in recovery are enlisted to assist in the creative development of alternative structures, models, and supports compatible with the lifestyles, values and beliefs of persons from different cultures.

### Implementation Guidelines

Recovery, self-help groups and natural supports are culturally appropriate when:

**1.** Programs identify and refer persons to culturally-appropriate recovery and self-help supports that are available in a variety of settings, including neighborhoods, spiritual communities, educational settings, etc.

**2.** More persons and their family members from different cultures utilize recovery and natural support activities across cultures.

**3.** Consultants from community groups, persons in recovery and other natural supports are engaged in the development of recovery and self-help models.

**4.** Evidence from focus groups comprised of persons served, indicates that culturally-relevant recovery, self-help and natural support program models are available to them.

# APPENDIX

**1.** Glossary

**2.** References

**3.** Multicultural-Competence Program Monitoring Instrument

# GLOSSARY

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

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

**Alternative/Traditional Healer (folk healer):** An individual who is respected by the community, who has cultural knowledge and training to relieve people of their physical and emotional afflictions utilizing physical approaches, spirituality, herbs, counseling and other techniques as a form of healing.

**Belief:** Culturally-acceptable conviction of the truth held by a group of people.

**Bicultural:** The ability to understand and function effectively in two or more cultural environments. An individual who is bicultural is not necessarily culturally competent.

**Bilingual:** The ability to both send and receive communication in two or more languages.

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

**Cultural Assessment:** The process which occurs between persons served, their significant others and service providers which determines the cultural factors that are significant to treatment and continuing care.

**Cultural Compatibility:** The existence of services, intervention programs that are designed to incorporate the language, history, names, values and behaviors of persons served from different ethnic/culture groups.

**Culturally Compatible:** Shared values, understanding, knowledge and skills which are adaptable and beneficial for individual and service improvement.

**Cultural Competence:** A set of congruent practice skills, attitudes, policies and structures which come together in a system, agency or among professionals and enable that system, or those professionals to work effectively in cross-cultural situations.

**Cultural Competency:** Acceptance and respect for difference, continuing self-assessment regarding own and other culture, attention to the dynamics of difference, ongoing

development of cultural knowledge and resources and flexibility within service models to work towards better meeting the needs of diverse populations (Cross, Brazron, Dennis, & Isaacs, 1989).

**Cultural Consultation:** Seeking feedback or consultation from an individual recognized by the professional and lay community as knowledgeable or expert about cultural patterns, beliefs, norms, values and life styles.

**Cultural modalities:** Specific culturally-targeted treatment interventions that allow individual growth and understanding of differences and modes of self-expression.

**Cultural relevance:** Services that bear a traceable, significant, logical connection, to the culturally-based needs, expectations, desires and existential realities of the individuals to whom the services are directed.

**Culture:** Culture includes, but is not limited to, the shared values, norms traditions, customs, arts, history, folklore, religious and spiritual healing practices and institutions of a racial, ethnic, religious or social group of people that are generally transmitted to succeeding generations.

**Discrimination:** The practice or act of withholding or preventing access to an opportunity or resource, based on a prejudice, because of a characteristic or attribute of a person perceived to be undesirable.

**Ethnocentric:** Believing in the superiority of one's own ethnic group.

**Family (self-defined):** The identification, by the client, of persons who fulfill relational, functional familial roles whether or not these individuals are biologically related to the client.

**Holism:** The use and integration of different methods, practices and modalities to address the needs of persons and their families in multiple arenas: biological, psychological, social, medical, and spiritual.

**Holistic:** Emphasizes the importance of a broader cultural and alternative treatment perspective.

**Interpreter:** Individual trained and/ or certified in facilitating oral, written, or manual communication between two or more people who speak different languages; interpreters shall have in-depth knowledge not only of the language, but also of cultural values, beliefs, and verbal and non-verbal expressions.

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

**Multicultural:** The inclusion of persons with the cultural characteristics representative of their own and one or more additional ethnic groups, who may also become comfortable operating in the cultural perspective of others.

**Natural Support:** Individuals who are recognized by persons, their family members and local communities, as being able to provide help and assistance when needed. Examples of such supports may include family, friends, lay healers, co-workers, peer support groups, religious and community organizations.

**Norms:** The shared rules and/or patterns that are typical for a specific group and may specify appropriate and inappropriate behavior within that group.

**Person(s):** An individual who receives care or services, or one who may be represented by an appropriately authorized person. Synonyms used by various health care fields include client, resident, consumer, individual, family unit, etc. (Joint Commission)

**Performance Improvement:** The continuous study and adaptation of a health care organization's functions and processes to increase the probability of achieving desired outcomes and better meet the needs of individuals and other users of services. This is the third segment of a performance measurement, assessment, and improvement system. (Joint Commission)

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

**Principles:** Rule of conduct or action, fundamental truth or cause.

**Qualified Interpreter:** A qualified interpreter is a person who not only translates orally, but also bridges the cultural gaps present in cross-cultural communication. An interpreter is someone who is trained in cross-cultural interpretation. This includes training in the health care field. Interpreters are proficient in the culture of the client and that of the health care professionals. They have an understanding of the significance of the particular health matter being discussed as well as an understanding of the importance of confidentiality.

**Standard:** a statement that defines the performance expectations, structures, or processes that must be substantially in place in an organization to enhance the quality of care. (Joint Commission 1999)

**Strength-Based Focus:** An approach to assessment, treatment and rehabilitation care processes which takes into account the cultural values, norms, practices and behaviors of the particular person served in planning and designing culturally-consistent strategies, interventions and modalities.

**Surface Culture:** The use of symbols or representations of different cultures that are observable such as food, music, artwork and drama. These representations can be utilized in service environments to promote cultural understanding, appreciation, and perceptions of hospitality and openness.

**Values:** A principle standard or quality belief shared by people which is considered vital to their well being and psychosocial survival.

# REFERENCES

A report by the Minority Concerns Committee to the Ohio Department of Mental Health, **Use of Public Mental Health Services by Minorities in Ohio**, Submitted to Michael F. Hogan, Ph.D. Director, Ohio Department of Mental Health, An update of the 1988 Minority Concerns Committee Report, Published May 1992.

Cultural Competence Strategic Framework Task Force, Developed by New York State **Cultural Competence Standards**, Draft Final Report, New York State Office of Mental Health, December 1996.

Joint Commission on Accreditation of Health Care Organizations, **HAS 1999 Hospital Accreditation Standards.**

International Association of Psychosocial Rehabilitation Services, **Standards For Cultural Competent PSR Programs,** 10025 Governor Warfield Pkwy, Suite 301, Columbia MD 21044.

Houghton Mifflin Company, Boston, **The American Heritage Dictionary**, Second College Edition, 1991.

Muñoz, Jr. Robert Hernandez and Sanchez, A. Marie**, Developing Culturally Competent Systems of Care for State Mental Health Services,** Western Interstate Commission for Higher Education (WICHE), Boulder, Colorado. 1996

Stone, James L. MSW, CSW, Commissioner, **New York State Cultural and Linguistic Competency Standards**, Developed by Cultural Competence Strategic Framework Task Force New York State Office of Mental Health, Revised September 1997.

The National Latino Behavioral Health Work Group, Developed by **Cultural Competence Guidelines in Managed Care Mental Health Services for Latino Populations,** Sponsored by Western Interstate Commission for Higher Education (WICHE) Mental Health Program, Boulder December 1996.

The Western Interstate Commission for Higher Education (WICHE) Mental Health Program**, Master Copy Draft Competence Cultural Standards in Managed Care Mental Health Services For Four Under-served/Under-represented Racial/Ethnic Groups**, Funded by The Center for Mental Health Services Administration, Boulder August 1997.

The Western Interstate Commission on Higher Education (WICHE) Prepared by for the U.S. Center for Mental Health Services, **Cultural Competence Report Card Items**, Boulder January 1998, Purchase Order No. 97M047619, Harriet G. McCombs, Ph.D., Project Officer.

## Department of Mental Health and Addiction Services

### Division of Community Services and Hospitals

# Instrument for Monitoring Program Cultural Competence

**Part One:** **Program Information**. This part is to be completed only by appropriate persons in the program. Prior to each site visit, the information would be requested by DMHAS to be available on site for review.

**Part Two:** **Focus Groups.** For each monitoring site visit conducted by the DMHAS Division of Community Services and Hospitals, a focus group will be conducted with 5-7 active clients. The issues addressed in this part will help to assess client experience related to the program's cultural competence.

***Part Three:*** ***Monitoring Checklist.*** *The monitor doing the site visit is responsible for completing this part. The evaluation and assessment made is indicated based on the monitor's customary comprehensive evaluation and review.*

**DMHAS Division of Community Services and Hospitals**

# Instrument for Monitoring Program Cultural Competence

## Part One

## Program Information

Prior to each site visit, the following information may be requested to be available for review.

**Do not send Part One information to DMHAS.**

**Place an "X" in the blank after the number to indicate that the requested information is available for review by the DMHAS monitor in preparation for the __ __ / __ __ / __ __ __ __ monitoring visit. If information requested does not exist, mark "NA" in the blank.**

### I. Agency demographic data over the last twelve months

**1.** ____ The demographic composition (%'s of population) of the **program's service area** which include ethnicity, race, and gender. Wherever possible include populations not usually in the clinical data collected by DMHAS.

**2.** ____ Provide the demographic composition (numbers and percentages) of the **client** population over the last twelve months.

**3.** ____ List primary languages spoken by individual clients as reported at intake.

**4.** ____ Number of Non English-speaking monolingual individuals listed by language.

**5.** ____ Provide a current (as of the first of this month) updated Table of Organization (p.16 DMHAS Funding Application) for each program in the agency which lists the current staff titles with demographic composition with gender, ethnic and racial breakdowns. Also include any languages spoken by staff.

### II. Policies, Procedures and Governance

1. ____ Provide an updated list of the names of persons on your board of directors and various advisory committees and the diversity breakdown.

2. ____ Who is responsible for the development, implementation, and monitoring of the Cultural Competence Plan.

3. ____ Provide a copy of the agency commitment statement to cultural competence.

4. ____ Provide copies of agency documents that have been translated into the principle language of the client(s)/consumer(s) (E.g., confidentiality, individual patient rights and grievance procedures, medication fact sheets, legal assistance, etc.)

## III. Services and Programs

1. ____ Identify staff able to communicate in languages other than English when answering the telephone.

2. ____ Identify culturally oriented community services and organizations that provide services to your clients.

3. ____ Describe any staff orientation and ongoing training in cultural-competence skills.

4. ____ Identify staff recruitment and retention efforts to serve cultural and linguistic diversity of populations needing services.

5. ____ Provide a copy of the section of the agency's Quality Improvement (QI) Plan that addresses the clients cultural/ethnic and language needs.

6. ____ Provide copies of agency client satisfaction surveys that address language and cultural issues.

## Part Two

## Focus Groups

For each monitoring site visit conducted by the DMHAS Division of Community Services and Hospitals, a focus group will be conducted with 5-7 active clients to assess client experience related to the program's cultural competence.

The following issues will be addressed in each focus group. The facilitator may add, but not eliminate, an issue from the group discussion.

### Issues for Focus Group Discussion

1. A description of family involvement in the treatment process (making appointments, developing treatment plan, support, and comfort level).

2. Person's language of choice usage in the program.

3. If other than English, the use of interpretation/interpreters when no one in program who provides services speaks the person's language.

4. Environment that is welcoming and appropriate to individual's culture and background.

5. Attitude and/or inclusion of cultural healing practices that are part of the family heritage or common to the community customs.

6. Is communication satisfactory in the areas of: Telephone, brochures, mail/letters, notices (personal or public), appointments.

7. Individual's experience and relationship to the program's direct service staff: (culturally appropriate: respect, language or manner of speech, assessment and evaluation, treatment plan, SA client participation, referral process).

8. Individual's personal and overall experience/impressions of the agency.

## Part Three
## <u>Monitoring Checklist</u>

Note: **<u>Any rating of "2" or less in Part 3</u> must be reported in writing to address the problem and to make recommendations for corrections.** Using the scale below with "**5**" as the highest and "**1**" as the lowest, indicate the rating in the blanks after the item numbers as follows:

**5 (Highest)** **4** **3** **2** **1 (Lowest)**

**<u>The eight Multicultural Best Clinical/Rehabilitation Practices are addressed in the following items:</u>**

1. ____ Admissions in each level of care correspond proportionately to public demographic percentages (census, Etc.). (Ecura)

2. ____ Clients are evaluated/assessed using a culturally appropriate assessment instrument approved by DMHAS. (Client File)

3. ____ Clients receive culturally compatible treatment/rehabilitation services. (Client File)

4. ____ Clients are not denied admission resulting from language incompatibility. (Intake information and first contact data)

5. ____ Clients receive treatment which includes culturally appropriate resources to meet his/her goals for "quality of life" as determined in the individualized treatment plan. (Discharge plan as signed by individual served)

6. ____ Clients receive culturally appropriate case management.

7. ____ Discharged persons access, identify and utilize culturally appropriate referrals to treatment and rehabilitation as indicated in the discharge plan.

8. ____ Persons in recovery transition from treatment to groups or support systems that provide culturally compatible recovery environments.

**<u>Cultural Competence Plan</u>**

9. ____ **Yes,** the cultural competence plan is being appropriately implemented as evidenced by:

10. ____ **No,** the cultural competence plan is not being appropriately implemented as evidenced by: