Guidelines for Culturally Competent Organizations

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Minnesota Department of Human Services

Executive Summary: Policy and Overview

Policy.
The Minnesota Department of Human Services (DHS) encourages health and human services providers and organizations to demonstrate their ability to serve diverse populations before they serve individuals from diverse cultures. When an organization lacks knowledge and skills in a client's culture, it refers the client to someone who has the expertise. The organization and its personnel are always accountable for culturally appropriate services.

An organization cannot be clinically or programmatically competent unless it is culturally competent. Health and human services organizations can enhance their cultural competence with:
- culturally competent personnel
- culturally appropriate services
- culturally competent organizations

Why cultural competence?
Culture influences one's behavior and family practices. Culture influences an individual's health and mental health beliefs, practices, behaviors, and even the outcomes of interventions. Health behavior depends on how one understands the cause of illness. In mental health and medicine, research indicates that culturally-appropriate service improves diagnostic accuracy, increases adherence to recommended treatment, and reduces inappropriate emergency room and psychiatric hospital use. Cultural competence is a requisite of doing business with diverse clients. Organizations enhance their cultural competence because:
- Demographics of the state are rapidly becoming more diverse.
- Disparities in health and service outcomes exist between mainstream and diverse populations.
- Access barriers mean clients' needs are not identified and effective service is not provided.
- Culture influences assessment accuracy and service effectiveness so quality may suffer.
- Law and accreditation standards increasingly demand cultural competence.
- Liability exposure increases and costs rise when services are not effective.
- Competition in funding and business markets favor the culturally competent organization.

Who should implement these guidelines?
County social services organizations and their vendors; managed care organizations and their providers; and community-based mental health and human services providers will benefit from implementing these Guidelines. Health Care providers may be more familiar with the national CLAS standards for cultural competence. The CLAS standards are consistent with the Guidelines but the Guidelines go further to support direct case work by agency staff. The Guidelines are not a mandate but are designed as an educational tool that answers the question: How do we become more culturally competent?

Incremental approach and coalition building
Striving toward cultural competence is a developmental process, a goal toward which professionals and organizations can strive. These Guidelines envision an incremental approach toward cultural competence, based on sustained, achievable actions with realistic time lines. Organizations can implement these guidelines according to a plan they develop for themselves.

What is cultural competence?
Cultural competence or *culturally competent* is the ability and the will to respond to the unique needs of an individual client that arise from the client's culture and the ability to use the person's culture as a resource or tool to assist with the intervention and help meet the person's needs.

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I. Overview: Why cultural competence?

Cultural competence is programmatic competence.
The reason to become culturally competent is to become a better clinician, social worker, or teacher; to become a more effective health, mental health, or social services organization. An organization cannot be clinically or programmatically competent unless it is culturally competent.

How to become more culturally competent?
Professionals improve their skills and increase their knowledge. Organizations anticipate which cultural communities they are likely to serve and then develop the competence to serve them appropriately. The organization hires and trains culturally skilled and knowledgeable people. When it lacks professionals competent in the culture or language of a client in the waiting room, it consults with—or refers to—someone who possess those skills. In an emergency, meet immediate needs. Then make a referral for culturally appropriate follow-up.

Cultural competence is both personal and organizational.
Cultural competence is a personal pursuit. The interpersonal relationship between the service professional and the client is what most determines whether services are appropriate. Competence requires openness to long-term and persistent development. The culturally skilled professional is one who is in the process of actively developing and practicing strategies and skills in working with culturally different clients.

An individual professional cannot be culturally competent alone. It requires organizational commitment. Management creates the service delivery structure and environment where cultural competence is possible.

Who can receive culturally competent services?
Everyone has a culture. Should everyone get culturally competent service? The practical standard is that extraordinary effort is directed toward any cultural group likely to receive inadequate services because of differences in understanding of health, mental health, illness, and disability or differences in family customs, social patterns, child-rearing practices, and religious values or differences in language and literacy or because they have experienced a history of war or ethnically, racially, socially, or class-related discrimination. Language assistance for people with limited English proficiency is required by federal law.

Individualized services.
Any mainstream intervention will work extremely well for a small segment of racial/ethnic-minority clients, produce mediocre results for a large segment, and extremely bad results for another small segment. Thus, interventions need to be based not on the client's cultural group but, rather upon the nature of the individual client whose individuality is partly a manifestation of his or her culture.

Is cultural competence aimed at the provider or the administration?
Both. View your organization and its products as a whole. Both the providers who perform services and the organizations that provide access through service authorization, client intake, payments and billing will pursue cultural competency.

II. Organization and Administration Support for Culturally Competent Service Delivery

[*Numbers in brackets refer to sections in the main document*]

1. Cultural competence planning. Develop a long-term incremental plan to enhance capacity to serve diverse clients. The Cultural Competence Plan will define the organization's strategy and guide its efforts. It will set clear, timely, and achievable expectations and tasks for staff and contractors and it will establish goals and adequate resources for the effort.

Components of cultural competence planning include:
▪ **STEP ONE: COMMUNITY NEEDS ASSESSMENT.** Analyze the demographic characteristics of the service population and how a specific group's service needs differ from the mainstream. [1.1]
▪ **STEP TWO: ORGANIZATIONAL AND PROVIDER CAPABILITY ASSESSMENT.** Assess your organization's ability to provide culturally appropriate services and access for diverse populations. [1.2]
▪ **STEP THREE: CULTURAL COMPETENCE PLAN.** Compare the community needs assessment to the organization's capability assessment, then develop a plan to address the organization's deficiencies. Design action steps regarding:
  ▫ Administrative and organizational support
  ▫ Culturally appropriate service delivery
  ▫ Language assistance (Federally mandated) [1.3]

2. Community partnership and governance. The organization uses a variety of formal and informal mechanisms to develop relationships with diverse communities and gain their knowledge and trust.
▪ Involve clients and the community in designing and implementing cultural competence.
▪ Collaborate among providers and community organizations on outreach, provider network building, making service referrals, and enhancing public relations.
▪ Designate seats on the governing body for clients and families of diverse communities. [2.1]
▪ Establish advisory councils comprising clients, parents of minor clients, and non-client community members. [2.2]

3. Human resource development. Launch a variety of strategies to enhance the capacity of service providers to ensure culturally appropriate services. Focus simultaneously on strengthening existing personnel and recruiting diverse personnel:
▪ Recruit new diverse staff; improve retention with incentives and mentoring programs. [3.1]
▪ Train existing providers, administrators, and direct-contact staff such as schedulers, intake workers, receptionists. Curriculum includes culturally-specific knowledge, skills in cross-cultural communication and language, and practica related to professional discipline. [3.2]
▪ Contract with culturally-specific providers for assessment, services, and cultural consultations and establish referral arrangements with out-of area providers. [3.3]
▪ Cultivate professionals from the community and use non-professionals; train or mentor paraprofessionals into professionals. [3.4]
▪ Use non-traditional practitioners or healers and culturally-specific practices that have proven effective for specific cultural or linguistic populations. [3.5]
▪ Develop alternative credentialing standards: clinical supervision; immigrant professionals; pairing a mainstream professional with a diverse paraprofessional. [3.6]
▪ Use culturally-trained paraprofessional staff for prevention, education, and support services; client advocacy; follow-up care under clinical supervision; and community liaison efforts. [3.7]
▪ Use culturally-informed consultants, interpreters, and cultural brokers to confer with a professional who is not skilled in or knowledgeable about a client's culture. [3.8]

4. Prevention, public education, and client outreach. Establish a prevention, community education, and outreach program based on the organization's initial and ongoing community needs assessments. [4.1]
▪ Prevention. Screen children for developmental, mental health, social, and environmental risk.
▪ Health education. Teach clients how to be more responsible for their own health; child development education for parents of newborns.
▪ Outreach. Identify barriers to accessing services. Conduct outreach to children and adolescents in restrictive settings. Out-of-home placement data shows that children of color are disproportionately placed in foster care and the juvenile justice system.   [4.2]

5. Eligibility, intake, client education. When conducting eligibility or intake activities, ensure that:
▪ Communication is designed primarily to establish rapport with the client and, secondarily, to gather administrative information;
▪ Oral and written communication is understandable to clients and parents with limited English proficiency and cognitive disabilities and understandable to clients who have low levels of literacy, are non-verbal, unable to understand directions, or unable to make informed choices.
▪ Intake or enrollment forms indicate the client's preferred language and need for an interpreter. [5.2]
▪ Client is contacted by phone, mail, or other means, in the appropriate language, to inform the client how to obtain services. [5.3]
▪ Scheduling staff arranges for language or hearing interpreters for scheduled appointments. [5.5]

6. Conflict Resolution. Anticipate the inevitable cross-cultural differences that arise between clients and the organization and among members of a multicultural staff. Ensure that the organization's conflict and grievance resolution processes are able to identify and resolve:
▪ cross-cultural complaints related to services and appeals;
▪ cultural conflicts between a client and the organization; and
▪ intra-organizational conflicts.

7. Quality Management. The organization's overall quality management activities are linked to needs identified in the cultural competence plan.
▪ Use periodic organizational self-assessments to measure progress toward cultural competence.
▪ Integrate cultural competence measures into internal audits, performance improvement programs, client satisfaction assessments, and outcomes-based evaluations.
▪ Identify both the organization's strengths and weaknesses.

8. Data and Management Information Systems (MIS). Enhance data collection and management information systems in order to better identify the specific needs of the diverse populations served, evaluate service outcomes of diverse clients, and track the organization's progress toward delivering more appropriate services.
▪ Collect individual-client data on race/ethnicity, preferred language and limited English proficiency, nation of origin, and literacy in any language. [8.3]
▪ The federal government mandates that all health and human services organizations that receive federal dollars directly or indirectly must collect at least minimum categories of race and ethnicity data on clients as of January 1, 2003, and must use the Census 2000 format. [8.3.2]
▪ As indicated by the client population, an organization may want to identify race and ethnicity sub-populations. (Example: "Black" distinguished by "African American" and Somali; "Asian" distinguished by "Hmong," "Vietnamese," "Asian Indians.") [8.3.3]
▪ Collect and evaluate client outcomes data by cultural and linguistic group. [8.3.5]
▪ Analyze aggregate data as necessary to determine how the service needs of one group may be different from needs of another. [8.3.4]
▪ Client protections are crucial to minimize potential discriminatory use of data. [8.2]
   ▫ inform clients about the purposes for collecting data;

▫ provide written policy statements and verbal assurances that data will not be used for purposes of discrimination;
▫ allow clients to self-identify race and ethnicity and to select more than one category; but no client may be denied services for refusal to provide race, ethnicity, or nation-of-origin information.

III. Service Delivery System Support for Culturally Competent Practice

9. Service Array or Benefit Design. Enhance cross cultural and culturally-specific services to serve diverse clients well. Organizations may:
▪ tailor customary services to be effective with diverse populations:
  ▫ client records indicate the need for a cultural broker, a bilingual provider, or an interpreter; [9.1]
  ▫ sign and spoken language interpreters are available during all hours of operation free of charge (federal mandate); [9.3]
  ▫ emergency and urgent care facilities have access to 24-hour medically-trained telephone interpreter services for each linguistic population in the service area; [9.4]
  ▫ discharge and transition planning is negotiated with the client, family, and other persons requested by the client in a communication style congruent with the client's values in order to ensure effective services with follow-up providers. [9.5]
▪ add culturally-specific services and therapies to its service array:
  ▫ culturally-specific providers are available to clients and families if requested. [9.2]
▪ encourage individualization and innovation in services provided.

High quality will be maintained.
▪ Culturally-specific services are those that have been proven effective.
▪ Non-traditional practitioners or healers have demonstrated their competency to their peers.

10. Access and Service Authorization. Service authorization procedures and criteria are designed by, or in consultation with, culturally competent professionals in the appropriate field and give consideration to cultural and linguistic needs and differences. Those developing authorization criteria for children will include professionals specializing in child welfare, children's mental health, or pediatrics.

An organization provides equal access to diverse populations as follows:
▪ Service authorization is performed by, or under the supervision of, bicultural or bilingual professionals in the appropriate field or mainstream professionals in the appropriate field who have demonstrated competence with diverse clients. [10.1]
▪ Orientation is offered to each client explaining the culturally-specific services available.
▪ Culturally-specific services may be requested by the client at any time. [10.4]
▪ Culturally specific services are offered by the organization at the following times:
  ▫ at intake or enrollment in the program;
  ▫ at least annually after intake; and
  ▫ upon first contact with each new provider.
▪ Space is provided in the client's case file or medical record to indicate whether the client has requested culturally-specific services and to record instructions and details pertinent to the request.
▪ A copy of the organization's guidelines for culturally and linguistically appropriate services is given to client and families in the appropriate language.

11. Client needs determination. Determining what is normal within the client's culture is fundamental to accurate needs assessment.
▪ Assessments and diagnoses are performed or supervised by professionals who are clinically competent and who have demonstrated competence in determining the needs of culturally diverse clients.

- Assessment instruments are validated and normed for use with the client's cultural group and assessment practices are culturally appropriate.
  - Evaluators understand the norms, biases, limitations, and appropriate uses of each assessment or diagnostic instrument. [11.3]
- Personnel administering the assessment need to understand how the bicultural encounter may distort the results. Both the professional evaluator and the client or client family may alter their typical behavior. [11.1]
- An evaluator who encounters a culture-based issue that he/she is not qualified to address will initiate a professional consultation with a culturally-qualified colleague. [11.2]
- Do not delay crisis care for lack of a culturally competent professional; rather address the immediate needs and then make a referral to a appropriate provider for follow-up assessment and care. [11.2]

12. Service Planning. Service and case planning is performed or directly supervised by individuals skilled in, and knowledgeable about, the client's culture. When service planners are not so qualified, they confer with a culturally-informed consultant.
- An organization and its service providers develop sufficient knowledge of client's cultures to enable the use of cultural strengths to assist in the intervention. [12.1]
- The planning process incorporates culturally-defined factors including, but not limited to: [12.2]
  - cultural attitudes toward health, mental health, family roles and success;
  - English proficiency and preferred language;
  - literacy;
  - religious and spiritual needs;
  - level of acculturation;
  - use of alternative healers and therapies;
  - interdependence among family members;
  - nutritional practices;
  - cultural differences among groups;
  - socioeconomic stressors relevant to the client's condition; and
  - use of natural support systems and community organizations.

13. Service Coordination / Case Management. Organizations maximize the opportunity for client and family-directed decision-making in the delivery of services and supports. Clients and families can help to identify culture-related needs. Organizations:
- adjust case loads to allow for the extra time required for clients with limited English proficiency and for those who need family or supporters to be present;
- hire, credential, and evaluate service coordinators and case managers based, in part, on their demonstration of cultural and linguistic competence.
- help case managers learn to use the client's own informal support network.

14. Self-Help. Organizations encourage or create culturally-specific family and client self-help groups. Self-help groups are directed by the group and function as part of the continuum of service. Groups focus on the current needs of clients and families.

15. Practice standards for health and mental health.
- Providers tailor general clinical practice so it will be more effective with diverse clients. [15.1]
- Clinical practice is expanded to: [15.2]
  - provide culturally-specific interventions or treatment modalities that are common to particular cultural or linguistic populations and
  - include practitioners who are characteristically found within a particular cultural or linguistic population or whose practices have their roots within particular cultural or linguistic traditions.

16. Child welfare and social work practice. Child welfare and social work literature on cultural competence emphasizes attitudes, values, and the professional's personal attributes in addition to the knowledge and skills necessary to become more culturally competent.

IV. Linguistic Competence

17. Language Assistance. Federal law requires that each health and human services organization provide language assistance to (1) persons with limited English proficiency (LEP) and (2) persons with hearing and vision impairments and (3) people with disabilities which impede their ability to communicate effectively. Organizations must provide sufficient language assistance, free of charge, so that an LEP client has ***meaningful access*** to their services. Standards in this document are consistent with state-mandated LEP planning requirements.

▪ Oral language interpretation: Interpreter services must be made available to each individual with limited English proficiency, regardless of the size of the individual's language group in that community. Organizations must arrange a variety of options for oral interpretation and the available options must be of sufficient quantity and quality to serve their LEP clients. [17.2]
▪ Written translations: Written or audio-visual materials routinely provided in English to applicants, clients, and the public must be available in commonly encountered non-English languages. It is particularly important to translate ***vital documents***, such as:
   ▫ applications and consent forms,
   ▫ letters with information specific to a client regarding participation in a program,
   ▫ notices pertaining to the reduction, denial or termination of services or benefits,
   ▫ notices of the right to appeal,
   ▫ notices that require a response from the client, and
   ▫ notices advising LEP persons of the availability of free language assistance. [17.3]

I. Policy and Overview: Why Cultural Competence?

Policy

The Minnesota Department of Human Services (DHS) encourages health and human services providers and organizations to demonstrate their ability to serve diverse populations before they serve individuals from diverse cultures. The organization and its personnel are always accountable for culturally appropriate services.

DHS is committed to meeting the needs of Minnesotans in all their diversity. The department has dedicated itself to providing services, programs and policies that are appropriate and accessible to our customers, who encompass a broad range of human differences such as ability and disability, age, educational level, ethnicity, gender, geographic origin, race, religion, sexual orientation, socio-economic class, and values. If DHS is going to make that vision a reality, we must encourage all health and human services organizations to enhance their abilities to provide culturally competent services. (Former Commissioner Linda Anderson, Oct. 2002)

DHS recognizes that significant disparities exist between the outcomes experienced by minorities and American Indians and those experienced by the general population and is committed to overcoming those disparities.[1] (Commissioner Kevin Goodno, January 9, 2003)

Health and human services organizations can enhance their cultural competence with:
- culturally competent personnel – providers, paraprofessionals, and administrators with appropriate skills, knowledge, and attitudes
- culturally competent services – interventions and treatments proven effective with individuals from the diverse communities likely to be served
- culturally competent organizations – policies, administrative procedures, and management practices designed to ensure access to culturally appropriate services and competent personnel.

Professionals need to constantly improve their skills and increase their knowledge. Organizations hire and train culturally skilled and knowledgeable people. They anticipate which cultural communities they are likely to serve and then develop the competence to serve them appropriately. When an organization finds that it lacks a professional skilled in the culture or language of a client in the waiting room, it is incumbent upon the organization to consult with, or refer to, someone who possesses that skill. Prior to calling upon consultants or making referrals, the organization needs to have established relationships with them.

In an emergency, meet immediate needs. Make a referral for culturally appropriate follow-up.

Why cultural competence?

The reason to become more culturally competent is to provide better services. A health or social services organization cannot be clinically or programmatically competent unless it is culturally competent.

One cannot fully achieve cultural competence but one must strive toward greater cultural competence. These Guidelines are designed to help organizations and professionals move toward that goal.

Culture influences one's behavior and family practices. Culture influences an individual's health and mental health beliefs, practices, behaviors, and even the outcomes of interventions. Health behavior

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[1] In an address to department staff, January 9, 2003

depends on how one understands the cause of illness. In mental health and medicine, research indicates that culturally-appropriate service improves diagnostic accuracy, increases adherence to recommended treatment, and reduces inappropriate emergency room and psychiatric hospital use.

A professional strives for cultural competence to become a better clinician, social worker, or teacher; to provide more effective health, mental health, or social services; and to make services equally accessible to each of the diverse groups that the organization serves.

For a social worker or a clinician to accurately determine an individual's needs and to appropriately plan how to address those needs, the professional first needs to understand how clients' culture affects them and what cultural strengths might be exerted upon those needs. While all people share common basic needs, there are vast differences in how people of various cultures go about meeting those needs. [2]

Ultimately, cultural competence is a personal pursuit. The interpersonal relationship between the service professional and the client is what most determines whether services are appropriate. The first step toward achieving cultural competence is accepting the reality that openness to long-term, ongoing, and persistent development is required. The culturally skilled professional is one who is in the process of actively developing and practicing strategies and skills in working with culturally different clients. [3]

An individual professional cannot be culturally competent alone. It requires organizational commitment. Management creates the service delivery structure and environment where cultural competence is possible.

The more that health and human services systems move away from "one-size-fits-all" institutional services and, instead, focus on individualized and family-centered service, the more that organizations will have to address issues of cultural competence.[4] Culturally competent practice improves access and quality of service for individuals of diverse populations.

Striving for cultural competence is a long-term developmental process. It is a process in which an organization can measure its progress according to its achievement of specific developmental tasks. One of the most powerful conceptualizations of this is Terry Cross's *Cultural Competence Continuum*[5] which envisions a variety of ways that a person may respond to cultural differences on the path to competence:

1. cultural destructiveness
2. cultural incapacity
3. cultural blindness\cultural pre-competence
4. cultural competence; and
5. cultural proficiency.

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[2] Cross, Terry, with Bazron, Barbara J., Dennis, Karl W., Isaacs, Mareasa R. (1989) Toward a Culturally Competent System of Care: Vol.1, Washington, DC, National Technical Assistance Center for Children's Mental Health, Georgetown University Child Development Center, p.19.

[3] McPhatter, A.R. (1997), Cultural Competence in Child Welfare: What is it? How Do We Achieve It? What Happens Without It?, Child Welfare, 76, pp. 259-260.

[4] Regina Hicks, (Harris County [Houston] Texas) Workshop: Policy Issues in Child Welfare, Juvenile Justice, and Mental Health, June 8, 2000, New Orleans.

[5] Cross et al., pp. 13-18.

What is cultural competence?

Cultural competence is a journey; not a destination that one can ever fully attain. *Cultural competence* or *culturally competent* means the ability and the will to respond to the unique needs of an individual client or family that arise from the client's culture and the ability to use the person's cultural strengths as resources or tools to assist with the treatment, intervention or helping process. For the organization, cultural competence means the ability to provide equal and meaningful access and equal quality to individuals from each cultural and linguistic population served, based on an understanding of each population's distinct needs. For the professional, the ability to use the client's culture as a resource will depend, in part, upon knowledge of specific cultures and their histories, skills in cross-cultural and culturally-specific practices, and the ability to communicate effectively. (Cultural competence has been defined in a variety of ways. See Appendix E for other definitions.)

Cultural competence indicates the ability to work across cultures; to appropriately serve clients of cultures different from one's own. Since individuals and organizations are not, by nature, culturally competent[6], they take active steps to change behavior. They:
- learn what the client's culture believes about family, health, and mental health, cultural values, and patterns of family dysfunction, disease incidence and prevalence
- learn skills and behaviors to provide appropriate service for diverse populations.
- learn to effectively exchange information, perception, instruction, and preferences about the client's presenting problem or condition and related history.

In this document, *culturally competent* indicates the ability to work across multiple cultures and is, therefore, distinct from *culturally specific* which refers to capability with one particular culture.

Being of a cultural minority does not, itself, make a person culturally competent. For example, an African American psychologist may be competent to provide culturally-specific services to African American clients but would not be culturally competent unless she has demonstrated success in treating clients of at least one other culture.

Becoming more culturally competent requires not only learning more about others' cultures, but also about one's own culture, as a point of reference in trying to understand the more subtle effects of culture on behaviors and beliefs.

No individual can be deeply familiar with all of the cultural beliefs that affect health and behavior in Minnesota's heterogeneous society. It may be that an individual cannot become an expert in even one non-native culture. For this reason, these Guidelines eschew the notion of **being** culturally competent in favor of the notion of **pursuing** cultural competence. To develop increased cultural competence, every provider can acknowledge a culture's profound effect on health and social outcomes and can be willing to learn more about this powerful interaction.

Cultural competence does not mean treating all members of a cultural group in the same manner. Too much emphasis on gaining pedantic knowledge of a particular non-native culture could encourage stereotyping because it may distract even a well-meaning learner from the client's individualized response to his or her culture. Cultural competence is a subset of individualized care in the sense that it is the ability to provide individualized care that accounts for the influences and benefits of the client's culture. Thus, an organization that gains the skills in cultural competence, consequently increases its ability to serve all diversity, including those who are racial and ethnic minorities.

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[6] People of Color Institute (1996). Cultural Competency Manual for Child Protection Workers, Washington, D.C., National Center on Child Abuse and Neglect.

Who can receive culturally appropriate service?

Everyone has a culture. Should everyone get culturally competent service?

The practical standard is that extraordinary effort will be directed toward any cultural group:

- whose understanding of health, mental health, illness, or disability is sufficiently different from the mainstream to create a risk of sub optimal service as a result;
- whose family customs, social patterns, child-rearing practices, and religious values are sufficiently different from the mainstream to create a risk of inaccurately assessing family functioning;
- whose primary language is not English or whose means of communication is sufficiently different from mainstream as to risk misunderstanding essential elements of the clinical or professional interaction; or
- whose history of experiencing war or ethnic, racial, social, or class-related discrimination is likely to have produced trauma or stressors beyond the norm.

Civil rights guidelines[7] require agencies receiving federal health and human services funds to augment services or supports when cultural or linguistic factors have contributed to a client's condition or have a bearing on his or her capacity to effectively participate in the agency's services.

Legal requirements apply to linguistic competence. Each health and human services organization that receives federal dollars, directly or indirectly, must translate written materials where a significant number or percentage of the population eligible to be served or likely to be directly affected by the program needs services or information in a language other than English in order to communicate effectively. Oral interpretation services must be of sufficient quantity and quality to meet the needs of all clients with limited English proficiency. (See *Sections 17.3 and 17.4*)

The next question often is this: How much cultural competence is enough? Does a person need culturally competent care when he comes into the doctor's office with a broken arm? Or is it important only in culturally "loaded" situations like mental health therapy, termination of parental rights determinations, or end-of-life situations?

The answer is this: Cultural competence is necessary in all client encounters. "The ability to construct culturally competent relationships with patients throughout their lives is key to managing these more loaded situations with less panic, fear, and distress."[8] Because everyone has a cultural identify, cultural competence must be applied to everyone."[9]

Individualized services and cultural competence

Enhancing an organization's cultural competence consequently enhances its ability to provide individualized care. The skills and administrative structures necessary to provide culturally appropriate services are those required to provide individualized services.

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[7] *Guidelines for State Agency Civil Rights Compliance Plan* (October 1984), Office of Civil Rights, Region V, p. 29.
[8] Lonner, Thomas D. (2000), *Constructing the Middle Ground: Cultural Competence in Medicaid Managed Care,* The Cross Cultural Health Program, Seattle, p.25.
[9] From a self-description of the Mental Health Center of Dane County (Madison, Wisconsin) in Examples from the Field: Programmatic Efforts To Improve Cultural Competence in Mental Health Services (November 2000), National Technical Assistance Center for State Mental Health Planning, Alexandria, Virginia, p. 134.

Psychological assessment practice, for example, is shifting toward an emphasis on individual differences within social contexts. This new assessment perspective expands the concept of individual differences by adding dimensions based on culture and gender.[10]

Any mainstream intervention will work extremely well for a small segment of racial/ethnic-minority clients, produce mediocre results for a large segment, and extremely bad results for another small segment.[11] Thus, interventions need to be based not on the client's cultural group but, rather upon the nature of the individual client whose individuality is partly a manifestation of his or her culture.

Any assumption that members of an ethnic group are influenced in the same way by cultural beliefs is false. Considerable intragroup diversity exists among ethnic groups. Human services professionals consider the cultural context of an individual's life when deciding upon a service strategy, but failure to recognize a client's unique response to his or her own culture may result in miscommunication and missed opportunities to provide services that clients need.

Who should implement these guidelines?

These guidelines apply to all organizations and agencies that receive grant funds from, or that are under contract with, the Minnesota Department of Human Services, including county social services organizations and their vendors or contractors, managed care organizations and their provider networks, and community-based organizations. Health Care Providers may be more familiar with the national CLAS standards for cultural competence. The CLAS standards are consistent with the Guidelines but the Guidelines go further to support direct case work by agency staff. These guidelines are not a mandate except as noted. They are an educational tool that helps to answer the question: How do we become more culturally competent?

DHS encourages county social service agencies to develop and implement cultural and linguistic competence plans. These Guidelines will complement counties' Limited English Proficiency Plans. (See DHS Bulletin #00-89-4, December 28, 2000).

DHS's 2001-2002 health plan contracts for Medical Assistance, General Assistance Medical Care, and MinnesotaCare services required health plans to develop cultural and linguistic competence plans.

Why does cultural and linguistic competence matter to your organization?

The business and ethical cases for cultural competence are both powerful. In business terms, activities necessary to develop competence in serving diverse populations could be labeled "emerging market development."

Minnesota's demographics are changing rapidly. The changing populations present new market opportunities for health care products and social services. New customers bring more and different demands. If organizations are to succeed under these new market conditions, they will conduct market research, differentiate products to the diverse populations, create partnerships with cutting edge vendors and entrepreneurs, train workers in the new technologies, and listen to customers' feedback.

In government, changing demographics demands greater efficiencies in the use of limited public dollars. Those dollars must buy more effective services for a greater number of people.

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[10] Dana, Richard H. (1995), Impact of the Use of Standard Psychological Assessment on the Diagnosis and Treatment of Ethnic Minorities, in *Psychological Interventions and Cultural Diversity*, Aponte, Joseph; Young Rivers, Robin; Wohl, Julian; Boston, Allen and Bacon, p. 61.

[11] Tafoya, *op.cit.*

Cultural and linguistic competence are relevant to health and human services organizations because of: demographics, health disparities, access barriers, quality of services, legal and accreditation mandates, liability and fiscal efficiency, competition, and out-of-home placement costs.

A. DEMOGRAPHICS

Minnesota's county officials can no longer say: "We don't need to worry about diversity because we don't have any minorities here." According to the 2000 Census, 80 of Minnesota's 87 counties count at least 100 individuals in one or more of the four major racial/ethnic minority groups, Black, American Indian, Asian, and Latino.[12] Thirty-nine counties have racial/ethnic minority populations of at least 5 percent.[13]

Minnesota is experiencing record-breaking growth of ethnically and linguistically diverse populations. The 2000 Census tells us that Minnesota's minority population doubled in the last decade (1990 to 2000). Minnesota is one of three states ranked in the top ten in rate of growth of three major minority groups: Blacks, Hispanics and Asians. In the entire metro area, minorities represent one of every six residents, while in Minneapolis and St. Paul more than one of every three residents belongs to a racial/ethnic minority group.

This growth represents the immigration of new Americans, as well as the resettlement of ethnic minority populations from other parts of the United States. New Americans in Minnesota speak upwards of eighty different languages in their homes,[14] have limited English proficiency and often do not understand the intricacies of child protection law as it pertains to culturally different child rearing and disciplinary practices.

B. DISPARITY

Service outcomes are worse for diverse populations than for the general population. Minnesota leads the nation in the disproportionate numbers of African American and American Indian children involved in the child welfare system. They receive fewer services and experience less favorable outcomes.

African American and American Indian children are five times more likely to be in out-of-home placement than their White counterparts. They are more likely to experience multiple placements. They stay in placement longer and are less likely to be reunified with their parents. (DHS Bulletin #01-68-01, March 1, 2001).

The experience of African American and American Indian children in the juvenile justice system is perhaps even more disparate. The U.S. Department of Justice found that the custody rate for White juveniles in Minnesota was 155 per 100,000, while the rate for African American and American Indian youths was 1,690 per 100,000, a rate ten times greater.

According to the University of Minnesota Center for Urban and Regional Affairs, Minnesota has the highest concentration of inner-city African American poverty in the United States. The Center for Disease Control reports that Minnesota has the highest African American teen pregnancy rate in the country. Similarly, life expectancy for American Indians is dramatically worse than that for their White neighbors. The census also reveals that Minnesota is the fifth most racially segregated state in the union in terms of housing and neighborhood settlement patterns.

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[12] The counties below this threshold are: Grant, Kittson, Lac qui Parle, Lake of the Woods, Lincoln, Pope, and Red Lake. – StarTribune, March 29, 2001

[13] Census 2000, Minnesota county populations by race/ethnicity categories. The counties are: Anoka, Becker, Blue Earth, Carlton, Carver, Cass, Clay, Clearwater, Cook, Cottonwood, Dakota, Freeborn, Hennepin, Itasca, Kandiyohi, Le Sueur, Lyon, McLeod, Mahnomen, Mille Lacs, Mower, Nobles, Norman, Olmstead, Pine, Polk, Ramsey, Redwood, Renville, Rice, St. Louis, Scott, Sibley, Steele, Swift, Waseca, Washington, Watonwan, and Winona.

[14] See http://www.demography.state.mn.us/DownloadFiles/language/lang01.html

Minnesota is one of the healthiest states for White people. Diverse populations have much poorer health outcomes.[15] The infant mortality rate in the metropolitan area is four times greater for Indian and Black infants than for White infants.[16]

While 18 percent of Minnesota children under age 18 are listed in the 2000 Census as non-White or Hispanic, racial and ethnic minority children make up:
- 20 percent of children with emotional and behavioral disorders in special education;
- 24 percent of children born with low birth weight;[17]
- 27 percent of low birth weight babies;[18]
- 38 percent of children born to teenage mothers.[19]
- 45 percent of children in mental health residential treatment facilities;
- 45 percent of children found to be abused or neglected after being reported to county officials;[20]
- 55 percent of children in the corrections system;

The disparity in public service use by children and families is also complicated by culturally-specific health problems,[21] which may not receive appropriate treatment. The adjustment problems of deaf and hard-of-hearing children, for example, are only beginning to be commonly recognized, as are racial and ethnic differences in metabolizing some common psychotropic drugs. Further, behaviors which reflect cultural practices may be inappropriately pathologized by practitioners. Children and families seeking or in need of help instead experience misunderstanding and prejudice, and are likely to receive services that are ineffective or even harmful.[22] These practice issues are potent reminders that culture "affects everything we think and do from how we treat our aging relatives, to when and how we recognize a child's transition into adulthood, to what we do when we feel sick."[23] Providers risk doing harm when they fail to recognize and fix the causes of disparities.

"Over-representation of adolescents of color in the juvenile justice system result from decisions made very early on regarding the need to remove children from their homes; decisions that are based in some large part on the family's color or race."[24]

Some disparities are positive. Many cultural practices contribute to the health of a community, ranging from traditional diets that are low in fat, to emotionally and financially supportive bonds among extended families, or religious practices from which followers draw strength.[25] Such positive disparities, if they are understood by practitioners, could be used in the healing process.

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[15] Center for Cross Cultural Health (1997), *Caring Across Cultures: The Providers' Guide to Cross-Cultural Health Care,* p. x.

[16] Closing the Gap: A Public Health Report on Health Disparities: Data Report of the Twin Cities Metro Minority Health Assessment Project, (hereinafter "MHAP Data"), March 2001. Minnesota Department of Health, Minneapolis Department of Health and Family Support, Hennepin County Community Health Department, Anoka County Community Health and Environmental Services, Bloomington Health Division, Carver County Community Health Services, Dakota County Public Health Department, St. Paul-Ramsey County Department of Public Health, Scott County Public Health, and Washington County Department of Health and Environment, p. 22. The report also said that mothers and children from diverse communities are less likely to receive adequate prenatal care and immunizations than White mothers and children.

[17] Kids Count Minnesota 2001 Data Book, op. cite., p. 17

[18] MDH 2000: '94-'98 data

[19] Kids Count Minnesota 2001 Data Book, op. cite., p. 15

[20] Kids Count Minnesota 2001 Data Book, op. cite., p. 29

[21] Center for Cross Cultural Health, op. cite., p. x

[22] Walker, Janet S. (2000). *Caregivers Speak about the Cultural Appropriateness of Services for Children with Emotional and Behavioral Disabilities*; Research and Training Center on Family Support and Children's Mental Health, Portland State University, p. 6

[23] Center for Cross Cultural Health, op. cite., p. xi

[24] Regina Hicks (June 2000), workshop: Policy Issues Cross System, New Orleans

[25] Ohmans, Patricia (2000), *Getting the Word Out: Effective Health Outreach to Cultural Communities*, Medtronic Foundation, Minneapolis, p. 4. Available on the Web at: http://medtronic.com/downloadablefiles/outreach_brochure.pdf

C. ACCESS BARRIERS

Health and human services organizations will provide meaningful access to services they provide for individuals in all cultural and linguistic groups. "Access" refers to the client's ability to get needed services. For persons with limited English proficiency, meaningful access means effective communication between the organization and the client.[26]

Barriers include the inability to communicate with professionals and support staff in the organization; the inability of the organization to accurately determine a client's needs; failure to obtain authorization for necessary treatment or services; unavailability of needed services; inability of the organization to provide services in a manner that is effective; excessive distance and lack of transportation to services; inability of professionals to establish rapport conducive to effective services or treatment; inability to pay for needed services.[27]

D. QUALITY OF SERVICES

For social workers, psychologists, doctors, nurses, teachers, and other professionals, developing a relationship of mutual trust and confidence with a client is not merely "Minnesota Nice." These professionals provide vitally important services whose very nature requires the establishment of a close relationship with the client; a relationship that is based on empathy, confidence and mutual trust. Such intimate relationships depend heavily on the free flow of communication between professional and client. This essential exchange of information is difficult when the two parties involved speak different languages or come from different cultures. Competency in dealing with diverse populations is crucial and lack of it has especially adverse consequences.[28]

Culture influences the accuracy of assessment and the effectiveness of services or treatment. If social workers, therapists, doctors, and teachers are ignorant of the client's culture, they may make incorrect assumptions about what is causing a problem[29] and provide inappropriate services.

When children are the clients, parents play a crucial role in service and case planning and outcomes. Providers must be able to understand the family's values and utilize the family's cultural strengths. The family is an important source of insight into the child's problems and ideas for service and case planning. Families can help to identify culture-related needs when the professional is skilled in interviewing across cultures. Families and other community members can identify culturally normal and appropriate responses and behaviors and thus help the professional to distinguish culturally atypical or injurious responses from responses which simply are dissimilar from responses that are appropriate in the mainstream culture. Further, the family must be a partner in services if they are to succeed. Often, the provider or case manager's competence in the family's culture can be the factor that determines whether the organization and the family are working together—or against each other.

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[26] Title VI of the Civil Rights Act of 1964: Policy Guidance on the Prohibition Against National Origin Discrimination As It Affects Persons With Limited English Proficiency, (August 30, 2000), Office of Civil Rights, U.S. Department of Health and Human Services, published in the Federal Register, Vol. 65, No. 169, August 30, 2000, (hereinafter "OCR Guidance") p. 52765

[27] Cultural Competence Standards in Managed Care Mental Health Services for Four Underserved/Underrepresented Racial/Ethnic Groups, Western Interstate Commission for Higher Education Mental Health Program; the Managed Care and Workforce Training Initiative of the Center for Mental Health Services (CMHS) of the Substance Abuse and Mental Health Services Administration (SAMHSA) of the U.S. Department of Health and Human Services; and the University of Pennsylvania School of Medicine, (Hereinafter, "WICHE"), Section III, subsection on "Access and Service Authorization."

[28] OCR Guidance, op. cite., p. 52763.

[29] Walker, op. cite, p. 5

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E. LEGAL AND ACCREDITATION MANDATES

Cultural and linguistic competence are required by state and federal law. (See Appendix A.)

State and federal agencies increasingly rely on private accreditation to set standards and monitor compliance. Both the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), which accredits hospitals and other health care institutions, and the National Committee for Quality Assurance (NCQA), which accredits managed care organizations and behavioral health managed care organizations, have issued standards that require cultural and linguistic competence in health care.

F. LIABILITY AND FISCAL EFFICIENCY

Providers may be liable under malpractice laws and rules for claims that their failure to bridge communication gaps breached professional standards of service. Further, they may be liable for damages resulting from treatment in the absence of informed consent.[30]

Ineffective services and treatments exacerbate a client's problems, requiring a higher level of care. Ineffective services and treatments carry high costs for the organization, for taxpayers, and for society as a whole. Pursuing cultural competence enhances service effectiveness, which will either save money or allow the organization to increase its capacity to serve more clients.

G. COMPETITION IN THE FUNDING ARENA OR MARKETPLACE

State health care and social services purchasers and private funders have an increasing commitment to doing business with partners who provide equal access and quality to diverse populations. Provision of publicly-financed health and mental health care is increasingly delegated to the private, non-profit sector. Organizations that can improve outcomes for diverse populations, provide equal access to services, and increase client satisfaction will have the competitive edge.

Among the quickest ways for a mainstream organization to increase its capacity to serve diverse clients is to implement a partnership with an existing culturally-specific, community-based provider.

Incremental approach and coalition building

Striving toward cultural competence is a developmental process. It may be viewed as a goal toward which professionals, agencies, and systems can strive.[31] Guidelines outlined in Section II envision an incremental approach toward cultural competence, based on a sustained series of specific, achievable actions with realistic time lines. Organizations implement these guidelines over time according to a plan they develop for themselves.

Building internal-external coalitions helps to develop internal support for cultural competence efforts and promotes the organization's successes to clients and the community. The following coalition building principles may be useful:[32]
- Clients and parents are the best advocates for system change. As constituents and customers, they can get attention where professionals may be ignored.
- All stakeholders are included, especially those who are likely to resist.
- Anecdotes (personal stories) and data are both necessary to make a convincing case.

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[30] See Perkins et al., *Ensuring Linguistic Access in Health Care Settings: Legal Rights and Responsibilities,* National Health Law Program manual, Jan. 1998, available from the Henry J. Kaiser Family Foundation. An executive summary is available on the Web at *http://nhelp.org/pubs*.
[31] Terry Cross et al. (1989), op. cite., p.13.
[32] Guerro, Rachel; Isaacs, Mareasa; Echo-Hawk, Holly (June 2000), from a presentation to the "Building Community Capacity for Cultural Competence" conference, sponsored by the Georgetown University Child Development Center, New Orleans.

- Dialogues, not training sessions, will be most helpful in learning about people's issues and their perceptions of the organization's services. Find out why individuals within the organization might feel pursuing cultural competence could be difficult. Encourage discussion about racism and class, organizational costs, and political realities.
- No single leader speaks for an entire community. Get participation from several respected community leaders.
- Goals are real and meaningful. Be clear about what you want to accomplish.
- Goals address both equity and social justice as well as the system's self-interests, such as the reputation, financial benefits of cultural competence.
- Resistance is to be expected—so prepare your responses and pick your battles.
- Small victories create momentum.

A culture is not monolithic

To say that culture alone explains everything is as dangerous as saying culture counts for nothing.[33] Individuals within any particular ethnic or cultural group are different from one another. Values, opinions, and family practices differ. Diversity trainers often say the difference among individuals within a cultural group are greater than the difference between cultural groups. An organization must respond to an individual whose individuality is formed, in part, by the person's culture.

Further, organizations engaged in cultural competence planning need to recognize that clients' reactions to their efforts will differ. For example, one study looking at parents of children with severe emotional disturbances found African American parents split almost evenly over the desirability of programs targeted at specific racial or ethnic groups. While some parents were dissatisfied because providers failed to understand that norms of behavior could differ among communities, other parents felt that minority children should receive exactly the same treatment as anyone else.[34] (See Appendix C.)

Culture is not just race and ethnicity

Organizations must be careful not to view culture only as race or ethnicity. Many groups, such as the poor, homeless, disabled, gay/lesbian/bisexual/transgender, and immigrants/refugees exhibit distinct cultural characteristics, which may present special service delivery issues. Those who are deaf not only often use a distinct language but also manifest a "deaf culture." Poverty imposes demands that can manifest as distinct worldviews that are cultural in nature. While socio-economic status is independent of race/ethnicity, it has culture-like characteristics for its members and engenders culture-like responses from others. For example, a study of parents describing how families had been treated by child-serving agencies found that low-income parents of all races were almost three-times more likely than others to describe experiences in which they felt they were not treated with respect by service providers.[35]

Sovereignty of American Indian tribes

Sovereignty of American Indian tribes is recognized by the State of Minnesota.[36] State policy says: "When undertaking to formulate policies that directly affect Indian tribes and their members, the

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[33] Ida, D.J., Asian Pacific Development Center, Denver, in a presentation for the Pre-Institutes Training, Building Community Capacity for Cultural Competence conference, New Orleans, June 2000.

[34] Walker, op. cite., p. 10.

[35] Walker, op. cite., p. 14.

[36] Executive Order # 02-10: Order to Affirm the Government-to-Government Relationship between the State of Minnesota and the Indian Tribal Governments Located Within the State of Minnesota (October 16, 2002), *Minnesota State Register*, Vol. 27, No. 17, Oct. 21, 2002, p. 587. The order states: "The State of Minnesota, a sovereign state within the United States, recognizes the inherent sovereignty of Indian tribes and their right to existence, self-government, and self-determination."

State and its agencies must recognize the unique government-to-government relationships between the State and Indian tribes and whenever feasible consult with the governments of the affected Indian tribe or tribes regarding a State action or proposed action anticipated to directly affect an Indian tribe."

Health and human services organizations and programs must acknowledge tribal sovereignty as follows:

Health and mental health care providers must recognize the right of American Indian people—living on or off the reservation—to receive publicly funded services from Indian Health Services (IHS) facilities and tribal clinics operated under Public Law 93-638 (the so-called "Section 638" clinics and providers). Minnesota Health Care Programs must cover these services. [This includes Medical Assistance (MA fee-for-service and the Prepaid Medical Assistance Programs, including County Based Purchasing; Minnesota Senior Health Options, and Minnesota Disability Health Options); MinnesotaCare; and General Assistance Medical Care.] Additionally, when an IHS or 638 clinic provider refers an American Indian enrollee to a managed care organization provider, the managed care organization shall not require the enrollee to see a primary care provider prior to the referral; however, the referred provider may determine that the service is not medically necessary or not covered.

Child welfare agencies engaged in child custody, foster care placement, and termination-of-parental-rights cases and other child welfare cases must comply with the Tribal/State Indian Child Welfare Agreement, which was authorized by the Legislature and executed between DHS and several tribes and bands June 18, 1998. (See the Agreement at http://www.dhs.state.mn.us/FMO/LegalMgt/Bulletins/pdf/1999/99-68-11.pdf)

The Tribal/State Agreement is based on the federal Indian Child Welfare Act (ICWA), which authorizes states and Indian tribes to enter into agreements concerning the care and custody of Indian children and jurisdiction over child custody proceedings involving such children.[37] "The trust responsibility of the federal government and the status of tribes as sovereign governments together provide the basis for treating Indian children differently from non-Indian children for child welfare purposes," according to the Agreement. "Pursuant to the sovereign status of tribal governments, in their parens patriae capacity, tribes have substantial legal authority to determine the welfare of their members or individuals eligible for membership...Included under the tribe's authority are decisions regarding the type of care received by Indian children who require placement away from the home of their parent(s) or Indian custodian(s). The parens patriae interest of tribes includes any placement of Indian children made by the local social services agencies and child placement agencies licensed by DHS."

Contracts with tribes. A state agency or local subdivision contracting with a tribe for any reason "may not require an Indian tribe or band to deny its sovereignty as a requirement or condition of a contract with an agency." (Minnesota Statutes, Section 16C.05, Subdivision 7) This restriction is pertinent to all health and human service organizations and their individual cases. In addition, tribes are granted *Sovereign immunity* which means that a tribe or band that has entered into any type of contract (including a grant) with the state is immune from a lawsuit in state court to enforce the terms of the contract unless the tribe or band has waived its sovereign immunity or agreed to permit an arbitrator's decision to be enforced in state court.

In general, "states have no power to limit the tribes' sovereign powers...State civil regulatory laws do not apply to American Indians on reservations. A state has authority to act within the reservation

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[37] ICWA authorizes the states and Indian tribes to enter into agreements concerning the care and custody of Indian children and jurisdiction over child custody proceedings involving such children. (25 U.S.C. §§ 1919).

only to the extent that Congress explicitly authorizes it to act....Thus, even though a reservation is located within the boundaries of a state, and the state has some responsibilities to the members of the tribe, the state may exercise few of its normal powers of regulation and taxation within that reservation," according to the Minnesota Senate Counsel.[38]

The U.S. Congress found in Public Law 103-413 that:
- the tribal right of self-government flows from the inherent sovereignty of Indian tribes and nations;
- the United States recognizes a special government-to-government relationship with Indian tribes, including the right of the tribes to self-governance as reflected in the Constitution, treaties, and Federal statutes, and the course of dealings of the United States with Indian tribes.[39]

Is cultural competence aimed at the provider or the administration?

Both. View your organization and its products as a whole. Make no distinction between your organization and the vendors or providers with whom you contract to perform your work. Both the providers who perform services and the organizations that provide access through service authorization, client intake, payments and billing will pursue cultural competency.

When you pursue cultural competency, what can you expect?

Those who pursue personal and organizational cultural competency can expect both personal discomfort and institutional resistance.

The individual who is accustomed to a monocultural environment is likely to experience discomfort when interacting with people significantly different from themselves. This is true for the client as well as the professional. Nervousness and insecurity is driven by fear of offending and a fundamental lack of understanding of the other's culture. Overcoming such discomfort requires a sustained effort.[40]

For the organization, cultural competency is complicated. Discussions within the organization will be difficult and sometimes frustrating. This may be true even if all participants support the concept of cultural competence. Expect that some of those who oppose it will be less than forthright in their opposition.

Resistance takes many forms. To illustrate the thinking of those who resist cultural competence, their statements are quoted; these were written responses to a 1999 DHS document that proposed to mandate cultural competence standards for a health care program:

"It's an unfunded mandate. We're not getting paid for this."
"There are higher priorities. Our system lacks the basic services."
"These requirements are prescriptive and administratively burdensome."
"This is special treatment for a small group of people."
"These are 'best practices'– Cadillac services. We can only afford the basics."
"This is a rural area. We don't have any minorities here."
"These standards exceed current service standards."
"Our staff has already been trained in diversity and sensitivity."
"How do you know we're not (already) culturally competent?"

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[38] Office of Senate Counsel and Research, Minnesota Senate (December 1998), a research report entitled "American Indian Communities in Minnesota," section on "Basic principles."

[39] The Tribal Self Governance Act of 1994, Title II of P.L. 103-413, Section 202.

[40] McPhatter, op. cite., pp. 263-264.

"There aren't any minority professionals. Minorities never apply."
"Our services are available to everyone."
"How do we operationalize this?"
"There is some value in having these requirements as a straw man for negotiations."

Social and economic factors

Commentators in both the social work and health fields draw connections from social and economic factors to outcomes for persons from diverse cultures.

A person's health, for example, is said to be a product of social and economic environment as well as a product of service system competence, and individual factors (such as genes, beliefs, coping skills, and behavior). Socio-economic factors affecting health include income, education, housing, employment and working conditions, environmental health, crime, and cohesiveness of communities.

Achieving a vision in which all Minnesotans have an equal opportunity to enjoy good health, "is bigger than our systems of public health and health care," according to *A Call To Action: Advancing Health Through Social and Economic Change*, Minnesota Health Improvement Partnership, July 2001.[41] "All individuals, systems, and institutions in the community share responsibility for–and reap the rewards of– improved health."

Because social and economic factors are largely beyond the control of the individual health and human services organizations who are the audience of these guidelines, such factors are beyond the scope of this document. Social and economic factors, however, merit the reader's attention. For a comprehensive description, please see: http://www.health.state.mn.us/divs/chs/mhip/schaction.pdf

These "How to" Guidelines build on national standards

These Guidelines are the next generation. They address the "how to" questions that ensue from the rich legacy of work that has gone before it. These Guidelines build on and are consistent with national standards for health care, mental health care, child welfare, and language assistance. The Minnesota Department of Human Services is particularly indebted to:

The **CLAS** standards, properly entitled the *National Standards on Culturally and Linguistically Appropriate Services in Health Care* (December 22, 2000), Office of Minority Health, U.S. Department of Health and Human Services, published in the Federal Register, Vol. 65, No. 247, pp. 80877. http://www.omhrc.gov/clas/indexfinal.htm (See Appendix G for 14 CLAS Standards.)

The **WICHE** standards, properly entitled *Cultural Competence Standards in Managed Care Mental Health Services for Four Underserved/Underrepresented Racial/Ethnic Groups*, Western Interstate Commission for Higher Education Mental Health Program; the Managed Care and Workforce Training Initiative of the Center for Mental Health Services (CMHS) of the Substance Abuse and Mental Health Services Administration (SAMHSA) of the U.S. Department of Health and Human Services; and the University of Pennsylvania School of Medicine. http://www.wiche.edu/MentalHealth/Cultural_Comp/index.htm

OCR Guidance, properly entitled the Office of Civil Rights Policy Guidance on the Prohibition Against National Origin Discrimination As It Affects Persons with Limited English Proficiency, (*Federal Register*, Vol. 65, No. 169, Aug 30, 2000, pp. 52762 through 52774). http://www.hhs.gov/ocr/lep/guide.html

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[41] Published by the Minnesota Department of Health, Division of Community Health Services, p.3

II. Organization and Administration Supporting Service Delivery

1. Cultural Competence Planning.

Each health and human services organization will plan an incremental campaign to enhance its capacity to serve diverse individuals. Developing a Cultural Competence Plan will define the organization's strategy and guide its effort. The plan sets clear, timely, and achievable expectations and tasks for staff and contractors and it establishes goals and adequate resources for the effort.

Its cultural competence plan will address every level of the organization:
- the policy level including governing boards, internal funding allocation and external contracting requirements, decision-making processes, advisory councils, service standards, training policies, lobbying, and data and research;
- the administrative level;
- the practitioner or service provider level; and
- the client or consumer level.[42]

The first step in developing a cultural competence plan is collecting information about the client populations, their specific needs, and the ability of the organization to serve them appropriately. More client data is needed about diverse populations and their service outcomes. In particular, organizations can substantially modify their information collection practices to identify cultural variables in service delivery and outcome data. (See Section 8) However, planning can begin while information is being gathered for later use.

It is important not to research too much nor analyze too long. An organization may not need an encyclopedia of cultural knowledge in order to begin planning. What it needs is enough information to motivate, justify, and guide an initial planning process. Ironically, among key research findings is the "impatience in communities of color with the continued study of...disparities and limited action to address the issues."[43] Organizations should use existing valid data whenever possible.

Sections 1.1, 1.2, and 1.3 outline the three steps of cultural competence planning, according to a simple formula:

> Step 1……Assess community needs…
> — Step 2……then assess your organization's capability to serve those needs…
> Step 3……then develop a plan to address current organizational shortcomings.

1.1. Step One: Community needs assessment. Each health and human services organization analyzes the demographic characteristics of its service population. Then it completes a comprehensive needs assessment for each cultural and linguistic group. Data collection and analysis includes information that is necessary to plan, implement, and evaluate services tailored to the needs of diverse groups. Assessments compare the needs of these diverse populations to the general population.

The community needs assessment comprises a demographic and community profile, a community service needs assessment, an outcomes and disparities analysis, and a geographic and socio-economic profile.

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[42] See an extensive treatment of these levels in Cross et al. (1989), op. cite., pp. 25-39

[43] Closing the Gap: A Public Health Report on Health Disparities (March 2001), Twin Cities Metro Minority Health Assessment Project, a collaboration of the Minnesota Department and Health and metropolitan public health agencies, www.mncounties.org/metroplan/MinHealth.htm, p. 8.

1.1.1. Demographic and community profile.   The demographic analysis utilizes available data to the greatest extent possible. The U.S. Census 2000 breaks out population by five major racial/ethnic groups. The State Demographic Center has a Web site report of race/ethnicity by county at http://www.mnplan.state.mn.us/demography/index.html.

Organizations may further distinguish populations within the major Census categories. For example, American Indians can be identified by tribe; Asian/Pacific Islanders can be distinguished as Hmong, Vietnamese, Asian Indian, Chinese, etc.; Blacks can be distinguished as African American or Somali. Latinos can be distinguished as Mexican, Puerto Rican, Cuban, etc. (See Section 8.3.3 for Minnesota population categories.)

1.1.2. Community service needs assessment.   The organization can assess the culturally-specific service needs of each cultural and linguistic population in their area.   This is not client-specific. Rather, it is an endeavor to compile broad knowledge on the culturally-based needs of clients, using standard market-analysis methodologies or other methods (for example, literature reviews and focus groups).

A community needs assessment will necessarily be incomplete. Among the most relevant sources are studies that describe service outcome disparities among various groups. The differential outcomes between diverse communities and mainstream communities essentially define the crucial needs of diverse communities. Local culturally-informed experts from each pertinent population are involved in the design of the assessment.

1.1.3. Service outcomes and disparities analysis. If a disparity is identified between a cultural/linguistic group and the general population, more in-depth analysis is performed.

Each organization's internal service-utilization data is crucial to identifying disparities, though utilization alone may not equate to outcome disparities. Service utilization includes the number of units and timing of received services, such as: day treatment, therapeutic foster care, residential treatment, inpatient hospitalization, physician's services, child protection assessment, family-based crisis services, family foster care, or interpreter services.

Minimally, a utilization profile identifies race/ethnicity, preferred (or primary) language, age, gender, and nation of origin. (See Section 8.3.1 for recommended data categories.)

1.1.4. Geographic and socio-economic profile of the locality.   Organizations may find it useful to review the general socio-economic characteristics of its service area, including:
- Geographical attributes
  - main urban and rural centers
  - terrain and distances
  - transportation routes and availability of public transportation

- Socio-economic characteristics
  - primary economic support
  - income levels
  - percent on economic and medical assistance
  - employment data
  - home ownership, rentals, and public subsidy

1.2. Step Two: Organizational and service provider capability assessment. An organization can gather a picture of itself that is complete enough to identify its primary strengths and deficiencies in regard to serving its diverse populations. The organization assesses its ability to provide:

- culturally and linguistically appropriate services and
- access to services for diverse populations.

Organization means both the organization that determines access to services and the organization that performs services. For example, the organizational assessment would include both a county social services agency and its contracted vendors and service providers. Additionally, the assessment would cover both a managed health care plan (or HMO) and its network of physicians and other clinical professionals.

Organizational self assessment is a strength-based approach that identifies and promotes growth among individuals and organizations and enhances their abilities. It recognizes that cultural competence is a developmental process—not a "pass/fail" judgement. A self-assessment tool is included in Appendix H. In addition, a guide to planning and implementing cultural competence organizational self-assessment is available from the National Center for Cultural Competence at the Georgetown University Child Development Center: http://gucdc.georgetown.edu/nccc
The tool is at: http://georgetown.edu/research/gucdc/nccc/ncccorgselfassess.pdf

Organizations conduct both initial and ongoing self-assessments to obtain baseline and updated information that can be used to define service needs, identify opportunities for improvement, develop action plans, and design programs and activities. The self-assessment focuses on the capacities, strengths, and weaknesses of the organization.

Initial self-assessment—including an inventory of policies, practices, and procedures—is a prerequisite to developing and implementing the cultural competence plan.

Periodic evaluations are necessary to determine the organization's progress. Evaluations should be performed at least biennially to keep pace with demographic changes. Each organization may want to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, client satisfaction surveys, and outcome-based evaluations.[44]

A tool to help health and human services organizations and client advocates assess an agency's ability to provide linguistically accessible health care services can be found:
- in Appendix H
- at: http://www.healthlaw.org/docs/LangQuest.pdf

Additional tools for personnel self-assessment are available at the National Center for Cultural Competence Web site http://gucdc.georgetown.edu/nccc under "Publications."
Health and mental health organizations might find helpful the National Committee for Quality Assurance's performance measures, Healthplan Employer Data and Information Set (HEDIS). Look for the latest version at http://www.ncqa.org.

1.3. Step Three: Cultural competence plan. Each health and human services organization develops a cultural competence plan by comparing knowledge gained from its community needs assessment (Sect. 1.1) against knowledge gained from its organizational and service provider capability assessment (Sect. 1.2). The plan includes manageable and concrete goals, operational plans, management accountability, and oversight mechanisms. Representatives of diverse

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[44] National Standards on Culturally and Linguistically Appropriate Services in Health Care (December 22, 2000), Office of Minority Health, U.S. Department of Health and Human Services, (hereinafter "CLAS Standards") published in the Federal Register, Vol. 65, No. 247, pp. 80877

communities are prominent in developing and monitoring the written cultural competence plan.[45] The plan addresses the following issues:

1.3.1. Administrative and organizational support

- Assignment of responsibility to an executive-level individual
- Participation of top and middle management and front line staff
- Participation of affected communities such as clients, family members, tribal organizations, spiritual leaders and religious organizations, civic and community organizations
- Participation of sovereign tribal governments
- Process for integrating the cultural competence plan into overall operations
- Process for determining unique variables within the communities and populations served
- Strategy to ensure cultural competence for each service
- Provider capacity enhancement and human resource development (see Sect. 3), including incentives for culturally appropriate skills, performance, and training[46]
- Outreach and prevention
- Intake, assessment, eligibility, enrollment, and client education/marketing
- Conflict resolution or appeals, complaints, and grievances
- Quality management using culturally appropriate indicators
- Data collection and management information system capacity.

1.3.2. Culturally appropriate services

- Service array or benefit design, including culturally-specific services appropriate and effective with each population
- Access and service authorization
- Needs determination including triage, screening, assessment, and early intervention
- Service planning or treatment planning, including identification of natural supports to assist in reintegrating individual clients into their own natural environments
- Service coordination or case management.

1.3.3. Language assistance. Each health and human services organization shall provide language assistance, under federal law. Counties additionally must comply with Limited English Proficiency (LEP) Plan requirements established in DHS Bulletin #00-89-4 (December 28, 2000).

Guidelines in this section are consistent with both federal and state requirements. County agencies may use their approved LEP plans to implement Section 1.3.3. Both these Guidelines and the LEP bulletin are based on the federal Office of Civil Rights Policy Guidance on the Prohibition Against National Origin Discrimination As It Affects Persons with Limited English Proficiency (OCR Guidance), (*Federal Register*, Vol. 65, No. 169, Aug 30, 2000, pp. 52762 through 52774).

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[45] The elements and approach to cultural competence planning are consistent across the prominent national models. All elements selected here come from the CLAS Standards, WICHE Guidelines, and the Demonstration Project for People with Disabilities (hereinafter "DPPD"), Minnesota Department of Human Services, Request for Proposals, Sept. 1999, Section I.O.
[46] At the Mental Health Center of Dane County (Madison, Wis.), a training committee organizes ongoing (often bi-weekly) cultural and clinical training. For information, contact Gail Marker, Program Director, (608) 280-2700 or www.gail.marker@MHCDC.org

Each health and human services organization shall use the results of its community needs assessment to develop and implement Language Access Guidelines in its cultural competence plan, which include the following:

A. A statement of the organization's commitment to provide meaningful access for all persons, including persons with LEP.

B. Written policies and procedures for meeting the language needs of persons with LEP, including:

▪ the range of oral language assistance options and the process for providing timely interpreter services;

▪ a provision addressing how the organization will meet the needs of persons with LEP whose languages are not as commonly spoken;

▪ the process that staff will use to inform applicants, clients and the public that language assistance services are available to them free of charge;

▪ a provision describing the limited circumstances when it would be appropriate to use family and friends as interpreters, including the statement that minor children may never be used as interpreters;

▪ a provision addressing competency standards for interpreters;

▪ a method to inform applicants, clients and the public, in their own language, of the organization's LEP plan, including where it will be posted for public review, and the public's right to language assistance services;

▪ a provision addressing how to provide language services to persons with LEP who do not read their own language;

▪ a provision addressing how to provide interpreter services in emergency situations;

▪ confidentiality provisions for interpreters.

C. A process that enables ready access to appropriate interpreters free of charge and in a timely manner during all hours of operation.

D. An arrangement for how notice of language assistance services will be made available; that is, a notice to persons with LEP in their own language of the right to language assistance services free of charge.

E. A plan to provide staff with training on the LEP plan.

F. Steps to disseminate the LEP plan to all organization staff who are likely to have contact with persons with LEP, to ensure staff awareness of the plan and their Title VI obligations to persons with LEP.

G. A plan for evaluating the effectiveness of the LEP plan.

H. A plan to translate and make available, in regularly encountered non-English languages, organization-produced written materials that are routinely provided in English to the public.

I. The legal basis for the LEP plan and the legal obligations of the organization to provide meaningful access to persons with LEP.

J. Designation of a staff person to serve as the organization's contact on LEP and other civil rights matters. A name (or title) and telephone number must be prominently displayed on the organization's LEP plan.

K. A complaint resolution procedure so applicants, clients and members of the public know how to file a complaint about the provision of language assistance services with the organization, the state oversight agency, and the federal Office of Civil Rights. A complaint procedure must include the name (or title) and telephone number of the person responsible for receiving civil rights complaints for the organization.

2. Community Partnership and Governance.

The organization's governing body provides overall guidance in the campaign to develop cultural competence. It establishes policies, standards, and resources that define the organization's commitment to diverse populations.

Organizations use formal and informal mechanisms to involve clients and the community in designing and implementing cultural competence. Why? First, clients are experts. They have practical knowledge of what works and what does not. Second, it's fair. Direct involvement acknowledges the client's rights and responsibilities. Third, perception is reality. How clients and potential clients see an organization is critical to the organization's ability to achieve positive outcomes. If the population perceives that its concerns are heard, they will use the services.

Clients and communities impart critical knowledge to decision-making, provide a practical appraisal of policy and management initiatives, and monitor the implementation of cultural competence activities.[47] Clients and community representatives are actively involved in service design and delivery activities, organizational policies, evaluation mechanisms, marketing and communication strategies, and staff training programs. In addition, each organization collaborates with community organizations on outreach, provider network building, making service referrals, and enhancing public relations.

2.1. Governance of the organization. Each health and human services organization designates seats on governing bodies for clients and families who are representative of client populations and who are selected by independent councils of clients, family members, and communities.

One client-member is insufficient; a lone member is likely to be isolated and would be under far greater pressure than other decision makers. Three is the minimum to allow for the occasional absence. An independent body of clients can select the client members to provide accountability to broad client interests (as opposed to individually self-serving interests).[48]

Public agencies, which are governed by elected officials, can focus client involvement at the administrative level where program planning and evaluation is done.

Organizations provide technical training on administrative and clinical aspects of the organization to ensure full, active, and knowledgeable participation.

2.2. Advisory councils of clients, family members, and communities Each health and human services organization can establish advisory councils comprising clients, parents of minor clients, and non-client community members. Their membership represents populations with regard to age, gender, ethnicity, and disability (special needs). Advisory councils can:
- advise the organization about client, family and community needs, strengths, and resources, and effective service delivery;
- select from its membership the representatives to sit on the organizations' governing bodies;
- participate in the planning, implementation, and evaluation of cultural competency activities and policies; and
- receive formal training from the organization regarding policies, procedures, programming, and other areas related to provision of services.

3. Human Resource Development.

Each health and human services organization launches a variety of strategies to enhance the capacity of service providers and provider networks to improve culturally appropriate services. Human resource development focuses simultaneously on:
- recruiting diverse personnel;

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[47] CLAS, WICHE, and DPPD.
[48] DPPD, op. cite., Section IV.A.2.

■ strengthening the competency of existing personnel.

Among the specific strategies to enhance cultural competence capacity are the following:

3.1. Recruit new culturally and linguistically diverse staff. *Diverse staff* means staff who are representative of the demographic population of the service area; they work in all levels of the organization. Diversity is critical but not sufficient. As in any effort to recruit personnel in a competitive work force market, success is likely to improve by developing differential pay rates and career ladders for staff who have demonstrated proficiency with diverse clients. Acknowledging the practical difficulties in achieving full racial, ethnic, and cultural parity within the workforce, this standard emphasizes commitment and a good-faith effort rather than specific numeric outcomes. Organizations continue efforts to design, implement, and evaluate strategies for recruiting and retaining a diverse staff. Each organization can improve retention by incentive and mentoring programs and by fostering a culture of responsiveness toward the ideas and challenges that a culturally diverse staff offers. (One approach would be to pay the recruit's education costs in exchange for a commitment to work a prescribed number of years in the community.) One commentator indicates that organizations improve their success in recruiting and retaining diverse staff when they reach a "critical mass" of three or more people from a particular cultural group: This allows for within-group support and for diffusing the stress of an otherwise solitary member who often is expected to represent the entire cultural group.[49]

3.2. Training for existing staff, providers, and administrators. Health and human services organization provide core and continuing education for professional and clinical staff and contractors, paraprofessionals, administrators, and support personnel. Training should emphasize development of cross-cultural knowledge and skills; that is, the ability to appropriately serve more than just one's own cultural group. Staff receive cultural competence training regardless of their cultural backgrounds. According to D.J. Ida of the Asian Pacific Development Center (Denver): "Hiring a person who is merely bilingual or of the same ethnicity is not sufficient and may only result in insensitivity in two languages."[50]

The training curriculum includes culturally-specific knowledge, cross cultural skills and languages, and practica related to service delivery in particular disciplines. Staff development programs may provide for individual self-assessment of skills and knowledge, along with differential pay for workers who gain or already possess cultural and linguistic competence skills. *(See Appendix B for a listing of suggested education components.)*

3.3. Contract with culturally-specific providers. Utilize existing culturally-specific providers within the service area and establish referral arrangements with out-of-area providers. Ensure that provider organizations are prepared to function within the existing business environment. Some studies indicate that clients who are matched ethnically and linguistically to their clinicians, therapists, and service coordinators are engaged in and complete their interventions more often than those who are not matched. Such matching reduces the premature termination of interventions, which is common in many organizations serving culturally diverse populations and the poor.[51] However, studies differ on this point and differences in individual response probably accounts for the conflict.

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[49] Torralba-Romero, Josie (1999). *Recruitment, Retention, Training, and Supervision of Mental Health Services Staff*, in Hernandez, Mario, and Isaacs, Mareasa R., (Eds.) Promoting Cultural Competence in Children's Mental Health, Baltimore, MD, Paul H. Brooks Publishing Company, pp. 81-93.
[50] From a presentation handout, Pre-Institute Training of the Building Community Capacity for Cultural Competence conference, New Orleans, June 2000.
[51] Torralba-Romero, ibid.

3.4. Cultivate professionals from communities and non-professionals. In fields such as mental health where a dearth of culturally diverse professionals exists, extraordinary effort may be necessary to cultivate professionals from communities and from among non-professional staff. Some programs report greater success when they "grow their own" professionals[52] by putting resources into educating community members rather than by attempting to recruit already-qualified professionals from outside the area.

3.5. Use non-traditional practitioners or healers. Facilitate the acceptance and utilization of non-traditional practitioners or healers who have proven effective for specific cultural or linguistic populations. "Proven effective," means positive empirical results or historic acceptance for a practice used within a specific cultural or linguistic population.

3.6. Use alternative provider credentialing. Strategies may include:
- professionals supervising direct services provided by paraprofessionals;[53]
- utilizing immigrant professionals who were certified outside of the United States;[54]
- paying non-traditional providers;
- teaming or pairing workers cross-culturally;
- establishing cross-cultural teams including professionals and cultural experts;
- providing internship opportunities or work exchanges with culturally-specific organizations;
- demonstrating how a non-traditional intervention fits an existing services billing codes.

3.7. Paraprofessional staff. Implement programs using culturally-trained paraprofessional staff for prevention services, support services, health care services, service coordination, client advocacy, clinical follow up under supervision, and community liaison or development. In child welfare, this would include use of case management associates; in mental health, the use of mental health behavioral aides; in a medical setting, the use of licensed practical nurses.

3.8. Culturally-informed consultants. A professional who is not skilled and knowledgeable with regard to a client's culture confers with a culturally-informed consultant. A culturally-informed consultant is recognized by members of the cultural group as one who has knowledge of a particular culture and its definition of health and mental health and who is hired to assist in providing culturally-appropriate service. An organization will need to develop its own criteria for culturally-informed consultants and the consultants receive approval from the community they represent.

4. Prevention, Public Education, and Client Outreach.

Health and human services organizations establish a prevention, community education, and outreach program focused on at-risk populations as identified by its initial and ongoing community needs assessments.

4.1. Prevention and public education. Components of the program may include:
- Screening children for developmental, mental health, social, and environmental risk;
- Assessment and early intervention;

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[52] The PACT 4 Families Collaborative (Willmar, Minnesota) has been successful hiring parents of children with serious emotional disturbances as Family Liaisons. They receive training and clinical supervision and, by the end of training, the parent liaisons become qualified as mental health practitioners. Four of seven are Latinas.
[53] Paraprofessionals may include a Mental Health Behavioral Aide, a category recently promulgated in Minnesota Rules 9505.0326, Subpart 5a. See Minnesota State Register, Nov. 27, 2000, Vol. 25, No. 22, pp. 1016-1017
[54] Minnesota Statutes, Section 148B.21 (amended in 2001), authorizes the Minnesota Board of Social Work to license and issue temporary permits to foreign-born applicants at the LSW, LGSW, LISW, and LICSW levels if they have failed the licensure exam so long as the applicant speaks English as a second language, provides letters of recommendation and experience ratings from two licensed social workers and one professor, and meets all other licensure requirements. (www.socialwork.state.mn.us)

- Protocols for timely referrals indicated by screening and early identification activities;
- Education for parents of newborns;
- Health education for clients and professionals regarding how clients and their families can be more responsible for their own health and family well-being, targeting at-risk factors identified in the community needs assessment;
- Specific services for at-risk youth;
- Link faith-based organizations, cultural and civic organizations with updated listings of community resources that may provide prevention, education, and outreach activities;
- Identify barriers to accessing services;
- Identify economic and social barriers that contribute to neglect and maltreatment of children.

4.2. Outreach. Organizations conduct outreach to clients in restrictive settings. Organizations can be diligent to determine if people might be better served in less-restrictive settings.[55] Conversely, organizations can evaluate whether earlier intensive interventions might achieve better long-term outcomes.

Organizations can increase the provider's knowledge of what each community wants and needs; how each community obtains new information, and what each community's experience has been with existing services.[56]

4.2.1. Report accomplishments. Outreach efforts can regularly make information available to the public about progress and successful innovations in achieving the cultural competence plan. This establishes useful relationships and institutionalizes innovations.

4.2.2. Promote services. Each organization can provide clients with education and information about available services and how to access them.

4.2.3. Tailor outreach to each community. Prevention, education, and outreach approaches may be tailored to particular cultural communities; efforts may include links to religious organizations in the community.[57] In particular, programs reaching out to the African American community may be most successful when they work through churches, social fraternities/sororities, community-controlled media, and civic leaders. Reaching out to American Indian communities requires a more personal approach using a door-to-door, neighbor and relative network building process. In the Latino community, outreach may call for the inclusion of natural helpers and clergy. Reaching Asian communities may require a formalized face-to-face process involving community leaders, elders, clergy, and self-help associations as well as using bilingual media and locating services within the community.[58]

4.2.4. Understandable materials. Each organization must ensure that all intake, eligibility determination, and marketing materials will be understandable to potential clients with limited English proficiency, clients with cognitive disabilities, and to people who are non-verbal, unable to understand directions, or unable to make informed choices. The organization may consider contracting with client groups and culturally-specific groups to provide information to clients and to assist in the development of such materials. Court documents must be made understandable to clients regardless of how the documents are received from the courts.

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[55] Cross, et al., op. cite., p. 44.
[56] WICHE, op. cite, section on Prevention, Education, and Outreach
[57] ibid.
[58] Cross, et al., op. cite., p. 45.

5. Eligibility, Intake, and Client Education.

Health and human services organizations ensure that, for the purposes of eligibility determination (health and mental health) and assessment and intake (child welfare):
- communication is designed primarily to establish rapport with the client and, secondarily, to gather administrative information; and
- oral, written, and audio-visual communication is understandable to clients and parents with limited English proficiency and cognitive disabilities and understandable to clients who have low levels of literacy, are non-verbal, unable to understand directions, or unable to make informed choices.

5.1. Social interaction before forms. Intake workers spend some time in polite conversation with new clients prior to doing business. Workers will need to gain knowledge on the appropriate way of doing this for different cultures. This will begin to ease the natural tensions and discomfort of cross-cultural interactions, particularly in a situation where individuals have unequal power in the encounter. In addition, personal conversation can overcome the distrust some groups feel for an organization, distrust about revealing personal information, and reluctance to fill out legal documents.[59]

5.2. Preferred language indicator. When an individual is enrolled, the intake or enrollment form indicates:
- the client's preferred language and
- whether the client needs the services of an interpreter.

Whenever a client requests an interpreter in order to obtain services, the organization must provide the client with access to an interpreter.[60] If either the client or the intake/enrollment worker is aware of qualified interpreters, this can be noted. This information is forwarded to all service providers and included in the client's case records.

5.3. Initial contact with provider. Upon receipt of intake or enrollment information indicating interpreter services are needed, the provider organization contacts the client by phone, mail, or other means, in the appropriate language, to inform the client how to obtain services.

5.4. Translated written materials. Written materials provided to clients and families may need to be translated into the client's preferred language. (See Section 17.)

5.5. Intake staff duties. Scheduling staff arrange for language and hearing interpreters as necessary to ensure that all clients are served in a timely manner and are given appropriate choices and information.

6. Conflict Resolution.

Health and human services organizations ensure that conflict and grievance resolution processes are capable of identifying and resolving cross-cultural complaints related to service appeals and complaints, cultural conflicts between a client and the organization, and intra-organizational conflicts. Each organization anticipates the inevitable cross-cultural differences that arise between clients and the organization and between members of a multicultural staff.[61]

6.1. Service appeals, complaints, and grievances. Conflict resolution mechanisms are:

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[59] Cross et al. (1989), op.cite., p. 44
[60] See Prepaid Medical Assistance Program (PMAP), 2001 Contract, Section 6.16.4. Also see Demonstration Project for People with Disabilities, Request for Proposals, Sept. 1999, Section VIII.C.13.
[61] CLAS Standards, op.cite, Standard 13, p. 80878.

- written notice of denial, termination, or reduction of service, with sufficient detail to explain the reason. (A vague explanation like "Not medically necessary" is not sufficient);[62]
- internal complaint and appeals procedures;
- external appeal to local review board, state review, or mediation;
- second opinions, as provided in Minnesota Statutes, Section 62D.103 and Section 62Q.73, Subdivision 2(b);
- client advocacy;
- judicial review.

6.2. Cultural conflicts between a client and the organization. Cultural appropriateness is integrated into existing appeals, complaints, and grievance procedures by:
- training staff to recognize and prevent cultural conflicts as a basis of complaints;
- increasing diversity of staff responsible for client relations, appeals, and legal or ethical issues;
- establishing complaint mechanisms that cover all aspects of interaction with the organization and that inform clients about them in their preferred language;
- offering ombudsman services;
- establishing group or other methods to identify conflicts for clients and families who may not be comfortable expressing their own concerns.

6.3. Intra-organizational conflicts. Each organization:
- supports and guides staff on the implementation of cultural competency programs and policies;
- provides supervisors and staff with cultural competence training; and
- evaluates supervisors on their cultural competence skills.

Management is the key. Supervisors who have committed themselves to enhancing their own cultural competence may be better able to support and encourage a multicultural staff. Organizations can manage culturally diverse staff by:
- Acknowledging the range of attitudes and norms about cultural differences and their effect on the organization;
- Encouraging administrative and line staff to examine their own cross-cultural interactions for misinterpretation, ethnocentrism, prejudice, or racism;
- Adopting a policy for resolution of disputes involving cultural differences and a plan for reviewing complaints. By establishing a dispute resolution procedure to review all nature of staff disputes—both cultural and non-cultural in nature—organizations may overcome employees' reluctance to bring forward disputes which are cultural in nature;
- Using management skills, which actively enhance or mediate cross-cultural relations within the organization.

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[62] DPPD, op.cite, Section VII.H.2.1(3).

7. Quality Management.

The organization's overall quality management activities are linked to initiatives identified in its cultural and linguistic competence plan. Programs include both initial and ongoing organizational self-assessments. Cultural and linguistic competence-related measures are integrated into internal audits, performance improvement programs, client satisfaction assessments, and outcomes-based evaluations.[63]

The quality management program address all activities included in the cultural competence plan. The purpose of ongoing organizational self-assessment is to obtain baseline and updated information that can be used to define service needs, identify opportunities for improvement, develop action plans, and design programs and activities. Self-assessment focuses on the capacities, strengths, and weaknesses of the organization in meeting cultural and linguistic competence standards. Quality management approaches include a combination of the following:[64]

7.1. Client surveys. Client satisfaction surveys are translated in oral, written, or audio-visual formats in appropriate languages and dialects to facilitate the participation of clients and families at all socioeconomic and educational levels. Surveys alone are insufficient to assess quality.

7.2. Sampling. Evaluate samples of current and past utilization data by service, modality, level of service, and demographics of clientele.

7.3. Quality improvement teams. Quality improvement teams review data from quality indicators relating to these populations. Teams comprise proportionate representation of diverse clients and families from the service area

7.4. Quality improvement procedures. Procedures are established to ensure that corrective actions will be undertaken with regard to deficiencies found.

7.5. Valid functional outcomes. Assessments include functional outcomes, which are valid and applicable to diverse populations receiving services, as well as the entire covered population. Outcomes are quantifiable objectives, not just process variables, and can be collected independent of agency billing records.

7.6. Records of appeals and complaints. A record is kept of all appeals, complaints, grievances, both formal and informal, and of lawsuits. Complaints are differentiated by ethnicity of the complainant and the specific provider. Records can be publicly reported.

7.7. Provider removal criteria. Criteria are developed for removal of providers. Criteria are public.

7.8. Tracking interventions. Tracking includes movement of clients across levels of service; the use of intrusive, specialized or restrictive interventions; and unusual occurrences by age, gender, ethnicity, and specific practitioner.

Whistle-blower immunity can be guaranteed for employees who, in good faith, draw attention to practices, actions, or policies that are not culturally competent.

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[63] DHS has undertaken its own quality-improvement project to examine disparities in the utilization of preventive and other medical care among enrollees in the state's publicly-financed health care programs. See a description of the project in the *Minnesota State Register*, Vol. 27, No. 14, Sept. 30, 2002, p. 473.
[64] WICHE, op.cite., section on Quality Monitoring and Improvement.

8. Data and Management Information Systems (MIS).

Health and human services organizations enhance their data collection and management information systems in order to better identify the specific needs of the diverse populations they serve, evaluate service outcomes of diverse clients, and track progress toward delivering more appropriate services. In particular, organizations collect individual-client data on race/ethnicity, language, and national origin[65] and integrate it into management information systems.[66] The information system can track individual utilization and outcomes across all levels of service and cross-check it against demographic data. Aggregate population data can include a current demographic profile, a culturally-specific service needs profile, and a service-outcomes or epidemiological profile of the organization's service-area communities.[67]

Some clients will be reluctant to provide race, nationality, or immigration information. An organization can address a client's reluctance by establishing early rapport (see Section 5); by explaining how the information will benefit the client (see Section 8.1); and by explaining the organization's use of the best data practices to protect privacy and prevent misuse of information.

According to federal requirements, health and human services organization must collect at least minimum categories of race and ethnicity data on clients as of January 1, 2003.[68] (See the categories in Section 8.3.2.)

8.1. Purpose of collecting individual data on race, ethnicity, and language. The primary purposes of collecting these data are to ensure measurable progress toward improving client outcomes and ensuring equity across populations. Organizations need to reduce disparities and improve service delivery to clients from diverse communities. Consistent, reliable racial and ethnic data are needed to develop and implement effective identification, prevention, and treatment programs and services.[69]

Data collection will help organizations to:[70]
- profile each population group in the service area;
- identify major health conditions and human services needs;
- identify patterns of treatment and services or illnesses and conditions;
- monitor progress in meeting diverse clients' needs;
- prioritize allocation of organizational resources;
- plan programs to enhance access and improve coordination; and
- ensure comparability and nondiscrimination in access, benefits, and outcomes;
- develop provider training and quality improvement programs;
- develop performance monitoring and evaluation.

8.2. Protections against improper and discriminatory use of data. Client protections are crucial to minimize potential discriminatory use of data. Organizations inform clients about the purposes for collecting data[71] and provide both written policy statements and verbal assurances

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[65] CLAS, op. cite., Standard No. 10; WICHE, op. cite., section on Decision Support and Management Information Systems; MHAP Data, op.cite., p. 39.
[66] WICHE, ibid.
[67] CLAS, op. cite, Standard 11
[68] Policy Statement on Inclusion of Race and Ethnicity in DHHS Data Collection Activities (October 24, 1997), Office of Information Resources Management, U.S. Department of Health and Human Services (Hereinafter "DHHS Policy Statement"). www.hhs.gov/oirm/infocollect/nclusion.html
[69] DHHS Policy Statement, op. cite., Section I.B.1.
[70] CLAS, op. cite., Standard No. 10, and DHHS Policy Statement, op. cite.
[71] CLAS Standards, op. cite., No. 10

that data will not be used for purposes of discrimination. Organizations allow clients to self-identify their race and ethnicity (see Section 8.4.3), giving them ultimate control. No client may be denied services for refusal to provide race, ethnicity, or nation-of-origin information.

Federal standards on racial and ethnic data:
- prohibit use of the categories for determining eligibility for programs;
- do not establish criteria or qualifications (such as blood quantum levels) to determine an individual's racial or ethnic classification; and
- do not designate certain population groups as "minority groups."[72]

Encouraging organizations to collect individual racial and ethnic data is relatively new thinking. For years, collection of racial data was assumed to be for purposes of discrimination and, thus, was discouraged or prohibited. Recently, advocates for diverse populations have concluded that the need for race data has overwhelmed earlier fears. Nevertheless, organizations should be prepared to address lingering fears among individual clients.

8.2.1. Are race and ethnicity categories meaningful? There is no biological basis for the concept of race. In defining the required racial/ethnic categories of data collection, OMB Directive 15 states: "The categories represent a socio-political construct designed for collecting data…and are not anthropologically or scientifically based."

The supposed ability of race/ethnicity to "predict" social outcomes comes not from the individual's existence in a racial or ethnic group, but from the attribution of characteristics or expectation of certain outcomes by others.[73] "It is important to recognize the categories to which individuals have been assigned historically in order to be vigilant about the elimination of discrimination. Yet ultimately, the effective elimination of discrimination will require an end to such categorization."[74]

These Guidelines support the collection and analysis of these data as a tool towards elimination of the disparities that do exist along lines of racial and ethnic categories. The Guidelines support the particular categorization prescribed in OMB Directive 15 for the sake of consistency with other data collection and analysis, particularly the 2000 Census.

8.3. What data to collect. Organizations collect and track the following data:[75]

8.3.1. Individual demographic data. Demographic categories recommended by current literature are:
- race/ethnicity/tribe[76]
- nation of origin[77]
- length of time in U.S. (as a rough indicator of acculturation)[78]
- preferred spoken and written language (including dialects and American Sign Language)[79]

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[72] U.S. Office of Management and Budget, *Statistical Policy Directive No. 15, Race and Ethnic Standards for Federal Statistics and Administrative Reporting* (hereinafter "OMB Directive 15"), section D.

[73] American Anthropological Association (September 1997), *American Anthropological Association Response to OMB Directive 15*, page 5. www.aaanet.org/gvt/ombdraft.htm The article discusses historic transformation of racial identities and recommends the replacement of the term "race" with a less confusing term such as "ethnic origin" for the 2010 census. The article says, on page 4: The danger in attempting to tie race and biology is not only that individuals are never identical within any group but that physical traits used for such purposes may not even be biological in origin."

[74] American Anthropological Association, op. cite., page 9.

[75] Data elements are recommended in CLAS, op. cite.; WICHE, op. cite.; OCR, op. cite; DPPD, op.cite., MHAP Data, op. cite.

[76] CLAS, WICHE, and MHAP

[77] CLAS

[78] CLAS, WICHE

- limited-English proficiency[80]
- literacy in any language[81]
- immigration status[82]
- gender[83]
- age[84]
- disability[85]
- household income[86]
- educational level[87]
- correct address (so information can be geo-coded)[88]
- health insurance status[89]
- sexual orientation (at option of client).[90]

8.3.2 Minimum race and ethnicity data categories to collect. When collecting race and ethnicity data, each organization must, minimally, collect the data categories outlined in the federal Office of Management and Budget's *Statistical Policy Directive No. 15, Race and Ethnic Standards for Federal Statistics and Administrative Reporting* ("OMB Directive 15") and any subsequent revisions. This standard was used for the Census 2000 Short Form. The federal Department of Health and Human Services (HHS) adopted this minimum standard as a requirement (effective January 1, 2003) for HHS funded and sponsored data collection and reporting systems covering all programs of the department including health and human/social services.[91] The standard includes two ethnic and five race categories, along with the following definitions:

ETHNICITY CATEGORIES

Hispanic or Latino. A person of Mexican, Puerto Rican, Cuban, South or Central American, or other Spanish culture or origin, regardless of race.

Not Hispanic or Latino

RACE CATEGORIES

American Indian and Alaska Native. A person having origins in any of the original peoples of North and South American (including Central America), and who maintains tribal affiliation or community attachment.

Asian. A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian Subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

Black or African American. A person having origins in any of the black racial groups of Africa.

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[79] CLAS, OCR Guidance

[80] WICHE, OCR Guidance

[81] OCR Guidance, DHS' LEP Bulletin

[82] CLAS

[83] CLAS, WICHE

[84] CLAS, WICHE

[85] Recommended in *Key Approaches To The Use Of Managed Care Systems For Persons With Special Health Care Needs* (October 1998), Health Care Finance Administration (HCFA), U.S. Department of Health and Human Services.

[86] WICHE. Income is a measurable component of "socioeconomic status."

[87] WICHE

[88] WICHE, MHAP, and the U.S. Department of Health and Human Services (December 1999), Improving the Collection and Use of Racial and Ethnic Data in HHS, a Joint Report of the HHS Data Council Working Group on Racial and Ethnic Data and the Data Work Group of the HHS Initiative to Eliminate Racial and Ethnic Disparities in Health, (Hereinafter "HHS Joint Report.") Recommendation 1.N.

[89] WICHE

[90] WICHE

[91] DHHS Policy Statement, op. cite. The OMB Directive 15 establishes the minimum data collection standard, but it is the DHHS Policy Statement that requires health and human services agencies to implement the OMB standard.

Native Hawaiian or Other Pacific Islander. A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. (A small group in Minnesota of less than one-tenth of 1 percent.)

White. A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

8.3.3. Expanded data categories for racial/ethnic subpopulations. Within each major race/ethnicity category are subpopulations who will come into the system with unique characteristics that will impact the effectiveness of their services. Organizations may find that collecting only the major racial/ethnic categories fails to provide sufficient information for quality service delivery. The Long Form of the U.S. Census 2000 collected race/ethnicity subpopulation categories

Organizations may want to collect data by racial and ethnic subgroups—provided that subcategories can be aggregated into the minimum categories defined in OMB 15.[92] The following subpopulations are prominent in Minnesota:[93]

Black	**Latino/Hispanic**	**Asian/Pacific**
African American	Mexican	Hmong
Somalian	Puerto Rican	Vietnamese
Ethiopian	Cuban	Asian Indians
Nigerian	Central American	Chinese
Liberian	South American	Korean
Blacks of Hispanic descent	Other Caribbean	Laotian
		Cambodian
American Indian	**White**	Filipino
Dakota (Sioux)	U.S.- born	
Ojibwe, (Chippewa, Anishinaabe)	Russian	
	Ukrainian	
	Bosnian	
	Arabic	

8.3.4. Culturally-specific needs and service-delivery data.   Health and human services organizations need information on at least some subpopulations in order to differentiate the needs of one cultural group from the needs of another group. For planning purposes, organizations may seek quickly-accessible, if incomplete, external sources of these data— such as regional research and professional studies or county, public health, school district, and state data. For evaluation and quality improvement purposes, organizations can begin to add such data elements pertaining to their own client groups to internal information systems.

These are aggregate data, not individual data. Differences between groups indicate areas in which organizations may need to change service delivery practice in order to eliminate a barrier. Organizations may consider such information when determining the most appropriate way to deliver services to a specific cultural group. Some of these data relate to conditions or risks applicable to specific populations (known in health literature as "culture-bound syndromes").

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[92] OMB Directive 15, op. cite., and DHHS Policy Statement, op. cite., which further states: "HHS encourages the expanded collection of data that will improve research on disparities in health status and social services needs between minority groups and the general population."
[93] See Appendix G for 2000 Census data on ethnic populations in Minnesota.

In planning how to reduce service outcome disparities, organizations cannot view race and ethnicity solely in terms of genetic differences. Genetic factors alone cannot explain trends in racial and ethnic differences in health and human services outcomes, since more than 90 percent of genetic differences occur within racial groups rather than between groups. For health and mental health problems in which genetic factors play a role, racial trends may often be explained by differing environmental factors, which then have the greatest impact on persons who are most at risk genetically.[94]

An organization may go beyond its own data—such as marketing, intake/enrollment, and termination figures—and use data sources such as census (both Short Form and Long Form) figures or adjustments, voter registration, school enrollment profiles, county and state health status reports, and data from community agencies and organizations. Both quantitative and qualitative methods are used to determine cultural factors related to client needs, attitudes, behaviors, health practices, and concerns about using services. Methods include epidemiological and ethnographic profiles, focus groups, interviews, and surveys conducted in the appropriate languages.

Utilize these data categories by cultural group:
- epidemiological profiles by cultural and linguistic group
- varying physiological responses to medication[95]
- ethnically distinct responses to health, diet, and nutrition
- symptom expression
- beliefs related to health
- beliefs related to mental health
- child rearing practices
- child discipline practices
- effects of racially, culturally, or class-related stressors such as discrimination
- role of the family
- family organization and relational roles of family members
- spirituality
- level of acculturation and assimilation
- history of immigration
- barriers to seeking traditional services
- patterns of help-seeking
- problem-solving styles
- traditional and non-traditional beliefs and knowledge about child development
- knowledge of systems of care.

8.3.5. Service outcomes and disparities data. Organizations may collect and track the following data categories for each individual client to be aggregated by the demographic categories defined in Section 8.3.1.
- diagnostic and assessment information;
- service utilization trends;
- costs of services;
- self-termination of services;
- clinical or service outcomes;
- client satisfaction;
- appeals, complaints, and grievances;
- termination or disenrollment;

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[94] HHS Joint Report, op. cite, Section 2, 1st page.
[95] See: http://www.npcnow.org/issues_productlist/PDF/culturaldiversity.pdf for Levy, Richard and Hawks, John, Cultural Diversity and Pharmaceutical Care, National Pharmaceutical Council, Reston, Virginia.

- child maltreatment reports;
- substantiated child maltreatment reports.

8.4. How to collect data. Federal rules and national literature agree that individual demographic data is collected as follows:

8.4.1. Two-question format for race/ethnicity data. Use two separate questions: one for race and one for ethnicity.[96]

8.4.2. Reporting more than one race/ethnicity. Allow clients to identify more than one race or ethnic category.[97] The list of races provided to clients cannot contain a "multiracial" category.

8.4.3. Self-identified race/ethnicity. Allow clients to self-identify racial and ethnic categories. Organizations will avoid use of observation by staff to visually assess and assign categories.[98]

8.4.4. Preferred language. Collect information on language:
- to identify the client's preferred language;
- to enable organizations to develop language assistance that facilitates service delivery for limited English-proficient clients and families;
- to document the client's preferred written language in which to receive service and health-promotion materials;
- to determine the client's literacy in the preferred or native language. Data collected on language can include dialects and American Sign Language.

"Preferred language," means the self-identified language that the client prefers to use in a service or clinical encounter.[99] The preferred language need not be the client's native or primary language if the client prefers to use English.

8.4.5. Preferred language of parent or guardian. For children or disabled adults where encounters require the presence of a parent or guardian who does not speak English, the case record and management information system documents the preferred language of the accompanying parent or guardian.[100]

8.4.6. Collect data at first point of contact. Organizations collect data from clients and families at the first point of contact, using personnel who are trained to be culturally appropriate in the data collection process. Personnel use forms in the appropriate language. Organizations can inform clients and families about the purposes (as stated in Section 8.1) of collecting data on race, ethnicity, and language, and emphasize that such data are confidential and will not be used for discriminatory purposes.

8.4.7. Client protection when refusing disclosure. Clients cannot be required to provide race, ethnicity, or language information. Nor may a client be denied services because he or she refuses to provide race, ethnicity, or national origin data.[101]

8.5. Unified clinical and service record: long-term goal. Health and human services organizations strive to link individual and aggregate data, by race/ethnicity and national origin

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[96] OMB Directive 15, op. cite.
[97] OMB Directive 15 adopted by CLAS, op. cite., Standard No. 10, and MHAP Data, p. 39.
[98] OMB Directive 15 adopted by CLAS, op. cite., Standard No. 10.
[99] OMB Directive 15 adopted by CLAS, op. cite., Standard No. 5.
[100] CLAS, op. cite., Standard No. 10.
[101] ibid.

across child welfare, mental health, primary health care, developmental disabilities services, public health, juvenile justice, and schools for the purpose of creating unified clinical or service records.

III. Service Delivery System Supporting Culturally Competent Practice

9. Service Array or Benefit Design.

Health and human services organizations can:
- tailor customary services to be effective with diverse populations;
- add culturally-specific services and therapies to the service array or benefit set; and
- encourage individualization and innovation in services provided.

Services for culturally-specific groups can be comparable, though not necessarily identical, to those provided to the general population, acknowledging that culturally competent practice provides for variance in individualized service.

High quality is to be maintained. Increasing access to culturally-specific providers and services is not an excuse for lowering quality standards. Culturally-specific services are those that have been proven effective. Non-traditional practitioners or healers will have demonstrated their competency to their peers.

9.1. Need for cultural broker or interpreter.
The individual case record, client record, or medical record that providers receive prior to services or treatment will indicate the client's need for a cultural broker and also indicate the client's need for either a bilingual provider or language interpreter. If the client's record fails to note a need indicated by the client, the service provider can accommodate it as soon as possible and note the need in the client's record.

9.2. Culturally-specific service providers.
Organizations ensure that culturally-specific providers are available to clients and families, if requested. If such providers are not part of the organization's normal provider staff or network, then non-staff or out-of-network providers are authorized.

9.3. Interpreter services.
Each organization must provide sign and spoken language interpreters to assist clients in obtaining services. The responsibility to provide an interpreter applies during all hours of operation.

9.3.1. Federal mandate.
Each organization shall provide interpreter services to the extent required by federal rule, pursuant to *Policy Guidance on the Title VI Prohibition Against National Origin Discrimination As It Affects Persons With Limited English Proficiency*, Office of Civil Right, U.S. Department of Health and Human Services, August 30, 2000.[102]

9.3.2. Guidelines for linguistic support.
In any clinical or professional service interaction, an interpreter is available if the service provider is not fluent in the client's language. The interpreter may be present on site or may provide the service off-site through electronic media, except that no mental health clinical interaction can be conducted unless the interpreter is present with the client. The test of whether the off-site service is adequate shall be the opinion of the client.[103] "Clinical interaction" means provision of professional or para-professional services, authorization, triage, assessment/diagnosis, service or case planning, service coordination or case management, or treatment monitoring activities between the organization's providers or subcontractors and the client, in person or via any other medium.

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[102] See Federal Register, Vol. 65, No. 169, Wed., Aug. 30, 2000, page 52762 or see DHS Bulletin #00-89-4, Dec. 28, 2000, hereinafter referred to as the "LEP Bulletin".
[103] DPPD, op.cite., see *Guidelines for Implementing DPPD*, October 15, 1999, Section VI.C.10.

9.3.3. Interpreter certification. Language and hearing interpreters can be certified or otherwise demonstrate competence. Use of family members, especially minor children, as interpreters is prohibited.

9.3.4. Interpreter standards. Standards for on-site and off-site interpreters include, at minimum, qualifications in both languages with regard to idioms and dialects and technical terminology in the appropriate field and training in maintaining confidentiality. (See Section 17.2.1 for detailed interpreter standards.)

9.3.5. Health interpretation
To view online recommendations for professional standards, training, and proof of skills for health care interpreters, see: http://www.crosshealth.com/Bridging_Lg_Gap.pdf.

9.3.6. Legal interpretation
For legal interpreter standards, see the Minnesota Supreme Court's *Rules on the Certification of Court Interpreters.* To see a statewide roster of certified court interpreters, go to:
http://www.courts.state.mn.us/interpreters/default.asp?IncPage=search

9.4. Emergency and urgent care. An organization may arrange a 24-hour medically trained telephone interpreter service for each linguistic group in the client population to assist emergency personnel.

9.5. Discharge and transition planning. Discharge planning includes involvement of the client and family in the development and implementation of the plan and the evaluation of outcomes. Discharge planning is the means by which a professional or organization plans to end its relationship with a client. The ending of such relationships often need to be negotiated across cultures in a communication style congruent with the client's values in order to ensure effective services with follow-up providers.[104]

10. Access and Service Authorization.

Service authorization procedures and criteria used to determine whether services are appropriate, reasonable, entitled, or medically necessary for diverse clients is designed by, or in consultation with, professionals in the appropriate fields who have demonstrated competence with culturally diverse clients. Consideration is given to cultural and linguistic needs and differences. Those developing authorization criteria for children include professionals specializing in child welfare and child protection services, children's mental health, or pediatrics. With regard to medical and mental health services, Minnesota Statutes, Section 62M.09, Subdivision 5, requires that clinical criteria and review procedures must be established with appropriate involvement from actively practicing physicians. With regard to court-ordered placement or treatment of juveniles, including child protection screening teams, Minnesota Statutes 260C.157, Subdivision 3, requires the screening team to include social workers, juvenile justice professionals, and persons with expertise in the treatment of juveniles who are emotionally disabled, chemically dependent, or have a developmental disability and involve parents or guardians in the screening process as appropriate.

10.1. Culturally competent gatekeepers. Service authorization, or gate keeping, for diverse populations is performed by or under the supervision of bicultural or bilingual professionals in the appropriate field or professionals in the appropriate field who have demonstrated competence with diverse clients. Professionals who are not trained in cultural differences may misjudge the client's natural tension and frustration from being served by someone who is different and, thus,

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[104] WICHE, op. cite., Section on Discharge Planning.

misunderstand service needs or misjudge the client's actions rather than viewing the tension as a natural part of cross-cultural relations.[105]

For American Indians, gatekeeper qualifications can be consistent with the definition for a "qualified expert or qualified expert witness," pursuant to the Minnesota Tribal/State Agreement (June 1998) (see DHS Bulletin 99-68-11, Section E.32) as follows: A qualified expert is a person who is a member of the Indian child's tribe, who is recognized by the tribal community as knowledgeable in tribal customs as they pertain to family organization and child rearing practices or *knowledgeable in health and human services beliefs and practices.* (language added by editor)

10.2. Placement decisions. Except when a client is in imminent physical or psychological danger, restrictive placements for diverse clients are made with prior appropriate cultural consultation. If the individual or team making the placement decision is not knowledgeable about and skilled in the culture of the child and the client family, a culturally-informed consultant can be utilized. Restrictive placements include residential treatment, inpatient psychiatric hospitalization, foster care, and other involuntary treatment.

10.3. Points of access. Access to services may be facilitated through co-location within ethnic community organizations, neighborhood locales, and places of worship. Access points are culturally inviting.

10.4. Access to culturally specific services by request. Each organization provides culturally-specific services at the request of the client or family and establishes, at minimum, the following opportunities for the client to request culturally-specific services:
- The organization provides orientation to each client explaining the culturally-specific services available, including signs explaining services offered.
- The client may request culturally-specific services at any time.
- Clients or applicants are asked whether they wish to receive culturally specific services at the following times:
  - at intake or enrollment in the program;
  - at least annually after intake; and
  - upon first contact with each new provider.
- Space is provided in the client's case file or medical record to record whether the client has requested culturally-specific services and to record instructions and details pertinent to the request.
- The client receives in writing in the appropriate language a copy of the organization's guidelines for culturally and linguistically appropriate services.

10.5. Service and payment authorization criteria. Organizations establish service and payment authorization criteria that consider cultural and linguistic needs and differences. Criteria or protocols can be designed by, or in consultation with, professionals in the appropriate discipline who have demonstrated competence with culturally diverse clients. Access criteria can include functional criteria, in addition to diagnosis. Placement consideration can include family and client preferences.

10.6. Managed care coverage for tribal-provided health services. American Indian enrollees in prepaid Minnesota Health Care Programs, living on or off a reservation, will have direct out-of-network access to Indian Health Service (IHS) facilities and facilities operated by a tribe or tribal organization under the Indian Self-Determination Act, Public Law Number 93-638 (Section

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[105] Tension resulting when the system of one culture interacts with a population from another has been called the "dynamics of difference". Cross, Terry L., with Bazron, Barbara J.; Dennis, Karl W.; Isaacs, Mareasa (1989). *Towards a Culturally Competent System of Care (Vol. 1)*, Washington D.C., National Technical Assistance Center for Children's Mental Health, Georgetown University Child Development Center, p 20.

638 facilities or providers), for services covered by Medical Assistance (M.S., §256B.0625) even if such facilities are not network providers. No prior authorization or other condition may be imposed.[106]

11. Client Needs Determination.

Determining what is normal within the client's culture is fundamental to accurate assessment of atypical or pathological conditions or behavior.[107] Assessments and diagnoses are performed or supervised by professionals both who are clinically competent and who have demonstrated competence in determining the needs of culturally diverse clients. Organizations will ensure that assessment practices are appropriate and instruments are validated and normed for use with the client's cultural group.

Clients and families have insights into behaviors and symptom expression of diverse cultures that can be invaluable for assessment and diagnosis, effectiveness of services or treatments, and compliance with treatment and other expectations. Clients and families can help to identify culture-related needs when the professional has the interviewing skills to draw out this knowledge. (See Appendix I for training opportunities.) Further, families and other community members can identify culturally normal and appropriate responses and behaviors and thus help the professional to distinguish culturally atypical or injurious responses from those which simply are dissimilar from responses appropriate in the mainstream culture.

Assessments can be multidimensional, including individual, family, and community strengths; functional, psychiatric, medical, and social status; as well as family support.

11.1. Individual behaviors when two cultures interact. A professional of a culture different from that of the client needs to understand how the bicultural encounter may distort the results of an assessment. Both the professional evaluator and the client or client family may alter their behavior. If the evaluator judges the client on the basis of such behavior, the diagnosis or evaluation is likely to be inaccurate.[108] (See *Dynamics of Difference* in the Glossary.)

11.2. Qualifications of the individual conducting the assessment. Organizations will ensure that the individual conducting a clinical or functional assessment or a diagnosis is qualified in the appropriate discipline and has demonstrated competence in the client's cultural group. Competence can be demonstrated by training and performance evaluation. Being a member of a cultural group—while a valuable asset when serving that group—does not itself demonstrate competence.

Providers (culturally trained or not) who encounter a culture-based issue that they are not qualified to address will initiate a professional consultation with a culturally-qualified colleague.

An organization cannot delay crisis care for want of a culturally competent professional. An organization lacking individuals qualified to serve the client's cultural needs must address the immediate needs and then make a referral to a appropriate provider for follow-up assessment and care.

11.3. Culturally validated assessment tools and bias supplements. Organizations will understand the norms, biases, limitations, and appropriate uses of each assessment or diagnostic instrument. Organizations use assessment tools that have been scientifically validated and

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[106] Model Contract for Prepaid Medical Assistance, General Assistance, and MinnesotaCare Medical Care Services, 2003-2004, §6.23.
[107] Cross et al, op. cite., p. 46.
[108] Cross, et al., op. cite., p.47.

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normed for use with the cultural or linguistic group of the client. If such tools are not available, the organization can use supplemental assessment tools or other means to compensate for potential cultural bias. In addition, organizations can use non-verbal I.Q. measurements, linguistically appropriate tests, and training in interpretation of test results based on culture. Organizations understand that each instrument has limitations and biases.

11.4. Assessment components. Assessment for all clients do the following:
- Identify cultural beliefs and practices and socioeconomic factors affecting physical or mental health or illness and the client's presenting condition or situation;
- Evaluate socioeconomic stressors, such as poverty; ethnically-related stressors, such as discrimination; and immigrant/refugee stressors, such as culture shock, war, and post-traumatic stress syndrome;
- Rule out cultural and ethnic factors that might contribute to misdiagnosis, such as: language, symptom expression, non-verbal communication, attribution of condition, spiritual beliefs, history of help-seeking, culture-bound syndromes, or behavioral styles;
- Identify family organization and relational roles (traditional and non-traditional) and include both nuclear and extended family, especially family decision-makers;
- When assessing children, consider parents' expectations of the child's behavior.

11.5. Early intervention. Identify individual and family strengths, resiliency, and protection factors that derive from the individual's culture.

11.6. Mental health assessment of a minority client. Psychological evaluation is conducted by qualified practitioners trained in ethnic-specific biological, physiological, cultural, socioeconomic, and psychological variables. Psychological evaluations also can be based on the use of culturally and linguistically appropriate literature and other specialized approaches.

Pursuant to Minnesota Rules, Part 9520.0909, Subpart 4, if a mental health professional conducts a diagnostic assessment of an child of a minority race or minority ethnic heritage, the mental health professional must be skilled in and knowledgeable about the client's racial and ethnic heritage. If the mental health professional is not skilled and knowledgeable in conducting the diagnostic assessment, the professional must use a culturally informed mental health consultant to assure that the diagnostic assessment is relevant, culturally-specific, and sensitive to the child's cultural and ethnic needs. The organization is encouraged to apply the same criteria to assessments for adults. (*Culturally informed mental health consultant* is defined at Minn. Stat., Sect. 245.4871, Subd. 33a.. The meaning is essentially the same as *cultural broker* as defined in the Glossary.)

12. Service Planning.

Service and case planning is performed or directly supervised by individuals skilled in, and knowledgeable about, the client's culture. When none of the individuals leading the development of the client's service plan is so qualified, service planners confer with a culturally-informed consultant. Credentialing standards for the cultural consultant can be established locally.

12.1. Using cultural strengths as basis for intervention. Each organization and service provider develops sufficient knowledge of client's cultures to enable the use of cultural strengths to assist in the intervention.[109]

12.2. Service and case planning considerations. Service plans and the planning process can incorporate the following:

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[109] Cross, et al., op. cite., p.48.

- Extended family members, spiritual/religious leaders, traditional healers, tribal elders, natural support systems, and community organizations, at the discretion of the client or client's parents or guardian;
- Non-professional members of the client's cultural group for the provision of support services;
- Culturally-defined factors including, but not limited to, cultural attitudes toward health, mental health, family roles and success; English proficiency and preferred language; literacy; religious and spiritual needs; level of acculturation; use of alternative healers and therapies; interdependence among family members; nutritional practices; cultural differences among groups; socioeconomic stressors relevant to the client's condition; and use of natural support systems and community organizations;
- Mainstream and alternative services, client and family education regarding the problems and conditions being addressed, treatment methods, and education about self-help and preventive approaches. Plans can consider a client's strengths, cultural norms, values and critical life experiences;
- Coordination of mental and physical health needs, social services, child protection actions, juvenile justice actions, substance abuse services, and school-based services according to the beliefs and practices of the client and family;
- The family's or client's goals and objectives used in a manner that is functionally defined and oriented towards measurable outcomes;
- Awareness of the needs of the entire family;
- Innovative options for clients who have been labeled historically as non-compliant with treatment or services.

13. Service Coordination/Case Management.

Health and human services organizations maximize the opportunity for client and family-directed decision-making in the planning and delivery of services and supports.[110] Clients and families can help to identify culture-related needs. Professionals may encourage client and family participation by increasing cross-cultural interviewing skills. (See Appendix I for training opportunities in ethnographic interviewing, which helps to understand another culture while avoiding stereotyping.) Further, families and other community members can identify culturally normal and appropriate responses and behaviors and thus help the professional to distinguish culturally atypical or injurious responses from those which simply are dissimilar from responses appropriate in the mainstream culture.

Organizations can adjust case loads to allow for the extra planning and coordination time required for clients with limited English proficiency and for clients who need family or supporters to be present.[111] Each organization can hire, credential, and evaluate service coordinators and case managers based, in part, on their demonstration of cultural and linguistic competence.

13.1. Use of informal support network. Each service coordinator or case manager can learn to utilize the client's own informal support network, the one that is often the greatest resource available to the client but is least accessible to the professional. It is within the natural support networks that a client's cultural strengths are most likely to emerge.[112]

13.2. Qualifications of the service and case coordinator. The client's service coordinator is skilled in and knowledgeable about the client's culture. When the coordinator is not so qualified,

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[110] DPPD, op. cite., Sections V.D and V.E.
[111] WICHE, op. cite., Section on Case Management, under Implementation Guidelines.
[112] Cross, et al., op. cite., p.50.

the coordinator confers with a culturally-informed consultant. Credential standards for the cultural consultant can be established by leaders in the cultural community.

13.3. Cultural competence training for service and case coordinators. Each organization can provide ongoing cultural competence training for service coordinators in at least the following areas:
- culturally competent professional skills;
- culturally specific knowledge relevant to populations served in the professional practice;
- assessment of the service coordinator's cultural competence and of his/her need to consult with a culturally-informed consultant;
- development of skills to use the client's natural support network and to identify culturally appropriate informal or non-professional resources available within the community.

13.4. Client-selected service coordinator. Each organization can promote self-directed services for diverse populations and provide culturally and linguistically appropriate support to client-selected, non-professional coordinators and to parents who choose to direct their own children's care, including:[113]
- training on the operations of family/consumer-directed service delivery, including budgeting and financial accountability, selection and evaluation of service providers that is culturally appropriate;
- assignment of a liaison who has demonstrated competence with culturally and linguistically diverse clients to perform internal administrative functions;
- permitting the client-selected coordinator to act as a consultant to assist the service providers in providing culturally appropriate services.

14. Self-Help.

Health and human services organizations can create or encourage culturally-specific family and client self-help groups. Self-help groups are directed by the group and function as part of the continuum of service. Groups focus on the current needs of clients and families.[114]

15. Practice Standards for Health and Mental Health.

15.1. General practice standards. In general clinical practice, services can be tailored to be culturally acceptable and effective.[115] To enhance the knowledge and skills of physicians, nurses, psychologists, and other clinical professionals, practitioners can:
- Develop culturally appropriate interviewing skills;
- Seek input from cultural groups and specialists to guide assessments and service planning;
- Seek personal and agency contact with healthy members of clients' cultural communities;
- Conduct psychotherapeutic modalities within a context of the client's cultural values and norms;
- Conduct psychopharmacological interventions by psychiatrists trained in ethnically-based biological differences;

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[113] DPPD, op. cite., Section V.E.3.

[114] WICHE, op. cite., section on Self Help

[115] It's not always necessary for a provider to be of the same race or to use culturally-specific interventions. Sometimes, successful intervention comes from simply possessing some rudimentary understanding of the client's life conditions. Dr. Terry Tafoya tells of an Indian man who was involuntarily committed to a psychiatric hospital on the basis of two facts: He cut his hair and he stuck knives in the doors of his house. To the psychotherapist, this indicated suicidal ideation. In fact, the man cut his hair as a widely recognized, traditional act of honoring a recently deceased family member. He stuck knives in his doors because he lived in a HUD house whose locks had fallen apart. On his reservation, jamming knives between the door and door-frame was a common, if derisively humorous, means of securing the doors.

- Allot more than the standard time for clinical interactions that require use of an interpreter;
- Provide travel assistance if public transportation is not reasonably available when clients with limited English proficiency must travel more than 30 minutes or 30 miles to access service in their primary language.

15.2. Culturally-specific therapeutic interventions. Clinical practice is expanded to include culturally-specific therapeutic interventions or treatment modalities that are common to particular cultural or linguistic populations or are especially effective with them. In addition, the types of practitioners are expanded to include those who are characteristically found within a particular cultural or linguistic population or whose practices have their roots within particular cultural or linguistic traditions. Suggested standards include:

(a) Practitioners who recognize and, when appropriate, incorporate culturally-specific interventions and healers.[116] *Healer* means an individual who has demonstrated success in healing or preventing health or mental health problems or conditions using practices that are based in, and recognized by, the culture of the client, and who is acknowledged by peers as an appropriate practitioner, whether or not the individual holds a license or certification recognized by law.

(b) Practitioners who evaluate the feasibility of providing culturally-specific interventions under existing diagnostic codes or service categories and, where this is not feasible, seek alternative funding sources so that such intervention can be accessible to clients.

15.3. Enhancement of provider or network capacity for cultural competence.
(See Section 3 of the Guidelines.)

15.4. Psychological testing for non-assimilated individuals. Standard psychological testing has deficits for an ethnic minority individual who does not have an assimilated cultural orientation.[117]

15.4.1. Distinguish non-assimilated individuals. Prior to conducting an assessment, the individual conducting the assessment will distinguish those clients who are not assimilated and for whom standard psychological assessment may not be valid. Cultural identity assessment tools can be used to distinguish among assimilated, traditional, bicultural, marginal, and transitional cultural orientations.

15.4.2. Use validated psychological assessment tools. Organizations must use assessment tools that have been validated and normed with the diverse population being assessed.

15.4.3. Evaluator knowledge. Organizations ensure that individuals who assess psychological test data are educated regarding the cross-cultural validity literature for the racial/ethnic group being tested[118] and further be knowledgeable about:
- Limitations of standard psychological assessment;
- Assessment materials validated for the assessed population or existing tests modified;
- Acceptable translations of standard psychological tests.

15.4.4. Training in cultural relativism. Organizations that must be responsive to individual differences, can provide training in ethnocentrism and ethnorelativism. Regardless of whether one believes that all persons can be assimilated into an American "melting pot,"

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[116] Dr. Terry Tafoya explains how traditional healers can be as effective as Western psychology: By naming a person's problem, a healer limits it to something that can be restored. A psychologist and a medicine man name the problem differently, but both limit it. Tafoya, *op.cit.*
[117] Dana, (1995), *op.cit.*, p. 57.
[118] Dana, (1995), *ibid.*, p. 68.

the fact is that failure to understand the varying stages of assimilation or to account for a client's level of assimilation can distort psychological test results.[119]

15.5. Evaluating quality of service.   The definition of quality varies according to culture; many cultures value the quality of the service delivery process as distinct from the outcome. As a result, the quality indicators to be evaluated are negotiated between the professional and the client.

16. Child Welfare and Social Work Practice.

Child welfare and social work literature on cultural competence emphasizes attitudes, values, and the professional's personal attributes in addition to the knowledge and skills necessary to become more culturally competent. Suggested practice standards, condensed from National Association of Social Workers,[120] include the following:

Ethics and Values. Social workers shall...recognize how personal and professional values may conflict with or accommodate the needs of diverse clients.

Self-Awareness. Social workers shall...develop an understanding of their own personal, cultural values and beliefs as one way of appreciating...multicultural identities in the lives of people.

Cross-Cultural Knowledge. Social workers shall...develop specialized knowledge and understanding about the history, traditions, values, family systems, and artistic expressions of major client groups.

Cross-Cultural Skills. Social workers shall use appropriate methodological approaches, skills, and techniques that reflect...the role of culture in the helping process.

Service Delivery. Social workers shall be knowledgeable about and skillful in the use of services available in the community and broader society.

Empowerment and Advocacy. Social workers shall be aware of the effect of social policies and programs on diverse client populations, advocating for and with clients whenever appropriate.

Diverse Workforce. Social workers shall support and advocate for recruitment, admissions and hiring, and retention efforts...that ensure diversity within the profession.

Professional Education. Social workers shall...advance cultural competence within the profession.

Language Diversity. Social workers shall...provide or advocate for the provision of information, referrals, and services in the language appropriate to the client.

Cross-Cultural Leadership. Social workers shall be able to communicate information about diverse client groups to other professionals.

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[119] Dana, (1995), *ibid.,* p. 63.
120 Guidelines in this section are condensed from *NASW Standards for Cultural Competence in Social Work Practice* (June 23, 2001), National Committee on Racial and Ethnic Diversity, National Association of Social Workers, pp. 8-20.

IV. Linguistic Competence

17. Language Assistance.

Each health and human services organization shall provide language assistance to:
- persons with limited English proficiency (LEP);
- persons with hearing and vision impairments;
- people with disabilities which, impede their ability to communicate effectively.

Limited English proficiency refers to people who cannot speak, read, write or understand English at a level that permits them to interact effectively with health care providers and human services agencies. Minnesota requires that counties use their best effort to assign clients with limited English proficiency to bilingual staff who speak their language.[121] Such staff know the programs, communicate directly without potential conflicts arising from interpreter use, and are more cost effective.

In addition to state requirements, federal standards for persons with limited English proficiency (implemented by Minnesota in 2001) require that organizations provide sufficient language assistance, free of charge, so that an LEP client has ***meaningful access*** to their services. Each health and human services organization shall ensure that the LEP client can communicate effectively. The steps taken by an organization must ensure that the LEP person "(1) is given adequate information, (2) is able to understand the services and benefits available, (3) is able to receive services for which he or she is eligible, and (4) can effectively communicate the relevant circumstances of his or her situation to the service provider."[122]

Federal standards for people with disabilities are defined in the Americans with Disabilities Act and Section 504 of the Rehabilitation Act of 1973. Both provide similar prohibitions against discrimination on the basis of disability and require organizations to provide language assistance such as sign language interpreters for hearing impaired individuals or alternative formats for vision impaired individuals. In developing a comprehensive language assistance program, each health and human services organization must be mindful of its responsibilities under the ADA and Section 504 to ensure access to programs for individuals with disabilities.[123]

Counties in Minnesota are required to assist limited-English proficient people who are not literate in their primary languages to the same extent it would help an English speaker who does not read English.[124] For individuals who are not literate in any language, for those who speak non-written languages, and for people with sensory, developmental, and/or cognitive impairments, organizations must provide notice of the availability of oral or audio-visual translation of written materials.[125]

Each health and human services organization must establish language assistance programs[126] comprising an assessment of language needs, oral interpretation, translation, notice of assistance, staff training, monitoring, complaint resolution, an LEP coordinator, and mental health clinical assistance.

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[121] DHS Bulletin 01-89-01, March 14, 2001, page 3

[122] OCR Guidance, op. cite,. p. 52765

[123] OCR Guidance, op. cite., p. 52766, footnote 4.

[124] DHS Bulletin 01-89-01, op. cite.

[125] CLAS, op. cite, Standard No. 7.

[126] For nearly two decades, until recently, civil rights compliance required language assistance programs for linguistic groups that rose to a population threshold defined as "a non-English or limited-English speaking minority group constituting 5 percent or 100 individuals, whichever is smaller, of the total service area population and which speaks the same language." (*Guidelines for State Agency Civil Rights Compliance Plan*, Office of Civil Rights (OCR), U.S. Department of Health and Human Services, Oct. 1984.) Newer guidelines have moved toward a broader standard in which any individual who needs language assistance in order to access services must be offered assistance.

17.1. Assessment of language needs. Organizations assess the following:[127]

17.1.1. Languages spoken in the community. An organization identifies the non-English languages likely to be encountered in its program and estimates the number of LEP persons who are eligible or entitled for services and the number likely to be directly affected by its program. This can be done by reviewing census data, client utilization data from client files, and data from school systems and community agencies and organizations. In Minnesota, school districts collect data on what languages are spoken in students' homes.

17.1.2. Clients' language needs. Organizations ask applicants, as part of the intake process, to identify their preferred language and their need for interpreters. Organizations record this information in the client's file in a manner that makes it readily available to providers at all points of contact.

17.1.3. Where assistance is needed. Organizations assess the points of contact in the program or activity where language assistance is likely to be needed.

17.1.4. Resources needed. Organizations assess the resources that will be needed to provide effective language assistance for each client.

17.1.5. Availability of resources. Organizations identify the location and availability of resources for each client and note it in the client's file.

17.1.6. Client specific arrangement. Organizations identify the arrangements that must be made to provide language assistance resources for each client in a timely fashion.

17.2. Oral language interpretation. Each health and human services organization shall arrange a variety of options for oral interpretation. The available options must be of sufficient quantity and quality to serve their LEP clients. While the option chosen may depend upon the number of clients who speak a particular language and upon the organization's resources, some form of interpreter services must be made available to each individual with limited English proficiency, regardless of the size of the individual's language group in that community.

17.2.1. Qualifications of interpreters. Each organization ensures that it uses persons who are competent to provide interpreter services. Competency does not necessarily mean formal certification as an interpreter, though certification is helpful. On the other hand, competency requires more than self-identification as bilingual. The OCR Guidance standard for competency contemplates:
- demonstrated proficiency in both English and the second language,
- orientation and training that includes the skills and ethics of interpreting, with particular competence in maintaining confidentiality,
- fundamental knowledge, in both languages, of any specialized terms or concepts peculiar to the organization's program or activity,
- sensitivity to the LEP person's culture,
- a demonstrated ability to accurately convey information in both languages.[128]

Interpreters used in the delivery of services can further demonstrate the following abilities. The competent interpreter:
- accurately and completely relays the message between the client and the provider by converting the message expressed in one language into the equivalent in the other;

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[127] OCR Guidance, op. cite, p. 52766, under 3 (b) "Assessment".
[128] OCR Guidance, op. cite., p. 52769, under 5(b), "Competence of Interpreters."

- uses the interpretation mode that best enhances comprehension and encourages direct communication between the client and the provider;
- reflects the style and the vocabulary of the speaker, including level of formality and use of slang as well as the emphasis and degree of emotion of the speaker;
- ensures that the interpreter understands the message by asking for clarification or repetition if unclear;
- remains neutral where there is conflict between the client and the provider;
- does not project his or her own values onto the client and identifies and separates personal beliefs;
- identifies and corrects his or her own mistakes; and
- addresses cultural based miscommunication by identifying instances in which cultural differences between the client and provider have the potential to seriously impair communication.[129]

Except in an emergency, friends and family members may not be used as interpreters and organizations can establish an absolute prohibition against use of minor children as interpreters. Use of such persons could result in a breach of confidentiality or reluctance on the part of individuals to reveal personal information critical to their situations. In a medical setting, this reluctance could have serious, even life threatening, consequences. Using children undermines family authority, making a parent dependent on the child. In addition, family and friends usually are not competent to act as interpreters, since they are often insufficiently proficient in both languages, emotionally biased, unskilled in interpretation, and unfamiliar with specialized terminology. Any organization that requires, suggests, or encourages an LEP person to use friends or family as interpreters may expose itself to liability under federal civil rights law.[130]

17.2.2. Quantity and availability of interpreters. Each organization can make the following arrangements to secure interpreter services, in descending order of preference:[131]
- hire bilingual staff, including service providers and those who regularly come in contact with clients;
- hire staff interpreters for frequently encountered languages;
- contract for interpreter services for languages less frequently encountered;
- make formal arrangements with community volunteers, making certain they are competent in the language;
- use telephone interpreter lines for languages rarely or unexpectedly encountered. This cannot be the only language assistance available.

17.3. Translation of written materials. Each organization shall ensure that written or audio-visual materials routinely provided in English to applicants, clients, and the public are available in commonly encountered non-English languages. It is particularly important to translate *vital documents*, such as:
- applications,
- consent forms,
- letters with information specific to a client regarding participation in a program,
- notices pertaining to the reduction, denial or termination of services or benefits,
- notices of the right to appeal,
- notices that require a response from the client, and

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[129] These standards are from *Bridging the Language Gap* (November 1998), pp. 11-12, a report from the Working Group of Minnesota Interpreter Standards Advisory Committee. The committee consists of individuals from academia, health care, government, business, law, advocacy, community, and interpreter organizations. They receive funding from the University of Minnesota, the Minnesota Department of Health, and the Minneapolis Department of Health and Family Support.
[130] OCR Guidance, op. cite., p. 52769, under 5(a), "Use of friends, Family and Minor Children as Interpreters."
[131] OCR Guidance, op. cite, p. 52766, under 3(c)(1), "Oral Language Interpretation."

- notices advising LEP persons of the availability of free language assistance.

The OCR Guidance defines the population threshold for requiring translations as the level "where a significant number or percentage of the population eligible to be served or likely to be directly affected by the program needs services or information in a language other than English to communicate effectively." Civil rights enforcers will determine the extent of an organization's obligation to provide written translations "on a case by case basis, taking into account all relevant circumstances, including the nature of the (organization's) services or benefits, the size of the (organization), the number and size of the LEP language groups in its service area, the nature and length of the document, the objectives of the program, the total resources available to the (organization), the frequency with which translated documents are needed, and the cost of translation."[132]

17.3.1. Numerical guidelines. While federal guidance does not establish a strict numerical threshold, OCR Guidelines provides a "safe harbor." An organization that meets the following minimum standards may have confidence that it is in compliance with civil rights law. It defines the safe harbor as follows:

(a) For each language group that constitutes **10 percent or 3,000**, whichever is less, of the population of persons eligible to be served or likely to be directly affected by the program, organizations must provide translated *written material including vital documents.*

(b) For each language group that constitutes **5 percent or 1,000**, whichever is less, of the population of persons eligible to be served or likely to be directly affected, the organization must, at a minimum, provide translated *vital documents*. Translation of other documents, if needed, may be provided orally.

(c) For each language group that constitutes fewer than **100 persons** eligible to be served or likely to be directly affected, the organization need not translate written materials but must provide in the primary language of the client *written notice of the right to receive competent oral translation* of written materials.

17.3.2. Quality check. Minimally, translations must be performed by a trained and demonstrably-qualified person. Preferably, each organization checks quality of translations by performing back-translations, review by target-audience groups, and periodic updates. It's important to note that, in some cases, verbatim translation may not accurately or appropriately convey the substance of the original English materials.

17.4. Notice to LEP persons of assistance available. Each health and human services organization shall establish several methods to notify LEP persons of their right to language assistance and the availability of such assistance free of charge. Notification methods in Minnesota focus on 10 "primary languages" of Arabic, Hmong, Khmer (Cambodian), Lao, Oromiffa (Afaan Oromo) [spoken in parts of Kenya and Ethiopia], Russian, Serbo-Croatian (Bosnian), Somali, Spanish, and Vietnamese. The state has established a methodology for adding new languages.

Notification methods may include language blocks, language identification cards and posters, translations of applications, instructions, and other materials, signage, and telephone assistance:[133]

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[132] OCR Guidance, op. cite., p. 52767
[133] OCR Guidance, op. cite., p. 52768, under (3) "Methods for Providing Notice to LEP Persons."

17.4.1. Language blocks. Organizations may use four approved "language blocks" to notify limited-English proficient clients that free language assistance is available in appropriate non-English languages. These notices are inserted into brochures, booklets, outreach and recruitment information, and other materials that are routinely disseminated to the public. Organizations must either translate such materials or otherwise ensure that the information and materials are meaningful and accessible.

The DHS language block is a graphic block of text that informs readers, in 10 languages, how they can get help with understanding the information in a particular document at no cost to them. The DHS language block is now available in four approved versions, as follows:

"Attention. If you want free help translating this information, ask your worker."

"Attention. If you want free help translating this information, ask your worker or call the number below for your language."

"Attention. If you want free help translating this information, call the number below for your language."

"Attention. If you want free help translating this information, call _____ [insert the organization's name and/or phone number here]."

The Minnesota Department of Human Services must provide for translations of the language block into additional languages as their speakers grow in number.[134]

The language blocks include separate telephone numbers for each of the specified languages. (See Appendix H.) A person speaking that language must answer the phone during regular business hours, with voice mail backup.

The multilingual referral lines are not an interpreter service. Rather, they refer callers to bilingual persons who help to make contact with the appropriate county or state agency. When a caller calls one of the multilingual referral line numbers, the caller will be asked his or her name, the reason for the call, and the name of the county of residence. The multilingual referral line operator then leaves a message with a pre-designated contact person at the county or state agency as appropriate. It is the responsibility of the county or state agency to return the call with an interpreter or bilingual staff member.

The second and third versions are for use with DHS documents only. Counties cannot use these versions of the language block on county-generated documents.

The first and fourth versions of the language block are appropriate for counties to use on county-generated documents. To obtain one of these language blocks, contact Lisa M. Nelson, LEP Coordinator in Management Services, at 651-282-5082 or by e-mail at lisa.m.nelson@state.mn.us.

17.4.2. Language identification cards and posters. Each organization may use language identification cards and posters which allow LEP beneficiaries to identify their language needs to staff and which allow staff to identify the language needs of applicants and clients. To be effective, the cards must invite LEP persons to identify the language they speak. This must then be recorded in the LEP person's file.

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[134] *Neng Yang, et al. v. Michael O'Keefe, as Commissioner of the Minnesota Department of Human Services,* U.S. District Court, Fourth Division, File No. 99-CV-2033 (hereinafter "LEP Settlement"), Section 6.

The Minnesota Department of Human Services has developed and distributed "I speak" cards and posters to applicants, clients, members of the public, counties, and community agencies that allow LEP clients to identify their preferred language to organization staff. The palm-sized cards say, for example, "I need a Hmong interpreter" in both English and Hmong. English speaking staff can see from reading the English message that they must arrange for the services of a Hmong interpreter. Posters say: "Free interpreter services are available. Please ask someone at the front desk." The message is displayed in a variety of languages which allows clients and applicants to point to the language he or she speaks. This alerts the receptionist to arrange for an interpreter. "I speak" cards and posters are currently available in the 10 languages identified in Section 17.4.

17.4.3. Translation of applications, instructions, information, and other materials.
Each health and human services organization shall translate application forms and instructional, informational, and other written materials into appropriate non-English languages or otherwise make the information in those documents meaningfully accessible. Counties must develop translation plans to translate and make available any **county-produced** materials that are routinely provided in English to the public.[135] Other health and human services organizations can do the same.

DHS has translated a number of forms into 10 languages and has completed a department-wide assessment of what it considers "vital documents"[136] for translation. The translated documents are available at: http://edocs.dhs.state.mn.us

In addition, managed care organizations under contract with the state to provide Prepaid Medical Assistance Program (PMAP) services must provide clients with the Certificate of Coverage, describing benefits, in 10 primary languages.[137]

17.4.4. Signage. Each organization may post signs in regularly encountered languages in waiting rooms, reception areas and other initial points of entry. These signs inform clients and applicants of:
- their right to free language assistance services,
- other rights,
- the availability of conflict and grievance resolution processes,
- directions to facilities and services and an invitation to clients to identify themselves as persons needing language assistance.

17.4.5. Telephones. Each organization may establish uniform procedures for timely and effective telephone communication between staff and LEP persons. This can include instructions for English-speaking employees to obtain assistance from interpreters or bilingual staff when receiving calls from or initiating calls to LEP persons. Other assistance is available:

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[135] LEP Bulletin, op. cite., p. 9

[136] Vital documents include applications, consent forms, letters containing information regarding eligibility or participation criteria, and notices pertaining to reduction, denial, or termination of services or benefits. These are documents that require a response from beneficiaries or that advise of free language assistance. Large documents such as enrollment handbooks, may not need to be translated in their entirety. However, vital information contained in large documents must be translated. See OCR Guidance, op.cite, p. 52767, footnote 6.

[137] Model Contract for Prepaid Medical Assistance Program services, Prepaid General Assistance Medical Care Program Services, and MinnesotaCare Program Services, 2001-Two-Year Contract, Section 3.2.5(A)(1)(d).

Telephone interpreters. Over-the-phone interpretation services are available in 140 languages from Language Line Services (formerly the AT&T Language Line) 800-752-0093 or http://www.LanguageLine.com

17.5. Staff training. Each organization disseminates its language assistance policy to all employees likely to have contact with LEP persons and institutes periodic training of employees. Training can promote: (a) employees' knowledge of LEP policies and procedures, (b) skills in working effectively with in-person and telephone interpreters, and (c) understanding of the dynamics of interpretation among clients, providers, and interpreters. Such training can be part of the orientation for new employees. An organization may find it useful to maintain a training registry that records the names and dates of employees' training.

17.6. Monitoring. Each organization must monitor its language assistance program at least annually to assess:
- the current makeup of limited English proficient populations in its service area,
- the current communication needs of LEP applicants and clients,
- whether existing assistance is meeting the needs of such persons,
- whether staff is knowledgeable about policies and procedures and how to implement them,
- whether sources of and arrangements for assistance are still current and viable.

Organizations may want to seek feedback from clients and advocates.

17.7. Complaint resolution. Each organization adopts and publicizes pre-judicial procedures for resolution of complaints regarding the provision of language assistance. For example, some communities have trained professional and volunteer mediators who may be willing to work with LEP complaints.

17.8. LEP coordinator. Each organization appoints a senior-level employee to coordinate the language assistance program and monitor its performance.

17.9. Mental health clinical encounters. Bilingual mental health staff and interpreters shall be certified or otherwise have formally demonstrated their linguistic competence. Use of family members as interpreters, especially children, can be strictly prohibited.

17.9.1. Telephone interpreters. Telephone interpreters can never be used in a mental health clinical encounter.[138]

17.9.2. Interpreter supervision. Interpreters and translators working with LEP clients and families can be supervised by linguistically competent mental health professionals.

17.9.3. Training in the use of interpreters. Training is provided to all service providers in the use of interpreters for LEP clients. Training can emphasize linguistics and culture.

17.9.4. Residential and inpatient settings. Restricted or residential settings must have the capacity to communicate effectively with monolingual, non-English speakers and individuals with culturally different or unique communication styles.

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[138] This prohibition will seem obvious to a mental health clinician. Nevertheless, the WICHE standards would allow use of a telephone interpreter in an emergency situation, in areas with limited linguistic support resources, if the interpreter were trained in mental health. WICHE, op.cite., section on Communication Styles, Cross-Cultural Linguistic and Communication Support, under Implementation Guidelines.

17.9.5. Interpreter directory. Mental health organizations develop and annually update a directory of paid trained interpreters who are available within 24 hours for routine situations and within one hour for urgent situations.

Legal mandates

Most of the Language Assistance standards described here are enforceable under federal and state law because a client's lack of English proficiency can have the effect of limiting clients' access to important public services to which they may be entitled.

For clients with LEP, each public and private health and human services organization can consult:
- Minnesota Department of Human Services Bulletin, #00-89-4 (Dec. 28, 2000), which directs each county human services agency to develop and implement a written limited English proficiency plan to ensure compliance with federal law;
- Regulations under *Title VI of the Civil Rights Act of 1964* (regulatory cite is: 45 CFR Part 80; statutory cite is: 42 U.S.C. 2000d et seq.);
- *Policy Guidance on the Prohibition Against National Origin Discrimination as it Affects Persons With Limited English Proficiency*, published by the Office of Civil Rights, Federal Register, Vol. 65, No. 169, August 30, 2000, pp. 52762 through 52774. All entities that receive federal financial assistance from the Department of Health and Human Services, either directly or indirectly, through a grant, contract or subcontract, are responsible for implementing this policy guidance;
- The Substance Abuse and Mental Health Reorganization Act, which requires services to be bilingual if appropriate, at 42 U.S.C. Section 290aa(d)(14);
- Regulations issued by the Centers for Medicare and Medicaid Services (CMS) (formerly HCFA), which require that evaluations for the mentally ill and the mentally retarded be adapted to the cultural background, language, ethnic origin, and means of communication of the person being evaluated, at 42 CFR section 483.128(b);
- U.S. Department of Justice regulations, under 28 CFR Part 42.405(d)(1), describes circumstances under which a federally-assisted program must translate documents into non-English languages.

For clients with disabilities, organizations can consult:
- The Americans with Disabilities Act and
- Section 504 of the Rehabilitation Act of 1973.

Glossary

Acculturation means the process of adopting the cultural traits or social patterns of a group other than one's own. In regard to immigrant groups, acculturation is the process of incorporating values, beliefs and behaviors from the dominant culture into the immigrants' cultural worldview.

Assimilation means the process of taking on the cultural traits and characteristics of another distinct group; absorption of a new or different culture into the main cultural body; to make like; to cause to resemble.

Bicultural means the ability to understand and function effectively in two cultural environments. An individual who is bicultural is not necessarily culturally competent.

Bilingual means the ability to effectively speak two languages.

CLAS Standards means a set of 14 Culturally and Linguistically Appropriate Services, published under the title: *Assuring Cultural Competence in Health Care: Recommendations for National Standards and an Outcomes-Focused Research Agenda*, by the Office of Minority Health, U.S. Department of Health and Human Services, in the *Federal Register,* December 22, 2000 (Volume 65, Number 247), pp. 80865-80879. It recommends adoption of a nationwide set of standards.

Comparability of access or benefits means meaningfully equal access and benefits across all populations served, including any adaptations necessary to achieve equality.

Cultural broker or Culturally-informed consultant means a person serving in a non-clinical or non-professional capacity who is recognized by the client's cultural or linguistic community as one who has knowledge of a particular culture or language and its definition of health, mental health, and family dysfunction and who is used by service providers and organizations to assist in providing culturally and linguistically-appropriate service. The term should not be confused with a professional consultation between a mainstream provider and a culturally-specific provider. There are no established criteria for certifying when an individual is culturally informed, but the organization may establish a test to determine a consultant's usefulness in facilitating positive client outcomes. An organization that uses cultural consultants to facilitate face-to-face client encounters may use feedback from clients and families.

Cultural competence or *Culturally competent* means the capability and will of a provider or service delivery organization to respond to the unique needs of an individual client, which arise from the client's culture and to use the client's cultural strengths as a tool in the healing or helping process. In this document, *culturally competent* indicates the ability to work across multiple cultures and is, therefore, distinct from *culturally specific* which refers to capability with one particular culture. For example, an African American psychologist may be competent to provide culturally-specific services to African American clients but would not be culturally competent unless she has demonstrated success in treating clients of at least one other culture.

Cultural competence means: (1) the attainment of knowledge regarding beliefs and values (e.g., related to health, mental health, or child rearing), and disease incidence and prevalence; (2) the ability to communicate effectively for the thorough and accurate exchange of information, perception, instruction, and preferences with regard to the client's presenting condition and related history; and (3) skills and behaviors that will enable practitioners and systems to provide appropriate service for the diverse populations. The word *culture* is used to imply the integrated pattern of human behavior that includes thoughts, communication, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, or social group. **For the organization or service delivery**

system, cultural competence means the ability to provide equal access and quality of services to individuals from each cultural and linguistic population served, based on an understanding of each population's distinct needs. **For the individual professional,** cultural competence additionally means the ability to use the client's culture as a resource or tool to aid in the service or treatment process and to aid in addressing human needs. Such ability will depend, in part, upon knowledge of specific cultures, skills in cross-cultural and culturally-specific clinical practices, and proficiency in clients' languages.

Cultural consultation means advice from an individual knowledgeable about a particular group's culture but not necessarily knowledgeable in the professional field or discipline.

Culturally competent provider means a service professional who understands, and can utilize to the client's benefit, the client's culture either because he or she is of the same cultural or ethnic group or because the provider has developed the knowledge and skills through training and personal growth to provide high-quality service to diverse clients. The term can be used in a practical sense to indicate success in achieving positive outcomes for clients. At this time, DHS has not adopted criteria to certify or measure cultural competence.

Culturally-specific intervention means interventions or treatments that are common to or are especially effective with a specific population or services provided by practitioners who are characteristically found within a particular population. Expectations of high service quality remain.

Culturally-specific provider means one who is characteristically found or proven especially effective within a particular cultural and linguistic population.

Culture means (a) the integrated pattern of socially transmitted human behavior that includes thoughts, communication, actions, customs, beliefs, values, and institutions, and all other products of human work or thought, characteristic of a particular community or population. (b) Cultural defines the preferred ways for meeting needs.[139] (c) Culture is created by people as a dynamic adaptive mechanism, continuously changing to allow a more effective adaptation to new circumstances. (d) Culture is a set of guidelines, both explicit and implicit, which individuals inherit as members of a particular society, and which tells them how to view the world, how to experience it emotionally, and how to behave in relation to other people, to supernatural forces and gods, and to the natural environment." [140] (e) Culture also involves the historical circumstances leading to a group's economic, social, and political status in the social structure. (f) Culture involves the circumstances and experiences associated with developing certain beliefs, norms, and values.[141] Culture provides the "big story." This story, repeated from generation to generation, provides both individuals and the group with their reason for being. If the story is not passed on by families to children, the children will make up compensatory–and typically less satisfying–stories out of deep-felt, if unconscious, necessity.[142]

Cultural is the most broad and overarching fabric of the social environment. It may include racial, ethnic, religious, or social communities or populations. Race is separate from culture. Culture is more about behavior than biology. Emphasizing culture when discussing how human services workers develop cultural competency—and removing race from that discussion—helps to focus on

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[139] Cross, et al., op. cite.

[140] Helman, Cecil (1994), *Cultural, Health, and Illness*, ed. 3, London, Wright, 1994)

[141] Charon, J. M.(1995), *Ten Questions: A Sociological Perspective*, [2nd ed.], International Thomson, and American Psychological Association, (1996) *APA Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations,* (See http://www.apa.org//pi/guide.html)

[142] Dr. Terry Tafoya, Seattle, Washington, in a presentation to the Specialty Providers Network Development Institute, Children's Mental Health Division of the Minnesota Department of Human Services, June 8, 2001.

the behaviors, attitudes, and practices needed in order to effectively serve diverse cultural communities.[143]

Culture-bound behaviors or culture-bound syndrome means culture-specific behaviors, conditions, and diseases that affect a person's health and well-being. For example, in some cultures, a person can become ill and suffer "soul loss" because another person has cursed them. In some cultures, women breast-feed babies until they are two or three years old while in others, women learn that bottle feeding is more appropriate. In some cultures, a person who sees a vision can be a gifted healer while, in others, she may be labeled schizophrenic. In some cultures, young women are circumcised when they reach puberty; in others, baby boys are circumcised.

Disparity means inequality in outcome or condition between cultural groups or differences in outcomes or conditions between cultural groups that are not predictable based on the number of group members present in the general population.

Diverse populations means distinct groups including, but not limited to, racial and ethnic minorities, persons of color, American Indians, gay, lesbian, bisexual, and transgender cultures, deaf culture, disabilities culture, economic class cultures, and immigrants.

Diverse staff means organization workers who are representative of the demographic characteristics of the service area. The concept focuses on recruitment and retention. It is distinct from the concept of "culturally competent staff," which focuses on issues of education and training to achieve greater skills and knowledge. The diversity of an organization's staff is a necessary, but not sufficient, condition for providing culturally and linguistically appropriate services.[144]

Dynamics of Difference means the interpersonal interactions that occur in a cross-cultural encounter. When one culture interacts with the population of another, both may misjudge the other's actions based on learned expectations. Each party brings to the relationship unique histories with the other group and the influence of the current political relationship between the two groups. Both will bring culturally-prescribed patterns of communication, etiquette, and problem solving. Both may bring stereotypes or underlying feeling about serving—or being served by—someone who is "different." Such tension is part of the cross-cultural encounter. Both professionals and clients should be vigilant against misinterpretation and misjudgment.[145]

Ethnic means designating basic groups or divisions of human beings as distinguished by customs, a common language, a common history, a common religion, or other such characteristics.

Ethnographic interview means a meeting with a person of another culture in order to begin understanding his or her worldview, beliefs and life situation. It is a way to examine the patterned interactions and significant symbols of specific cultural groups to identify cultural rules that direct behaviors and the meaning people ascribe to such behaviors. Ethnographic interviewing helps a person understand another culture while avoiding stereotyping. An ethnographic interviewer is in control of the structure of the event, while the interviewee is in control of the cultural content of the event. The interviewer is the learner and the interviewee is the teacher.

Healer means an individual who has demonstrated success in healing or preventing health or mental health problems or conditions using practices that are based in, and recognized by, the culture of the client, and who is acknowledged by peers as a competent practitioner, whether or not licensed or certified by law.

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[143] Ouida Crozier e-mail (February 2002), Office for Equal Opportunity, Affirmative Action, and Civil Rights, Minnesota Department of Human Services.
[144] CLAS, op. cite., Standard No. 2.
[145] Cross, et al., op. cite., p. 20.

Health plan means (1) an organization that manages and provides health care in exchange for monthly prepayments for each of its members or (2) the set of benefits and access rules, which is sold by the organization as a product. The term is used interchangeably with *managed care organization.* A *health maintenance organization* (HMO) is a sub-type of health plan.

Interpreter means an individual trained and/or certified in facilitating oral, written, or manual communication between two or more people of different languages. For the purpose of these Guidelines, a qualified interpreter possesses in-depth knowledge, not only of the language, but also of cultural values, beliefs, and verbal and non-verbal expressions. A technically proficient interpreter who is lacking specific cultural knowledge can work in conjunction with a culturally informed consultant (also known as a *cultural broker*).

Limited English proficiency (LEP) or persons with LEP, means individuals who cannot speak, read, write or understand the English language at a level that permits them to interact effectively with health care providers and social service agencies. (Note: This may not be easy to identify. Some people may know enough English to manage basic life skills but may not speak, read, or comprehend English well enough to understand in a meaningful way some of the more complicated concepts they may encounter in the health and human services systems.)

Managed care organization (MCO) means an organization that manages and provides health care in exchange for monthly prepayments for each of its members or enrollees. It is used interchangeably with *health maintenance organization* (HMO) or *health plan*.

Meaningful access means the ability to use services and benefits comparable to those enjoyed by members of the mainstream cultures. It is achieved by eliminating communication barriers and ensuring that the client or potential client can communicate effectively. An organization must ensure that the LEP person:
- is given adequate information
- is able to understand the services and benefits available
- is able to receive services for which he or she is eligible
- can effectively communicate the relevant circumstances of his or her situation to the service provider and
- receives language assistance at no cost.[146]

According to the Office of Civil Rights (OCR) Guidance: "The type of language assistance an (organization) provides to ensure meaningful access will depend on a variety of factors, including the size of the (organization), the size of the eligible LEP population it serves, the nature of the program or service, the objectives of the program, the total resources available to the (organization), the frequency with which particular languages are encountered, and the frequency with which LEP persons come into contact with the program. There is no 'one size fits all' solution for Title VI compliance with respect to LEP persons. OCR will make its assessment of the language assistance needed to ensure meaningful access on a case by case basis." [147]

OCR Guidance means the federal language assistance requirements as defined in *Title VI of the Civil Rights Act of 1964; Policy Guidance On The Prohibition Against National Origin Discrimination As It Affects Persons With Limited English Proficiency*, published by the Office of Civil Rights, Federal Register, Vol. 65, No. 169, August 30, 2000, pp. 52762 through 52774.

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[146] OCR Guidance, op. cite., p. 52762, under "Supplementary Information", and p. 52765, under C.2., "Basic Requirements Under Title VI."
[147] OCR Guidance, op. cite., p. 52765.

Organization means both the entity that determines access to services and the entity that performs services. For example, it would include both a county social services agency and its contracted vendors and service providers. Additionally, it would include both a managed care organization (or health maintenance organization–HMO) and its network of physicians and other clinical professionals.

Persons eligible to be served or likely to be directly affected means clients and applicants in a program's approved geographic service area who are eligible for services or benefits. OCR will address this standard on a case-by-case basis. See the OCR Guidance, page 52767, online at http://www.hhs.gov/ocr/lep/guide.html for further discussion.

Preferred language means the self-identified language, which the client prefers to use in a service or clinical encounter.[148] The preferred language need not be the client's native or primary language if the client indicates sufficient proficiency in English and prefers to use English.

This term is not used in the OCR Guidance which, instead, uses the term "primary language." The term "preferred" originated in public comments to the CLAS standards as having "the advantage of implying that the client, rather than the organization's staff, makes the decision about which language is noted in the management information system (MIS) and patient record." (See CLAS Standards, General Discussion of Standard 10.)

Proven effective, as used in this document, means positive empirical results or historic acceptance and use of a practice within a specific cultural or linguistic population. Such practices may be facilitated by classifying the treatment under existing diagnostic codes, alternative credentialing processes, or seeking funding not subject to restrictive funding criteria.

Race means any of the different varieties of human beings as distinguished by physical characteristics; one among the group of populations constituting humanity, where differences are biological in nature and are transmitted genetically. The term is inaccurate when applied to national, religious, geographic, linguistic, or cultural groups.

Safe Harbor means criteria established in the OCR Guidance that assures an organization that it has complied with the federal obligation to provide translated written materials for persons with limited-English proficiency. However, the Safe Harbor provisions are not mandatory and do not establish numerical thresholds. OCR will review a number of other factors in determining compliance. See OCR Guidance, pages 52762 and 52767.

Sovereignty means, for the purposes of this document, the American Indian tribal right of self-government that is inherent in Indian tribes and nations and that does not depend upon any federal or state law for its existence. This legal concept has significant impact upon how state and local governments must relate to tribes.

Title VI of the Civil Rights Act of 1964 means federal law found at 42 U.S.C. 2000d et. seq. and its implementing legislation at 45 CFR Part 80.

Unduly burdensome means the level of cost or time beyond which the translation of documents will not be required by the federal government. The Office of Civil Rights (U.S. Department of Health and Human Services) will determine the extent of an organization's obligation to provide written translations of documents on a case by case basis. According to the OCR Guidance: "OCR recognizes that recipient/covered entities in a number of areas, such as many large cities, regularly serve LEP persons from many different areas of the world who speak dozens and sometimes over

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[148] CLAS, op. cite., Standard No. 5, and LEP Settlement, op. cite., Section 24.

100 different languages. It would be unduly burdensome to demand that recipient/covered entities in these circumstances translate all written materials into dozens, if not more than 100 languages."

Appendix A: Legal Requirements

Child Welfare and Child Protection
Cultural competence is incorporated into Minnesota statutes governing service delivery in areas such as adoption and post-placement assessment, mental health screening of children, child welfare services, and training for foster care providers, court officials, public policymakers, and service providers. These laws require, among other things, that services for children and families be culturally competent. These provisions supplement other federal and state laws that prohibit discrimination based on race, color, or national origin.

Minnesota Family Preservation Act
Minnesota laws require family preservation services to be culturally competent. Minnesota Statutes, Section 256F.01, sets forth that all children live in families that offer a safe, permanent relationship with nurturing parents or caretakers. To help assure children the opportunity to establish lifetime relationships, public social services must strive to provide culturally competent services and be directed toward:

> (1) Preventing the unnecessary separation of children from their families by identifying family problems, assisting families in resolving their problems, and preventing breakup of the family if it is desirable and possible;
> (2) Restoring to their families children who have been removed, by continuing to provide services to the reunited child and the families;
> (3) Placing children in suitable adoptive homes, in cases where restoration to the biological family is not possible or appropriate; and
> (4) Assuring adequate care of children away from their homes, in cases where the child cannot be returned home or cannot be placed for adoption.

Minnesota Statutes, Section 260.012(a), requires the juvenile court to "ensure that reasonable efforts including culturally appropriate services by the social services agency are made to prevent placement or to eliminate the need for removal and to reunite the child with the child's family at the earliest possible time, consistent with the best interests, safety, and protection of the child." Section 260.012(c)(3) requires courts, when considering whether reasonable efforts have been made to preserve a family, to consider whether services to a child and family are culturally appropriate.

Indian Child Welfare Act
Public Law 95-608, the federal Indian Child Welfare Act (ICWA) of 1978 (codified at 25 U.S.C. §§ 1901 et. seq.) was passed to remedy the problem of disproportionately large numbers of Indian children being placed in foster care. The law recognized "there is no resource more vital to the continued existence and integrity of the Indian Tribe than their children" and that there has been a failure by non-Indian organizations "to recognize the essential tribal relations of Indian people and the culture and social standards prevailing in Indian communities and families."

Minnesota adopted the ICWA policy as the Minnesota Indian Family Preservation Act (Minnesota Statutes, Sections 260.751 – 260.835) (MIFPA) in 1985. MIFPA emphasizes the state's interests in supporting the preservation of the cultural heritage of Indian children and recognizes tribes as powerful resources. These two laws apply specifically to the provision of child welfare services to Indian children. Indian children are entitled also to all rights granted other children under any other federal, or state law when those rights are not in conflict with federal law and when the state statute provides greater protection for the preservation of Indian family unity, extended family members and continued tribal affiliation. ICWA law takes precedence over all state laws and all other federal laws regarding Indian child welfare cases, unless the state law or other federal law provides a higher standard of protection for the rights of the parents(s) or Indian custodians. (25 U.S.C.1921 et. seq.)

Despite the passage of the Indian Child Welfare Act in 1978, American Indian children continue to be over represented in the child welfare system. For this reason, cultural competency is especially relevant in interventions involving American Indian children. First and foremost, it is against the law to disregard this act that seeks to protect Indian children. Decisions about the removal and placement of an Indian child that fail to consider lifestyle and parenting differences fall short of addressing the best interests of the child. It is important that the documented long-term damage, which too often results from placing an American Indian child with a non-Indian family, be weighed heavily, even when such a placement satisfies short-term goals.

Title VI of the Civil Rights Act
All health and human services organizations must comply with Title VI of the Civil Rights Acts of 1964, as amended, which mandates accessibility to programs and to the facilities at which services are dispensed. Title VI provides that no person shall, on the grounds of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance. It is therefore critical for public agencies and private agencies under contract with public agencies to provide equal access.

Office of Civil Rights Guidance–Disabilities and Limited English-speaking
Federal guidelines emphasize the need for organizations serving people with disabilities to develop the capacity to ensure access for non-English speaking and sensory impaired enrollees. Pursuant to "Guidelines for State Agency Civil Rights Compliance Plan", Office of Civil Rights (OCR), U.S. Department of Health and Human Services, 1984, an organization shall communicate effectively and fully with non-English or limited-English speaking and sensory impaired groups in order to ensure that services, financial assistance, and/or other benefits of the program are fully available to non-English or limited-English speaking minority groups and sensory impaired groups.

Translation of materials by managed care organizations
Pursuant to the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services or CMS) guidelines for persons with disabilities, entitled *Key Approaches to the Use of Managed Care Systems for Persons with Special Health Care Needs* (Oct. '98), a managed care organization shall develop the capacity to translate written materials and develop the staff capability to communicate in "threshold languages."

Comprehensive Children's Mental Health Act
Minnesota's mental health law requires the state mental health agency–the Minnesota Department of Human Services (DHS)–to create and ensure a continuum of children's mental health services that are "sensitive to cultural differences." [M.S. §245.4871] The law mandates counties' "use of culturally informed mental health consultants to assess and provide appropriate treatment for children of cultural or racial minority heritage" [§245.4874, paragraph (13)] and requires that children's mental health services must be "based on individual, clinical, cultural, and ethnic needs." [§245.4876]

Children's Therapeutic Services and Supports (a Medical Assistance benefit)
CTSS defines "culturally competent provider" as one "who understands and can utilize to a client's benefit the client's culture when providing services to the client. A provider may be culturally competent because the provider is of the same cultural or ethnic group as the client or the provider has developed the knowledge and skills through training and experience to provide services to culturally diverse clients." Further, a CTSS provider must have personnel procedures for "recruiting, hiring, training, and retention of culturally and linguistically competent providers" and have a "performance measurement system, including monitoring to determine cultural appropriateness of services identified in the individual treatment plan, as determined by the client's culture, beliefs, values, and language, and family-driven services. CTSS providers must have a clinical infrastructure that utilizes diagnostic assessment, an individualized treatment plan, service delivery, and individual

treatment plan review that are culturally competent, child-centered, and family-driven and an individual treatment plan that "identifies service needs and individualized, planned, and culturally appropriate interventions that contain specific treatment goals and objectives for the client and the client's family or foster family. Providers that employ mental health behavioral aides, must ensure that aides have "the skills to interact with the client and the client's family in ways that convey personal and cultural respect..." (Laws 03, 1Sp14, Art. 4, Sec. 8)

Appendix B: Knowledge and Skills
<div align="center">(Related to Section 3.2)</div>

Each health and human services organization can develop core and continuing education curricula for professional and clinical staff and contractors, paraprofessionals, administrators, and support personnel. Training can enhance (a) culturally-specific knowledge, (b) cross-cultural skills in service and treatment provision, (c) skills in cross-cultural communication and languages, and (d) attitudes.

Culturally-Specific Knowledge. Each organization can develop standards of cultural knowledge for clinical professionals, paraprofessionals, and administrators and can provide continuing education to improve cultural knowledge among these staff and contractors. Staff education and training are also crucial to ensuring appropriate delivery because staff interact with clients and families representing different countries of origin, acculturation levels, and social and economic standing. Each organization can develop education components examining:

- Factors which define cultural differences between and among different racial/ethnic populations, including differences related to history, traditions, values, belief systems, acculturation and migration patterns, reasons for immigration/migration, dialect, language fluency, concepts of health and mental health, child rearing practices and appropriate child behavior, and family composition and roles;
- Particular social and psychological stressors and traumas relevant for clients from diverse groups. These include poverty, racism, war, violence, migration, unique aspects of cultural survival and maintenance, discrimination, and culturally-based belief systems.
- How class, ethnicity, social status, and racism affect behavior, attitudes, values, belief systems, health, and mental health of clients.
- Effects of differences in the cultures of staff and clients on professional encounters, including effects of the culture of American social work, mental health, medicine, and education;
- Differences in the response to family and social difficulties.

Cross-Cultural Skills in Service and Treatment Provision. Each organization can develop education components examining:

Service and Treatment Provision
- Differences in the acceptability and effectiveness of various treatment modalities for individuals from diverse groups.
- Use of culturally informed and qualified interpreters for monolingual clients when qualified bilingual service providers are not available.
- Use of culturally informed individuals, including family members when appropriate, by service providers.
- Social, political, and economic conditions in the community when developing, implementing, and evaluating programs.
- Use of natural community supports and other community resources.
- Indigenous healing practices and the role of belief systems (religion and spirituality) in the treatment of clients.
- Resources (agencies, persons, informal helping networks, research) that shall be utilized on behalf of clients from diverse groups.
- Culturally appropriate service plans (case management and treatment) that fit clients' and families' concepts of mental illness, health, child rearing, etc.
- Multidimensional service plans (case management and treatment) that include culture, family, and community.
- Culturally appropriate community resources (e.g., family, clans, societies, church, community members, and other groups).
- Recognition of ones own limitations, and know when to refer clients to consultants.

- Evaluate applications of new techniques, exemplary practices, research, and knowledge as to their validity and applicability.

Mental Health Clinical Issues
- Differences in symptom expression, symptom language, and symptomatic patterns of individuals from the four major racial groups with mental illness/emotional disturbance.
- Culture-bound syndromes associated with the four groups and their subpopulations.
- Differences in thresholds of psychiatric distress and tolerance of symptomotology by their natural support systems.
- Nuances of verbal and nonverbal language, speech patterns, and communication styles.
- Dynamics of language use and conceptual frameworks among monolingual and bilingual.
- Differences in the attribution of mental illness (religious, supernatural, etc.) and issues of stigma specific to specific diverse groups.
- Differences between culturally acceptable behaviors and psychopathology.
- Help-seeking behaviors.
- Role and manifestation of spirituality, tradition, values, and practice beliefs and their integration into treatment.
- Clients within a family life cycle and intergenerational conceptual framework in addition to individual identity development framework.
- The varying effects of commonly used medications on individuals from diverse groups.
- Assessment tools and their limitations.
- The impact of psychosocial stressors versus intrapsychic stressors.
- Cultural differences in symptom expression, thresholds of psychiatric distress, and culture-bound syndromes and psychological, social, biological, physiological, cultural, political, spiritual, and environmental aspects of the client's experience.
- Provide psychotherapeutic and psychopharmacological interventions with an understanding of different biological and physiological responses to medications based on physical, cultural, and racial/ethnic differences.

Skills in Cross-Cultural Communication and Languages. Each organization can develop skill-training components including:
- Standards for non-English-language competency among professionals and para-professionals and language training, including training in the use of interpreters. Training for mental health professionals may address issues and problems that arise from a triadic relationship in a therapeutic context;
- Elements of effective communication among staff and clients of different cultures and different languages;
- Techniques for the resolution of racial, ethnic, or cultural conflicts among staff or between staff and clients;
- Personal and cultural biases of staff and how they may affect benefits and service design and delivery.
- Role and types of power relationships within the community, agency, or institution and their effect on diverse clients.
- Ways that mainstream professional values may conflict with, or be responsible to, the needs of clients.
- Effects of institutional racism and historical barriers on social service policies for individuals, and knowledge of how to reduce barriers through use of and participation in systems change efforts.
- Rapport with individuals from diverse communities using socially and culturally appropriate conventions.
- Skills required to establish and maintain comfortable relationships with clients.

Organizational Knowledge. Each organization can develop education components examining:
- The organizations' written language access policies and procedures, including how to access interpreters and translated written materials;
- The applicable provisions of law;
- The organizations' complaint/grievance procedures.

Attitudes. Each organization can develop education components examining:
- Attitudes that indicate a respect for the client's immigration, migration, colonization, and acculturation experiences.
- Attitudes that indicate a respect for the diverse heritages, cultures, and experiences of clients from the four groups.
- Attitudes that indicate a willingness to work with culturally, ethnically, and racially diverse populations.
- Understanding of and respect for how the service provider may influence the therapeutic relationship. Recognize the need to process this dynamic, and in some cases refer the client to another provider.

Appendix C: Diversity Among Five Major Racial/Ethnic Groups

Black or African Americans. From 1860 until the last decade, growth in the United States of people of African descent has come about primarily through births. Immigration of Black people from Somalia, Ethiopia, Nigeria, Liberia, and Latin America has significantly increased the nationalistic, cultural, religious, and language diversity within the Black population in Minnesota.

Asian and Pacific Islanders. Asian Americans are a diverse group in terms of ethnic origin, cultural background, immigration history, and acculturation to U.S. culture. Asian Americans comprise at least 31 ethnic groups. Their diverse immigration history spans over 200 years. Early immigrants to Minnesota came from China and Japan. This has broadened in recent years to include immigrants from Cambodia, Laos, Vietnam, and Tibet. These national immigrant groups, in turn have many different subgroups, among which the Hmong are most populous. In 1990, 68 percent of Asian Americans were born outside the U.S. A myriad of issues surround this diverse immigration history, and contribute to a situation of economic polarity among Asian Americans.

Latinos or Hispanics. The Latino population in the United States is not homogenous, but is composed of an extremely diverse group of nationalities of origin. These include 13.4 million of Mexican origin, 2.4 million of Puerto Rican heritage, Cuban, 1.1 million, and 2.9 million from Central and South American countries. Their cultural backgrounds are diverse, including Spanish, Aztec, Mayan, Incan, and Caribbean cultures. Racial origins include American Indian, Caucasian, and African American. Their common language and link with Spanish culture serve as a means of considering them in unison, but they have great diversity in their religious, folk, family, and health beliefs and values as well as in their linguistic idioms. Most are Roman Catholic, but a growing number are Moslem. Hispanics, as defined by the 2000 Census, may be of any race. Portuguese-speaking Brazilians are not a large group in Minnesota.

American Indian or Native Americans. People categorized as American Indians by the 2000 Census have origins in the original people of North, Central, or South America and who retain tribal affiliation or community attachment.[149] In Minnesota, a rich diversity exists among the 11 reservations and within urban American Indian communities. The largest tribes are the Dakota (Sioux) and the Anishinaabe (Ojibwe or Chippewa). (For more information on Minnesota tribes and reservations, see: http://www.indians.state.mn.us/tribes.html)

Whites. People categorized as White by the 2000 Census are people having origins in the original people of Europe, the Middle East, or North Africa.[150] (The term "White" is used by the Census. This group also is known as Caucasian, Anglos, and European Americans.) Ancestry reported to the 2000 Census shows the largest groups as: German (36.7%); Norwegian (17.3%); Irish (11.2%); Swedish (9.9%); English (6.3%); Polish (4.9%); French (4.1 %); Italian (2.3%); Czech (2.1%); and Dutch (2.0%). The largest White immigrant groups are Russian, Ukrainian, Bosnian, and Arabic; though they remain a small segment of the overall population with the largest group, Russian, at 0.7% of the state population.

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[149] Grieco, Elizabeth, and Cassidy, Rachel, (March 2001), Overview of Race and Hispanic Origin: Census 2000 Brief, U.S. Census Bureau, p. 2.
[150] ibid.

Appendix D: DHS Multilingual Telephone Service

The Minnesota Department of Human Services now has a toll-free 1-800 multilingual telephone service for non-English-speaking residents who need to connect with human services at the state and county levels. The telephone lines operate in 10 languages.

Callers can talk to a native speaker and/or hear instructions in their respective languages. Callers are asked to provide contact information so the state or county service representatives can return their calls and provide additional information and/or refer them to the proper agencies for further assistance. Calls are normally returned within a 24-hour period, except for weekends and holidays.

The telephone numbers are as follows:

Language	Phone number
Arabic	(800) 358-0377
Hmong	(888) 486-8377
Khmer (Cambodian)	(888) 468-3787
Lao	(888) 487-8251
Oromo	(888) 234-3798
Russian	(888) 562-5877
Serbo-Croatian (Bosnian)	(888) 234-3785
Somali	(888) 547-8829
Spanish	(888) 428-3438
Vietnamese	(888) 554-8759

The Minnesota Department of Human Services staff has worked with community organizations and businesses to provide the telephone service through the department's Limited English Proficiency Project. This project includes other related services, such as translations of signs and posters, which will allow non-English-speaking Minnesotans to have better access to state and county programs. (See: http://www.dhs.state.mn.us/infocenter/multilingual.htm)

Appendix E: Definitions of Cultural Competence

Many have offered definitions of cultural competence. That literature posits so many definitions indicates that the answer still is evolving. We thought that the interested reader might benefit by an opportunity to compare thinking. However, it is crucial that no agency or professional wait for any conclusive definition of cultural competence before embarking on the necessary work nor use the absence of a universally recognized definition as an excuse not to act.

From Terry Cross, et al. (1989)
Toward a Culturally Competent System of Care: Vol.1, Washington, DC, National Technical Assistance Center for Children's Mental Health, Georgetown University Child Development Center.

"Cultural competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or amongst professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations. The word culture is used because it implies the integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs, values, and institutions of a racial, ethnic, or religious group. The word competence is used because it implies having the capacity to function effectively. A culturally competent system of care acknowledges and incorporates—at all levels—the importance of culture, the assessment of cross-cultural relations, vigilance towards the dynamics that result from cultural difference, the expansion of cultural knowledge, and the adaptation of services to meet culturally-unique needs. (pp. iv. and v.)

"Five essential elements contribute to a system's, institution's, or agency's ability to become more culturally competent. The culturally competent system would: (1) value diversity; (2) have the capacity for cultural self-assessment; (3) be conscious of the dynamics inherent when cultures interact; (4) have institutionalized cultural knowledge; and (5) have developed adaptations to diversity. Further, each of these five elements must function at every levels of the system. Practice must be based on accurate perceptions of behavior, policies must be impartial, and attitudes must be unbiased." (p. v.)

From the National Association of Social Workers (NASW)
Standards for Cultural Competence in Social Work Practice.
"Cultural competence is never fully realized, achieved, or completed, but rather cultural competence is a lifelong process for social workers who will always encounter diverse clients and new situations in their practice. Supervisors and workers must have the expectation that cultural competence is an ongoing learning process integral and central to daily supervision.

"Cultural competence refers to the process by which individuals and systems respond respectfully and effectively to people of all cultures, languages, classes, races, ethnic backgrounds, religions, and other diversity factors in a manner that recognizes, affirms, and values the worth of individuals, families, and communities and protects and preserves the dignity of each.

"Cultural competence is a set of congruent behaviors, attitudes, and policies that come together in a system or agency or among professionals and enable the system, agency, or professionals to work effectively in cross-cultural situations.

"Operationally defined, *cultural competence* is the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes used in appropriate cultural settings to increase the quality of services, thereby producing better outcomes (Davis & Donald, 1997). Competence in cross-cultural functioning means learning new patterns of behavior and effectively applying them in appropriate settings.

"Gallegos (1982) provided one of the first conceptualizations of ethnic competence as "a set of procedures and activities to be used in acquiring culturally relevant insights into the problems of minority clients and the means of applying such insights to the development of intervention strategies that are culturally appropriate for these client." (p. 4). This kind of sophisticated cultural competence does not come naturally to any social worker and requires a high level of professionalism and knowledge.

From the CLAS health care standards
"Cultural competence includes being able to recognize and respond to health-related beliefs and cultural values, disease incidence and prevalence, and treatment efficacy. Examples of culturally competent care include striving to overcome cultural, language, and communications barriers; providing an environment in which patients/ consumers from diverse cultural backgrounds feel comfortable discussing their cultural health beliefs and practices in the context of negotiating treatment options; using community workers as a check on the effectiveness of communication and care; encouraging patients/ consumers to express their spiritual beliefs and cultural practices; and being familiar with and respectful of various traditional healing systems and beliefs and, where appropriate, integrating these approaches into treatment plans. When individuals need additional assistance, it may be appropriate to involve a patient advocate, case manager, or ombudsperson with special expertise in cross-cultural issues."

From the WICHE mental health standards
"Cultural competence includes attaining the knowledge, skills, and attitudes to enable administrators and practitioners within systems of care to provide effective care for diverse populations, i.e., to work within the person's values and reality conditions. Recovery and rehabilitation are more likely to occur where managed care systems, services, and providers have and utilize knowledge and skills that are culturally competent and compatible with the backgrounds of consumers from the four underserved/underrepresented racial/ethnic groups, their families, and communities. Cultural competence acknowledges and incorporates variance in normative acceptable behaviors, beliefs, and values in:
  • determining an individual's mental wellness/illness, and
  • incorporating those variables into assessment and treatment."

From Elizabeth Vonk, Operational Definition of Cultural Competence for Transracial Adoptive Parents (2001)
Social Work, Vol. 46, No. 3, p. 247. The author calls this a detailed operationalized definition of cultural competence for transracial adoptive parents with concrete "I know..." and "I do..." statements defining what it means to be a culturally competent parent of a child of a different race. "Knowledge is needed to understand the client's life experiences and life patterns. Skills are tailored to meet the needs of a client from a different culture, including cross-cultural communications skills. Attitude is related to social workers' awareness of assumptions, values, and biases that are a part of their own culture and worldview and understanding the worldview of the client who is a member of a different culture. It includes principles such as understanding ethnocentric thinking and learning to appreciate differences."

From the Child Welfare League of America
"Cultural Competence is the ability of individuals and systems to respond respectfully and effectively to people of all cultures, classes, races, ethnic backgrounds, and religions in a manner that recognizes, affirms, and values the worth of individuals, families, and communities and protects and preserves the dignity of each. The knowledge and skill set necessary to identify and address the issues facing your organization, that have cultural implications, and the ability to operationalize this knowledge into the routine functioning of the agency."
http://www.cwla.org/programs/culturalcompetence/

From A.R. McPhatter (1997)
Child Welfare, Vol.76, Child Welfare League of America
"Cultural competence means an ability to provide services that are perceived as legitimate for problems experienced by culturally diverse persons." [p. 261] *"Cultural competence* denotes the ability to transform knowledge and cultural awareness into health and psychosocial interventions that support and sustain healthy client system functioning within the appropriate cultural context." [p. 261]

"The *culturally skilled counselor* is one who is in the process of actively developing and practicing appropriate, relevant, and sensitive intervention strategies and skills in working with his or her culturally different clients. Thus, any serious initiative to work effectively with diverse client populations begins with this premise." [p. 260]

"Culturally competent practitioner means one who is able to conduct his or her professional work in a way that is congruent with the behavior and expectations that members of a distinctive culture recognizes as appropriate among themselves." [p. 261]

Federal Medicaid Managed Care Rule (a.k.a. "BBA rules")
The proposed federal Medicaid managed care rules, require that managed care organizations ensure that services are provided in a culturally appropriate manner. However, the proposed rule does not define cultural or linguistic competence.

See: *Federal Register*, Vol. 66, No. 161, Monday, August 20, 2001, Page 6414, Section 438.206(e)(2)

Federal Bureau of Primary Health Care (1997)   This uses the Terry Cross definition in its second part. The definition was adopted by Thomas D. Lonner in *Constructing the Middle Ground: Cultural Competence in Medicaid Managed Care*.
   "Cultural competence within the public health system refers to the development and provision of systems of care for diverse populations with a demonstrated awareness and integration of health related beliefs and cultural values, disease incidence and prevalence, and the appropriate management and prevention of disease as it relates to the populations seeking care. Staff within a culturally competent health-care system honor and respect beliefs, interpersonal styles, attitudes, and behaviors of individuals, families and communities they serve. Cultural competence is a lifelong process which includes the examination of one's own attitudes and values, and the acquisition of knowledge and appreciation of cultural differences and similarities within, among, and between groups. A culturally competent system of care reflects and responds to the communities it serves through its administrative policies and procedures, hiring practices, training and professional development, and the active participation of community members and consumers. Self-assessment, culturally based needs assessments, and the active incorporation of findings from these assessments into practice are essential elements of culturally competent systems.

Appendix F: Data Sources

Languages spoken at home
The Minnesota Department of Education collects data on the language spoken at home by all students (PreK-12) in Minnesota's school districts. The department aggregates some languages together. As a result, some languages may not appear in the file. Each year, new languages are added to the file. For the 2000-2001 school year, the Department added Oromo, Albanian and Tibetan. Some languages listed in the file may represent a family of languages, and the user should be aware of these aggregations. Access the data through the Office of the State Demographer:
http://www.mnplan.state.mn.us/demography/DownloadFiles/language/lang01.html

Out-of-home placements of minority children
DHS Bulletin #01-68-01, March 1, 2001
http://www.dhs.state.mn.us/FMO/LegalMgt/Bulletins/pdf/2001/01-68-01.pdf

Health disparities in the Twin Cities Metro area
Closing the Gap: A Public Health Report on Health Disparities: Data Report of the Twin Cities Metro Minority Health Assessment Project, (hereinafter "MHAP Data"), March 2001. Minnesota Department of Health, Minneapolis Department of Health and Family Support, Hennepin County Community Health Department, Anoka County Community Health and Environmental Services, Bloomington Health Division, Carver County Community Health Services, Dakota County Public Health Department, St. Paul-Ramsey County Department of Public Health, Scott County Public Health, and Washington County Department of Health and Environment.

Health status of diverse people
Populations of Color in Mineesota: Health Status Report
Minnesota Department of Health, Office of Minority Health, and The Urban Coalition, Spring, 1997

Children's Health
Current Challenges to Health Care Coverage in Minnesota: A Survey of Health Care Outreach Workers by *Covering Kids.* Children's Defense Fund, May 2000

Social and economic cause of health disparities
A Call to Action: Advancing the Health for All Through Social and Economic Change
Minnesota Health Improvement Partnership, July 2001.
http://www.health.state.mn.us/divs/chs/mhip/action.pdf

Diabetes in Black, Indian, Latino, and Hmong communities
Voices from the Community: Focus Groups with African American, American Indian, Hispanic, and Hmong People with Diabetes
Minnesota Diabetes Control Program, Minnesota Department of Health, August 1998

Immigrants and refugees
Welcoming New Arrivals to Minneapolis: Issues and Recommendations
Minneapolis Department of Health and Family Support, August 2000

Immunization and the Twin Cities Somali Community: Findings from a Focus Group Assessment
Refugee Health Program, Minnesota Department of Health, March 2001

Prenatal Care among SEA Women in St. Paul and Minneapolis: A Survey of Cambodian, Hmong, Laotian and Vietnamese Women in the Twin Cities
The Urban Coalition, January 1997

Health care access
Ethiopian and Somali Families in Minneapolis
Minneapolis Way To Grow, April 1999

Public Health an Health Care Access: Minnesota's Latino Community
University of Minnesota, School of Public Health, CLUES, HACER, and Minnesota Department of
Health, October 1999.

Appendix G: CLAS Standards

Federal Standards for Culturally and Linguistically Appropriate Health Care Services

Preamble: Culture and language have considerable impact on how patients access and respond to health care services. To ensure equal access to quality health care by diverse populations, health care organizations and providers can:

1. Promote and support the attitudes, behaviors, knowledge, and skills necessary for staff to work respectfully and effectively with patients and each other in a culturally diverse work environment.

2. Have a comprehensive management strategy to address culturally and linguistically appropriate services, including strategic goals, plans, policies, procedures, and designated staff responsible for implementation.

3. Utilize formal mechanisms for community and consumer involvement in the design and execution of service delivery, including planning, policy making, operations, evaluation, training and, as appropriate, treatment planning.

4. Develop and implement a strategy to recruit, retain and promote qualified, diverse and culturally competent administrative, clinical, and support staff that are trained and qualified to address the needs of the racial and ethnic communities being served.

5. Require and arrange for ongoing education and training for administrative, clinical, and support staff in culturally and linguistically competent service delivery.

6. Provide all clients with limited English proficiency (LEP) access to bilingual staff or interpretation services.

7. Provide oral and written notices, including translated signage at key points of contact, to clients in their primary language informing them of their right to receive interpreter services free of charge.

8. Translate and make available signage and commonly-used written patient educational material and other materials for members of the predominant language groups in service areas.

9. Ensure that interpreters and bilingual staff can demonstrate bilingual proficiency and receive training that includes the skills and ethics of interpreting, and knowledge in both languages of the terms and concepts relevant to clinical or non-clinical encounters. Family or friends are not considered adequate substitutes because they usually lack these abilities.

10. Ensure that the clients' primary spoken language and self-identified race/ethnicity are included in the health care organization's management information system as well as any patient records used by provider staff.

11. Use a variety of methods to collect and utilize accurate demographic, cultural, epidemiological and clinical outcome data for racial and ethnic groups in the service area, and become informed about the ethnic/cultural needs, resources, and assets of the surrounding community.

12. Undertake ongoing organizational self-assessments of cultural and linguistic competence, and integrate measures of access, satisfaction, quality, and outcomes for CLAS into other organizational internal audits and performance improvement programs.

13. Develop structures and procedures to address cross- cultural ethical and legal conflicts in health care delivery and complaints or grievances by patients and staff about unfair, culturally insensitive or discriminatory treatment, or difficulty in accessing services, or denial of services.

14. Prepare an annual progress report documenting the organizations' progress with implementing CLAS standards, including information on programs, staffing, and resources.

Appendix H: Organizational Self-Assessments

This assessment tool helps an organization to identify its strengths and areas where it may want to enhance its ability to serve culturally diverse populations. The tool will focus on:
- service delivery and quality management
- human resources practices
- governance, community relations, and marketing
- administration and policy
- organizational culture

Instructions
For each statement below, circle the one response that best describes your current organization. If you do not have sufficient information to respond to the statement, leave it blank.

Service Delivery and Quality Management

1. The organization provides culturally-specific programs or services.

1	2	3	4
Disagree	Somewhat Disagree	Somewhat Agree	Agree

2. Program design reflects input by people from diverse cultures.

1	2	3	4
Disagree	Somewhat Disagree	Somewhat Agree	Agree

3. Intake procedures are compatible with the needs of cultural groups being served.

1	2	3	4
Disagree	Somewhat Disagree	Somewhat Agree	Agree

4. Service authorization criteria are developed by, or in consultation with, professionals from the cultural communities being served.

1	2	3	4
Disagree	Somewhat Disagree	Somewhat Agree	Agree

5. Our organization uses the expertise of individuals from diverse cultural backgrounds to assist in providing services to other individuals from similar cultural backgrounds.

1	2	3	4
Disagree	Somewhat Disagree	Somewhat Agree	Agree

6. Referrals are made to culturally-specific organizations.

1	2	3	4
Disagree	Somewhat Disagree	Somewhat Agree	Agree

7. The organization is able to serve culturally diverse individuals in their own languages, written and verbal.

1	2	3	4
Disagree	Somewhat Disagree	Somewhat Agree	Agree

8. Client education materials are culturally appropriate and translated into the languages of diverse clients.

1	2	3	4
Disagree	Somewhat Disagree	Somewhat Agree	Agree

9. Workers assess how clients' cultures and their own cultures affect their perceptions and decisions when assessing a client's needs and developing service plans.

1	2	3	4
Disagree	Somewhat Disagree	Somewhat Agree	Agree

10. Cultural knowledge and cross-cultural skills are assessed as a part of employee and contractor performance evaluations.

1	2	3	4
Disagree	Somewhat Disagree	Somewhat Agree	Agree

11. Our organization has a clear process for evaluating the short and long-term impact of its programs and policies on culturally diverse clients.

1	2	3	4
Disagree	Somewhat Disagree	Somewhat Agree	Agree

12. Service providers solicit the client's story and ask for feedback on the service encounter.

1	2	3	4
Disagree	Somewhat Disagree	Somewhat Agree	Agree

13. Resources are allocated in a manner that addresses the needs of diverse populations.

1	2	3	4
Disagree	Somewhat Disagree	Somewhat Agree	Agree

14. Service providers and clinicians are knowledgeable about cultural differences regarding child rearing practices, role of family in decision-making, concepts of mental health and the nature of illness, and other culturally-specific needs and service-delivery considerations?

1	2	3	4
Disagree	Somewhat Disagree	Somewhat Agree	Agree

15. Service providers and clinicians are knowledgeable about disparities in service outcome among diverse cultural groups.

1	2	3	4
Disagree	Somewhat Disagree	Somewhat Agree	Agree

16. Service providers and clinicians are knowledgeable about aggregate differences among cultural groups in areas relevant to their disciplines, such as disease prevalence, variances in physiological response to medications, poverty levels, violence levels, and implications of varying levels of assimilation and acculturation.

1	2	3	4
Disagree	Somewhat Disagree	Somewhat Agree	Agree

17. Providers are familiar with social problems that have a different impact on minority group members (socio-economic disadvantage).

1	2	3	4
Disagree	Somewhat Disagree	Somewhat Agree	Agree

Human Resources Practices

18. The cultural make-up of the staff reflects the cultural diversity of clients served. The organization has developed a staff profile and compared it to a client demographic profile.

1	2	3	4
Disagree	Somewhat Disagree	Somewhat Agree	Agree

19. The organization actively recruits and hires bilingual staff.

1	2	3	4
Disagree	Somewhat Disagree	Somewhat Agree	Agree

20. Culturally diverse staff occupy positions at every level of the organization.

1	2	3	4
Disagree	Somewhat Disagree	Somewhat Agree	Agree

21. The organization provides opportunities for leadership development and advancement for all staff, including staff members from culturally diverse groups.

1	2	3	4
Disagree	Somewhat Disagree	Somewhat Agree	Agree

22. Job descriptions and performance evaluations give explicit value to experience and competence in working with culturally diverse clients, staff, and contractors.

1	2	3	4
Disagree	Somewhat Disagree	Somewhat Agree	Agree

23. Job announcements and descriptions indicate that candidates must have an understanding of and sensitivity to serving culturally diverse populations.

1	2	3	4
Disagree	Somewhat Disagree	Somewhat Agree	Agree

24. Potential candidates are required to demonstrate cross-cultural interaction skills.

1	2	3	4
Disagree	Somewhat Disagree	Somewhat Agree	Agree

25. The organization has been successful in retaining staff of diverse cultures.

1	2	3	4
Disagree	Somewhat Disagree	Somewhat Agree	Agree

26. The organization has staff training and development programs to enhance cultural knowledge and cross-cultural skills.

1	2	3	4
Disagree	Somewhat Disagree	Somewhat Agree	Agree

27. Supervisors are routinely evaluated on advancing cultural competence.

1	2	3	4
Disagree	Somewhat Disagree	Somewhat Agree	Agree

28. Newly-hired staff are matched with mentors within the organization.

1	2	3	4
Disagree	Somewhat Disagree	Somewhat Agree	Agree

29. Volunteer recruitment strategies target people from diverse cultural backgrounds.

1	2	3	4
Disagree	Somewhat Disagree	Somewhat Agree	Agree

Governance, Community Relations, and Marketing

30. Members of diverse communities are incorporated into our decision-making processes. The composition of our decision-making bodies reflect the cultures of the communities we serve. Our organization has an articulated strategy to recruit governing board members from clients, parents, and community members who are representative of the communities we serve.

1	2	3	4
Disagree	Somewhat Disagree	Somewhat Agree	Agree

31. New governing board members are provided with the skills-development, training, support, and orientation they need to become effective decision-makers. Board members have the opportunity to learn about cultural competency and how those issues affect the organization's functioning.

1	2	3	4
Disagree	Somewhat Disagree	Somewhat Agree	Agree

32. Our organization solicits program ideas from an advisory committee which includes clients, parents, and community members from diverse cultural groups and our organization follows the advice of the advisory committee.

1	2	3	4
Disagree	Somewhat Disagree	Somewhat Agree	Agree

33. Our organization collects and analyzes demographic and statistical information on culturally diverse populations for use in its planning process and regularly discusses how policy decisions may affect diverse communities.

1	2	3	4
Disagree	Somewhat Disagree	Somewhat Agree	Agree

34. The organization periodically reports back to culturally diverse communities on progress made.

1	2	3	4
Disagree	Somewhat Disagree	Somewhat Agree	Agree

35. The organization affords administrators and staff time to participate in the community's cultural activities and civic organizations.

1	2	3	4
Disagree	Somewhat Disagree	Somewhat Agree	Agree

36. Our organization maintains a current list of culturally diverse media contacts, vendors, contractors and organizations.

1	2	3	4
Disagree	Somewhat Disagree	Somewhat Agree	Agree

37. Our organization advertises special events, program information, and funding opportunities in culturally diverse print and broadcast media and through community information networks and organizations that represent culturally diverse groups.

1	2	3	4
Disagree	Somewhat Disagree	Somewhat Agree	Agree

38. Our organization makes its facilities available to diverse community groups.

1	2	3	4
Disagree	Somewhat Disagree	Somewhat Agree	Agree

39. The location of the facility, programs and services run by our organization are accessible by public transportation.

1	2	3	4
Disagree	Somewhat Disagree	Somewhat Agree	Agree

Administration and Policy

40. Responsibility for our organization's cultural competence planning and implementation is assigned to a high-level manager.

1	2	3	4
Disagree	Somewhat Disagree	Somewhat Agree	Agree

41. The organization's vendors and contractors represent diverse cultural communities.

1	2	3	4
Disagree	Somewhat Disagree	Somewhat Agree	Agree

42. Vendor contract specifications and requests-for-proposals establish requirements for culturally appropriate performance.

1	2	3	4
Disagree	Somewhat Disagree	Somewhat Agree	Agree

43. The organization has developed specific goals, objectives, and performance measures related to achieving outreach, service delivery, and other desired outcomes to culturally and ethnically diverse communities.

1	2	3	4
Disagree	Somewhat Disagree	Somewhat Agree	Agree

44. Policies and procedures manuals enforce the practice and value of cultural competence

1	2	3	4
Disagree	Somewhat Disagree	Somewhat Agree	Agree

45. Our organization reviews our performance in serving individuals from diverse cultural backgrounds.

1	2	3	4
Disagree	Somewhat Disagree	Somewhat Agree	Agree

46. Our organization ensures that the announcements of vacant positions are circulated through culturally diverse networks.

1	2	3	4
Disagree	Somewhat Disagree	Somewhat Agree	Agree

47. Our organization supports the coordination and integration of services that appropriately and effectively serve culturally diverse populations.

1	2	3	4
Disagree	Somewhat Disagree	Somewhat Agree	Agree

48. The organization has mechanisms in place to identify and resolve cross-cultural conflicts among staff; between management and staff; and between staff and clients.

1	2	3	4
Disagree	Somewhat Disagree	Somewhat Agree	Agree

49. The organization collects race/ethnicity, language, and national origin data, explains its use to clients, and protects against using it in discriminatory ways.

1	2	3	4
Disagree	Somewhat Disagree	Somewhat Agree	Agree

50. Our organization regularly discusses how its policy decisions affect progress toward cultural competence and is willing to adapt its programs and services to make them appropriate to people of different cultures.

1	2	3	4
Disagree	Somewhat Disagree	Somewhat Agree	Agree

51. The organization has staff assigned to know and ensure compliance with federal and state laws and rules on language assistance and culturally diverse populations.

1	2	3	4
Disagree	Somewhat Disagree	Somewhat Agree	Agree

Organizational Culture

52. The organization communicates its values about cultural competency to staff and volunteers.

1	2	3	4
Disagree	Somewhat Disagree	Somewhat Agree	Agree

53. The organization encourages staff to learn more about their own cultures and the effect their own cultures have on their day-to-day work.

1	2	3	4
Disagree	Somewhat Disagree	Somewhat Agree	Agree

54. The informal (practices, attitudes, beliefs) operating structure is conducive to the development of cultural competency.

1	2	3	4
Disagree	Somewhat Disagree	Somewhat Agree	Agree

55. The organization has demonstrated its commitment to cultural diversity in the past year through culturally relevant activities or programs.

1	2	3	4
Disagree	Somewhat Disagree	Somewhat Agree	Agree

56. The organization considers client's language, race, ethnicity, customs, family structure, and community dynamics when developing its management and service delivery strategies.

1	2	3	4
Disagree	Somewhat Disagree	Somewhat Agree	Agree

57. The organization views natural systems (family, community, church, healers, etc.) as primary mechanisms of support for culturally and ethnically diverse populations.

1	2	3	4
Disagree	Somewhat Disagree	Somewhat Agree	Agree

58. The organization affirms that an individual's culture is an integral part of the physical, emotional, intellectual, and overall development and well being of that individual.

1	2	3	4
Disagree	Somewhat Disagree	Somewhat Agree	Agree

Appendix I: Resources

The International Institute of Minnesota
The International Institute of Minnesota is an inter-racial, non-political, non-sectarian social service agency founded in 1919 to serve both foreign and native-born. It is affiliated with the Immigration and Refugee Services of America (IRSA) and the United Way. On the Web at: http://www.iimn.org

Minnesota Ethnic Resources Directory
Minnesota Ethnic Resources Directory grew out of continuous inquiries to the International Institute of Minnesota (IIM) for information about organizations engaged in ethnic/nationality activities and services. The resultant Minnesota Ethnic Resources Directory is online at:
http://64.122.39.233/default.html

Copies of the printed Directory may be purchased for $16.95 + $2.50 to cover postage and handling at the International Institute of Minnesota, 1694 Como Ave., St. Paul, MN 55108.

Council on Black Minnesotans
The Council on Black Minnesotans (CMB) was created in 1980 to address the unmet needs and ongoing issues impacting Minnesotans of African descent and ensure that the needs of their constituents are conveyed to policy makers. Go to http://www.yellowpages.state.mn.us then select "B" in the Table of Contents, then select Black Minnesotans Council.

Chicano Latino Affairs Council
The Chicano Latino Affairs Council (CLAC) is a statewide government agency created by the legislature in 1978. The primary mission of the CLAC is to advise the governor and the state legislature on issues of importance to Minnesota's Chicano Latino community.
http://www.clac.state.mn.us

Council on Asian-Pacific Minnesotans
The Council on Asian-Pacific Minnesotans was created to advise the governor and members of the legislature on issues pertaining to Asian Pacific Minnesotans; to advocate on issues of importance to the Asian Pacific community; and to act as a broker between the Asian Pacific community and mainstream society. http://www.state.mn.us/ebranch/capm/

Minnesota Indian Affairs Council
The Minnesota Indian Affairs Council is the official liaison between state and tribal governments. The mission of the Indian Affairs Council is to protect the sovereignty of the 11 Minnesota Tribes and the well-being of American Indian people throughout the state of Minnesota.
http://www.indians.state.mn.us

The Council and the eleven Minnesota Indian Tribes have prepared a comprehensive set of protocols for government agencies, municipalities, businesses and individuals who seek to develop sound relationships with tribal officials. See: http://www.indians.state.mn.us/protocol.html

Office of Minority and Multicultural Health Overview
The mission of the Office of Minority and Multicultural Health is to assist in improving the health of people of color in Minnesota. http://www.health.state.mn.us/ommh/index.html

Minnesota Legislative Reference Library
"Links to the World–Minorities" lists web link around the country related to ethnic and racial minority groups.
http://www.leg.state.mn.us/lrl/links/minority.htm

Ethnographic interviewing
Ethnographic interviewing is a method to meet with a person of another culture in order to begin understanding his or her worldview, beliefs and life situation. Ethnographic interviewing helps a person understand another culture while avoiding stereotyping. The following instructors provide training in the methodology:

Dianna J. Shandy, Assistant Professor
Dept. of Anthropology
Macalester College
1600 Grand Avenue
Saint Paul, MN 55105
Phone: 651-696-6439
http://www.macalester.edu/anthropology/shandy.htm

Pamela Walker, MSW, MFT
Child Welfare Training Center
California State University at Long Beach
6300 East State University Drive, Suite 180
Long Beach, CA 90815-4600
Phone: 562-985-7374
E-mail -- pwalker@csuld.edu

For an article describing ethnographic interviewing, see:
"The Contribution of Ethnographic Interviewing to Culturally Competent Practice."
By Esther Wattenberg and Annette Semanchin. *Child Law Practice* 20 (July 2001): 59-61.
This article, co-authored by CURA associate Esther Wattenberg, argues that ethnography provides a framework for child welfare practitioners to deliver culturally competent services to children and families. The article describes ethnographic interviewing, discusses the stages and techniques of interviewing, reviews the limitations of ethnographic interviewing, and offers a case study and practical recommendations for practitioners. Reprints of this article are available from the University of Minnesota Center for Advanced Studies in Child Welfare by calling Anne Preston at (612) 624-4231 or sending E-mail to cascw@che.umn.edu.

Translated Health Resources Exchange
The Translated Health Resources Exchange is a collaboration among more than a dozen health care organizations in Minnesota that shares the responsibility and cost of creating and distributing health education materials for non-English speaking patients. Organizations join by paying an annual fee of $3,500 and contributing three or more of their own translated print materials for inclusion in the Exchange Website. Members then have free access to materials contributed by other members. Materials may be used in the original format or may be reformatted to fit member's needs with permission from the originating organization. Contact Patricia Ohmans, consultant, Health Advocates, at 651-489-4238 or send E-mail to pohmans@umn.edu.

AMA Cultural Competence Compendium
The American Medical Association has compiled the Cultural Competence Compendium to help physicians and other health care professionals communicate with patients and to provide individualized, respectful, patient-centered care. http://www.ama-assn.org/ama/pub/category/4848.html

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[11] Tafoya, *op.cit.*

[12] The counties below this threshold are: Grant, Kittson, Lac qui Parle, Lake of the Woods, Lincoln, Pope, and Red Lake. – StarTribune, March 29, 2001

[13] Census 2000, Minnesota county populations by race/ethnicity categories. The counties are: Anoka, Becker, Blue Earth, Carlton, Carver, Cass, Clay, Clearwater, Cook, Cottonwood, Dakota, Freeborn, Hennepin, Itasca, Kandiyohi, Le Sueur, Lyon, McLeod, Mahnomen, Mille Lacs, Mower, Nobles, Norman, Olmstead, Pine, Polk, Ramsey, Redwood, Renville, Rice, St. Louis, Scott, Sibley, Steele, Swift, Waseca, Washington, Watonwan, and Winona.

[14] See http://www.demography.state.mn.us/DownloadFiles/language/lang01.html

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[17] Kids Count Minnesota 2001 Data Book, op. cite., p. 17

[18] MDH 2000: '94-'98 data

[19] Kids Count Minnesota 2001 Data Book, op. cite., p. 15

[20] Kids Count Minnesota 2001 Data Book, op. cite., p. 29

[21] Center for Cross Cultural Health, op. cite., p. x

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[25] Ohmans, Patricia (2000), *Getting the Word Out: Effective Health Outreach to Cultural Communities*, Medtronic Foundation, Minneapolis, p. 4. Available on the Web at: http://www.medtronic.com/downloadablefiles/outreach_brochure.pdf

[26] Title VI of the Civil Rights Act of 1964: Policy Guidance on the Prohibition Against National Origin Discrimination As It Affects Persons With Limited English Proficiency, (August 30, 2000), Office of Civil Rights, U.S. Department of Health and Human Services, published in the Federal Register, Vol. 65, No. 169, August 30, 2000, (hereinafter "OCR Guidance") p. 52765

[27] Cultural Competence Standards in Managed Care Mental Health Services for Four Underserved/Underrepresented Racial/Ethnic Groups, Western Interstate Commission for Higher Education Mental Health Program; the Managed Care and Workforce Training Initiative of the Center for Mental Health Services (CMHS) of the Substance Abuse and Mental Health Services Administration (SAMHSA) of the U.S. Department of Health and Human Services; and the University of Pennsylvania School of Medicine, (Hereinafter, "WICHE"), Section III, subsection on "Access and Service Authorization."

[28] OCR Guidance, op. cite., p. 52763.

[29] Walker, op. cite, p. 5

30   See Perkins et al., *Ensuring Linguistic Access in Health Care Settings: Legal Rights and Responsibilities,* National Health Law Program manual, Jan. 1998, available from the Henry J. Kaiser Family Foundation. An executive summary is available on the Web at *http://nhelp.org/pubs*.

31   Terry Cross et al. (1989), op. cite., p.13.

32   Guerro, Rachel; Isaacs, Mareasa; Echo-Hawk, Holly (June 2000), from a presentation to the "Building Community Capacity for Cultural Competence" conference, sponsored by the Georgetown University Child Development Center, New Orleans.

33   Ida, D.J., Asian Pacific Development Center, Denver, in a presentation for the Pre-Institutes Training, Building Community Capacity for Cultural Competence conference, New Orleans, June 2000.

34   Walker, op. cite., p. 10.

35   Walker, op. cite., p. 14.

36   Executive Order # 02-10: Order to Affirm the Government-to-Government Relationship between the State of Minnesota and the Indian Tribal Governments Located Within the State of Minnesota (October 16, 2002), *Minnesota State Register*, Vol. 27, No. 17, Oct. 21, 2002, p. 587. The order states: "The State of Minnesota, a sovereign state within the United States, recognizes the inherent sovereignty of Indian tribes and their right to existence, self-government, and self-determination."

37   ICWA authorizes the states and Indian tribes to enter into agreements concerning the care and custody of Indian children and jurisdiction over child custody proceedings involving such children. (25 U.S.C. §§ 1919).

38   Office of Senate Counsel and Research, Minnesota Senate (December 1998), a research report entitled "American Indian Communities in Minnesota," section on "Basic principles."

39   The Tribal Self Governance Act of 1994, Title II of P.L. 103-413, Section 202.

40   McPhatter, op. cite., pp. 263-264.

41   Published by the Minnesota Department of Health, Division of Community Health Services, p.3

42   See an extensive treatment of these levels in Cross et al. (1989), op. cite., pp. 25-39

43   Closing the Gap: A Public Health Report on Health Disparities (March 2001), Twin Cities Metro Minority Health Assessment Project, a collaboration of the Minnesota Department and Health and metropolitan public health agencies, www.mncounties.org/metroplan/MinHealth.htm, p. 8.

44   National Standards on Culturally and Linguistically Appropriate Services in Health Care (December 22, 2000), Office of Minority Health, U.S. Department of Health and Human Services, (hereinafter "CLAS Standards") published in the Federal Register, Vol. 65, No. 247, pp. 80877

45   The elements and approach to cultural competence planning are consistent across the prominent national models. All elements selected here come from the CLAS Standards, WICHE Guidelines, and the Demonstration Project for People with Disabilities (hereinafter "DPPD"), Minnesota Department of Human Services, Request for Proposals, Sept. 1999, Section I.O.

46   At the Mental Health Center of Dane County (Madison, Wis.), a training committee organizes ongoing (often bi-weekly) cultural and clinical training. For information, contact Gail Marker, Program Director, (608) 280-2700 or www.gail.marker@MHCDC.org

47   CLAS, WICHE, and DPPD.

48   DPPD, op. cite., Section IV.A.2.

49   Torralba-Romero, Josie (1999). *Recruitment, Retention, Training, and Supervision of Mental Health Services Staff*, in Hernandez, Mario, and Isaacs, Mareasa R., (Eds.) Promoting Cultural Competence in Children's Mental Health, Baltimore, MD, Paul H. Brooks Publishing Company, pp. 81-93.

50   From a presentation handout, Pre-Institute Training of the Building Community Capacity for Cultural Competence conference, New Orleans, June 2000.

51   Torralba-Romero, ibid.

52   The PACT 4 Families Collaborative (Willmar, Minnesota) has been successful hiring parents of children with serious emotional disturbances as Family Liaisons. They receive training and clinical supervision and, by the end of training, the parent liaisons become qualified as mental health practitioners. Four of seven are Latinas.

53   Paraprofessionals may include a Mental Health Behavioral Aide, a category recently promulgated in Minnesota Rules 9505.0326, Subpart 5a. See Minnesota State Register, Nov. 27, 2000, Vol. 25, No. 22, pp. 1016-1017

54   Minnesota Statutes, Section 148B.21 (amended in 2001), authorizes the Minnesota Board of Social Work to license and issue temporary permits to foreign-born applicants at the LSW, LGSW, LISW, and LICSW levels if they have failed the licensure exam so long as the applicant speaks English as a second language, provides letters of recommendation and experience ratings from two licensed social workers and one professor, and meets all other licensure requirements. (www.socialwork.state.mn.us)

55   Cross, et al., op. cite., p. 44.

56   WICHE, op. cite, section on Prevention, Education, and Outreach

57   ibid.

58   Cross, et al., op. cite., p. 45.

59   Cross et al. (1989), op.cite., p. 44

60   See Prepaid Medical Assistance Program (PMAP), 2001 Contract, Section 6.16.4. Also see Demonstration Project for People with Disabilities, Request for Proposals, Sept. 1999, Section VIII.C.13.

61   CLAS Standards, op.cite, Standard 13, p. 80878.

62   DPPD, op.cite, Section VII.H.2.1(3).

63   DHS has undertaken its own quality-improvement project to examine disparities in the utilization of preventive and other medical care among enrollees in the state's publicly-financed health care programs. See a description of the project in the *Minnesota State Register*, Vol. 27, No. 14, Sept. 30, 2002, p. 473.

[64] WICHE, op.cite., section on Quality Monitoring and Improvement.

[65] CLAS, op. cite., Standard No. 10; WICHE, op. cite., section on Decision Support and Management Information Systems; MHAP Data, op.cite., p. 39.

[66] WICHE, ibid.

[67] CLAS, op. cite, Standard 11

[68] Policy Statement on Inclusion of Race and Ethnicity in DHHS Data Collection Activities (October 24, 1997), Office of Information Resources Management, U.S. Department of Health and Human Services (Hereinafter "DHHS Policy Statement"). www.hhs.gov/oirm/infocollect/nclusion.html

[69] DHHS Policy Statement, op. cite., Section I.B.1.

[70] CLAS, op. cite., Standard No. 10, and DHHS Policy Statement, op. cite.

[71] CLAS Standards, op. cite., No. 10

[72] U.S. Office of Management and Budget, *Statistical Policy Directive No. 15, Race and Ethnic Standards for Federal Statistics and Administrative Reporting* (hereinafter "OMB Directive 15"), section D.

[73] American Anthropological Association (September 1997), *American Anthropological Association Response to OMB Directive 15*, page 5. www.aaanet.org/gvt/ombdraft.htm The article discusses historic transformation of racial identities and recommends the replacement of the term "race" with a less confusing term such as "ethnic origin" for the 2010 census. The article says, on page 4: The danger in attempting to tie race and biology is not only that individuals are never identical within any group but that physical traits used for such purposes may not even be biological in origin."

[74] American Anthropological Association, op. cite., page 9.

[75] Data elements are recommended in CLAS, op. cite.; WICHE, op. cite.; OCR, op. cite; DPPD, op.cite., MHAP Data, op. cite.

[76] CLAS, WICHE, and MHAP

[77] CLAS

[78] CLAS, WICHE

[79] CLAS, OCR Guidance

[80] WICHE, OCR Guidance

[81] OCR Guidance, DHS' LEP Bulletin

[82] CLAS

[83] CLAS, WICHE

[84] CLAS, WICHE

[85] Recommended in *Key Approaches To The Use Of Managed Care Systems For Persons With Special Health Care Needs* (October 1998), Health Care Finance Administration (HCFA), U.S. Department of Health and Human Services.

[86] WICHE. Income is a measurable component of "socioeconomic status."

[87] WICHE

[88] WICHE, MHAP, and the U.S. Department of Health and Human Services (December 1999), Improving the Collection and Use of Racial and Ethnic Data in HHS, a Joint Report of the HHS Data Council Working Group on Racial and Ethnic Data and the Data Work Group of the HHS Initiative to Eliminate Racial and Ethnic Disparities in Health, (Hereinafter "HHS Joint Report.") Recommendation 1.N.

[89] WICHE

[90] WICHE

[91] DHHS Policy Statement, op. cite. The OMB Directive 15 establishes the minimum data collection standard, but it is the DHHS Policy Statement that requires health and human services agencies to implement the OMB standard.

[92] OMB Directive 15, op. cite., and DHHS Policy Statement, op. cite., which further states: "HHS encourages the expanded collection of data that will improve research on disparities in health status and social services needs between minority groups and the general population."

[93] See Appendix G for 2000 Census data on ethnic populations in Minnesota.

[94] HHS Joint Report, op. cite, Section 2, 1st page.

[95] See: http://www.npcnow.org/issues_productlist/PDF/culturaldiversity.pdf for Levy, Richard and Hawks, John, Cultural Diversity and Pharmaceutical Care, National Pharmaceutical Council, Reston, Virginia.

[96] OMB Directive 15, op. cite.

[97] OMB Directive 15 adopted by CLAS, op. cite., Standard No. 10, and MHAP Data, p. 39.

[98] OMB Directive 15 adopted by CLAS, op. cite., Standard No. 10.

[99] OMB Directive 15 adopted by CLAS, op. cite., Standard No. 5.

[100] CLAS, op. cite., Standard No. 10.

[101] ibid.

[102] See Federal Register, Vol. 65, No. 169, Wed., Aug. 30, 2000, page 52762 or see DHS Bulletin #00-89-4, Dec. 28, 2000, hereinafter referred to as the "LEP Bulletin".

[103] DPPD, op.cite., see *Guidelines for Implementing DPPD*, October 15, 1999, Section VI.C.10.

[104] WICHE, op. cite., Section on Discharge Planning.

[105] Tension resulting when the system of one culture interacts with a population from another has been called the "dynamics of difference". Cross, Terry L., with Bazron, Barbara J.; Dennis, Karl W.; Isaacs, Mareasa (1989). *Towards a Culturally Competent System of Care (Vol. 1)*, Washington D.C., National Technical Assistance Center for Children's Mental Health, Georgetown University Child Development Center, p 20.

[106] Model Contract for Prepaid Medical Assistance, General Assistance, and MinnesotaCare Medical Care Services, 2003-2004, §6.23.

[107] Cross et al, op. cite., p. 46.

[108] Cross, et al., op. cite., p.47.

[109] Cross, et al., op. cite., p.48.

[110] DPPD, op. cite., Sections V.D and V.E.

[111] WICHE, op. cite., Section on Case Management, under Implementation Guidelines.

[112] Cross, et al., op. cite., p.50.

[113] DPPD, op. cite., Section V.E.3.

[114] WICHE, op. cite., section on Self Help

[115] It's not always necessary for a provider to be of the same race or to use culturally-specific interventions. Sometimes, successful intervention comes from simply possessing some rudimentary understanding of the client's life conditions. Dr. Terry Tafoya tells of an Indian man who was involuntarily committed to a psychiatric hospital on the basis of two facts: He cut his hair and he stuck knives in the doors of his house. To the psychotherapist, this indicated suicidal ideation. In fact, the man cut his hair as a widely recognized, traditional act of honoring a recently deceased family member. He stuck knives in his doors because he lived in a HUD house whose locks had fallen apart. On his reservation, jamming knives between the door and door-frame was a common, if derisively humorous, means of securing the doors.

[116] Dr. Terry Tafoya explains how traditional healers can be as effective as Western psychology: By naming a person's problem, a healer limits it to something that can be restored. A psychologist and a medicine man name the problem differently, but both limit it. Tafoya, *op.cit.*

[117] Dana, (1995), *op.cit.*, p. 57.

[118] Dana, (1995), *ibid.,* p. 68.

[119] Dana, (1995), *ibid.,* p. 63.

120 Guidelines in this section are condensed from *NASW Standards for Cultural Competence in Social Work Practice* (June 23, 2001), National Committee on Racial and Ethnic Diversity, National Association of Social Workers, pp. 8-20.

[121] DHS Bulletin 01-89-01, March 14, 2001, page 3

[122] OCR Guidance, op. cite,. p. 52765

[123] OCR Guidance, op. cite., p. 52766, footnote 4.

[124] DHS Bulletin 01-89-01, op. cite.

[125] CLAS, op. cite, Standard No. 7.

[126] For nearly two decades, until recently, civil rights compliance required language assistance programs for linguistic groups that rose to a population threshold defined as "a non-English or limited-English speaking minority group constituting 5 percent or 100 individuals, whichever is smaller, of the total service area population and which speaks the same language." (*Guidelines for State Agency Civil Rights Compliance Plan*, Office of Civil Rights (OCR), U.S. Department of Health and Human Services, Oct. 1984.) Newer guidelines have moved toward a broader standard in which any individual who needs language assistance in order to access services must be offered assistance.

[127] OCR Guidance, op. cite, p. 52766, under 3 (b) "Assessment".

[128] OCR Guidance, op. cite., p. 52769, under 5(b), "Competence of Interpreters."

[129] These standards are from *Bridging the Language Gap* (November 1998), pp. 11-12, a report from the Working Group of Minnesota Interpreter Standards Advisory Committee. The committee consists of individuals from academia, health care, government, business, law, advocacy, community, and interpreter organizations. They receive funding from the University of Minnesota, the Minnesota Department of Health, and the Minneapolis Department of Health and Family Support.

[130] OCR Guidance, op. cite., p. 52769, under 5(a), "Use of friends, Family and Minor Children as Interpreters."

[131] OCR Guidance, op. cite, p. 52766, under 3(c)(1), "Oral Language Interpretation."

[132] OCR Guidance, op. cite., p. 52767

[133] OCR Guidance, op. cite., p. 52768, under (3) "Methods for Providing Notice to LEP Persons."

[134] *Neng Yang, et al. v. Michael O'Keefe, as Commissioner of the Minnesota Department of Human Services,* U.S. District Court, Fourth Division, File No. 99-CV-2033 (hereinafter "LEP Settlement"), Section 6.

[135] LEP Bulletin, op. cite., p. 9

[136] Vital documents include applications, consent forms, letters containing information regarding eligibility or participation criteria, and notices pertaining to reduction, denial, or termination of services or benefits. These are documents that require a response from beneficiaries or that advise of free language assistance. Large documents such as enrollment handbooks, may not need to be translated in their entirety. However, vital information contained in large documents must be translated. See OCR Guidance, op.cite, p. 52767, footnote 6.

[137] Model Contract for Prepaid Medical Assistance Program services, Prepaid General Assistance Medical Care Program Services, and MinnesotaCare Program Services, 2001-Two-Year Contract, Section 3.2.5(A)(1)(d).

[138] This prohibition will seem obvious to a mental health clinician. Nevertheless, the WICHE standards would allow use of a telephone interpreter in an emergency situation, in areas with limited linguistic support resources, if the interpreter were trained in mental health. WICHE, op.cite., section on Communication Styles, Cross-Cultural Linguistic and Communication Support, under Implementation Guidelines.

[139] Cross, et al., op. cite.

[140] Helman, Cecil (1994), *Cultural, Health, and Illness*, ed. 3, London, Wright, 1994)

141 Charon, J. M.(1995), *Ten Questions: A Sociological Perspective*, [2nd ed.], International Thomson, and American Psychological Association, (1996) *APA Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations,* (See http://www.apa.org//pi/guide.html)

142 Dr. Terry Tafoya, Seattle, Washington, in a presentation to the Specialty Providers Network Development Institute, Children's Mental Health Division of the Minnesota Department of Human Services, June 8, 2001.

143 Ouida Crozier e-mail (February 2002), Office for Equal Opportunity, Affirmative Action, and Civil Rights, Minnesota Department of Human Services.

144 CLAS, op. cite., Standard No. 2.

145 Cross, et al., op. cite., p. 20.

146 OCR Guidance, op. cite., p. 52762, under "Supplementary Information", and p. 52765, under C.2., "Basic Requirements Under Title VI."

147 OCR Guidance, op. cite., p. 52765.

148 CLAS, op. cite., Standard No. 5, and LEP Settlement, op. cite., Section 24.

149 Grieco, Elizabeth, and Cassidy, Rachel, (March 2001), Overview of Race and Hispanic Origin: Census 2000 Brief, U.S. Census Bureau, p. 2.

150 ibid.