Ensuring Cultural and Linguistic Competence

We are all likely familiar with the critically important non-discrimination policies included in the policies and procedures of many workplaces and service agencies. These policies usually indicate the various groups of individuals that the agency promises to treat fairly, as well as a commitment to taking allegations of discrimination seriously. For systems of care, cultural competence is a core value that should result in, among other things, upholding these non-discrimination statements. But how can a local community know if their system of care is holding up these values of cultural competence and non-discriminatory practices?

Particularly when an organization's workforce consists mostly of one demographic (for example, women who are White, straight, middle class, Christian, native English speakers, and do not have a disability), the default for that organization as a whole may be to only take into account the needs of individuals who fit that same demographic unless intentional steps, including integrating youth and family voice, are taken to change this default. But how can those involved with an organization or larger system of care know if youth and families are being served in a culturally and linguistically competent (CLC) manner?

In order to begin to answer this question, it is important to understand health equity and how it differs from the concept of equality. Equality speaks to the quality of being equal: that all persons are of equal worth and value. Health equity, however, is defined as the attainment of the highest level of health for all people (U.S Department of Health and Human Services, 2010). That is to say that equality promotes the *same treatment* for all people, while the concept of health equity promotes the use of resources in a way that will *result in the highest level of health possible* for all people.

BOTH THE CONCEPT OF EQUALITY AND EQUITY ASSUME EQUAL VALUE OF HUMAN BEINGS, BUT TRULY PROVIDING BEHAVIORAL HEALTH SERVICES THAT SERVE THE NEEDS OF ALL... REQUIRES A HOLISTIC UNDERSTANDING OF EACH PERSON'S NEEDS.

Though it is common in U.S. society to hear talk of equality, health equity may be a less known term. The difference between attitudes of equality and equity in institutions can create vast differences in outcomes for minority populations. While equality assumes that treatment approaches should be the same for all people, as the value of individuals is equal, discussions of equity recognize that different approaches may be appropriate in a diverse society where the real life experiences and needs of individuals may not fit into one overarching mold that is reflective of the experiences of the majority population.

Both the concept of equality and equity assume equal value of human beings, but truly providing behavioral health services that serve the needs of all, regardless of race, ethnicity, religion, color, sex, age, national origin or ancestry, language, genetic information, marital status, parental status, sexual orientation, gender identity and expression, or any other

marginalized status, requires a holistic understanding of each person's needs. As systems tend to be created in a way that benefit those who held (and may continue to hold) substantial power at the formation of the system, ensuring equity requires a purposeful evaluation of the outcomes from a particular system among different groups of people.

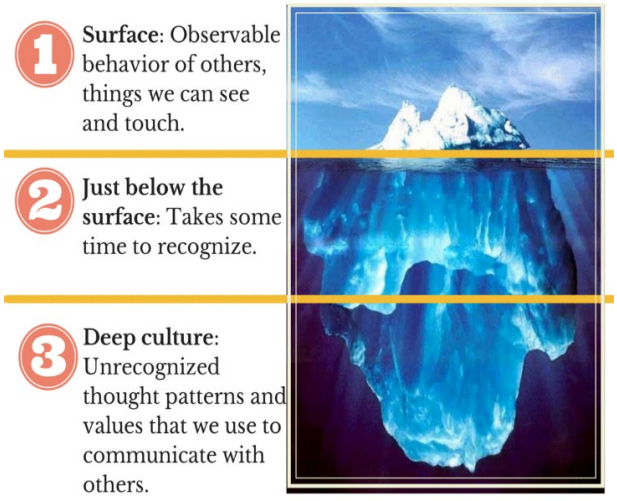
This image further illustrates the difference between equality and equity.
Source: Robert Wood Johnson Foundation

When professionals, organizations, and larger systems provide equitable services, they recognize that some populations may need a special focus in order to ensure that no group is being underserved. In this picture, the different types of bikes that best meet each person's needs can symbolize many things: time, linguistic assistance, disability access, attention to communication style, specialized training, etc.

Providing services in a way that is culturally and linguistically competent will contribute to a program, organization, or system that is equitable. If our evaluation of outcomes determines that there are disparities or if the client population shows a disproportionality from the larger community population, it is a strong indicator that there is work to be done in the area of cultural and linguistic competence.

CLC: Cultural Competence

Cultural competence is "a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enable that system, agency or those professions to work effectively in cross-cultural situations," (Cross et al., 1989). Cultural competence is not limited to making sure that staff members don't yell racial slurs or use other derogatory language (though of course this is important!). Cultural competence will result in all persons served feeling comfortable and receiving satisfactory customer service at the same rate as clients who happen to share demographic features with the majority of the employees at an agency. That is to say that if most workers within an organization are women who are straight, cis gender, middle class, Protestant, English speaking, non-disabled, and White,



Cultural differences are about more than what is easily observed, and cultural competence is deeper than learning what hand gestures could be offensive in other cultures.

Source: *Recognizing Deep Culture's Influence on Communicative Behavior* by Stephen B. Ryan

clients who do not share these demographic characteristics will still receive care at the same frequency and quality as any client who would have these characteristics in common with the workers.

Culture is a complex component of each person's identity. In the US, there is so much variety in regards to race and ethnicity, religion, country of origin, language, interests, community groups, etc. that the task of understanding the intricacies of each culture an agency may serve can seem overwhelming. Unfortunately, the impact of these intricacies is not always appreciated and especially in behavioral health can be grossly misunderstood. Cultural differences include more than which holidays people celebrate and what food they eat, and a failure by organizations and workers to recognize this will certainly lead to cultural clashes. Such clashes can result in a lack of outreach to a particular community, misdiagnoses, over or under-prescription of psychotropic medications, premature discharge due to "noncompliance," or a variety of other negative outcomes.

CLC: Linguistic Competence

Linguistic competence is "the capacity of an organization and its personnel to communicate effectively, and convey information in a manner that is easily understood by diverse audiences including persons of limited English proficiency, those who have low literacy skills or are not literate, and individuals with disabilities," (Goode & Jones, 2002).

Is your agency's website translated well? Or does it suggest beating a moose?

Source: LifeBuzz

Though linguistic competence may be easier to measure than cultural competence, due to the obvious intricacies of successful cross-cultural communication, linguistic competence often gets minimal attention or is even overlooked completely. Even though some documents may be translated, or an organization may have a couple of bilingual staff members, this alone will not likely meet the high standards set by the above definition of linguistic competence. True linguistic competence will result in persons with Limited English Proficiency (LEP) being able to understand written and oral communication just as well as a native English speaker with the same intellectual capabilities, though of course through a slower process when interpretive services are needed. When LEP clients come away from an interaction confused and frustrated because the translation efforts were insufficient, the service lacks proper linguistic competence.

To see how insufficient attempts at linguistic competence can result in clients feeling frustrated, view the video "'Let it Go' From Frozen According to Google Translate," at https://www.youtube.com/watch?v=2bVAoVlFYf0. In this video, song lyrics have been

translated into various languages and then back into English to show the comically incorrect translations. Though the multiple layers of translating to various languages probably resulted in higher error rates than agency websites that use Google translation to serve LEP clients, it is important to note that even a few translation errors can result in a complete misunderstanding of the original message. For example, even the title of the song in this example was changed from, "Let it go," to, "Give up," which carries a very different meaning. Agencies should be careful in fully understanding the strengths and weaknesses of any translation technology used in the interest of serving LEP clients well.

Using Data and the CLAS Standards

One red flag that major work needs to be done in the areas of cultural and linguistic competence is if the demographics of the clients an agency serves do not match the demographics of the local community. For example, if a local community is composed of 2.5% Asian Americans but only 0.1% of clients served by an agency are Asian American, this is a strong indicator that something is wrong. Another example is an agency reporting anecdotally that the agency serving thousands of people does not and has never had any clients who identify as LGBTQ+ (lesbian, gay, bisexual, transgender, queer/questioning, and other sexual orientations and gender identities). Discerning *what* is going wrong in these situations can take some extra work, including further assessments that will be discussed in this module. However, with both of these examples the demographic data of the client population should be sending red flags that these populations are not being properly served.

Don't be a "Hammertime" agency that forces "non-compliant" families to use services that weren't created with them in mind- find something else that fits the client population better!

Simply offering services and hoping that they will be appropriate for all people is certainly not the best approach to ensuring that services are culturally and linguistically appropriate. The first step to making changes that will lead to health equity is to assess the current situation. This is reflected in the Office of Minority Health's national Cultural and Linguistically Appropriate Services (CLAS) Standards (https://www.thinkculturalhealth.hhs.gov/clas/standards). These standards, created in 2000 and modified in 2010, outline specific goals for health organizations to meet in order to display equitable services. The first standard is considered the principle standard and sets the purpose of the following fourteen:

Provide effective, equitable, understandable, respectful, and quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

This first standard is in its own category and is the core of the fourteen standards that follow. The remaining fourteen standards are then split into the following categories: Governance,

Leadership, & Workforce; Communication & Language Assistance; and Engagement, Continuous Improvement, & Accountability. Because the final category of the CLAS Standards is typically used to evaluate the cultural and linguistic competence of behavioral health organizations, the remainder of this module will focus on Engagement, Continuous Improvement, and Accountability.

Standard 10: Organizational Assessments

Standard 10 of the National CLAS Standards states that organizations should conduct ongoing assessments of their CLAS-related activities and integrate CLAS-related measures into ongoing quality improvement activities**.** Organizational assessments can be a great starting point for evaluating the current level of integration of CLAS Standards, which is an indicator of effective cultural and linguistic practices. These assessments can consist of a mix of different methods (interviews, focus groups, surveys, etc.) and will give the most useful results when they include not only responses from leadership and staff, but also from board members, funders, clients served, volunteers, and anyone else who may have some level of knowledge about the agency's services and impact on the larger community. If participation is limited to only employees of the organization, the results will show a bias and may reveal only minimal areas for improvement.

In addition, it is important to make sure that all populations served by the agency are proportionately represented in survey responses. For example, if clients of one program are invited to participate because getting responses is logistically easier than in other programs, the client responses cannot be considered reflective of client responses from agency services as a whole. Special attention and effort (in other words, equity in effort) need to be paid to make sure that all groups of people are represented in the responses. This also includes making sure that the racial/ethnic, socio-economic status, transportation status, language abilities, etc. are considered and properly represented in final assessment responses.

HHS's *Blueprint for advancing and Sustaining CLAS Policy and Practice* provides a Table titled, "A

When?	Ask for data early — ideally, during admission or registration
Who?	Properly trained admissions or reception staff could collect data
What will you tell individuals?	Before obtaining information, develop a script to communicate that: o This information is important. o It will be used to improve care and services and to prevent discrimination. o This information will be kept confidential. In addition, address any concerns up front and clearly.
How?	Individual self-report — select their own race, ethnicity, language, etc.
What information will you collect? (Individual Data)	o Race o Ethnicity o Nationality o Nativity o Ability to speak English o Language(s) other than English spoken o Preferred spoken/written languages or other mode of communication o Age o Gender o Sexual orientation o Gender identity o Income o Education o Informed of right to interpreter services o Request for, and/or use of, interpreter services o Treatment history o Medical history o Outcome data (service type, utilization, length of stay) o Client satisfaction See also aforementioned HHS Data Collection Standards
What information will you collect? (Staff Data)	o Race o Ethnicity o Nationality o Nativity o Primary/preferred language o Gender o Records of cultural and linguistic competency training participation and evaluations
Tools to collect and store data	Use standard collection instruments. Store data in a standard electronic format.

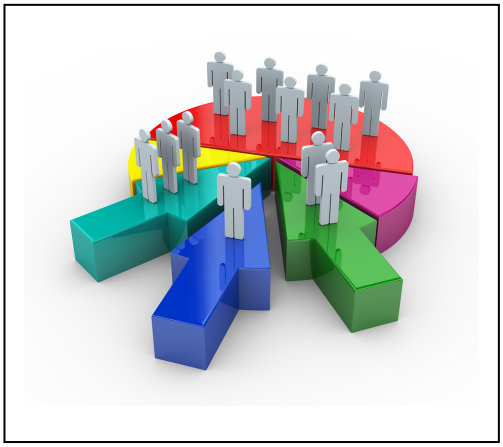
In addition to organizational assessments dedicated to assessing cultural and linguistic competence, implementing an equity lens into already existing assessments allows opportunity for ongoing input. It's beneficial to review all client surveys that are required by the agency, funders, etc. and see if the existing surveys address CLAS standards in some manner. If they do, and the agency is not tracking these responses before sending away results, the agency can begin to track and monitor responses to those particular items. If existing surveys do not address CLAS in some way, then the workers in charge of collecting survey responses could also be asked to take note of a couple additional questions specifically created to measure whether the client's experience with the agency has met their specific cultural and linguistic needs.

One tool that could help get started with this process is the CLC Assessment Tool: Based on the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS Standards) from the TA Network (http://www.fredla.org/wp-content/uploads/2015/09/CLASStandardsCLCAssessmentTool_FINAL.pd_.pdf). In addition, some organizations have created their own assessment tool, including the Indiana Prevention Resource Center's CLAS Standards Checklist/Assessment Tool (http://iprc.iu.edu/training/docs/CLAS%20Standards%20Coalition%20Assessment%20Tool.docx). Finally, there are companies that can conduct a CLAS Standards Organizational assessment for a fee, including Stratis Health (http://www.culturecareconnection.org/navigating/assessment.html) and CM ELearning

(https://www.cmelearning.com/assessments/clas-based-assessment/). For additional assessments, see lists compiled by Virginia's Department of Health (http://www.vdh.virginia.gov/ohpp/clasact/AT.aspx) and Georgetown University's National Center for Cultural Competence (https://nccc.georgetown.edu/assessments/).

Standard 11: Demographic Data

Standard 11 is concerned with collecting and maintaining accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes as well as inform service delivery. The concept of collecting demographic data is not a new one, but sometimes this standard is one that is treated as a menial task, and proper attention may not be paid to ensure that accurate data is collected. Clients may be given checklists in the midst of mounds of paperwork at registration with little or no assistance to walk through the purpose of demographic data being collected, how the information will or could be used, and full explanations of what the various demographic options may be. The following are examples of how this frivolous approach to demographic data collection can backfire:



-A person with limited English proficiency can communicate with the intake staff verbally, but has difficulty understanding the vocabulary used on intake sheets.

-Someone who recently emigrated from a country where collecting demographic data is not common is not sure how answer certain questions, as the options have never been explained to them before.

-A person who is transgender does not see an option that expresses their gender identity, or they do see an option but are afraid of how the information will be used.

-A member of a population that has a history of being manipulated and tricked by healthcare professionals into participating in harmful research is leery about providing accurate information.

Demographic data collection can easily become just another task to a worker, particularly when there is a time-crunch to complete multiple tasks and documents during one client encounter. Agency leadership can assist with this by taking a look at data collection practices, including how much time is given to complete this task in a culturally and linguistically appropriate manner. Using the appropriate amount of time and approach will help make sure that the collected information is accurate and useful for the purpose of identifying disparities and disproportionality.

The Office of Minority Health of the U.S. Department of Health and Human Services authored a publication titled *National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care: A Blueprint for Advancing and Sustaining CLAS Policy and Practice* (https://www.thinkculturalhealth.hhs.gov/assets/pdfs/EnhancedCLASStandardsBlueprint.pdf). This blueprint contains helpful guidance on gathering demographic data from HHS Data Collection Standards, which can be found beginning on page 110 of the blueprint.

Standard 12: Community Assets and Needs Assessments

Standard 12 states that organizations should conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area. One situation in which a mismatch between the demographics of an organization and of the larger community can be expected is if members of a particular population are getting their needs met adequately elsewhere in the community. However, even when this is the case, a strong relationship with the underserved population and the people or places where their needs are being met is necessary. The only way to be sure that all bases are covered for each demographic group is to conduct regular community assessments to evaluate the needs of the community, compare this with the resources within the community, and then determine if there are any gaps or unmet needs that nobody is providing for a particular population.

It may sometimes be the case that the needs of a population are genuinely being fulfilled without high engagement with a particular agency's services. However, it is much more likely that gaps will indeed be found when an agency conducts both an organizational assessment and a larger community asset and needs assessment. It may turn out that a population is being served by other resources in the community to a certain extent, but for more severe situations families tend to resort to the ER or other crisis facilities. In this case, having a strong relationship with the other support services in the area and providing early referral education to leaders may be an appropriate approach.

THE ONLY WAY TO BE SURE THAT ALL BASES ARE COVERED FOR EACH PEOPLE GROUP IS TO CONDUCT REGULAR COMMUNITY ASSESSMENTS.

For example, if it is found that a portion of the local community relies on mental health assistance from religious leaders and tends to only access services once an individual is in crisis and in need of inpatient care, there is certainly room for a closer relationship with those religious leaders and groups. Though it should not be the aim of a professional or organization to discourage the guidance of religious leaders, some education may be needed so that referrals to more intensive treatment can be made before an individual reaches a crisis point.

In some cases, like the previous example, it may be that behavioral health needs are entirely unmet for a particular population. This presents a wonderful opportunity for the system of care model to be implemented. If the local system of care community is just getting started and identifies this need, it is extremely important to bring members of the underserved population to the table to make sure that procedures are created with the specific needs of each group in mind (and in the spirit of health equity, that special attention is given to this underserved group). If a system of care has existed in a local community for some time when it is discovered that a particular population is being underserved, it likely means that the current system of care is insufficient in its culturally and linguistically appropriate services and that some change is in order.

The CDC has a helpful guide to conducting a community needs assessment (https://www.cdc.gov/globalhealth/healthprotection/fetp/training_modules/15/community-needs_pw_final_9252013.pdf). Rotary International also has a helpful guide that explores different methods to conducting a community asset and needs assessment, including surveys, focus groups, community meetings, and community mapping (file:///C:/Users/skm2857/Downloads/605en.pdf).

Reviewing Information from Standards 10-12

Once a system of care has completed an organizational assessment, ensures accurate collection of demographic data, and has conducted a community asset and needs assessment, this information can be used together to help form a bigger picture of the system's cultural and linguistic practices. This process will likely find many areas of strength, which stakeholders can proudly profess and attract more funders to continue providing appropriate services. On the other hand, it is also likely that this process will identify key areas for improvement in upholding the CLAS Standards. These are areas that are keeping back partnering agencies and the system of care as a whole from best utilizing existing resources to serve the local community. Identifying those areas is the first step to making positive changes that take those existing resources to work smarter and produce better outcomes for everyone. The other CLAS Standards not explored in this toolkit can provide some insight into *how* to improve any deficits that are found through this evaluation process.

Resource Tools

Title	Purpose	Website
A Blueprint for Advancing and Sustaining CLAS Policy and Practice	Implementation guide to implement the National CLAS Standards.	https://www.thinkculturalhealth.hhs.gov/clas/blueprint
Cultural & Linguistic Competence (CLC) Resource Library for Eliminating Behavioral Health Disparities	Information and assessment tools to address behavioral health disparities and improve organizational cultural competence.	http://cfs.cbcs.usf.edu/projects-research/CLC_BHDIS.cfm
A System of Care Team Guide to Implementing Cultural and Linguistic Competence	Guide to assisting communities in developing and strengthening CLC initiatives in their local systems of care.	http://fredla.org/wp-content/uploads/2016/01/SOCTeamGuideToImplementingCLC.pdf
CLC Assessment Tool: Based on the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS Standards)	Tool to assess the cultural and linguistic competence of organizations and service providers in the behavioral health field.	http://cfs.cbcs.usf.edu/projects-research/_docs/CLASStandardsCLCAssessmentTool_FINAL.pdf
Indiana Prevention Resource Center's CLAS Standards Checklist/Assessment Tool	Example of an organization-created tool to self-assess adherence to the National CLAS Standards.	http://iprc.iu.edu/training/docs/CLAS%20Standards%20Coalition%20Assessment%20Tool.docx
Culture Care Connection CLAS Assessment	Information on an organizational CLAS assessment available for a fee from Stratis Health.	http://www.culturecareconnection.org/navigating/assessment.html
CLAS Based Assessment	Information on an organizational CLAS assessment available for a fee from CM Elearning	https://www.cmelearning.com/assessments/clas-based-assessment/
CLAS Act Virginia Assessment Tools	List of CLAS organizational assessments compiled by the Virginia Department of Health	http://www.vdh.virginia.gov/ohpp/clasact/AT.aspx
CLAS A-Z: A Practical Guide for Implementing the National Standards for Culturally and	How-to guide on implementing all 15 National CLAS Standards.	www.minorityhealth.hhs.gov/assets/pdf/checked/CLAS_a2z.pdf

Linguistically Appropriate Services (CLAS) in Health Care		
CDC Community Needs Assessment Guide	Guidance on conducting a community needs assessment.	https://www.cdc.gov/globalhealth/healthprotection/fetp/training_modules/15/community-needs_pw_final_9252013.pdf
Rotary International Community Assessment Tools	Instructions on community asset and needs assessment approaches	file:///C:/Users/skm2857/Downloads/605en.pdf
U.S. Department of Health & Human Services Office of Minority Health website	Information on Office of Minority Health activities, resources, policies, data, and cultural competency information.	https://minorityhealth.hhs.gov/
Planning for Cultural and Linguistic Competence in Systems of Care	Checklist to assess CLC of organizations and systems of care.	http://nccc.georgetown.edu/documents/SOC_Checklist.pdf
National Center for Cultural Competence website	Information on NCCC resources, publications, initiatives, promising practices, and assessment tools.	nccc.georgetown.edu
Think Cultural Health website	Information and tools on National CLAS Standards.	www.thinkculturalhealth.hhs.gov
The Health Literacy Environment of Hospitals and Health Centers	Guidance and tools to address various health literacy levels in client navigation, print communication, policies and procedures, oral exchange, and technology.	https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&cad=rja&uact=8&sqi=2&ved=0ahUKEwi1l9HhzOfPAhXCQD4KHWYZDNYQFggfMAA&url=https%3A%2F%2Fcdn1.sph.harvard.edu%2Fwp-content%2Fuploads%2Fsites%2F135%2F2012%2F09%2Fhealthliteracyenvironment.pdf&usg=AFQjCNGzLePNU3BZL-IVsFSrd0KeA7pweQ&sig2=OHaQDKaogllo0rC810JLTQ&bvm=bv.135974163,d.cWw
Language Assistance Toolkit	Toolkit that addresses culture and language in behavioral health care	https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=2&cad=rja&uact=8&ved=0ahUKEwjKjp750-fPAhXG8z4KHbSaClgQFggkMAE&url=http%3A%2F%2Fwww.covianconsulting.com%2Fwp-content%2Fuploads%2F2015%2F04%2F2015-01-Language-

		Toolkit.pdf&usg=AFQjCNHQf8rYygQlgBuXNIq7-xp49Xhr0A&sig2=l9xcCguXIM0QGJeSvUaefg&bvm=bv.135974163,d.cWw
Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations	CLC guidelines from the American Psychological Association	http://www.apa.org/pi/oema/resources/policy/provider-guidelines.aspx
National Equity Atlas website	Information on the National Equity Atlas, data summaries, equity indicators, reports, and tools to identify local demographics.	http://nationalequityatlas.org/
Advancing Health Equity in Texas Through Culturally Responsive Care	Online training on the CLAS Standards, available for CEUs in a variety of healthcare professions.	https://www.txhealthsteps.com/391-advancing-health-equity-in-texas-through-culturally-responsive-care

References

Cross, T. L., Bazron, B. J., Dennis, K. W., & Isaacs, M. R. (1989). *Towards a culturally competent system of care: A monograph on effective services for minority children who are severely emotionally disturbed*. Washington, DC: Georgetown University Child Development Center.

Goode, T. & Jones, W. (2002). *Definition of linguistic competence*. Washington, DC: National Center for Cultural Competence, Georgetown University for Child and Human Development.

U.S. Department of Health and Human Services, Office of Minority Health. National Partnership for Action to End Health Disparities. The National Plan for Action Draft as of February 17, 2010 [Internet]. Chapter 1: Introduction. Available from: http://www.minority health.hhs.gov/npa/templates/browse.aspx?&lvl=2&lvlid= 34.

Equality. (2016). *Dictionary.com*. Retrieved from http://www.dictionary.com/browse/equality ?s=t