

Definitions

Cultural Competence - Acceptance and respect for culture is consistently demonstrated in policies, structures, practices, and attitudes.

Cultural Humility - The “ability to maintain an interpersonal stance that is other-oriented (or open to the other) in relation to aspects of cultural identity that are most important to the [person]” (p. 2). (Cook, Davis, Owen, Worthington, and Utsey, 2013)

Cultural Responsiveness - The ability to learn from and relate respectfully to people from your own and other cultures.

Ethnocentrism - The belief that one's own culture is superior to other cultures.

Health Disparities - Health disparities adversely affect groups of people who have systematically experienced greater social or economic obstacles to health based on their racial or ethnic group, religion, socioeconomic status, gender, age, or mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.

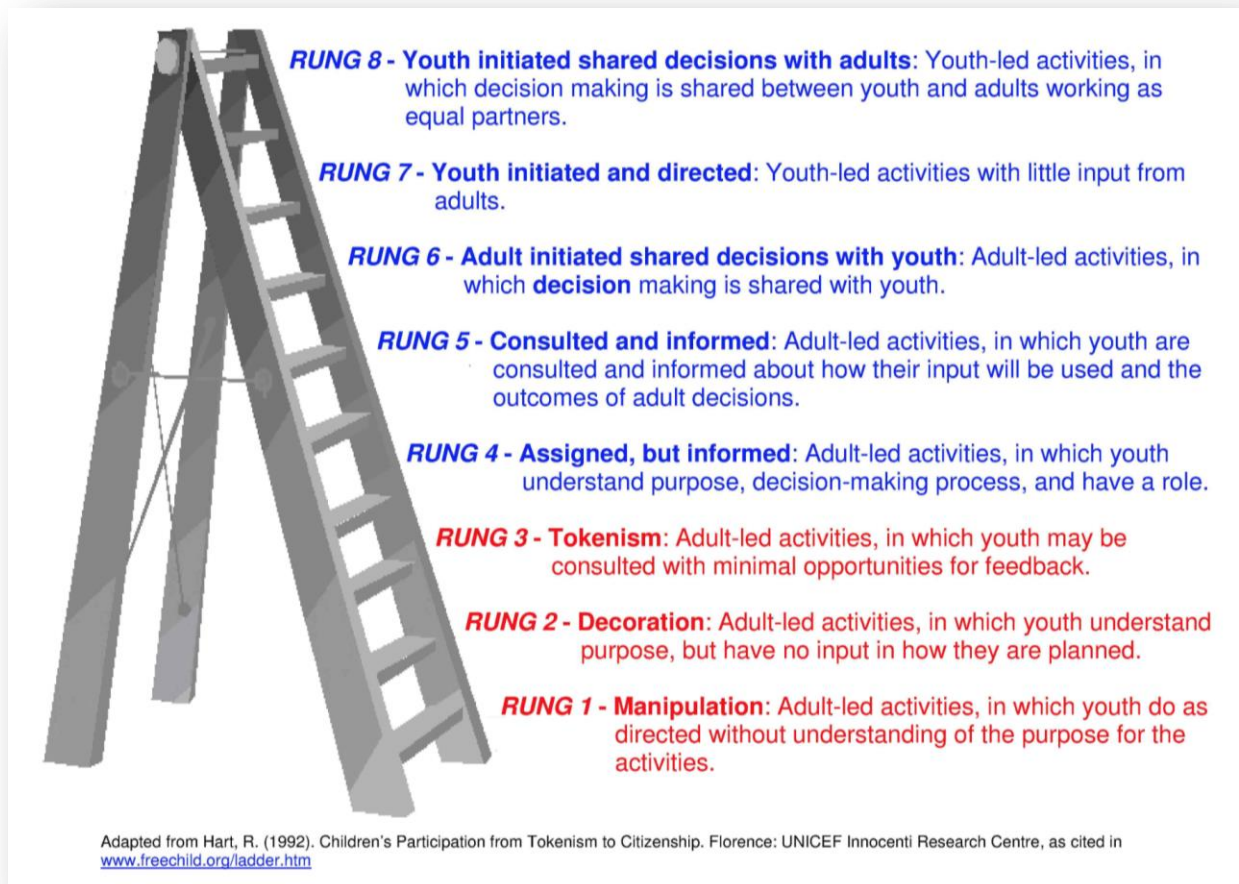
Health Equity - Everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.

Social Determinants of Health - Conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Trauma - Trauma results from an event, a series of events, or a set of circumstances that is experienced by an individual, group, or community as physically or emotionally harmful or life threatening and that has lasting adverse effects on their functioning and mental, physical, social, emotional, or spiritual well-being.

Roger Hart's Ladder of Participation

The ladder of participation is a model developed by Hart (1992) which identifies eight levels of children's participation in projects. It is designed to encourage those working with youth to think more closely about the nature and purpose of children's participation in community activities.



Questions to Consider:

- Where does your organization fall on Hart's Ladder?
- How can your organization improve, or build buy-in towards Rung 8?

PROMOTING CULTURAL DIVERSITY AND CULTURAL COMPETENCY

Self-Assessment Checklist for Personnel Providing Behavioral Health Services and Supports to Children, Youth and their Families

Directions: Please select A, B, or C for each item listed below.

A = Things I do frequently, or statement applies to me to a great degree

B = Things I do occasionally, or statement applies to me to a moderate degree

C = Things I do rarely or never, or statement applies to me to minimal degree or not at all

PHYSICAL ENVIRONMENT, MATERIALS & RESOURCES

- _____ 1. I display pictures, posters and other materials that reflect the cultures and ethnic backgrounds of children, youth, and families served by my program or agency.
- _____ 2. I insure that magazines, brochures, and other printed materials in reception areas are of interest to and reflect the different cultures of children, youth and families served by my program or agency.
- _____ 3. When using videos, films, CDs, DVDS, or other media resources for mental health prevention, treatment or other interventions, I insure that they reflect the cultures of children, youth and families served by my program or agency.
- _____ 4. When using food during an assessment, I insure that meals provided include foods that are unique to the cultural and ethnic backgrounds of children, youth and families served by my program or agency.
- _____ 5. I insure that toys and other play accessories in reception areas and those, which are used during assessment, are representative of the various cultural and ethnic groups within the local community and the society in general.

COMMUNICATION STYLES

- _____ 6. For children and youth who speak languages or dialects other than English, I attempt to learn and use key words in their language so that I am better able to communicate with them during assessment, treatment or other interventions.
- _____ 7. I attempt to determine any familial colloquialisms used by children, youth and families that may impact on assessment, treatment or other interventions.
- _____ 8. I use visual aids, gestures, and physical prompts in my interactions with children and youth who have limited English proficiency.
- _____ 9. I use bilingual or multilingual staff or trained/certified interpreters for assessment, treatment and other interventions with children and youth who have limited English Proficiency.
- _____ 10. I use bilingual staff or multilingual trained/certified interpreters during assessments, treatment sessions, meetings, and for other events for families who would require this level of assistance.
11. When interacting with parents who have limited English proficiency I always keep in mind that:
- _____ *
- _____ *
- _____ *
- _____ 12. When possible, I insure that all notices and communiqués to parents, families and caregivers are written in their language of origin.
- _____ 13. I understand that it may be necessary to use alternatives to written communications for some families, as word of mouth may be a preferred method of receiving information.
- _____ 14. I understand the principles and practices of linguistic competency and:
- _____ *
- _____ *
- _____ 15. I understand the implications of health/mental health literacy within the context of my roles and responsibilities.

VALUES AND ATTITUDES

- _____ 16. I use alternative formats and varied approaches to communicate and share information with children, youth and/or their family members who experience disability.
- _____ 17. I avoid imposing values that may conflict or be inconsistent with those of cultures or ethnic groups other than my own.
- _____ 18. In group therapy or treatment situations, I discourage children and youth from using racial and ethnic slurs by helping them understand that certain words can hurt others.
- _____ 19. I screen books, movies, and other media resources for negative cultural, ethnic, or racial stereotypes before sharing them with children, youth and their parents served by my program or agency.
- _____ 20. I intervene in an appropriate manner when I observe other staff or parents within my program or agency engaging in behaviors that show cultural insensitivity, bias or prejudice.
- _____ 21. I understand and accept that family is defined differently by different cultures (e.g. extended family members, fictive kin, godparents).
- _____ 22. I recognize and accept that individuals from culturally diverse backgrounds may desire varying degrees of acculturation into the dominant or mainstream culture.
- _____ 23. I accept and respect that male-female roles in families may vary significantly among different cultures (e.g. who makes major decisions for the family, play and social interactions expected of male and female children).
- _____ 24. I understand that age and life cycle factors must be considered in interactions with individuals and families (e.g. high value placed on the decisions of elders or the role of the eldest male in families).
- _____ 25. Even though my professional or moral viewpoints may differ, I accept the family/parents as the ultimate decision makers for services and supports for their children.
- _____ 26. I recognize that the meaning or value of behavioral health prevention, intervention and treatment may vary greatly among cultures.
- _____ 27. I recognize and understand that beliefs and concepts of emotional well-being vary significantly from culture to culture.
- _____ 28. I understand that beliefs about mental illness and emotional disability are culturally-based. I accept that responses to these conditions and related treatment/interventions are heavily influenced by culture.
- _____ 29. I understand the impact of stigma associated with mental illness and behavioral health services within culturally diverse communities.

VALUES AND ATTITUDES (CONT'D)

- _____ 30. I accept that religion, spirituality and other beliefs may influence how families respond to mental or physical illnesses, disease, disability and death.
- _____ 31. I recognize and accept that folk and religious beliefs may influence a family's reaction and approach to a child born with a disability or later diagnosed with a physical/emotional disability or special health care needs.
- _____ 32. I understand that traditional approaches to disciplining children are influenced by culture.
- _____ 33. I understand that families from different cultures will have different expectations of their children for acquiring self-help, social, emotional, cognitive, and communication skills.
- _____ 34. I accept and respect that customs and beliefs about food, its value, preparation, and use are different from culture to culture.
- _____ 35. Before visiting or providing services in the home setting, I seek information on acceptable behaviors, courtesies, customs and expectations that are unique to families of specific cultures and ethnic groups served by my program or agency.
- _____ 36. I seek information from family members or other key community informants that will assist in service adaptation to respond to the needs and preferences of culturally and ethnically diverse children, youth, and families served by my program or agency.
- _____ 37. I advocate for the review of my program's or agency's mission statement, goals, policies, and procedures to insure that they incorporate principles and practices that promote cultural diversity and cultural and linguistic competence.
- _____ 38. I keep abreast of new developments in pharmacology particularly as they relate to racially and ethnically diverse groups.
- _____ 39. I either contribute to and/or examine current research related to ethnic and racial disparities in mental health and health care and quality improvement.
- _____ 40. I accept that many evidence-based prevention and intervention approaches will require adaptation to be effective with children, youth and their families from culturally and linguistically diverse groups.

How to use this checklist

This checklist is intended to heighten the awareness and sensitivity of personnel to the importance of cultural diversity and cultural competence in human service settings. It provides concrete examples of the kinds of values and practices that foster such an environment. There is no answer key with correct responses. However, if you frequently responded "C", you may not necessarily demonstrate values and engage in practices that promote a culturally diverse and culturally competent service delivery system for children and youth who require behavioral health services and their families.

A Guide for Using the Cultural and Linguistic Competence Policy Assessment Instrument



DEVELOPED BY

**National Center for
Cultural Competence**

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Introduction

Assessing attitudes, practices, structures, and policies of programs and their personnel is a necessary, effective, and systematic way to plan for and incorporate cultural and linguistic competency within organizations. The National Center for Cultural Competence (NCCC) supports the concept that cultural competence is a developmental process and evolves over an extended period. Both organizations and individuals are at various levels of awareness, knowledge, and skill acquisition along the cultural competence continuum. The capacity to engage in self-assessment helps organizations to:

- gauge the degree to which they are effectively addressing the preferences and needs of culturally and linguistically diverse groups;
- establish partnerships that will meaningfully involve consumers and key community stakeholders;
- improve consumer access to and utilization of health and mental health services;
- increase consumer satisfaction with services received;
- plan for the systematic incorporation of culturally and linguistically competent policies, structures, and practices;
- allocate personnel and fiscal resources to improve the quality of services that are culturally and linguistically competent; and
- determine individual and collective strengths and areas for growth.

There are numerous benefits of cultural and linguistic competence organizational self-assessment. Such processes can lead to the development of a strategic organizational plan with clearly defined short-term and long-term goals, measurable objectives, identified fiscal and personnel resources, and enhanced consumer and community partnerships. Self-assessment can also provide a vehicle to measure outcomes for personnel, organizations, population groups, and the community at large.

Values & Principles for Self-Assessment

The NCCC uses a set of values and principles to guide all self-assessment processes.

- **Self-assessment is a strengths-based model.**
The purpose of self-assessment is to identify and promote growth among individuals and within organizations that enhances their ability to deliver culturally and linguistically competent services and supports. Self-assessment emphasizes the identification of strengths, as well as areas of growth, at all levels of an organization. The process also allows organizations to identify and acknowledge the internal strengths and assets of personnel who in many instances are inadvertently overlooked.
- **A safe and non-judgmental environment is essential to the self-assessment process.**
Self-assessment is most productive when conducted in an environment that (1) offers participants a forum to give honest statements of their level of awareness, knowledge, and skills related to cultural and linguistic competence; (2) provides an opportunity for participants to share their individual perspectives in a candid manner; and (3) ensures that information provided will be used to effect meaningful change within the organization. The NCCC embraces the concept that cultural competence is developmental and occurs along a continuum (Cross et al., 1989). It matters not where an individual or organization starts, as long as there is continued progression toward the positive end of the continuum.

- **A fundamental aspect of self-assessment ensures the meaningful involvement of consumers, community stakeholders, and key constituency groups.**

Principles of self-determination and cultural competence ensure that consumers are integrally involved in processes to plan, deliver, and evaluate services they receive. These principles extend beyond the individual to the community as a whole. Self-assessment must solicit and value the experiences and perspectives of consumers. Similarly, opinions should be sought from key stakeholders and constituency groups within the broad integrated service delivery system. An inclusive self-assessment process can forge alliances and partnerships that have long-lasting benefit for the organization and for the larger community.

- **The results of self-assessment are used to enhance and build capacity.**

The intent of the self-assessment process is neither to render a score or rating nor to label an individual or an organization. Rather, it is intended to provide a snapshot of where an individual or organization is at a particular point in time. Results should be used for strategic planning to improve the organization's capacity to deliver culturally and linguistically competent services at all levels, including policy makers, administrators, providers, subcontractors, communities, and consumers. The NCCC's experiences with self-assessment have demonstrated that comparisons between professionals and among organizations are of little benefit. Greater benefit is derived from individual and organizational self-comparison over extended periods of time to ascertain the extent to which growth has occurred.

- **Diverse dissemination strategies are essential to the self-assessment process.**

Self-assessment results should be shared with participants and key stakeholders in a manner that meets their unique needs. The NCCC has employed an array of dissemination strategies that are tailored to the specific interests of the participating organization. This information sharing involves identification of the audiences and presentation of the data in formats that are most useful and accessible. This approach recognizes that the need for information may vary for policy makers, administrators, service providers, consumers and other stakeholders.

From 1999 to 2006, the NCCC provided training and technical assistance to health centers and other programs funded by the Bureau of Primary Health Care (BPHC), Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services (DHHS), with a primary focus on planning and conducting processes for cultural and linguistic competence organizational self-assessment. The NCCC created a tool, the Cultural and Linguistic Competence Policy Assessment (CLCPA), designed to support the BPHC, and its funded programs, in (1) improving health care access and utilization, (2) enhancing the quality of services within culturally diverse and underserved communities, and (3) promoting cultural and linguistic competence as an essential approach in the elimination of health disparities.

Instrument Description

The CLCPA is designed to examine cultural and linguistic competence in four dimensions: values, policy, structure, and practice. Within these four dimensions, the CLCPA assesses Knowledge of Diverse Communities, Organizational Philosophy, Personal Involvement in Diverse Communities, Resources and Linkages, Human Resources, Clinical Practice, and Engagement of Diverse Communities.

The **Knowledge of Diverse Communities** subscale consists of 11 questions. It concerns knowledge of the identified cultural groups, how they differ internally, and how they differ from the dominant culture. The central focus is organizational policy that takes into consideration cultural beliefs, strengths, vulnerabilities, community demographics, and contextual realities.

The **Organizational Philosophy** subscale consists of 10 items. It involves organizational commitment to the provision of culturally and linguistically competent services and the extent to which it is legitimized in policy. This subscale probes the incorporation of cultural competence into the organization's mission statement, structures, practice models, collaboration with consumers and community members, and advocacy.

The **Personal Involvement in Diverse Communities** subscale consists of 7 items. It concerns the degree to which organizations and their staff demonstrate reciprocity within diverse and ethnic communities. The subscale addresses the extent to which an organization and its staff participate in social and recreational events and purchase goods and services within the communities they serve.

The **Resources and Linkages** subscale consists of 4 items. It concerns the ability of an organization and its staff to effectively use both formalized and natural networks of support within culturally diverse communities to develop an integrated primary care, community-based health system. The focus is organizational policy that promotes and maintains such linkages through structures and resources.

The **Human Resources** subscale consists of 8 items. It involves an organization's ability to sustain a diverse workforce that is culturally and linguistically competent. This subscale probes policy that supports workforce demographics, inservice training/professional development, and related resource allocation.

The **Clinical Practice** subscale consists of 8 items. It concerns the ability of the organization and its staff to adapt approaches to health care delivery based on cultural and linguistic differences. The focus is on assessment/diagnosis, the provision of interpretation/translation services, use of community-based resources, and adaptation based on literacy and health literacy levels.

The **Engagement of Diverse Communities** subscale consists of 3 items. It involves the nature and scope of activities conducted by an agency and its staff to engage diverse communities in health and mental health promotion and disease prevention.

The CLCPA is designed as a self-assessment instrument and requires approximately 30 minutes to complete. Most items use a four-point Likert scale (e.g., from Never to Often). The instrument can be administered to all agency personnel.

The CLCPA has a demographic form that elicits information such as job title, educational level, previous training in cultural and linguistic competence, and racial and ethnic affiliation. The form can be modified to include information pertinent to an individual health center.

Checklist for Conducting Cultural and Linguistic Competence Organizational Self-Assessment

General steps for the self-assessment are delineated below; however, considerable flexibility must be built into the proposed process.

Phase 1. Establish a structure to guide the work

- Identify an external organization or consultant to coordinate the self-assessment process.
- Convene a committee or work group, endorsed by the governing body, and discuss the self-assessment process (i.e., review the CLCPA and discuss data collection and analysis strategies, issues of staff confidentiality, timelines, and logistics).
- Identify past and current agency efforts and resources.
- Review the geographic service area and determine what demographic data are available.
- Establish parameters of the assessment process (i.e., timelines, sample population, logistics, and roles and responsibilities of the committee/work group).

Phase 2. Create a shared vision

- Convene a forum to explore and define the concepts of cultural and linguistic competence and their value and relevance for the agency and community members served.
- Convene agency leadership (governance body and executives) to develop consensus and ensure “buy in” for the process.

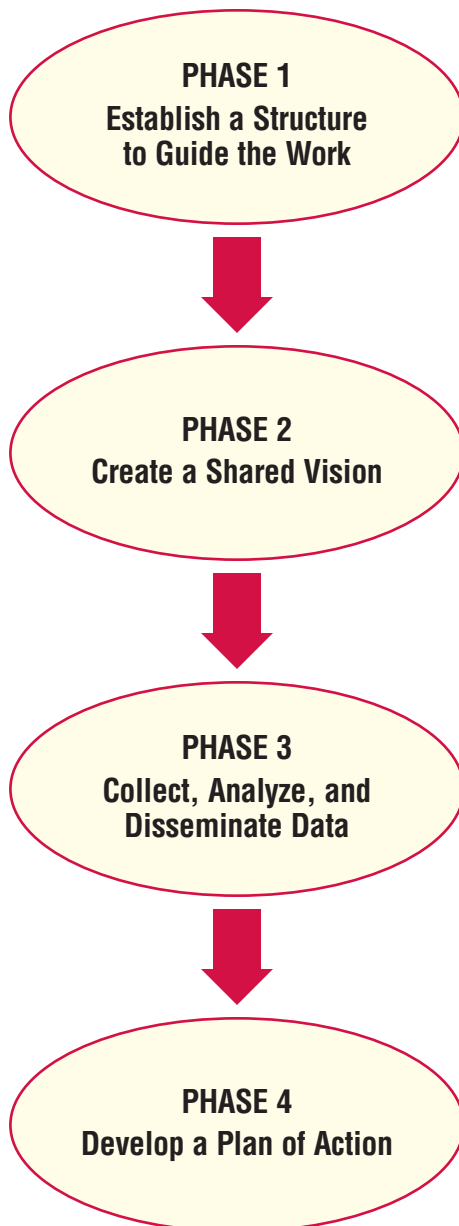
Phase 3. Collect, analyze, and disseminate data

- Conduct interviews with key staff and cultural key informants.*
- Pre-test the CLCPA among committee/work group members.
- Conduct consumer focus groups.
- Distribute the CLCPA to staff, governing board, and other participants.
- Forward CLCPA data to the organization or consultant conducting data analysis.
- Organization or consultant prepares a preliminary data summary and narrative report for review by the committee/work group.
- Disseminate the report to agency leadership and governing body, solicit feedback, and revise the report as needed.
- Develop the final report.
- Disseminate report findings in a variety of formats accessible to the diverse stakeholders including, but not limited to, consumers, community-based organizations, health and mental health providers, and state and local government agencies.

**Cultural key informants are those individuals who are knowledgeable about the beliefs and practices of a racial, ethnic, or cultural group and able to articulate these beliefs and practices to another group or individual for the purpose of promoting understanding of diversity.*

Phase 4. Develop and implement a plan of action

- Use a facilitator to guide a consensus planning process to develop a plan of action.
- Develop a draft plan for review by key stakeholders and incorporate their recommendations accordingly.
- Finalize the plan of action.



Phases to Conduct an Organizational Self-Assessment

- **Establish a structure to guide the work**
Convene a work group, committee, or task force with the responsibility of coordinating the organizational self-assessment. This group can serve as the primary entity to plan, implement, and provide oversight to this process. The group should include representation from all levels of the organization, consumers, the governing board, and community partners.
- **Create a shared vision**
Convene a forum to explore and define the concepts of cultural and linguistic competence and their value and relevance for the health center, consumers and their families, and communities served. Forum participants should be composed of key stakeholders including, but not limited to, staff, consumers, community organizations in the service area, clinics and hospitals, and other invested constituency groups.
- **Collect, analyze, and disseminate data**
Data for analysis are collected from the administration of the CLCPA, consumer focus groups, interviews with key health center staff, a review of demographic data, and organizational records. Results are interpreted and compiled within a comprehensive report that can be adapted for dissemination to diverse audiences.
- **Develop and implement a plan of action**
Create a plan of action based on the results of the organizational assessment that identified priorities. Determine the specific strategies/activities, partners, resources, timetables, and responsible parties and establish benchmarks to monitor and assess progress.

PHASE 1 Establish a Structure to Guide the Work

It is important to take the time to carefully plan the process of conducting a cultural and linguistic competence organizational self-assessment. The process of self-assessment is as important as the outcome. Phase 1 of this guide is devoted to establishing a structure to guide the work.

■ **Identify an organization or consultant to coordinate the self-assessment**

Ideally, a health center should partner with an organization or consultant to coordinate the assessment process. This partnership will ensure objectivity. Suggestions include local universities; regional clinic consortia; the state primary care association; member organizations of local, state, or regional health coalitions; or individual consultants. The organization or consultant should adhere to a conceptual framework of cultural competence organizational self-assessment that is strengths based and developmental.

There are other factors that need to be considered in the selection of the organization or consultant. These factors may include, but are not limited to, the extent to which they have experience with underserved or underrepresented groups, and the dynamics of difference that may occur based on race, ethnicity, gender, age, sexual orientation, or other cultural factors. Careful attention must be given to the particular cultural context of both the organization and the community served.

The organization or consultant should have expertise in the analysis and evaluation of data trends related to cultural and linguistic competence. The health center may choose to have the self-assessment conducted by one organization or consultant or may contract major aspects of the self-assessment process separately (i.e., data analysis, focus groups, report, and dissemination). If the latter approach is chosen, it is vital that the health center identify an individual whose primary responsibility is to coordinate all aspects of the assessment process.

■ **Structure support for the process**

Some organizations use the resources of an existing committee structure, and others find it beneficial to create an ad hoc committee, task force, or work group devoted to this function. The group should have representation from all levels of the health center including policy making, administration, practice/service delivery, support staff, consumers and their families, and other community stakeholders. It should also reflect the racial, ethnic, cultural, and linguistic diversity of the health center and the community at large. This group is the primary entity for planning and implementing the self-assessment process, and should have ready access to decision makers or have the authority to make decisions.

Committees or work groups will go through a process of “group norming.” Let the group “be” before it “does.” Consider the need for cross-cultural team building that explores issues such as race, ethnicity, nationality, gender, sexual orientation and identity, class, language, power, and job functions. Initially, the exploration may require a facilitator to ensure a safe forum for the exchange of ideas and feelings.

The diversity of the committee or work group results in a collection of people who have not previously worked together, and may have very different experiences and preferences for how work is to be accomplished. For example, some group members will want to progress quickly through an agenda because saving time is an important value. For others who value relationships or may need additional time to process complex information, longer meetings may be more desirable. These diverse perspectives and group dynamics will require an excellent chair or leader. Agreements need

to be reached related to how the work is to be accomplished early in the process. The committee or work group should consider establishing ground rules that include, at a minimum, communication styles, conflict resolution, and decision making and should review them periodically.

Another helpful strategy is to use “parking lots of ideas.” Use large sheets of paper, visible to all members, to capture important ideas or questions. The ideas are important, but they may be off the current topic of discussion or require additional meeting time to fully address. By writing them, the contributors see that their ideas are respected, and this strategy assists the chair or leader so that no ideas are lost. There may be times when the chair or leader will need to ask a member to stop and move on. Meeting discussions should avoid a debate of ideas. It is important that all participants understand that the variability of ideas is important to both the process and the outcome.

A final strategy to consider is preparing all members to participate fully and effectively. Provide meeting summary notes, agendas, and reading/recorded materials in advance. Some members may benefit from being paired with another who has more experience in group processes.

■ **Allocate personnel and fiscal resources**

Personnel resources

Conducting a self-assessment process is resource intensive. It requires a dedicated budget and a level of effort for agency personnel. These requirements may also extend to community partners and key stakeholders involved in the process. Consideration should be given to the necessary level of effort for personnel who have responsibility for this process. This work will entail delineating responsibilities and determining the duration and intensity of time required for personnel. It may require deferment or reassignment of current workload and duties. The success of a self-assessment process depends on a well-crafted allocation of personnel and fiscal resources.

The ability to coordinate numerous logistical tasks effectively is vital to the self-assessment process. The committee or work group needs to establish the parameters of assessment, including timelines, the number of people to be sampled, and individual staff responsibilities. A plan must be established to ensure the timely dissemination of information to all work group members and the development of a calendar and schedule of activities (e.g., sites and times for regular meetings, teleconferences, focus groups, administration of the self-assessment instrument, data collection and analysis, and dissemination of results).

Fiscal resources

The budget amounts will depend on the resources of the agency. Some resources may be accrued as in-kind or donated from community partners and key stakeholders. Although the amounts and sources of funding may vary, the following categories are essential:

- Organization or consultant to coordinate and/or conduct the self-assessment process
- Organization or consultant to complete the data analysis and develop the final report
- Supports for focus group participation (see Appendix 1, “Self-Assessment Protocol”)
- Stipends and honoraria to support consumer and family participation in committee or work group meetings and activities
- Translation and adaptation of English language materials
- Accommodations for people with disabilities
- Interpretation services for focus groups and/or committee and work group meetings as required

- Refreshments need to be appropriate for the time of day the focus group or meeting is scheduled. (Snacks are sufficient for early afternoon or late evening, but if the focus group occurs during lunch or dinner, more substantial food needs to be provided. Food choices should reflect community preferences.)
- Meeting space rental
- Local and/or domestic travel reimbursement
- Copying, mailing, and other dissemination activities

■ **Identify collaborating partners and engage community members**

A self-assessment process that is inclusive of a variety of community partners provides an opportunity to obtain rich information and lays the foundation for developing innovative strategies to promote cultural and linguistic competence. A major principle of cultural competence involves working in conjunction with natural, informal, support and helping networks within diverse communities (Cross et al., 1989). Oftentimes, health centers are reticent about involving other organizations in this process for fear of exposing their inadequacies. Including a variety of partners initially takes extra time and resources. However, when partnerships are developed early in the process, and when community members see themselves as part of the visioning and decision making, all will see a stake for themselves in the collaborative effort. These partners may inform other community members about the self-assessment and its role in quality improvement efforts for diverse populations served, thus providing positive public relations for the health center.

Examples of meaningful involvement include developing a shared vision, identifying leadership roles and responsibilities, distributing tasks equitably based on capacity, and allocating resources in compensation for contributing time and talents. It is important to recognize that individuals and groups will choose different levels of involvement and ways to participate that may be culturally based. Their choices may vary from serving on committees or work groups, participating in focus groups, making in-kind or other fiscal contributions, and subcontracting for specific services to providing meeting facilities and other accommodations. It is essential to demonstrate that the contributions of each community partner are valued and respected (Goode, Jones, & Mason, 2002).

■ **Review demographic data for the service area and select designated cultural groups for the CLCPA**

The committee or task force can access demographic data from varied sources such as the U.S. Census Bureau; U.S. Departments of Agriculture, Housing and Urban Development, and Labor; state offices of minority health; local health and mental health departments; tribal councils or governments; territorial governments; school districts; and health policy centers. This information can be used to identify emerging issues impacting culturally and linguistically diverse groups receiving services from the health center (e.g., changes in local or regional demographics such as new immigrant or refugee populations, relocation of low-income housing, increase in the number and composition of the homeless and migrant/seasonal farm worker populations, incidence of racial and ethnic health and mental health disparities, changes in state health policy for Medicaid or State Children's Health Insurance Program [SCHIP], new federal statutes, and literacy and health literacy data).

The committee or task force should use these data in several ways. They provide an overview of populations in the service area, raise critical issues impacting these population groups, describe consumer populations currently served by the health center, and identify new groups that need to be engaged. These data should be used as a basis to choose the designated cultural groups that will be listed on the CLCPA. Centers may choose racial or ethnic groups (i.e., Asian Pacific Islander,

Latino, Native American, and African American), and/or other non-ethnic cultural groups such as homeless, HIV/AIDS, gay, lesbian, transgender and bisexual, and rural populations. These data will be thoroughly analyzed along with other data collected in Phase 3.

PHASE 2 Create a Shared Vision

Convene a forum to explore and define the concepts of cultural and linguistic competence and their value and relevance for the health center, consumers and their families, and communities served. Forum participants should be composed of key stakeholders including, but not limited to, staff, consumers, community-based organizations in the service area, clinics and hospitals, and other invested constituency groups. The issues discussed during the forum should be reviewed by the health center governing board and leadership to offer formal acknowledgment of the process and to provide guidance about how to approach significant issues. It is incumbent upon leadership to convey a clear message that the process of cultural and linguistic competence assessment is important to the future of the health center and is essential to the provision of quality care.

PHASE 3 Collect, Analyze, and Disseminate Data

The data set that will be analyzed and developed into a report will come from five primary sources: (1) the CLCPA instrument completed by policy makers, administrators, and practice, service delivery, and support staff; (2) consumer focus groups; (3) interviews with the agency executive directors, administrators, staff, and the health center governing board; (4) demographic information about the geographic area of service delivery; and (5) organizational records. The organization or consultant that is responsible for data analysis and interpretation must be skilled in integrating cultural and linguistic competence into self-assessment processes or must be able to collaborate with someone who possesses those skills.

■ Determine analytic strategy and choose appropriate software

1. Completion of the CLCPA instrument

The NCCC has always sought the widest level of participation of all stakeholders in using the CLCPA and other cultural competence organizational self-assessment instruments. This approach has several benefits; the primary benefit is that employees see that this process seeks and respects their input no matter what their role within the organization. If the agency is viewed as having a “top-down style of management,” more time will be needed to elicit staff participation. The request may need to be made through a union representative or shop steward.

The best results have been achieved when an opportunity is given for staff to be informed of the process and when staff are given some incentive for participation. For example, the progress of the committee or work group should be reported at regular staff meetings or published in newsletters or e-alerts. Whichever method is chosen, it is important for staff to know why the information is collected, understand the philosophy of self-assessment, and know that the information provided is confidential. Some health centers have been successful in soliciting participation when a meal is provided in conjunction with the time to complete the CLCPA. Larger health centers may need to assign team captains or managers to be responsible for the collection of the completed CLCPA.

The NCCC currently has a Web-based methodology for the collection of CLCPA data. Rather than using a paper-and-pencil format, participants can log onto a site and complete the CLCPA. The

method has several benefits by assuring participant confidentiality, eliminating consultant or staff time for data entry, and allowing staff to complete the CLCPA at time convenient to their schedule (NCCC, 2006).

2. Consumer focus groups

The collection of data from consumer focus groups adds to the reliability of the information collected from staff and board members. These data serve as a reflection to ascertain whether consumers view services in the same way that staff do.

Recruitment	<ul style="list-style-type: none"> • Assign health center staff to recruit participants. • Participants should reflect the demographics of the populations served by the health center. • Include representatives of demographic groups new to the geographic area served, or groups that the health center has not been effective in engaging. • Collaborate with community-based organizations including churches, synagogues, and mosques; faith-based and spiritual organizations; ethnic-specific advocacy groups; schools; or legal advocacy groups. • Develop a simple flyer describing the purpose of the focus groups, logistical information, and a personal contact. • Provide information in other formats including translated texts, community newsletters, Web sites, and via by “word of mouth.”
Compensation for participation	<ul style="list-style-type: none"> • Consumers who participate in focus groups should receive a stipend or honoraria for the valuable service they provide. Be aware that some consumers may have cultural beliefs that equate the acceptance of honoraria as a “pay off or bribe” for making positive statements. • The amount should be determined according to community norms. • Consider providing compensation in cash or gift cards (may be donated by local businesses). • Determine if cultural norms preclude giving cash based on gender, family position or age. • To ensure full participation by a wide variety of consumers, additional reimbursement may be needed for transportation, childcare costs, or respite care for adult dependents.
Provision of interpretation and translation services	<ul style="list-style-type: none"> • Notices of focus groups, directions to the site, and questions asked during the focus groups should be translated into languages other than English based on need and preferences of participants. • Preference for interpreter services should be indicated by the participant, and not assigned by someone else, no matter how well intentioned. • Interpreters can be those used by the health center in their normal course of business with the exception of staff that who serves as interpreters. • All interpreters should be oriented by the focus group facilitator as to the objectives and should discuss how the interpretation should take place. • Ensure that the interpreter understands terms used by the facilitator, and colloquialisms that may be used by participants. • Have a discussion with the interpreter to mitigate the influence of cultural biases on the process. • In small communities, interpreters may need to be sought from outside the area to promote the comfort level of participants. If this is not possible, participants should be informed of the interpreter’s responsibility for confidentiality. • Hold a review with the interpreter periodically to be sure that information is not being filtered.

Starting the focus group	<ul style="list-style-type: none"> • The focus groups should not include any staff. • Participants must receive assurances that their comments will be confidential and that no one will be able to trace their comments back to them. • Focus group, participants may be concerned that the information will be used to discontinue the funding for the health center. This erroneous belief must be dealt with at the beginning of the focus group. • All participants should sign a consent that is available in the language of their preference, and has been explained to them if they cannot read. (A sample consent form is provided in the Appendix 3, "Sample Consent Form for Focus Group.") • Flyers and the agenda should clearly state if whether there will be a time for registration and refreshments before the actual focus group begins. This point addresses the differences in the way people approach tasks and time. Someone oriented to punctuality will show up at the scheduled time, ready to work. Others, who are more socially oriented, will come, and use the time to eat and socialize as a way to get acclimated and ready to work. In order to honor the value of time for the first group, the agenda should clearly state that the first half hour will be for registering registration and refreshments.
During the focus group	<ul style="list-style-type: none"> • Information should be available in a variety of formats so that the needs of participants with low literacy are accommodated. Information may need to be presented orally. • Jargon and complex statements should be avoided. • Assure Ensure that all information presented is accessible to people with disabilities (e.g., sign language interpretation, Braille, large print, and simple explanations).
Logistics	<ul style="list-style-type: none"> • Select times and locations that will allow maximum participation of consumers. • In some communities, it may be necessary to select sites other than the health centers that are considered neutral. • Consider collaborating with schools of social work, psychology, public health, or public policy as interns, and faculty may be a ready resource for this type of data collection. • Multiple focus groups may be required so that the number of participants per group does not exceed 15 or to accommodate multiple linguistic groups.
Other considerations	<ul style="list-style-type: none"> • Avoid a debate of ideas. Be sure that all participants understand that the variability of ideas is important to the data. • Pay particular attention to tension that may arise based on race, ethnicity, culture, language, sexual orientation and identity, class, or other factors. Some people may feel more comfortable discussing highly charged issues within homogeneous groupings. See http://www.evaluationtoolsforracialequity.org, Tip Sheet 4b.TS1, for other suggestions.

3. Interviews

Data collected by interviewing the executive director, members of the senior management team, and members of the Board of Directors can be important for analysis.

Staff focus groups or interviews

The planning group may want to consider conducting a staff focus group or interviews before distributing self-assessment instruments. These groups may elicit questions about the purpose of organizational self-assessment that administrators thought had been answered, or may uncover other issues not directly associated with cultural competence, but that could present barriers to systems change.

Sample Interview Questions

- What do you believe is your health centers' greatest strength related to the delivery of culturally and linguistically competent health care services?
- What are some approaches that have assisted you in making progress?
- What are some of the barriers that limit your progress in the development of culturally and linguistically competent services and supports?
- What additional resources are needed, including non-fiscal resources?

Post-assessment focus group or interview

In the event of conflicting data from instruments or focus groups, reconvening some members or eliciting information from a different source may clarify some information. Apparent conflicts can also be followed up as part of the strategic planning process.

4. Demographic information

The demographic information reviewed by the committee or task force early in the process needs to be included in the final analysis. It is useful for the analysis to include the following factors:

- Does the health center serve a population reflected in the diversity of census data?
- Are there trends in health disparities that need to be addressed?

5. Organizational records

The health center's mission statement, policies and reports, and marketing material should all be included in the data collection process.

■ Data analysis

The organization or consultant chosen to conduct the data analysis will review data generated from five primary sources: (1) the CLCPA instrument completed by policy makers, administrators, practice, service delivery, and support staff; (2) consumer focus groups; (3) interviews with the agency executive directors, administrators, staff, and the health center governing board; (4) demographic information about the geographic area of service delivery; and (5) organizational records.

1. Self-Assessment instrument data

A variety of statistical software packages can be used to analyze both qualitative and quantitative data. The number of assessment instruments to be analyzed and the depth of statistical analysis will dictate the statistical software package selected. A spreadsheet is appropriate when there are fewer than 20 instruments that require analysis and if analysis is limited to a frequency count. SPSS or SAS will be needed for larger data sets and greater testing capacity. The most important consideration is that the organization or consultant needs to have experience using the statistical package and is familiar with its assets and liabilities. A process for data entry needs to be established so that data are entered consistently and accurately. Personnel resources to accomplish this task must be planned in advance.

The following steps are useful in performing the data analysis:

- A. Generate individual subscale means.
- B. Rank subscales from high to low.
- C. Repeat the process within each subscale.
- D. Examine the numbers within the subscale, looking at what is high. Generate the subscale mean. Items below the subscale mean may indicate areas that need enhancement.
- E. Report areas of strength that fall above the mean. These are the areas that the organization can likely build on.
- F. Differences in knowledge between groups (administrators vs. staff) may indicate that some groups within the organization have access to information that others do not. For example, clinical staff may have knowledge of diverse groups through day-to-day contact, whereas administrators may not have this knowledge because their daily functions are removed from direct patient contact. Conversely, administrators may be engaged in interagency and community collaborations that are unknown to clinical staff. These differences may indicate that there is a

need for clear policy, or that staff need to be made aware of existing policy, or that staff are failing to follow policies that are in place.

The CLCPA includes several questions that are open ended, and there are opportunities for respondents to include comments. Respondents may even write their comments in the margins. On the basis of the NCCC's experience, it is important to capture these data, because it may provide information about the atmosphere of an organization, including barriers to achieving cultural and linguistic competence. For example, one health center's staff made frequent comments suggestive of racial hostilities.

Some questions and items can be considered "high impact." For example, the majority of respondents may give the same response to an item. However, if 25% of respondents give different responses, it may indicate that a significant subset of employees views the organization very differently. It may be indicative that some employees do not have sufficient information about an organization's policy, or it may indicate a group whose attitudes and values contrast with the majority of the organization. These types of findings merit further exploration such as conducting a post-assessment focus group to gain greater clarity. At times, the numerical data may not support precise conclusions. It is important in these situations for the organizations or consultants conducting the data analysis to remember that their role is to guide the organization to seek additional information rather than to assign a particular meaning to the data.

At least two individuals should analyze the data, looking for consensus, differences, or ambiguity. Themes and interpretive statements emerge from these data. Any differences in interpretation need to be resolved. If consensus cannot be reached, consider conducting post-assessment interviews or focus groups.

Each CLCPA question has a companion question about the existence of policy to support this activity, and the respondent's knowledge of such policy. Most organizations need to spend time developing policies that support cultural and linguistic competence, orienting staff to such policies, and ensuring that managers are supervising compliance. The NCCC's experience has shown that policy may be written, but not disseminated, or that staff may simply not implement existing policy.

2. Focus group data

Using a similar process, at least two individuals should develop an initial analysis of the focus group data. Comments should be analyzed for common trends within and between diverse groups, and for comments that note different experiences between groups. For example, one health center had a long history of serving diverse racial, ethnic, and cultural groups and the majority of focus group participants reported positively about the support they received in accessing services. One fairly new immigrant group, however, did not report the same level of satisfaction because the health center had not developed a network of supports for this group. Focus group data are also used to compare the quantitative data of the CLCPA with those of patient experiences. For example, if the organization rated itself highly in the provision of interpretation services, but the focus group participants do not, there may be several explanations. The health center staff do not consistently refer patients for interpretation services; interpretation services have not been evaluated by the patients who use them; insufficient interpreters are available during peak hours; or staff are overrating themselves.

3. Interviews

The NCCC has found it useful to conduct interviews with selected health center staff including, but not limited to, the Chief Executive Officer, Chief Financial Officer, Medical Director, Director of Human Resources, and Board Chair or Executive Committee. The questions can address issues germane to the organization or community that are not specifically addressed by the CLCPA. The organization or consultant conducting the self-assessment process in collaboration with the planning committee or work group should craft questions. These data should be analyzed using the same methods as those gleaned from the focus groups. Interview results may give a broader view of the organization's commitment and capacity to develop and administer policy that supports culturally and linguistically competent care.

4. Demographic data

The demographic data collected and reviewed in Phase 1 should be analyzed for trends and related information that will assist in interpreting data from the CLCPA and those derived from the focus groups.

5. Organizational records

The organization or consultant will review the health center's mission statement, policies, annual and other technical reports, and marketing material to determine the extent to which these documents address and support culturally and linguistically competent policy and practice. This is a subjective process, so it is useful to provide clear examples of indicators that support findings. For example, in a mission statement, the term "cultural and linguistic competence" may be used. Is the mission statement supported by policies that ensure language access, integrate cultural information in approaches to patient assessments, and support staff involvement in the communities served?

■ Report development

The development of the report must adhere to the philosophy that organizational cultural and linguistic competence is a strengths-based process that is non-threatening. Areas of program strengths need to be identified along with suggestions for program enhancement. As the results of each subscale are discussed, information obtained from focus groups should be incorporated into these results that either supports the quantitative data or provides contrast. Organizations may desire very detailed reports along with brief executive summaries, PowerPoint presentations, or simple fact sheets that will assist with the dissemination of results to diverse audiences.

■ Dissemination of results of the self-assessment

It is critical that the self-assessment results be reported to focus group participants, staff, the Board of Directors, and other community partners. The format in which information is shared may differ with each group. The Board of Directors may prefer a succinct executive summary, oral presentation, and PowerPoint multimedia presentation, while the health center's administrative team may require a very detailed report. A variety of dissemination strategies should be considered for consumer and other community organizations. These strategies may include detailed reports, summaries, and oral and multimedia presentations. There may be a need to translate and/or present information in languages other than English and to accommodate individuals with disabilities. Last, adaptations may be needed to address issues related to literacy and health literacy.

Self-assessment results should be disseminated broadly in a variety of venues. These venues can include information that is available at the health center, information posted on the health center's Web site with links to partner agencies and organizations, presentations at conferences and community meetings, Webcasts, and press releases to mainstream and ethnic media sources.

PHASE 4 Develop an Action Plan

The CLCPA and self-assessment process yields a wealth of information, including the extent to which cultural and linguistic competence is integrated into such areas as: organizational mission, policies, structures, and procedures; staffing patterns; position descriptions and personnel performance measures; clinical practice, services, and other supports; community engagement, outreach, and dissemination approaches; composition of advisory boards and committees; and professional development and inservice training activities. This information is intended to assist health centers in identifying strengths and areas of growth for the development and administration of organizational policy that underpins cultural and linguistic competence. The fourth phase of the process involves using this information to develop an action plan that delineates organizational goals and priorities to be achieved within a specified period of time. A well-developed plan will ensure that the organization has a fully detailed map for the journey it is undertaking and that all involved will be knowledgeable of their roles and responsibilities. This next phase will require a skilled facilitator to guide the development of the action plan.

Differentiate an action plan from a strategic plan

Many health centers have strategic plans that delineate broad directions for the organization over an established period of time, typically for 5 or more years. This strategic plan may or may not address cultural and linguistic competence. The action plan, as described in this guide, is not a substitute for a health center's strategic plan because its functions and purposes differ. The action plan is offered as an effective tool for using the self-assessment results to plan for organizational change specifically related to cultural and linguistic competence.

Action planning process

An action plan is a tool for moving forward on an event or project that has already been agreed on or about which there is already some consensus, such as how to implement needed change identified by the cultural and linguistic competence self-assessment process. This action planning process:

- clarifies and delineates the task;
- aligns creativity, capabilities, interests, and resources of the group;
- decides necessary actions, roles, and responsibilities;
- builds group trust, support, enthusiasm, and consensus;
- creates an implementation timeline to accomplish the task; and
- coordinates actions and assignments (Institute of Cultural Affairs, 2000).

Consensus planning

There are numerous planning processes, and each has unique features, advantages, and outcomes. This guide describes the consensus planning workshop method as a strategy for action plan development.

Developing a plan that is fully inclusive of all stakeholders is the best assurance for its success. However, ensuring full participation and inclusion is not a simple task. The NCCC has successfully used the consensus planning workshop method to assist many health organizations in developing plans for the infusion of cultural and linguistic competence in service delivery systems. Careful thought and preparation have to go into developing the protocols and processes for such a planning event, including who will participate. A consensus planning workshop provides an excellent opportunity to include, at a minimum, community partners, consumers, board members, policy makers, and diverse staff from all levels of the organization. It is important that this group have active participation from organizational leadership with decision-making authority.

A consensus planning workshop can range from simple to complex. The infusion of cultural and linguistic competence though a complex task is made manageable and achievable through this active planning process that involves:

- collecting the ideas of all participants,
- identifying broad patterns through dialogue,
- summarizing the group's insights, and
- reaching consensus on a resolution (Stanfield, 2002).

The consensus planning workshop method entails five steps: (1) creating a shared context for the group, (2) brainstorming ideas, (3) grouping or clustering the ideas, (4) naming the cluster/group, and (5) resolving to implement the results. Creating a common context of shared experiences for the group is critical. This step can be done in many ways, such as reviewing the accomplishments of the health center in the last several years, identifying challenges and barriers, or articulating the health and mental health issues endemic to a particular community. One of the most meaningful ways to build a shared context, once an organizational self-assessment has been completed, is to review strengths of the health center and desired areas of growth as identified in the report.

Components of an action plan

Create a plan of action, based on the results of the organizational self-assessment, which identifies priorities. Determine the specific strategies/activities, partners, resources, timetables, and responsible parties, and establish benchmarks to monitor and assess progress at regular intervals.

Conclusion

The process of conducting an organizational self-assessment is resource and time intensive. The energy and drive to continue the momentum will require leadership that is focused on the development of policies, identification of resources, encouragement and support provided to staff, and active engagement of diverse consumers and the communities in which they live. The process of self-assessment will become integral to planning, implementing, and evaluating all aspects of service delivery as health centers continue the journey toward achieving cultural and linguistic competence.

Citations

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Evaluation Tools for Racial Equity Web site at <http://www.evaluationtoolsforracialequity.org>

Goode, T., Jones, W., & Mason, J. (2002). *A guide to planning and implementing cultural competence organization self-assessment*. Washington, DC: National Center for Cultural Competence, Georgetown University Center for Child and Human Development.

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Healthy People 2010 at <http://www.healthypeople.gov/Document/pdf/uih/2010uih.pdf>

Miriam-Webster Online Dictionary, 2006

National Center for Cultural Competence Web site at <http://gucchd.georgetown.edu/nccc/>

Stanfield, R. B. (2002). *The workshop book: From individual creativity to group action*. British Columbia, Canada: New Society Publishers.

Webster's Collegiate Dictionary, 1985

APPENDIX 1: Definitions

Cultural Competence

The National Center for Cultural Competence (NCCC) embraces a conceptual framework and model of achieving cultural competence based on the Cross et al. (1989) definition. Cultural competence requires that organizations:

- have a defined set of values and principles, and demonstrate behaviors, attitudes, policies, and structures that enable them to work effectively cross-culturally;
- have the capacity to (1) value diversity, (2) conduct self-assessment, (3) manage the dynamics of difference, (4) acquire and institutionalize cultural knowledge, and (5) adapt to the diversity and cultural contexts of the individuals, families, and communities they serve; and
- incorporate the above in all aspects of policy making, administration, practice, and service delivery and systematically involve consumers and families.

Linguistic Competence

Definitions of linguistic competence vary considerably. Such definitions have evolved from diverse perspectives, interests, and needs and are incorporated into state legislation, Federal statutes and programs, private sector organizations, and academic settings. The following definition, developed by the NCCC, provides a foundation for determining linguistic competence in health care, mental health, and other human service delivery systems. It encompasses a broad spectrum of constituency groups that could require language assistance or other supports from an organization, agency, or provider.

The capacity of an organization and its personnel to communicate effectively and convey information in a manner that is easily understood by diverse audiences including persons of limited English proficiency, those who have low literacy skills or are not literate, and individuals with disabilities. Linguistic competency requires organizational and provider capacity to respond effectively to the health literacy needs of populations served. The organization must have policy, structures, practices, procedures, and dedicated resources to support this capacity. This may include, but is not limited to, the use of:

- bilingual/bicultural or multilingual/multicultural staff;
- cross-cultural communication approaches;
- cultural brokers;
- foreign language interpretation services including distance technologies;
- sign language interpretation services;
- multilingual telecommunication systems;
- videoconferencing and telehealth technologies;
- TTY and other assistive technology devices;
- computer-assisted real-time translation (CART) or viable real-time transcriptions (VRT);
- print materials in easy-to-read, low-literacy picture and symbol formats;
- materials in alternative formats (e.g., audiotape, Braille, and enlarged print);
- varied approaches to share information with individuals who experience cognitive disabilities;
- materials developed and tested for specific cultural, ethnic, and linguistic groups;

- translation services including those of:
 - legally binding documents (e.g., consent forms, confidentiality and patient rights statements, release of information, and applications)-
 - signage
 - health education materials
 - public awareness materials and campaigns; and
- ethnic media in languages other than English (e.g., television, radio, Internet, newspapers, and periodicals).

(Developed by Tawara D. Goode and Wendy Jones, 8/00, Revised 6/06.)

Culture

Culture is an integrated pattern of human behavior, which includes, but is not limited to, thought, communication, languages, beliefs, values, practices, customs, courtesies, rituals, manners of interacting, roles, relationships, and expected behaviors of a racial, ethnic, religious, social, or political group; is the ability to transmit the above to succeeding generations; and is dynamic.

Dialect

A regional variety of language distinguished by features of vocabulary, grammar, and pronunciation from other regional varieties and constituting together with them a single language (Merriam-Webster Online Dictionary, 2006)

Health Disparities

There are many definitions for health disparities. For the purposes of this instrument, the NCCC adopted the following definition of health disparities: population-specific differences in the presence of disease, health outcomes, or access to health care.

Health Literacy

The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.

<http://www.healthypeople.gov/Document/pdf/uih/2010uih.pdf>

Organizational Culture

Organizational culture is a pattern of shared basic assumptions that the group learned as it solved its problems of external adaptation and internal integration that has worked well enough to be considered valid and, therefore, to be taught to new members as the correct way to perceive, think, and feel in relation to those problems (Schein, 1985).

Policy

Policy is defined for the purposes of this instrument as a high-level overall plan embracing the philosophy, general goals, and acceptable procedures within an organization (Webster's Collegiate Dictionary, 1985). Additionally, formal policy is written and codified. Informal policy is shared and understood verbally; however, compliance may or may not be enforceable and adherence may vary.

APPENDIX 2: Resource List

Demographic Data

<https://perfddata.hrsa.gov/mchb/mchreports/Search/program/prgsch01.asp>

Maternal and Child Health Bureau—State Priority Health Areas (by state and region)

<http://www.childhealthdata.org/content/Default.aspx>

Data Resource Center for Child & Adolescent Health (home of searchable databases on the National Survey of Children's Health and on the National Survey of Children with Special Health Care Needs)

http://factfinder.census.gov/home/saff/main.html?_lang=en&_ts=

U.S. Census Bureau—American FactFinder (a wealth of Census-related information by county, state, and nation)

http://www.mla.org/census_compare&source=county

Modern Language Association (searchable data center with Census data on languages spoken and on the numbers of speakers; these data are available by age categories)

<http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi>

Kaiser Family Foundation Health Facts (state and national health facts including infant mortality, HIV/AIDS, child and adult immunizations, cardiac disease, and cancer)

<http://www.nicwa.org/resources/factsheets/index.asp>

National Indian Child Welfare Association (fact sheets provide tribal information by state and regional contacts)

<http://www.uscis.gov/graphics/shared/statistics/data/DSLPR04s.htm>

U.S. Department of Homeland Security, Office of Immigration Statistics (information on legal permanent residents)

<http://www.uscis.gov/graphics/shared/statistics/yearbook/index.htm>

U.S. Department of Homeland Security, Office of Immigration Statistics—*Yearbook of Immigration Statistics* (compendium of tables that provide data on foreign nationals who, during a fiscal year, were granted lawful permanent residence [i.e., admitted as immigrants or became legal permanent residents], were admitted into the United States on a temporary basis [e.g., tourists, students, or workers], applied for asylum or refugee status, or were naturalized)

<http://www.ers.usda.gov/statefacts>

U.S. Department of Agriculture—State Fact Sheets (provides statistics on urban and rural populations by state)

<http://www.urban.org/publications/1000587.html>

Urban Institute—Publications (provides materials that report on the numbers and status of undocumented citizens in the United States)

Plan Development

Disparities and quality improvement: Federal policy levers. (2005, March-April), by Nicole Lurie, Minna Jung, and Risa Lavizzo-Mourey, *Health Affairs, The Policy Journal of the Health Sphere* (Millwood), Volume 24, No. 2, 354-364. Available from <http://content.healthaffairs.org/cgi/content/full/24/2/354>

Improving Care for Children with Special Health Care Needs from Diverse Cultural Backgrounds: An Action Plan. (1999), by Theora Evans, Ann Garwick, and Peggy Mann Rinehart. For more information, call National Maternal and Child Health Clearinghouse at (888) 434-4624.

This monograph presents recommendations and strategies on how to improve care for children with special health care needs from diverse cultural backgrounds.

Building Cultural Competence: Guidelines for Action. (2001), by the Washington Department of Health; Multicultural Work Group. For more information, contact Ruth Abad, Health Educator, at www.HEREinWA.org

This resource was developed by the Multicultural Work Group of the Washington Department of Health. The group has worked since 1991 to integrate cultural competency at program and system levels. This resource documents their efforts and provides examples of strategies to operationalize concepts of cultural competence in a meaningful way for the health care staff and to aid programs with long-range planning in protecting and improving the health of Washington state residents.

Building Systems of Care: A Primer. (2002, Spring), by Sheila Pires.

This primer is intended for use with training in systems of care. It integrates concepts of cultural competence throughout the exploration and planning of structures of systems of care. Available from: National Technical Assistance Center for Children's Mental Health

Georgetown University Center for Child and Human Development

3300 Whitehaven Street, N.W., Suite 3300

Box 571485

Washington, DC 20057-1485

Tel.: (202) 687-5000

Fax: (202) 687-8899

<http://gucchd.georgetown.edu/research>

Sponsoring Organization: Child, Adolescent and Family Branch, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration (DHHS).

Crafting Logic Models for Systems of Care: Ideas into Action. (2003), by Mario Hernandez and Sharon Hodges.

This monograph presents an introduction to theories of change. It is designed to assist mental health Systems of Care stakeholders in developing a logic model that will aid at all levels of planning and implementation. It can be adapted to use with diverse community stakeholders for a more culturally competent organization and to encourage the development of culturally relevant outcome measures. Developing a logic model with a broad range of stakeholders can be part of an organizational cultural self-assessment process. Available from <http://cfs.fmhi.usf.edu/cfsnews/cfsnewscategory.cfm?category=1>

Cultural Competency Strategic Planning Process: Narrative and Appendices (HIV Client Services). (2001), by the Washington State Department of Health.

This report describes a year-long process to develop a plan to improve the cultural competence of HIV Client Services, a small program of the Washington State Department of Health. Appendices outline

the strategic plan and provide background documents (including NCCC Policy Brief 1). This report is available with or without appendices. For copies of either version, contact: HIV Client Services, PO Box 47841, Olympia, WA 98504-7841, (360) 236-3426.

Human Resources

In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce. (2004), by the Institute of Medicine. Washington, DC: National Academy Press.

See www.nap.edu

Disparities in Patient Experiences, Health Care Processes, and Outcomes: The Role of Patient-Provider Racial, Ethnic, and Language Concordance. (2004), by Lisa Cooper and Neil Powe.

This July 2004 report, supported by the Commonwealth Fund, reviewed the literature in race-discordant relationships between physicians and patients to determine whether this factor had an effect on outcomes for the patient. "Race-discordant" means when patients from ethnic groups are treated by professionals from a different ethnic background. From the abstract: "The research reviewed here documents ongoing racial and ethnic disparities in health care and links patient/physician race and ethnic concordance with higher patient satisfaction and better health care processes. Based on this research, the authors issue the following recommendations: 1) health policy should be revised to encourage workforce diversity by funding programs that support the recruitment of minority students and medical faculty; 2) health systems should optimize their providers' ability to establish rapport with minority patients to improve clinical practice and health care delivery; 3) cultural competency training should be incorporated into the education of health professionals; and 4) future research should provide additional insight into the mechanisms by which concordance of patient and physician race, ethnicity, and language influences processes and outcomes of care." See publications of the Commonwealth Fund available from <http://www.cmf.org>

Fostering Diversity: Some Major Hurdles Remain, by Mary P. Rowe.

This brief contains strategies to promote and maintain diversity, particularly in academic settings. See <http://aad.english.ucsb.edu/docs/Change6.html>

Promoting Cultural Competence in Children's Mental Health Services. (1998), by Mario Hernandez and Mareasa R. Isaacs, from the *Systems of Care for Children's Mental Health Series*, edited by Beth Stroul and Robert Friedman.

This book focuses on the implications of critical areas for growth of cultural competence for systems of care in children's mental health, including, but not limited to (1) the need to develop organizational infrastructures to support and enhance cultural competence; and (2) recruitment, retention, and training of staff. See bookstores such as www.amazon.com

Recruiting and Retaining Diverse Parent Representation on Interagency Councils. (2004), by the National Early Childhood TA Center (NECTAC).

This brief presents the recommendations of the NECTAC-sponsored meeting in Chapel Hill to discuss cultural and linguistic diversity in early childhood education. "Although it specifically concerns parent members, this paper can be useful for general recruitment to achieve diverse representation" (Introductory letter by Pascal Trohanis, Director of NECTAC). <http://www.nectac.org/pubs/titlelist.asp>

What are Some Strategies for Recruiting and Retaining a Diverse Workforce? (2003), by the Society for Human Resource Management.

This Web site offers advice for recruiting and retaining diverse employees, compiling suggestions from other sources. It also has links to other diversity and business issues.

<http://www.shrm.org/diversity/recruitretain.asp>

Clinical Practice

Cultural competence of nurse practitioner students: A consortium's experience. (2005, May), by Benkert R, Tanner C, Guthrie B, Oakley D, Pohl JM, *Journal of Nursing Education*, Volume 44, No. 5, 225-233.

Improving care and interactions with racially and ethnically diverse populations in healthcare organizations. (2004, July-August), Reynolds D., *Journal of Healthcare Management*, Volume 49, No. 4, 237-249.

Social work and the house of Islam: Orienting practitioners to the beliefs and values of Muslims in the United States. (2005, April), by Hodge DR, *Social Work*, Volume 50, No. 2, 162-173. (Review)

http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=15853193&query_hl=8

Cultural issues in palliative care. (2005, February), by Kemp C, *Seminars in Oncology Nursing*, Volume 21, No. 1, 44-52. (Review).

http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=15807056&query_hl=8

A course on the transition to adult care of patients with childhood-onset chronic illnesses. (2005, April), by Hagood JS, Lenker CV, Thrasher S, *Academic Medicine*, Volume 80, No. 4, 352-355. (Review).

http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=15793019&query_hl=8

Enhancing cultural competencies of advanced practice nurses: Health care challenges in the twenty-first century. (2004, Fall), by Ndiwane A, Miller KH, Bonner A, Imperio K, Matzo M, McNeal G, Amertil N, Feldman Z, *Journal of Cultural Diversity*, Volume 11, No. 3, 118-121.

http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=15689146&query_hl=8

Cultural caring in nursing practice: A meta-synthesis of qualitative research. (2004, Fall), by Coffman MJ, *Journal of Cultural Diversity*, Volume 11, No. 3, 100-109.

http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=15689144&query_hl=8

Cultural competence now mainstream medicine. Responding to increasing diversity and changing demographics. (2004, December), by Cole PM, *Postgraduate Medicine*, Volume 116, No. 6, 51-53. (Review).

http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=15620127&query_hl=8

Agenda dissonance: Immigrant Hispanic women's and providers' assumptions and expectations for menopause healthcare. (2005, February), by Esposito N, *Clinical Nursing Research*, Volume 14, No. 1, 32-56.

http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=15604227&query_hl=8

Budget Allocation

A Guide to Developing and Using Performance Measures in Results-Based Budgeting. (1997), by Mark Friedman; The Finance Project.

This paper is part of a series of papers published by The Finance Project on the subject of results accountability. A previous paper, *A Strategy Map for Results-Based Budgeting*, embedded the challenge of this paper of holding programs accountable for the best possible performance, while ensuring that their performance is aligned with, and supports, overall efforts to improve results, in other words, how to create performance accountability within a results framework.

Assessment of the Total Benefits and Costs of Implementing Executive Order 13166: Improving Access to Services for Persons with Limited English Proficiency. (2002, March 14), by the Office of Management and Budget (OMB), Report to Congress.

This report by OMB reflects that Office's cost-benefit analysis of implementing the contested Executive Order (E.O.) 13166. Highlights: (1) calls for clear and uniform standards for implementation, (2) cites substantial benefits to "improve health and quality of life of many LEP individuals and families. Moreover, language-assistance services may increase the efficiency of distribution of government services to LEP individuals and may measurably increase the effectiveness of public health and safety programs," (3) encourages a focus on Spanish language as the most frequent language spoken in the United States other than English, (4) predicts that provision of language services will be most costly for the healthcare sector, and (5) estimates a cost between \$1 billion and \$2 billion to implement E.O. 13166. See <http://www.omb.gov/inforeg/regpol.html>

Shortchanging America's Health: A State-by-State Look at How Federal Public Health Dollars are Spent. (2005), by the Trust for America's Health.

The Robert Wood Johnson Foundation sponsored a report just released (February 7, 2005) that gives information, by state, on (1) the difference between dollars spent on medical care/treatment versus health promotion; (2) defines the Federal agencies that have a role in public health (hint: the total is surprising); (3) charts per state give percentage of *adults* with asthma, diabetes, obesity, cancer, heart disease, West Nile disease, AIDS; *children* with asthma, overweight, fully immunized, infant mortality, rate of Low Birth Weight CDC funds per line item of cancer prevention; chronic disease prevention/health promotion; diabetes control; environmental health; HIV prevention; immunization; infectious disease, with totals and per capita as well as state rank; (4) bio-terrorism preparedness spending from the CDC and HRSA and the totals; (5) HRSA spending from Ryan White, Maternal and Child Health Block grant; and Health Professionals Grant; and (6) the number of primary care health professions shortage areas. See <http://healthyamericans.org/reports/budget05/>

Role of the Planning Process

The Role of Self-Assessment in Achieving Cultural Competence. (2001), by Tawara Goode. Available for direct download from the NCCC Web site at <http://guchd.georgetown.edu/nccc/documents/selfassessment.pdf>

The Cultural Competence Self Assessment Protocol for Health Care Organizations and Systems, developed by Dennis Andrulis, Thomas Delbanco, Laura Avakian, and Yoku Shaw-Taylor. Available from <http://erc.msh.org/mainpage.cfm?file=9.1g.htm&module=provider&language=English>

A Manager's Guide to Cultural Competence Education for Health Care Professionals. (2003), edited by M. Jean Gilbert and prepared for the California Endowment. See http://www.calendow.org/reference/publications/pdf/cultural/TCE0217-2003_A_Managers_Gui.pdf

Example of a cultural competence plan from the California Department of Mental Health (includes administration goals and structures). See <http://www.uacc4families.org/documents/CultCompPlan-for-LTCS.pdf>

Health sector reform and public sector health worker motivation: A conceptual framework. (2002, April), by L. M. Franco, S. Bennett, and R. Kanfer, *Social Science Medicine*, Volume 54, No. 8, 1255-1266.

Creating an Internal Management Structure for the Process

The NCCC Policy Brief series discusses organizational structures as a key part of cultural and linguistic competence. These policy briefs are available at <http://guchd.georgetown.edu/nccc/products.html>

There is some general information on establishing a diversity committee at <http://www.casanet.org/program-management/diversity/cultural-competence.htm>

The Director's Query, a report on the results of interviews of State Title V Directors, will be available from the NCCC Web site in 2005/2006. This report will contain information on the different internal structures some State Title V Directors are using to infuse cultural and linguistic competence at all levels of their organizations.

The Contra Costa Health Services for Contra Costa County in California (see www.cchealth.org) developed an organizational plan to address health disparities by infusing cultural and linguistic competence. See *Reducing Health Disparities: Diversity & Cultural and Linguistic Competence*. Available online at http://www.cchealth.org/topics/publications/pdf/reducing_health_disparities_article_nov03.pdf

Office of Multicultural Services, South Carolina Department of Mental Health, developed a cultural competence plan, which is available online at http://www.state.sc.us/dmh/cultural_competence/cultural_plan.htm

Identifying Fiscal and Personnel Resources

Assessment of the Total Benefits and Costs of Implementing Executive Order 13166: Improving Access to Services for Persons with Limited English Proficiency, by OMB. Report to Congress. See <http://www.omb.gov/infoereg/regpol.html>

Pay now or pay later: Providing interpreter services in health care. (2005, March-April), by L. Ku, G. Flores; Center on Budget and Policy Priorities, *Health Affairs: The Policy Journal of the Sphere* (Millwood), Volume 24, No. 2, 435-444.

Federal civil rights policy obligates health care providers to supply language services, but wide gaps persist because insurers typically do not pay for interpreters, among other reasons. Health care financing policies should reinforce existing medical research and legal policies: Payers, including Medicaid, Medicare, and private insurers, should develop mechanisms to pay for interpretation services for patients who speak limited English” Excerpt from abstract. Available from <http://content.healthaffairs.org/cgi/content/full/24/2/435?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&title=Pay+Now+or+Pay+Later&andorexacttitle=and&andorexacttitleabs=and&andorexactfulltext=and&searchid=1&FIRSTINDEX=0&sortspec=relevance&resourcetype=HWCIT>

Reducing disparities through culturally competent health care: An analysis of the business case. (2002, Summer), by C. Brach and I. Fraser, *Quality Management in Health Care*, Volume 10, No. 4, 15-28.

The Role of Self-Assessment in Achieving Cultural Competence. (2001), by Tawara Goode.

This is an excerpt from the Cultural Competence Exchange newsletter of 2001 that identifies fiscal and resource benefits of self-assessment by identifying and utilizing current staff knowledge and skills more effectively, for example, those with multiple language skills, experience, and credibility with communities. Available directly from the NCCC Web site at <http://gucchd.georgetown.edu/nccc/documents/selfassessment.pdf>

Identifying Collaborating Partners and Engaging Community Members in the Process

Policy Brief 4: Engaging Communities to Realize the Vision of One Hundred Percent Access and Zero Health Disparities: A Culturally Competent Approach. (2001), by Tawara Goode. Available for download directly from the NCCC Web site at <http://gucchd.georgetown.edu/nccc/documents/ncccpolicy4.pdf>

Bridging the Cultural Divide in Health Care Settings: The Essential Role of Cultural Broker Programs. (2003), by Tawara Goode, Suganya Sockalingam, and Lisa Lopez-Snyder. Available for download directly from the NCCC Web site at http://gucchd.georgetown.edu/nccc/documents/Cultural_Broker_Guide_English.pdf

The Contra Costa Health Department developed a guide for community building, *Healthy Neighborhoods Project: A Guide for Community Building and Mobilizing Around Health* (1.3MB PDF, 102pp.).

This guidebook presents a strategy that health departments and other agencies can use to improve community health. It presents the asset-based, community-building model of the Healthy Neighborhoods Project and how it has been implemented in Contra Costa County.

Keys to Access: Encouraging the Use of Mediation by Families From Diverse Backgrounds. (1999), by Anita Engiles, Cathy Fromme, Diane LeResche, and Philip Moses; Consortium for Appropriate Dispute Resolution in Special Education.

This resource, designed for professionals in special education, provides guidance on understanding “why some families may not participate in mediation, and strategies for increasing the participation

from diverse backgrounds...practical recommendations. to develop the knowledge, positive attitudes, skills and strengths necessary for genuine collaboration” (p. 3). <http://www.directionservice.org/cadre/audio55.cfm>

Community-based research partnerships: challenges and opportunities. (2005, June), by M. Minkler, *Journal of Urban Health*, Volume 82, No. 2, Suppl. 2, ii3-ii12. Epub 2005, May 11.

Abstract: “The complexity of many urban health problems often makes them ill suited to traditional research approaches and interventions. The resultant frustration, together with community calls for genuine partnership in the research process, has highlighted the importance of an alternative paradigm. Community-based participatory research (CBPR) is presented as a promising collaborative approach that combines systematic inquiry, participation, and action to address urban health problems. Following a brief review of its basic tenets and historical roots, key ways in which CBPR adds value to urban health research are introduced and illustrated. Case study examples from diverse international settings are used to illustrate some of the difficult ethical challenges that may arise in the course of CBPR partnership approaches. The concepts of partnership synergy and cultural humility, together with protocols such as Green et al.’s guidelines for appraising CBPR projects, are highlighted as useful tools for urban health researchers seeking to apply this collaborative approach and to deal effectively with the difficult ethical challenges it can present.” See http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=15888635&dopt=Abstract

Building on leadership and social capital to create change in 2 urban communities. (2005, April), by S. A. Farquhar, Y. L. Michael, and N. Wiggins, *American Journal of Public Health*, Volume 95, No. 4, 596-601.

This project addressed health disparities in the African American and Latino communities by enhancing community-level social capital. The article contains “specific examples of how this intervention uses community health workers and popular education to reduce language and cultural barriers and enhance community social capital. Although the communities share fundamental challenges related to health disparities, the ways in which the Latino and African American communities identify health concerns, create solutions, and think about social capital vary” (Abstract).

Using community-based participatory research methods to reach women with health messages: Results from the North Carolina BEAUTY and Health Pilot Project. (2005, April), by L. A. Linnan, Y. O. Ferguson, Y. Wasilewski, A. M. Lee, J. Yang, F. Solomon, and M. Katz, *Health Promotion Practice*, Volume 6, No. 2, 164-173.

This study used a community-based participatory research approach to recruit and train five licensed cosmetologists from two beauty salons to deliver health promotion messages to their customers. “At 12 months, 55% of customers reported making changes in their health because of the conversations they had with their cosmetologist. Customers who spoke more often with their cosmetologists about health also reported a higher percentage of self-reported behavior changes. It appears that trained licensed cosmetologists are effective in promoting health messages to their customers” (Abstract). See <http://hcpp.sagepub.com/cgi/content/abstract/6/2/164>

Community Engagement in Public Health. (2006, March), by Mary Anne Morgan and Jennifer Lifshay.

This paper introduces a conceptual framework for community engagement in public health. It highlights the examples of the Contra Costa (California) Health Services’ community engagement program. See http://www.cchealth.org/topics/publications/pdf/community_engagement_in_ph.pdf

Planning and Conducting Consumer Focus Groups

A New Use for Focus Groups—Building and Empowering a Culturally Diverse Team. (1996, November-December), by Sandra Hellman and Lynn Baker, *Best Practices and Benchmarking in Healthcare*, Volume 1, No. 6, 297-300.

Community-Based Participatory Research. (2004, July), by the Agency for Healthcare Research and Quality (AHRQ); Evidence-Based Practice Program.

[Full citation: Viswanathan M, Ammerman A, Eng E, Gartlehner G, Lohr KN, Griffith D, Rhodes S, Samuel-Hodge C, Maty S, Lux L, Webb L, Sutton SF, Swinson T, Jackman A, Whitener L. Community-Based Participatory Research: Assessing the Evidence. Evidence Report/Technology Assessment No. 99 (Prepared by RTI-University of North Carolina Evidence-based Practice Center under Contract No. 290-02-0016). AHRQ Publication 04-E022-2. Rockville, MD: Agency for Healthcare Research and Quality. July 2004.]

Families as Full Research Partners: What's in it for Us? (1999, August), by Ann Vander Stoep, Marilyn Williams, Robert Jones, Linda Green, and Eric Trupin, *Journal of Behavioral Health Services & Research*, Volume 26, No. 3, 329-344.

Hearing their Voices: Lessons from the Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA), Focus Group Findings from California. (2004, Fall), by the Kaiser Family Foundation. See <http://www.kff.org/womenshealth/7146.cfm>

Mexican-Origin Children's Health in Cultural Context. (2005), by Lauren Clark; University of Colorado Health Sciences Center.

This article is an example of a “focused ethnography” intended to describe the cultural context of “child health production activities” for the benefit of nurses assisting Mexican-origin families. Study structures include home visits, unstructured interviews, photographs, and focus groups with different stakeholders, including a grandmother group, a friends/sisters of mothers group, and a health care professionals group. See http://156.40.88.3/cpr/dbs/res_mexican.htm

Responsible Research with Communities: Participatory Research in Primary Care: A Policy Statement. (1998), by N. Gibson (Editor).

This is a policy statement on participatory research at the North American Primary Care Research Group (NAPCRG) Annual Membership Meeting. <http://napcrg.org/exec.html>

Developing Guidelines for Data Analysis and Report Development

W.K. Kellogg Foundation Evaluation Handbook. (1998), by W.K. Kellogg Foundation, Call (800) 819-9997 for a free copy.

This handbook was designed by the Kellogg Foundation staff in order to make evaluation techniques more useful to organizational and program development. According to the introduction, this handbook “provides a framework for thinking about evaluation and outlines a blueprint for designing and conducting evaluations, either independently or with the support of an external evaluator/consultant.” The process explicitly calls for addressing “real issues” in the community and creating a participatory process. When infused with principles of cultural and linguistic competence, this tool can be used to evaluate health and mental health systems for the diversity that exists in the United States.

Step into my zapatos, doc: Understanding and reducing communication disparities in the multicultural informed consent setting. (2005, Winter), by C. M. Simon and E. D. Kodish, *Perspectives in Biology and Medicine*, Volume 48, 1 Suppl., S123-138.

Abstract: "Current informed consent standards are aimed at promoting an equitable and ethical environment for conducting research across diverse patient populations. This paper explores the possible effects of ethnicity and culture on the consent process for pediatric cancer clinical trials. Informed consent discussions were observed, recorded, transcribed, and coded. Question asking by parents and clinician/parent word ratios were used to create an interactivity measure, or "I-score." Visual analog scales were used to rate the clarity of specific explanations. Cases were sorted into two groups on the basis of parents' self-reported ethnicity: Caucasian (n=79, 56%) and minority (predominantly Latino) parents (n=61, 44%). Chi-square and t-tests were used to compare the groups. A series of logistic regression analyses (controlling for ethnicity and SES) were run for variables that showed statistically significant differences ($p < 0.05$). Our findings suggest that the content and quality of the informed consent process is linked to parental ethnicity, or clinician attitudes toward parental ethnicity. These findings are discussed in terms of current perspectives on culture and "cultural competence" in health care. Further research is needed to understand how cultural factors affect outcomes such as parental understanding, decision making, mutual trust, and satisfaction within the informed consent process."

Developing a cultural competence assessment tool for people in recovery from racial, ethnic and cultural backgrounds: The journey, challenges and lessons learned. (2005, Winter), by T. E. Arthur, I. Reeves, O. Morgan, L. J. Cornelius, N. C. Booker, J. Brathwaite, T. Tufano, K. Allen, and I. Donato, *Psychiatric Rehabilitation Journal*, Volume 28, No. 3, 243-250.

Abstract: "In 1997, Maryland implemented a new managed care mental health system. Consumer satisfaction, evaluation and cultural competency were considered high priorities for the new system. While standardized tools for measuring consumer satisfaction were readily available, no validated, reliable and standardized tool existed to measure the perception of people from minority groups receiving mental health services. The MHA*/MHP* Cultural Competency Advisory Group (CCAG) accepted the challenge of developing a consumer assessment tool for cultural competency. The CCAG, composed of people in recovery, clinicians and administrators used their collective knowledge and experiences to develop a 52-item tool that met standards for validity and reliability. Consultation from a researcher helped to further develop the tool into one possessing tremendous potential for statewide implementation within Maryland's Public Mental Health System. Recognizing the limitations of the study and the need for further research, this instrument is a work in progress. Strategies to improve the instrument are currently underway with the Mental Hygiene Administration's Systems Evaluation Center of the University of Maryland and several national researchers."

Developing Suggested Best Practices for Disseminating the Results of the Self-Assessment

Promising Practices Contra Costa County (in progress, will be made available on the NCCC Web site in summer 2005).

Infusing Cultural & Linguistic Competence into Health Promotion Training (DVD).
See <http://gucchd.georgetown.edu/nccc/sidsdvd.html>

Changing Channels and Crisscrossing Cultures: A Survey of Latinos on the News Media (2004), by Roberto Suro; Pew Hispanic Center.

From the Introduction: "This report shows that the news media powerfully influence the twin processes of cultural change at work in the Hispanic population: the assimilation of American

attitudes and the formation of a distinct ethnic identity. Even as the English-language media purveys values and cultural expressions drawn primarily from the experience of the native born, the Spanish-language media reflects the immigrant experience and reinforces ties to the home country. Nearly half of the adult Hispanic population crisscrosses between the two, getting some of its news in both languages." <http://pewhispanic.org/reports/report.php?ReportID=27>

The value of engaging stakeholders in planning and implementing evaluations. (2002, June), by A. Gilliam, D. Davis, T. Barrington, R. Lacson, G. Uhl, and U. Phoenix, *AIDS Education and Prevention*, Volume 14, No. 3, Suppl. A, 5-17.

Abstract: "Stakeholder participation in evaluation has surfaced as a major factor contributing to the effectiveness of HIV prevention programs. In recognition of the multiple benefits, the Centers for Disease Control and Prevention (CDC), has used a framework to involve stakeholders in the evaluation of its programs. This article describes the framework used by the CDC and provides examples of four studies that involved various stakeholders from health departments, community-based organizations, and community planning groups to national and regional organizations in designing and implementing evaluations that yielded results useful for program improvement. The participatory process involved stakeholders in each of the four phases of the framework: evaluation planning, implementation, development of action plans, and dissemination. Lessons learned include the importance of having a facilitator to coordinate activities and ongoing communication with those involved in the evaluation. Stakeholders shared that using the evaluation results for action planning was beneficial for improving their programs. Despite many challenges faced in the stakeholder evaluation process, most stakeholders agreed that many benefits grew out of the multiple perspectives presented and understanding of the service agencies."

Policy Brief 3. Cultural Competence in Primary Health Care: Partnerships for a Research Agenda. (2000), by Tawara Goode and Sharonlyn Harrison.

This brief includes strategies for dissemination. See <http://guchd.georgetown.edu/nccc/documents/Policy%20Brief%203.pdf>

Cardiovascular health among Asian Indians (CHAI): A community research project. (2004, November), by S. L. Ivey, S. Patel, P. Kalra, K. Greenlund, S. Srinivasan, and D. Grewal, *Journal of Interprofessional Care*, Volume 18, No. 4, 391-402.

Abstract: "The object of this research was to assess cardiovascular (CV) risks in Asian Indians in California. We conducted eight focus groups and a pilot survey using community-based participatory research (CBPR) methods. Focus groups were held in six communities. Surveys were conducted by telephone or in person in areas selected for high population densities of Asian Indians. We selected focus group subjects by snowball sampling (n = 57). We held six English and two Punjabi groups. We used a surname-based phone list from three area codes for telephone interviews (n = 254). We added 50 in-person interviews for comparison (total n = 304) and did 50 interviews in Punjabi. We held community meetings for dissemination. Focus groups discussed CV risks; themes developed aided survey development. In-person and telephone surveys were feasible. Telephone surveys were more gender-balanced and people more often answered alcohol, tobacco, and income questions. Self-reported prevalences for hypertension, hypercholesterolemia, and diabetes were 20.4, 35.3 and 10.6%, respectively. Only 11.9% of persons reported ever smoking cigarettes. It was concluded that CBPR methods were effective in this exploratory study assessing CV risks in Asian Indians. Hypertension, high cholesterol, and diabetes were more prevalent in participants than the population average; other risk factors were less common (tobacco)."

‘Imi Hale—the Native Hawaiian cancer awareness, research, and training network: Second-year status report. (2003, Winter-Spring), by K. L. Braun, J. Tsark, L. A. Santos, and L. Abrigo; Native Hawaiian Cancer Awareness Research and Training Network, Asian American and Pacific Islander Journal of Health, Volume 10, No. 1, 4-16.

Abstract: “PURPOSE: The purpose of this paper is to describe ‘Imi Hale, a program developed and managed by Native Hawaiians to increase cancer awareness and research capacity among Native Hawaiians. This US subgroup of indigenous people of the Hawaiian islands has disproportionately high rates of cancer mortality and low rates of participation in health and research careers.

METHODS: As a community-based research project, ‘Imi Hale spent its first year gathering data from Native Hawaiians about their cancer awareness and research priorities. These findings guide ‘Imi Hale’s community and scientific advisors, a community-based Institutional Review Board, Na Liko Noelo (budding researchers), and staff in developing and carrying out projects that address these priority areas. Emphasis is placed on transferring skills and resources to Native Hawaiians through training, technical assistance, and mentorship. A biennial survey assesses the extent to which community-based participatory research principles are being followed. PRINCIPAL FINDINGS: By the end of the school year, statewide and island-specific awareness plans were produced, and 9 funded awareness projects are supporting the development and dissemination of Hawaiian health education materials. Research accomplishments include the enrollment of 42 Native Hawaiian Na Liko Noelo (budding researchers), 22 of which are involved in 14 funded research projects. The biennial evaluation survey found that 92% of our advisors felt that ‘Imi Hale was promoting scientifically rigorous research that was culturally appropriate and respectful of Native Hawaiian beliefs, and 96% felt that ‘Imi Hale was following its own principles of community-based participatory research.

CONCLUSION: ‘Imi Hale’s community-based approach to promoting cancer awareness will result in a sustainable infrastructure for reducing the cancer burden on Native Hawaiians.”

The East Side Village Health Worker Partnership: Integrating research with action to reduce health disparities. (2001, November-December), by A. J. Schulz, B. A. Israel, E. A. Parker, M. Lockett, Y. Hill, and R. Wills, Public Health Reports, Volume 116, No. 6, 548-557.

Abstract: “This article describes the work of the East Side Village Health Worker Partnership as a case study of an initiative that seeks to reduce the disproportionate health risks experienced by residents of Detroit’s east side. The Partnership is a community-based participatory research and intervention collaboration among academia, public health practitioners, and the east side Detroit community. The Partnership is guided by a steering committee that is actively involved in all aspects of the research, intervention, and dissemination process, made up of representatives of five community-based organizations, residents of Detroit’s east side, the local health department, a managed care provider, and an academic institution. The major goal of the East Side Village Health Worker Partnership is to address the social determinants of health on Detroit’s east side, using a lay health advisor intervention approach. Data collected from 1996 to 2001 are used here to describe improvements in research methods, practice activities, and community relationships that emerged through this academic-practice-community linkage.”

APPENDIX 3: Sample Consent Form for Focus Group

(Date)

Dear Focus Group Participant:

(Health Center name) is conducting an assessment of how well **(Health Center name)** meets the health care needs of its clients. It is important to hear from you about the successes and challenges you face in seeking health care services.

As part of this self-assessment, focus groups are being conducted. The focus group will 1) seek your views about services you are receiving and 2) make recommendations to improve services and supports. If you agree to participate in the focus group, you will receive a stipend of **(insert amount here)**. Language interpreters will be available.

Please be assured that your responses to the questions will be confidential. A summary of comments will be provided to **(Health Center's name)** in a report. Your name will not appear on the report. The report will be used to assist the health center in improving the way services are delivered to clients from culturally diverse groups.

If you agree to participate, please sign your name in the space provided.

Thank you.

(Signature) (Date)

APPENDIX 4: Sample Focus Group Protocol

Introduction

- Moderator or co-facilitator welcome participants and conduct introductions._
- Explain what a focus group is—like an opinion survey, but very general, broad questions with no right or wrong, good or bad answers. Express the importance of their presence and input.
- Guide for background information and purpose of group discussion:

We are from _____. We are working with the _____ to assist them in developing and implementing services that meet your health care needs both in a cultural and linguistic context.

The health center is very interested in finding out how the health center's policies and practitioners respond to the health care needs and preferences of diverse individuals. Of particular importance to them are the successes and challenges you have faced.

- Guide for explaining the letter of Agreement/Consent Form:

Voluntary participation: This form states that participation by consumers is voluntary.

Documentation Procedure & Confidentiality: Some individuals observing the focus group will be taking notes for submission in a report to the health center. Comments made by participants will be summarized; however, no one will be identified by name. Some direct quotes will be used.

Honoraria: An honorarium to each participating consumer.

- Ask for questions and distribute Agreement to Participate forms.
- Thank participants and disseminate honoraria forms or checks after the focus group.

REFERENCES:

1. Opportunities for Professionals and Families to Understand Strategies for Cross-Cultural Communication (OPUS) Project "Focus Group Protocol." Southwest Communication Resources, P.O. Box 788, Bernalillo, NM 87004; phone: (505) 867-3396 and fax: (505) 867-3398.
2. National Institute on Aging *Focus Group Moderator's Guide*.



About the National Center for Cultural Competence

The NCCC provides national leadership and contributes to the body of knowledge on cultural and linguistic competency within systems and organizations. Major emphasis is placed on translating evidence into policy and practice for programs and personnel concerned with health and mental health care delivery, administration, education and advocacy. The NCCC uses four major approaches to fulfill its mission including (1) web-based technical assistance, (2) knowledge development and dissemination, (3) supporting a “*community of learners*” and (4) collaboration and partnerships with diverse constituency groups. These approaches entail the provision of training, technical assistance, and consultation and are intended to facilitate networking, linkages and information exchange. The NCCC has particular expertise in developing instruments and conducting organizational self-assessment processes to advance cultural and linguistic competency.

Mission

The mission of the National Center for Cultural Competence (NCCC) is to increase the capacity of health care and mental health care programs to design, implement and evaluate culturally and linguistically competent service delivery systems.

The NCCC is a component of the Georgetown University Center for Child and Human Development (GUCCHD) and is housed within the Department of Pediatrics of the Georgetown University Medical Center. It is funded and operates under the auspices of Cooperative Agreement #U93-MC-00145 and is supported in part from the Maternal and Child Health program (Title V, Social Security Act), Health Resources and Services Administration, U.S. Department of Health and Human Services (DHHS). The NCCC conducts a collaborative project under the auspices of another Cooperative Agreement with the GUCCHD and the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, DHHS. Additionally the NCCC contracts with governmental and non-governmental organizations for specific scopes of work at the local, state and national levels.

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Cultural and Linguistic Competence Policy Assessment

National Center for Cultural Competence

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University Center for Excellence in Developmental Disabilities

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Overview/Purpose

The Cultural Competence and Linguistic Competence Policy Assessment (CLCPA) was developed at the request of the Bureau of Primary Health Care (BPHC), Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Service (DHHS). The CLCPA is intended to support community health centers on: (1) improve health care access and utilization, (2) enhance the quality of services within culturally diverse and underserved communities, and (3) promote cultural and linguistic competence as essential approaches in the elimination of health disparities. The NCCC developed *A Guide for Using the Cultural and Linguistic Competence Policy Assessment* that is available at <http://gucchd.georgetown.edu/nccc>.

Conceptual Framework of the CLCPA

The CLCPA is based on three assumptions: (1) achieving cultural competence is a developmental process at both the individual and organizational levels; (2) with appropriate support, individuals can enhance their cultural awareness, knowledge and skills over time; and (3) cultural strengths exist within organizations or networks of professionals but often go unnoticed and untapped (Mason, 1996). Linguistic competence, while defined differently, is integrally linked to cultural competence and is an essential aspect of cross-cultural communication. The CLCPA and the outcomes of the assessment process are intended to assist organizations to identify strengths and areas of growth for policy development and administration. The CLCPA captures a wide range of data in its seven subscales including: *Knowledge of Diverse Communities, Organizational Philosophy, Personal Involvement in Diverse Communities, Resources & Linkages, Human Resources, Clinical Practice and Engagement of Diverse Communities*.

Guidelines for Completing the CLCPA

The instrument requires that you respond to detailed questions including your awareness of supporting policy. It is important to answer every question to the best of your knowledge. There are no right or wrong answers. Your organization may use the data: (1) to provide a summary of the strengths and areas for growth in policy development and administration, (2) for strategic planning, and (3) for quality improvement processes.

Thank you for your candor, time and patience.

DEFINITIONS

Cultural Competence

The NCCC embraces a conceptual framework and model of achieving cultural competence adopted from the Cross et al. (1989) definition. Cultural competence requires that organizations:

- have a defined set of values and principles, and demonstrate behaviors, attitude policies and structures that enable them work effectively cross-culturally.
- have the capacity to (1) value diversity, (2) conduct self-assessment, (3) manage the dynamics of difference, (4) acquire and institutionalize cultural knowledge, and (5) adapt to the diversity and cultural contexts of the individuals, families and communities they serve.
- incorporate the above in all aspects of policy making, administration, practice, service delivery and systematically involve consumers and families.

Linguistic Competence

Definitions of linguistic competence vary considerably. Such definitions have evolved from diverse perspectives, interests and needs and are incorporated into state legislation, Federal statutes and programs, private sector organizations and academic settings. The following definition, developed by the National Center for Cultural Competence, provides a foundation for determining linguistic competence in health care, mental health and other human service delivery systems. It encompasses a broad spectrum of constituency groups that could require language assistance or other supports from an organization, agency, or provider.

The capacity of an organization and its personnel to communicate effectively, and convey information in a manner that is easily understood by diverse audiences including persons of limited English proficiency, those who have low literacy skills or are not literate, and individuals with disabilities. Linguistic competency requires organizational and provider capacity to respond effectively to the health literacy needs of populations served. The organization must have policy, structures, practices, procedures, and dedicated resources to support this capacity. This may include, but is not limited to, the use of:

- bilingual/bicultural or multilingual/multicultural staff;
- cross-cultural communication approaches
- cultural brokers;
- foreign language interpretation services including distance technologies;
- sign language interpretation services;
- multilingual telecommunication systems;
- videoconferencing and telehealth technologies;
- TTY and other assistive technology devices;
- computer assisted real time translation (CART) or viable real time transcriptions (VRT);
- print materials in easy to read, low literacy, picture and symbol formats;
- materials in alternative formats (e.g., audiotope, Braille, enlarged print);
- varied approaches to share information with individuals who experience cognitive disabilities;
- materials developed and tested for specific cultural, ethnic and linguistic groups;
- translation services including those of:
- legally binding documents (e.g., consent forms, confidentiality and patient rights statements, release of information, applications)
- signage
- health education materials
- public awareness materials and campaigns; and
- ethnic media in languages other than English (e.g., television, radio, Internet, newspapers, periodicals).

(developed by Tawara D. Goode and Wendy Jones, 8/00, Revised 6/06).

DEFINITIONS (CONTINUED)

Culture

Culture is an integrated pattern of human behavior, which includes but is not limited to—thought, communication, languages, beliefs, values, practices, customs, courtesies, rituals, manners of interacting, roles, relationships and expected behaviors of a racial, ethnic, religious, social or political group; the ability to transmit the above to succeeding generations; dynamic in nature. (“Key Definitions”, National Center for Cultural Competence, 1999, Revised 2002).

Dialect

A regional variety of language distinguished by features of vocabulary, grammar, and pronunciation from other regional varieties and constituting together with them a single language (Merriam Webster On-Line 2006)

Health Disparities

There are many definitions for health disparities. For the purposes of this instrument, the NCCC adopted the following definition of health disparities - population-specific differences in the presence of disease, health outcomes, or access to health care.

Health Literacy

The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions. [HP 2010: Health Communication](http://www.hrsa.gov/quality/healthlit.htm)
<http://www.hrsa.gov/quality/healthlit.htm>

Organizational Culture

Organizational culture is a pattern of shared basic assumptions that the group learned as it solved its problems of external adaptation and internal integration, that has worked well enough to be considered valid and therefore, to be taught to new members as the correct way to perceive, think, and feel in relation to those problems. (Schein, E., 1985)

Policy

Policy is defined for the purposes of this instrument as a high level overall plan embracing the philosophy, general goals and acceptable procedures within an organization (Webster’s Collegiate Dictionary, 1985). Additionally, formal policy is written and codified. Informal policy is shared and understood verbally, however, compliance may or may not be enforceable and adherence may vary.

References

- Cohen, E., & Goode, T. D. (1999), revised by Goode, T.D., & Dunne, C. (2003). Policy Brief 1: Rationale for Cultural Competence in Primary Care. Washington, DC: National Center for Cultural Competence, Georgetown University Center for Child and Human Development.
- Mason, J. L. (1995). Cultural Competence Self-Assessment Questionnaire: A manual for users. Portland, OR: Research and Training Center on Family Support and Children’s Mental Health, Portland State University.
- Schein, E. (1985), *Organizational Culture and Leadership*, Jossey-Bass, San Francisco, CA,

CULTURAL AND LINGUISTIC COMPETENCE POLICY ASSESSMENT

Guidelines for Completing the CLCPA

Please answer every question to the best of your knowledge. **Please remember to answer the question regarding supporting policy found adjacent to each question.**

Policy is defined for the purposes of this instrument as a high level overall plan embracing the philosophy, general goals and acceptable procedures within an organization (Webster's Collegiate Dictionary, 1985). Additionally, formal policy is written and codified. Informal policy is shared and understood verbally, however, compliance may or may not be enforceable and adherence may vary.

Knowledge of Diverse Communities

The **Knowledge of Diverse Communities** subscale consists of eleven questions. It concerns knowledge of the identified cultural groups, how they differ internally and how they differ from the dominant culture. Its central focus is organizational policy that takes into consideration cultural beliefs, strengths, vulnerabilities, community demographics and contextual realities. Responses to these items can range from "not at all" to "very well". The existence of supporting policy can range from "no policy" to "formal policy".

1. Is your agency able to identify the culturally diverse communities in your service area?

Designated Cultural Groups	Not At All	Barely	Fairly Well	Very Well	Is there supporting policy?
					<input type="checkbox"/> No policy
					<input type="checkbox"/> Informal policy
					<input type="checkbox"/> Developing policy
					<input type="checkbox"/> Formal policy
					<input type="checkbox"/> I do not know

2. Is your agency familiar with current and projected demographics for your service area?

Designated Cultural Groups	Not At All	Barely	Fairly Well	Very Well	Is there supporting policy?
					<input type="checkbox"/> No policy
					<input type="checkbox"/> Informal policy
					<input type="checkbox"/> Developing policy
					<input type="checkbox"/> Formal policy
					<input type="checkbox"/> I do not know

Knowledge of Diverse Communities Continued

3. Is your agency able to describe the social strengths (e.g., support networks, family ties, spiritual leadership, etc.) of diverse cultural groups in your service area?

Designated Cultural Groups	Not At All	Barely	Fairly Well	Very Well	Is there supporting policy?
					<input type="checkbox"/> No policy
					<input type="checkbox"/> Informal policy
					<input type="checkbox"/> Developing policy
					<input type="checkbox"/> Formal policy
					<input type="checkbox"/> I do not know

4. Is your agency able to describe the social problems (e.g., dispersed families, poverty, unsafe housing, etc.) of diverse cultural groups in your service area?

Designated Cultural Groups	Not At All	Barely	Fairly Well	Very Well	Is there supporting policy?
					<input type="checkbox"/> No policy
					<input type="checkbox"/> Informal policy
					<input type="checkbox"/> Developing policy
					<input type="checkbox"/> Formal policy
					<input type="checkbox"/> I do not know

5. Is your agency able to describe health disparities among culturally diverse groups in your service area?

Designated Cultural Groups	Not At All	Barely	Fairly Well	Very Well	Is there supporting policy?
					<input type="checkbox"/> No policy
					<input type="checkbox"/> Informal policy
					<input type="checkbox"/> Developing policy
					<input type="checkbox"/> Formal policy
					<input type="checkbox"/> I do not know

Knowledge of Diverse Communities Continued

6. Is your agency able to describe the languages and dialects used by the following culturally diverse groups in your service area?

Designated Cultural Groups	Not At All	Barely	Fairly Well	Very Well	Is there supporting policy? <input type="checkbox"/> No policy <input type="checkbox"/> Informal policy <input type="checkbox"/> Developing policy <input type="checkbox"/> Formal policy <input type="checkbox"/> I do not know

For the culturally diverse groups in your service area does your agency know:

7. The health beliefs, customs, and values? ☐ Not At All ☐ Barely ☐ Fairly Well ☐ Very Well

8. The natural networks of support? ☐ Not At All ☐ Barely ☐ Fairly Well ☐ Very Well

For the culturally diverse groups in your service area can your agency identify:

9. Help-seeking practices? ☐ Not At All ☐ Barely ☐ Fairly Well ☐ Very Well

10. The way illness and health are viewed? ☐ Not At All ☐ Barely ☐ Fairly Well ☐ Very Well

11. The way mental health is perceived? ☐ Not At All ☐ Barely ☐ Fairly Well ☐ Very Well

For questions 7–11

Is there policy to support staff to acquire knowledge about the cultural beliefs and practices of diverse groups?

☐ No policy ☐ Informal policy ☐ Developing policy ☐ Formal policy ☐ I do not know

COMMENTS: _____

Organizational Philosophy

The **Organizational Philosophy** subscale consists of ten items. It involves organizational commitment to the provision of culturally and linguistically competent services and the extent to which it is legitimized in policy. It probes the incorporation of cultural competence into the organization's mission statement, structures, practice models, collaboration with consumers and community members, and advocacy. Responses range from “*not at all or none*” to “*very often or many*” to “*yes or no*”. The existence of supporting policy can range from “*no policy*” to “*formal policy*”.

12. Does your agency have a mission statement that incorporates cultural and linguistic competence in service delivery?

☐ Yes ☐ No

13. Does your agency support a practice model that incorporates culture in the delivery of services?

☐ Not At All ☐ Sometimes ☐ Fairly Often ☐ Very Often

Is there supporting policy? ☐ No policy ☐ Informal policy ☐ Developing policy ☐ Formal policy ☐ I do not know

14. Does your agency consider cultural and linguistic differences in developing quality improvement processes?

☐ Not At All ☐ Sometimes ☐ Fairly Often ☐ Very Often

Is there supporting policy? ☐ No policy ☐ Informal policy ☐ Developing policy ☐ Formal policy ☐ I do not know

15. Does your agency advocate for culturally diverse consumers regarding quality of life issues (e.g., employment, housing, education) in your service area?

☐ Not At All ☐ Sometimes ☐ Fairly Often ☐ Very Often

Is there supporting policy? ☐ No policy ☐ Informal policy ☐ Developing policy ☐ Formal policy ☐ I do not know

16. Does your agency systematically review procedures to insure that they are relevant to delivery of culturally competent services?

☐ Not At All ☐ Sometimes ☐ Fairly Often ☐ Very Often

Is there supporting policy? ☐ No policy ☐ Informal policy ☐ Developing policy ☐ Formal policy ☐ I do not know

17. Does your agency systematically review procedures to insure that they are relevant to delivery of linguistically competent services?

☐ Not At All ☐ Sometimes ☐ Fairly Often ☐ Very Often

Is there supporting policy? ☐ No policy ☐ Informal policy ☐ Developing policy ☐ Formal policy ☐ I do not know

Organizational Philosophy Continued

18. Does your agency help consumers get supports they need (flexible service schedules, childcare, transportation, etc.) to access health care?

☐ Not At All ☐ Sometimes ☐ Fairly Often ☐ Very Often

Is there supporting policy? ☐ No policy ☐ Informal policy ☐ Developing policy ☐ Formal policy ☐ I do not know

19. Are there structures in your agency to assure for consumer and community participation in:

- **program planning?** ☐ Not At All ☐ Sometimes ☐ Fairly Often ☐ Very Often
- **service delivery?** ☐ Not At All ☐ Sometimes ☐ Fairly Often ☐ Very Often
- **evaluation of services?** ☐ Not At All ☐ Sometimes ☐ Fairly Often ☐ Very Often
- **quality improvement?** ☐ Not At All ☐ Sometimes ☐ Fairly Often ☐ Very Often
- **hiring practices?** ☐ Not At All ☐ Sometimes ☐ Fairly Often ☐ Very Often
- **performance appraisal?** ☐ Not At All ☐ Sometimes ☐ Fairly Often ☐ Very Often
- **customer satisfaction?** ☐ Not At All ☐ Sometimes ☐ Fairly Often ☐ Very Often

Is there policy that supports community and consumer participation?

☐ No policy ☐ Informal policy ☐ Developing policy ☐ Formal policy ☐ I do not know

20. Does your work environment contain décor reflecting the culturally diverse groups in your service area?

☐ None ☐ Some ☐ Quite a Few ☐ Many

Is there supporting policy? ☐ No policy ☐ Informal policy ☐ Developing policy ☐ Formal policy ☐ I do not know

21. Does your agency post signs and materials in languages other than English?

☐ None ☐ Some ☐ Quite a Few ☐ Many

Is there supporting policy? ☐ No policy ☐ Informal policy ☐ Developing policy ☐ Formal policy ☐ I do not know

COMMENTS: _____

Personal Involvement in Diverse Communities

The **Personal Involvement in Diverse Communities** subscale consists of seven items. It concerns the degree to which organizations and their staff demonstrate reciprocity within diverse and ethnic communities. It addresses the extent to which an organization and its staff participate in social and recreational events and purchase goods and services within the communities they serve. Responses range from “*not at all*” to “*very often*”. The existence of supporting policy can range from “*no policy*” to “*formal policy*”.

Does your agency identify opportunities within culturally diverse communities for you to:

- | | | | | |
|------------------------------------------------------------------------------------------------------------------------|-------------------------------------|------------------------------------|---------------------------------------|-------------------------------------|
| 22. Attend cultural or ceremonial functions? | <input type="checkbox"/> Not At All | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Fairly Often | <input type="checkbox"/> Very Often |
| 23. Purchase goods or services from a variety of merchants (either for personal use or job-related activities)? | <input type="checkbox"/> Not At All | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Fairly Often | <input type="checkbox"/> Very Often |
| 24. Subcontract for services from a variety of vendors? | <input type="checkbox"/> Not At All | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Fairly Often | <input type="checkbox"/> Very Often |
| 25. Participate in recreational or leisure time activities? | <input type="checkbox"/> Not At All | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Fairly Often | <input type="checkbox"/> Very Often |
| 26. Participate in career awareness days? | <input type="checkbox"/> Not At All | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Fairly Often | <input type="checkbox"/> Very Often |
| 27. Participate in community education activities? | <input type="checkbox"/> Not At All | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Fairly Often | <input type="checkbox"/> Very Often |

For questions 22–27

Is there policy that supports your participation within culturally diverse communities?

☐ No policy ☐ Informal policy ☐ Developing policy ☐ Formal policy ☐ I do not know

28. Does your agency identify opportunities for you to share with colleagues your experiences and knowledge about diverse communities?

☐ Not At All ☐ Sometimes ☐ Fairly Often ☐ Very Often

Is there supporting policy? ☐ No policy ☐ Informal policy ☐ Developing policy ☐ Formal policy ☐ I do not know

COMMENTS: _____

Resources and Linkages

The **Resources and Linkages** subscale consists of four items. It concerns the ability of an organization and its staff to effectively utilize both formalized and natural networks of support within culturally diverse communities to develop an integrated primary care, community-based health system. The focus is organizational policy that promotes and maintains such linkages through structures and resources. Responses range from “*not at all*” to “*very often*”. The existence of supporting policy can range from “*no policy*” to “*formal policy*”.

29. Does your agency collaborate with community-based organizations to address the health and mental health related needs of the culturally and linguistically diverse groups in the service area?

☐ Not At All ☐ Sometimes ☐ Fairly Often ☐ Very Often

Is there supporting policy? ☐ No policy ☐ Informal policy ☐ Developing policy ☐ Formal policy ☐ I do not know

30. Does your agency work with social or professional contacts (e.g., cultural brokers, liaisons) that help you understand health and mental health beliefs and practices of culturally diverse groups in the service area?

☐ Not At All ☐ Sometimes ☐ Fairly Often ☐ Very Often

Is there supporting policy? ☐ No policy ☐ Informal policy ☐ Developing policy ☐ Formal policy ☐ I do not know

31. Does your agency establish formal relationships with these professionals and/or organizations to assist in serving culturally and linguistically diverse groups?

☐ Not At All ☐ Sometimes ☐ Fairly Often ☐ Very Often

Is there supporting policy? ☐ No policy ☐ Informal policy ☐ Developing policy ☐ Formal policy ☐ I do not know

32. Does your agency use resource materials (including communication technologies) that are culturally and linguistically appropriate to inform diverse groups about health related issues?

☐ Not At All ☐ Sometimes ☐ Fairly Often ☐ Very Often

Is there supporting policy? ☐ No policy ☐ Informal policy ☐ Developing policy ☐ Formal policy ☐ I do not know

COMMENTS: _____

Human Resources

The **Human Resources** subscale consists of eight items. It involves an organization's ability to sustain a diverse work force that is culturally and linguistically competent. It probes policy that supports work force demographics, inservice training/professional development and related resource allocation. Responses range from "none to many" to "yes or no". The existence of supporting policy can range from "no policy" to "formal policy".

33. Are members of the following culturally diverse groups represented on the staff of your agency?

Designated Cultural Groups	None	Some	Quite a Few	Many	Is there supporting policy?
					<input type="checkbox"/> No policy
					<input type="checkbox"/> Informal policy
					<input type="checkbox"/> Developing policy
					<input type="checkbox"/> Formal policy
					<input type="checkbox"/> I do not know

34. Does your agency have culturally and linguistically diverse individuals as:

- board members? ☐ None ☐ Some ☐ Quite a Few ☐ Many
- center directors? ☐ None ☐ Some ☐ Quite a Few ☐ Many
- senior management? ☐ None ☐ Some ☐ Quite a Few ☐ Many
- physicians? ☐ None ☐ Some ☐ Quite a Few ☐ Many
- clinical staff? ☐ None ☐ Some ☐ Quite a Few ☐ Many
- administrative staff? ☐ None ☐ Some ☐ Quite a Few ☐ Many
- clerical staff? ☐ None ☐ Some ☐ Quite a Few ☐ Many
- support staff? ☐ None ☐ Some ☐ Quite a Few ☐ Many
- consultants? ☐ None ☐ Some ☐ Quite a Few ☐ Many
- volunteers? ☐ None ☐ Some ☐ Quite a Few ☐ Many

Is there policy that supports recruitment of diverse staff, board members, consultants and volunteers?

- ☐ No policy ☐ Informal policy ☐ Developing policy ☐ Formal policy ☐ I do not know

35. Does your agency have incentives for the improvement of cultural competence throughout the organization?

- ☐ None ☐ Some ☐ Quite a Few ☐ Many

Is there supporting policy? ☐ No policy ☐ Informal policy ☐ Developing policy ☐ Formal policy ☐ I do not know

Human Resources Continued

36. Does your agency have procedures to achieve the goal of a culturally and linguistically competent workforce that includes:

- **staff recruitment?** ☐ Yes ☐ No
- **hiring?** ☐ Yes ☐ No
- **retention?** ☐ Yes ☐ No
- **promotion?** ☐ Yes ☐ No

Is there policy that supports achieving a culturally and linguistically competent workforce?

☐ No policy ☐ Informal policy ☐ Developing policy ☐ Formal policy ☐ I do not know

37. Are there resources to support regularly scheduled professional development and inservice training for staff at all levels of the agency?

☐ None ☐ Some ☐ Quite a Few ☐ Many

38. Are inservice training activities on culturally competent health care (e.g., values, principles, practices, and procedures) conducted for staff at all levels of the agency?

☐ None ☐ Some ☐ Quite a Few ☐ Many

39. Are inservice training activities on linguistically competent health care (e.g., Title VI, CLAS Standards, ADA mandates) conducted for staff at all levels of the agency?

☐ None ☐ Some ☐ Quite a Few ☐ Many

For questions 37-39

Is there policy that supports professional development and inservice training for all staff?

☐ No policy ☐ Informal policy ☐ Developing policy ☐ Formal policy ☐ I do not know

40. Does your agency have incentives for the improvement of linguistic competence throughout the organization?

☐ None ☐ Some ☐ Quite a Few ☐ Many

Is there supporting policy? ☐ No policy ☐ Informal policy ☐ Developing policy ☐ Formal policy ☐ I do not know

Clinical Practice

The **Clinical Practice** subscale consists of eight items. It concerns the ability of the organization and its staff to adapt approaches to health care delivery based on cultural, and linguistic differences. It focuses on assessment/diagnosis, the provision of interpretation/translation services and use of community-based resources, and adaptation based on literacy and health literacy levels. Responses range from “*never to regularly*”. The existence of supporting policy can range from “*no policy*” to “*formal policy*”.

41. Do you use health assessment or diagnostic protocols that are adapted for culturally diverse groups?

Designated Cultural Groups	Never	Seldom	Sometimes	Regularly	Is there supporting policy? <input type="checkbox"/> No policy <input type="checkbox"/> Informal policy <input type="checkbox"/> Developing policy <input type="checkbox"/> Formal policy <input type="checkbox"/> I do not know

42. Do you use health promotion, disease prevention, and treatment protocols that are adapted for culturally diverse groups?

Designated Cultural Groups	Never	Seldom	Sometimes	Regularly	Is there supporting policy? <input type="checkbox"/> No policy <input type="checkbox"/> Informal policy <input type="checkbox"/> Developing policy <input type="checkbox"/> Formal policy <input type="checkbox"/> I do not know

43. Do you connect consumers to natural networks of support to assist with health *and* mental health care?

☐ Never
 ☐ Seldom
 ☐ Sometimes
 ☐ Regularly

Is there supporting policy?
☐ No policy
 ☐ Informal policy
 ☐ Developing policy
 ☐ Formal policy
 ☐ I do not know

44. Do you differentiate between racial and cultural identity when serving diverse consumers?

☐ Never
 ☐ Seldom
 ☐ Sometimes
 ☐ Regularly

Is there supporting policy?
☐ No policy
 ☐ Informal policy
 ☐ Developing policy
 ☐ Formal policy
 ☐ I do not know

45. Does your agency inform consumers of their rights to language access services under Title VI of the Civil Rights Act of 1964—Prohibition Against National Origin Discrimination and as required by the CLAS Standards 4-7 Federal mandates for language access?

☐ Never ☐ Seldom ☐ Sometimes ☐ Regularly

Is there supporting policy? ☐ No policy ☐ Informal policy ☐ Developing policy ☐ Formal policy ☐ I do not know

46. Does your agency use either of the following personnel to provide interpretation services:

• **certified medical interpreters?**

☐ Never ☐ Seldom ☐ Sometimes ☐ Regularly

• **trained medical interpreters?**

☐ Never ☐ Seldom ☐ Sometimes ☐ Regularly

• **sign language interpreters?**

☐ Never ☐ Seldom ☐ Sometimes ☐ Regularly

Is there policy for the provision of interpretation services for consumers with limited English Proficiency and those who are deaf or have hearing impairments?

☐ No policy ☐ Informal policy ☐ Developing policy ☐ Formal policy ☐ I do not know

47. Does your agency:

• **translate and use patient consent forms, educational materials and other information in other languages?**

☐ Never ☐ Seldom ☐ Sometimes ☐ Regularly

• **insure materials address the literacy needs of the consumer population?**

☐ Never ☐ Seldom ☐ Sometimes ☐ Regularly

• **assess the health literacy of consumers?**

☐ Never ☐ Seldom ☐ Sometimes ☐ Regularly

• **employ specific interventions based on the health literacy levels of consumers?**

☐ Never ☐ Seldom ☐ Sometimes ☐ Regularly

Is there policy that addresses translation services, literacy and health literacy?

☐ No policy ☐ Informal policy ☐ Developing policy ☐ Formal policy ☐ I do not know

48. Does your agency evaluate the quality and effectiveness of interpretation and translation services it either contracts for or provides?

☐ Never ☐ Seldom ☐ Sometimes ☐ Regularly

Is there supporting policy? ☐ No policy ☐ Informal policy ☐ Developing policy ☐ Formal policy ☐ I do not know

Engagement of Diverse Communities

The **Engagement of Diverse Communities** subscale consists of three items. It involves the nature and scope of activities conducted by an agency and its staff to engage diverse communities in health and mental health promotion and disease prevention. Responses range from “*never to regularly*”. The existence of supporting policy can range from “*no policy*” to “*formal policy*”.

49. Does your agency conduct activities tailored to engage the following culturally diverse communities?

Designated Cultural Groups	Never	Seldom	Sometimes	Regularly	Is there supporting policy? <input type="checkbox"/> No policy <input type="checkbox"/> Informal policy <input type="checkbox"/> Developing policy <input type="checkbox"/> Formal policy <input type="checkbox"/> I do not know	

50. Do agency brochures and other media reflect cultural groups in the service area?

☐ Never
 ☐ Seldom
 ☐ Sometimes
 ☐ Regularly

Is there supporting policy?
☐ No policy
 ☐ Informal policy
 ☐ Developing policy
 ☐ Formal policy
 ☐ I do not know

Engaging of Diverse Communities Continued

51. Does your agency reach out to and engage the following individuals, groups, or entities in health and mental health promotion and disease prevention initiatives:

	Never	Seldom	Sometimes	Regularly	
A. Places of worship (e.g., temples, churches, mosques, kivas), and clergy, ministerial alliances, or indigenous religious or spiritual leaders?					<p>Is there policy that supports engaging diverse sectors of the community?</p> <p><input type="checkbox"/> No policy</p> <p><input type="checkbox"/> Informal policy</p> <p><input type="checkbox"/> Developing policy</p> <p><input type="checkbox"/> Formal policy</p> <p><input type="checkbox"/> I do not know</p>
B. Traditional healers (e.g., medicine men or women, curanderas, espiritistas, promotoras, or herbalists)?					
C. Mental health providers, dentists, chiropractors, or licensed midwives?					
D. Providers of complimentary and alternative medicine (e.g., homeopaths, acupuncturists, or lay midwives)?					
E. Ethnic publishers, radio, cable or television stations or personalities, or other ethnic media sources?					
F. Human service agencies?					
G. Tribal, cultural or advocacy organizations?					
H. Local business owners such as barbers/cosmetologists, sports clubs, restaurateurs, casinos, salons, and other ethnic businesses?					
I. Social organizations (e.g., civic/neighborhood associations, sororities, fraternities, ethnic associations)?					

This image shows a blank sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

THANK YOU FOR YOUR VALUED PARTICIPATION

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CULTURAL AND LINGUISTIC COMPETENCE HEALTH PRACTITIONER

RESPONDENT DEMOGRAPHIC INFORMATION

The following questions are used to compile a demographic profile of respondents and are not intended to identify individuals. Please circle the appropriate number or write in your responses where requested. Questions regarding age, gender, race/ethnicity will assist in capturing work force diversity.

A. Gender

1. Female 2. Male

B. Race and Ethnicity *(These categories are based on options offered by the U.S. Census Bureau [2002].)*

Ethnicity

1. Hispanic
2. Non-Hispanic

Race

1. American Indian/Alaskan Native
2. Asian (specify) _____
3. Black (specify) _____
4. African American
5. Pacific Islander (specify) _____
6. White
7. Some Other Race (specify) _____
8. Two or More Races (specify) _____

C. Age

1. Under 30 years 4. 51 – 60 years
2. 31 – 40 years 5. Over 60 years
3. 41 – 50 years

D. List any languages you speak other than English:

E. Community Health Center Affiliation

1. Board Member
2. Administrator
3. Health Practitioner
4. Client/Consumer/Patient
5. Member of Client's Family
6. Community Member
7. Other: _____

F. Years of involvement with the community health center?

1. Under 1 year
2. 1 – 3 years
3. 3 – 5 years
4. Over 5 years

G. Most of my time is assigned to the following site:

(This response is optional)

H. To what extent are you involved with the analysis or formation of organization policy?

1. Not at All
2. A Little
3. A Fair Amount
4. Very Much
5. Other _____

I. State which best describes how and when you acquired your knowledge and skills related to cultural and linguistic competence: *(check and circle all that apply)*

- ☐ Academic curricula within the last
0-3 years 4-6 years 7-10 years more than 10 years
- ☐ Continuing education within the last
0-3 years 4-6 years 7-10 years more than 10 years
- ☐ Workshops/conferences within the last
0-3 years 4-6 years 7-10 years more than 10 years
- ☐ Employer sponsored training within the last
0-3 years 4-6 years 7-10 years more than 10 years
- ☐ On-the-job experiences within the last
0-3 years 4-6 years 7-10 years more than 10 years
- ☐ Living in diverse communities within the last
0-3 years 4-6 years 7-10 years more than 10 years
- ☐ Domestic/international travel within the last
0-3 years 4-6 years 7-10 years more than 10 years

J. Primary cultural groups served by the community health center?

K. With which group(s) do you feel most proficient?

L. With which group(s) do you feel least proficient?

Culturally Responsive Environmental Prevention

By Dustianne North, MSW, PhD

with contributions from Megan Coulter-Bracey, MSW, and Andrea Barrera

Introduction

Environmental prevention strategies are coordinated approaches to changing or influencing community conditions, standards, institutions, structures, systems, and policies. When done well, there is substantial evidence supporting the efficacy of environmental prevention strategies for reducing alcohol and other drug (AOD) use^{1,2}. Yet despite the fact that environmental prevention efforts are fundamentally community oriented, there has been little systematic research to explore the efficacy of specific environmental prevention approaches across racially, ethnically, and linguistically diverse communities. While there is increasing effort in the prevention field to evaluate prevention strategies across diverse cultural groups, this focus has largely been expressed in studies that examine direct services to youth. As more California counties begin to incorporate environmental prevention into their overall prevention approach, there is a need to understand how to implement environmental prevention strategies that are responsive to the particular strengths, challenges, and needs of diverse communities.

The goal of this Tactic is to assist professional prevention providers, grassroots citizen groups, prevention coalitions, and others who aim to change substance use and abuse patterns on a community scale by illuminating what culturally responsive selection, implementation, and evaluation of environmental AOD prevention efforts might look like. This Tactic provides suggested approaches to environmental prevention that aim to be both evidence-based and culturally responsive, offering a selection of frameworks, recommendations, and evidence-based models.



Methodology

This Tactic is necessarily exploratory since little is known about the efficacy of environmental prevention across diverse communities. This Tactic is informed by an extensive literature review as well as field interviews. Much of the information synthesized here comes from a review of the academic literature related to environmental prevention and culture; field publications related to cultural competence, community mobilization, and prevention strategies; and evidence-based models for environmental prevention. In addition to the literature review, six interviews were conducted in order to better understand the challenges encountered, lessons learned, and best-practices developed to implement environmental prevention across diverse communities. Expert testimony was collected from four active environmental prevention providers from different counties in California. In addition, two California technical assistance providers who are considered experts in environmental prevention, community mobilization, and community organizing were interviewed.

prevention *Tactics* 9:12 (2014)

Tactics (Tak'tiks) n. 1. a plan for promoting a desired end. 2. the art of the possible.

Environmental Prevention

Environmental prevention addresses the environmental factors (physical environment and community norms) that support the use of alcohol and other drugs. Environmental prevention specialists assist communities to identify and work to change elements in settings that contribute to unhealthy or unsafe behaviors, including substance abuse. Environmental prevention brings a specific community focus to prevention, which can complement individual strategies. While individual prevention strategies focus on behavior change, environmental prevention engages a public health approach to impact substance use on a larger scale by limiting access to substances, changing public laws, policies, and practices, and changing social norms that contribute to substance use. Typically, environmental prevention strategies aim to reduce substance use via changes in:

- Policy & Policy Enforcement
- Access and Availability
- Community Norms
- Media Messages

When done well, environmental prevention...

- Recognizes that problems are often not found within individuals, but in the environment.
- Improves community and individual understandings about direct and second-hand problems related to AOD.
- Facilitates the empowerment of communities to solve local AOD-related problems by providing opportunities for community resident leadership.
- Makes a broad impact on large numbers of people and organizations.
- Helps communities resist irresponsible business practices and ensures that substance abuse issues are addressed in local zoning and policy decisions.
- Works across silos to address an array of issues that relate to substance use and abuse.
- Is applicable across diverse communities.

Culturally Responsive Environmental Prevention

Broad agreement exists in the field of AOD prevention that culturally responsive strategies are a necessary foundation for effective program administration. The term “cultural responsiveness” refers to the capacity of an organization to respond to the particular cultural needs of those it seeks to serve. Culturally responsive

services recognize that beliefs, attitudes, norms, and expectations around health and wellness vary across cultures, and that responding to these differences is an integral part of equitable and effective service. While substance abuse problems are prevalent across populations and communities, the individual expectations, community norms, and institutional consequences attached to substance use vary from one community to another. The most effective environmental prevention efforts will begin with knowledge of the specific risk and protective factors of the community from a historical perspective, and work with the community to identify substance abuse problems to develop and implement substance abuse prevention strategies.

We define culturally responsive environmental prevention activities as those which:

- Effectively address a community’s unique history, strengths, challenges, and cultural diversity.
- Build sustained and powerful citizen-driven coalitions and practices aimed at the prevention of AOD abuse and other risk behaviors.
- Integrates community assessments and community-defined priorities, interventions, and involvement.

Importance of Culturally Responsive Environmental Prevention

Although environmental strategies are designed to affect community level change, providers should use caution before assuming that environmental prevention strategies shown to be effective in one community context are necessarily appropriate for another community context. Environmental prevention efforts that don’t attend to broader needs and challenges of specific communities, especially marginalized communities, may undermine the efficacy of prevention efforts. If the demographics and cultural norms of a community are not considered and existing leaders of a given community are not included in the planning and implementation process, prevention strategies may be less relevant to community members, and consequently less well supported and less successful.

Every community has a culture, and cultural responsiveness should always be a first principle of substance abuse prevention. While substance abuse is a public health issue, its consequences are also embedded within systems of inequality, including

institutional racism and poverty. Attention to issues of race, class, and immigration status are especially critical to the success of environmental prevention efforts. These realities may effect the appropriateness of some strategies, even if these strategies have been proven effective in other neighborhoods. For example:

- Policy strategies that depend on increased law enforcement activities may not be welcomed in neighborhoods with strained relationships with the police, including those with high numbers of undocumented residents fearful of deportation.
- Strategies to change the availability of alcohol through zoning reform may also limit economic expansion and subsequently be less popular in communities with high levels of poverty.
- Media messages that rely heavily on internet or Smartphone access have limited reach where such access is not the norm.

Building Foundations for Culturally Responsive Environmental Prevention

Implementing culturally responsive environmental prevention may require a subtle but significant rethinking of existing approaches. When working for community-level change, approaches should be designed for the community and implemented with the community. The prevention providers interviewed for this Tactic, as well as the literature on best-practices in environmental prevention, agree that involving community residents in the development and implementation of their own prevention efforts is critical to successful environmental prevention. Culturally responsive environmental prevention efforts, then, are both **responsive to** and **driven by** the members of the communities targeted.



Community Trials Intervention to Reduce High Risk Drinking is a multi-component environmental prevention model. It is one of the few SAMHSA- registered, evidence-based programs that has been successfully translated and adapted for various ethnic groups. It has produced significant results, including:

- Decreased alcohol sales to youth
- Increased enforcement of DUI laws
- Implementation and enforcement of RBS policies
- Adoption of policies limiting the dense placement of retail alcohol establishments
- Increased coverage of alcohol-related issues in local news media
- Decreased in binge drinking
- Decreased in drinking and driving
- Decreased in assaults³

Developing Culturally Responsive Prevention Strategies

Developing culturally responsive environmental prevention includes both organizational self-assessment and strategic planning to ensure meaningful community input. The assessment process can help environmental prevention providers identify their current capacity to implement culturally responsive strategies, especially in terms of community engagement. The self-assessment process can help determine the degree to which community residents, stakeholders, and leaders are currently engaged or still need to be engaged. The self assessment process can also help ensure that strategic planning follows culturally responsive principles in program design, implementation, and evaluation.

CLAS Standards

The Culturally and Linguistically Appropriate Service (CLAS) standards were developed by the U.S. Office of Minority Health for use in the healthcare field. These standards call for effective, equitable, understandable, and respectful quality of care and services; culturally responsive governance, leadership, and workforce practices; appropriate communication and language assistance; and engagement, continuous improvement, and accountability of practices. Subsequent to their release at the national level, the California Department of Health Care Services (DHCS) supported a diverse group of representative stakeholders through the California

Community Alliance for CLAS (CA-CLAS) to develop CLAS guidelines specifically for use by the California AOD field. The guidelines were published along with a checklist intended to help AOD providers assess their capacity to provide culturally responsive services. These checklists, which can be found in the CLAS California Standards 2012 guidelines, can help environmental prevention providers evaluate their existing knowledge of their community, the strength of their community partnerships, and the degree to which their staffing and materials meet the needs of diverse communities.

Strategic Prevention Framework

The importance of attending to culturally specific needs is the reason that cultural competence is at the heart of SAMHSA's Strategic Prevention Framework (SPF). In this five-step planning framework, cultural competence is intended to act as a guiding principle for the development of strategic prevention plans. The Community Anti-Drug Coalitions of America (CADCA) has developed an excellent *Cultural Primer* for prevention coalitions which offers a variety of insights and strategies for incorporating cultural competence into the SPF process, including community-driven planning, implementation, and evaluation.



California requires every county to develop an AOD prevention plan utilizing the SPF to ensure that prevention efforts reflect best-practices that are culturally responsive. The Cultural Primer can help guide the SPF development process to

reflect cultural responsiveness as a cross-cutting principle. For coalitions or other environmental prevention providers, these plans may also be good sources of data. Because successful environmental prevention efforts are informed by knowledge of the community, ongoing access to community-level data is essential. Achieving community-level data may require disaggregating the data beyond that which is presented in county prevention plans, but these data can provide a context for community-level work.

Approaches to Community Driven Prevention

Interview respondents emphasized the importance of community empowerment, and a focus on building personal, social, and political power among those most affected by substance abuse issues and whose voices are often left out of public debate on the subject. Interviewees noted that prevention efforts that are driven by professional prevention providers may alienate everyday residents and informal community leaders. Additionally, interview subjects noted that if these efforts are not aligned with community needs and do not represent community priorities, they are less likely to be sustainable.

Community Mobilization and Community Organizing

The limited literature on culturally responsive environmental prevention emphasizes the use of community mobilization and community organizing approaches. These approaches have in common an orientation toward services that are tailored to the specific needs of a community or group, and highlight the empowerment of community residents to act for change on their own behalf. The approaches also share a focus on meeting the needs of communities and groups who experience high economic challenges, various forms of structural oppression, and high levels of diversity.

CADCA notes that "Community mobilization [and organizing], when done comprehensively, is a culturally competent process. Mobilizing takes you to areas of the community where substance abuse issues are occurring to talk to those who are most impacted. Engaging in knock and talks in neighborhoods where open-air drug markets are flourishing will naturally bring you into contact with people from all walks of life. In this context, soliciting diverse opinions will happen as a natural part of the outreach process."⁴

Community mobilization is typically driven by subject experts who bring specific, predefined issues and proposed solutions to the community for “buy in.” A mobilization approach is best suited to specific, short-term campaigns responding to a widely identified problem through a generally supported solution. *Community organizing* approaches do not begin with problems or solutions predetermined by prevention professionals. Instead, an organizing process begins with one-on-one, often door-to-door, listening campaigns that yield insights into problems that community members care about, and the individual and personal ways in which they are affected by them. Community organizing may be thought of as a ‘bottom-up’ process, whereas community mobilizing may be seen as a ‘top-down’ process.⁵

Many environmental prevention campaigns use a community mobilizing model. A community organizing approach can complement existing efforts by increasing the level of resident involvement in the process and build a lasting base of resident experts invested in continued substance abuse prevention activities⁶. When elements of a longer-term community organizing approach are added to existing community mobilization efforts, prevention activities may be more effective in fostering empowerment among residents, and may do a better job of ensuring that campaigns are responsive to the issues that residents care about most. CADCA has presented a Power People manual⁷ which includes a step-by-step prevention model for a blended mobilization-organizing approach to prevention efforts, as shown in the diagram below.



Taking such an approach may also support sustainability, as an organized and bonded group of residents, providers, and allies may be more likely to remain in place for future efforts. Community organizers build lasting personal relationships with community residents and support ongoing relationships between residents. Actions determined with citizen leadership can be not only evaluated, but also reflected upon and celebrated, so that new efforts can be formulated with lessons learned and relationships deepened.

Recommendations for Culturally Responsive Environmental Prevention

A synthesis of extant research coupled with field interviews has identified six strategies to support culturally responsive environmental prevention. When available, specific evidence-based models are referenced to assist you in implementing the recommended strategies.

Strategy 1: Actively Acknowledge Diversity, Difference, and Issues of Oppression

Environmental prevention efforts should begin with knowledge of the racial, ethnic, linguistic, religious, economic, and political characteristics of the community within which they intend to work. Demographic and community data will also help environmental prevention providers gain a foundational understanding of the specific strengths and challenges in individual communities. For example, neighborhoods with a high percentage of residents who have been in their current homes for more than five years are strengthened by this stability, which in turn represents an opportunity for environmental prevention providers to foster increased community cohesion. Providers working in neighborhoods with high numbers of public transportation users will want to make certain that transportation challenges do not limit opportunities for meaningful community participation in meetings and events. These data should guide the planning and capacity building stages of environmental prevention development. Suggestions for ways to access these data can be found in the Resources section of this Tactic.

Working successfully with diverse communities also requires acknowledging that issues of racism, poverty, and other forms of structural oppression affect community members differentially. Norms,

expectations, and beliefs about how best to prevent substance abuse are shaped by the social, economic, and historical context of community residents. Environmental prevention efforts should recognize that some groups have historically been subjected to violence, abuse, and disrespect from civil and penal institutions. These experiences may affect perceptions of law enforcement and local government, which may not be seen by some community residents as supportive bodies. Be respectful of these perspectives when working on issues of access and enforcement by ensuring that decisions to increase government authority are supported across diverse sectors of the community and that meaningful alternatives are proposed.

Strategy 2: Respect the Individuals, Communities, and Cultures With Whom You Interact

Many environmental prevention approaches strive to reduce substance abuse by changing community norms. Understanding the particular norms around substance use in a given community requires working without judgments and assumptions. This can be difficult, since all people harbor conscious or unconscious biases which lead to assumptions about others. The practice of cultural humility and two-way learning can help prevention providers identify biases and enact their commitment to culturally responsive services.

Cultural Humility

An important step towards cultural responsiveness is developing an awareness of difference and privilege. The practice of cultural humility can help environmental prevention providers build respectful and productive relationships with diverse communities. A working definition of cultural humility includes three factors: 1) a commitment to self evaluation in order to understand personal privilege and bias; 2) a desire to correct power imbalances; and 3) a commitment to working with people who advocate on behalf of others.⁸ A cultural humility approach is particularly important for prevention efforts initiated by providers who differ demographically from the community of service, especially if they are racially and economically privileged.

Two-Way Learning

Two-way learning supports building relationships based on mutual respect and equal responsibility. In

this model, both community residents and prevention professionals bring specific skills, knowledge, and expertise to the problem of substance abuse; the emphasis is on the ability of each to learn from the other. For example, prevention professionals may have expertise in accessing and analyzing substance use data, while residents are best situated to prioritize the substance abuse problems within their community and to identify idiosyncratic risk factors. In a two-way learning situation, prevention professionals and community residents treat each other as equally qualified experts and approach collaboration as an experience in mutual learning.

Strategy 3: Build Citizen-Driven, Rather Than Provider-Driven, Approaches

Residents from all sectors should be included in environmental prevention efforts, especially those most affected by substance abuse issues in your community. This can be achieved by collaborating with all types of community organizations, especially those who serve or are led by diverse populations. Special efforts should be made to include youth, who are the primary consumers of prevention services.

The Drug Free Communities (DFC) Program

recommends “12 Community Sectors” as a basis for inclusion: youth, parents, business community, media, schools, youth-serving organizations, law enforcement agencies, religious or fraternal organizations, civic and volunteer groups, healthcare professionals, state and local and/or tribal government agencies with expertise in the field of substance abuse, and other organizations involved in reducing substance abuse.⁹

Professional and Community Collaboration

Prevention professionals should support environmental prevention campaigns that reflect the priorities of the community. Prevention providers bring important knowledge and skills to an environmental prevention campaign. For example, collecting disaggregated community-level data is an important contribution to this process¹⁰, as is the knowledge of multiple best-practice environmental prevention strategies. Community members and community leaders should play leading roles in identifying the specific substance abuse problems that the campaign will address.

As an example of the way this collaboration may work, consider a policy campaign to reduce underage drinking. There are many policy approaches to the problem of underage drinking: policies may target the ways in which alcohol is sold, the places in which it is consumed, or the laws that address its misuse. Prevention professionals can contribute their knowledge of policies that address each of these domains, but the decision about which domain to target and the strategies used to address it should come from the community, not the professional prevention providers. This approach helps ensure that prevention strategies do not conflict with values, norms, and traditions of community members, and so will not dissuade community participation.

Community-Based Participatory Research (CBPR)

Meaningful community partnerships are not easy to create and maintain. CBPR is a research-based strategy for supporting community participation in all stages of SPF planning and CBPR is an increasingly common strategy for community empowerment which can be used to build sustainable environmental prevention campaigns. CBPR aims to empower the voices of community residents in research and policy debates by teaching research skills to targeted community members. This is achieved with the support of researcher-organizers as technical assistants and political educators. Under this model, community leaders who conduct research also define issues to address, select, plan, implement, and evaluate.

Evidence-Based CBPR Models

- *Tribal participation approach*: culturally centered for American Indian/Alaskan Native tribes¹¹
- *Youth Action Research for Prevention (YARP)*: a SAMSHA-registered, evidence-based, youth-driven, multilevel, youth empowerment model¹²
- *Photovoice/Digital Stories*: creative and visual approaches to CBPR¹³

Strategy 4: Recognize Differing and Competing Views, and Help to Negotiate Arrangements that Consider and Benefit the Targeted Community

Providers and experts agreed that it is critical that environmental prevention professionals recognize and gain a familiarity with differing views and needs among community members. Culturally diverse residents, educators, parents, youth, local merchants, police, local



officials, people with substance use disorders, court-involved families, and prevention providers may have different understandings, perspectives, and priorities with regard to substance abuse problems. As community members and stakeholders, each of these groups should be encouraged to share their opinion.

Environmental prevention campaigns can support a dialogue that is sensitive to and respectful of multiple local views on substance abuse, especially opposing views. The role of the prevention professional is to negotiate compromise by establishing common ground. This means encouraging opponents to listen to one another, and to treat each other's views as valid. At the same time, the providers and organizers interviewed for this Tactic emphasized how crucial it is that providers not be afraid of conflict. It is important to challenge false beliefs that may undermine prevention goals.

Ultimately, effective environmental prevention strategies must engage various community constituents to negotiate their differences and develop thoughtful and well-planned partnerships and collaborative efforts. The goal is to seek solutions that bring the greatest benefit, and the least negative impact, to all. It is important to remember that the prevention effort may be the only cohesive voice in the community that specifically advocates for prevention. This means professionals should be willing to stand with residents against powerful interests who have no stake in community life, against negative community influences, and even against well-meaning funders and other power-holders who may sometimes misunderstand community needs.

Strategy 5: Work Across Silos Toward the Holistic Wellness of Communities

Substance abuse issues affect and are affected by a host of other social problems. Poverty, crime, unemployment, weak schools, and lack of access to resources are risk factors for substance use, and prevention efforts should support attempts to address these larger issues. These risk factors condition both the trajectory and consequences of substance use. Multiple risk factors increase the likelihood that occasional use will increase in frequency and dosage, making the trajectory between use and abuse occur more quickly. Neighborhoods with high crime rates are typically under heightened police surveillance, leading to higher rates of police contact. Under-resourced schools may lack early intervention programs to support youth who are indicated to be at risk. Environmental prevention campaigns should work collaboratively across sectors to develop interventions that work across these domains and also build on specific local strengths.

Some recent ventures in youth prevention have been lauded for their complex, multilevel efforts. PROSPER, or **P**ROmoting **S**chool-community-university **P**artnerships to **E**nhance **R**esilience, is an evidence-based model for prevention, involving stakeholders and power-brokers at multiple levels.¹⁴

Strategy 6: Be Strong Facilitators and Organizers

There was strong agreement among providers that the efficacy of environmental prevention activities often lies in the skills and attentiveness of facilitators. Prevention professionals must have strong facilitation and organizing skills in order to bring community voices into the public debate. These skills include appropriate language skills, the ability to create and maintain partnerships that are demographically representative of the community, and a working knowledge of community norms and expectations.

Skillful facilitation can prevent some voices at the table from dominating others, and mediate sometimes contentious situations. Organizing skills allow campaign conveners to build positive one-on-one relationships with community residents and build consensus around prevention priorities, approaches, and evaluation strategies from within the community. Yet, providers also pointed out that strong facilitators cannot be seen as a substitute for strong resident-based voices in the community. Ultimately, the goal of strong facilitation and organization is to let community members lead through the creation of sustainable community networks dedicated to substance abuse prevention.

Summary: Culturally Responsive Environmental Prevention

Cultural responsiveness is critical to effective and equitable environmental prevention, and should be integrated into the selection, development, implementation, and evaluation of environmental prevention campaigns. As defined in this Tactic, culturally responsive environmental prevention campaigns are responsive to and driven by the communities served, and make central a commitment to diversity. They are waged in the context of inclusive and citizen-driven prevention strategies.

More data is needed to determine whether many existing evidence-based environmental prevention frameworks and models may lend themselves to efficacy across diverse communities. However, this Tactic has presented six essential strategies to support the development of culturally responsive environmental prevention campaigns. The implementation of these strategies, and greater awareness of the centrality of cultural considerations to community engagement, can help change those elements in communities that promote unhealthy or unsafe behaviors, and help build environments that support healthier choices and habits among individuals and families.

ADDITIONAL RESOURCES

Online Tools and Resources

Community Prevention Initiative- Environmental Prevention

http://www.ca-cpi.org/docs/Publications/TARP/TARP_EnvironmentalProtection.pdf

Lessons from Prevention Research

http://web.uta.edu/projects/sswtech/sapvc/resources/lessons_from_prevention_research.htm

CADCA- People Power: Mobilizing Communities for Policy Change

<http://www.cadca.org/files/resources/CommunityMobilization-FINAL-07-22-12.pdf>

Community Readiness: Research to Practice

http://collectiveactionlab.com/sites/default/files/Edwards_et_al_2000_Community_Readiness.pdf

Community-Level Demographics: Search by city, county, or zip code to find key demographic information

<http://www.city-data.com/>

<http://www.zipskinny.com/>

http://www.ca-cpi.org/resources/community_indicators_2010.php

Culturally and Linguistically Appropriate Services Enhanced National Standards 2013

<http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15>

Culturally and Linguistically Appropriate Services California Standards 2012

<http://allianceforclas.org/wp-content/uploads/2011/05/CA-AOD-CLAS-Standards-and-Recommendations-7.pdf>

Cultural Competence Primer: Incorporating Cultural Competence into Your Comprehensive Plan

http://www.cadca.org/files/resources/Cultural_Competence-09-2010.pdf

Designing for diversity: Incorporating cultural competence in prevention programs for urban youth

<http://www.csuprofessionaldevelopment.com/images/pdfs/DesigningForDiversity.pdf>

Cultural Competence as part of SAMHSA's Strategic Prevention Framework

<http://captus.samhsa.gov/prevention-practice/strategic-prevention-framework/cultural-competence>

Drug Free Communities (DFC) Program: 12 Coalition Sectors

<http://www.samhsa.gov/grants/2012/SP-12-001.pdf> (pg. 9)

Drug Free Communities Support Program

<http://www.whitehouse.gov/ondcp/Drug-Free-Communities-Support-Program>

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Evidence-Based Models

SAMSHA-Approved Evidence-Based Environmental Prevention Models

- Adolescent Community Reinforcement Approach (A-CRA)
<http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=41>
- Community Trials Intervention To Reduce High-Risk Drinking
<http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=9>
- Creating Lasting Family Connections Fatherhood Program: Family Reintegration (CLFCFP)
<http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=324>
- Lead & Seed
<http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=335>

PROSPER Partnerships

- Official Website
<http://www.prosper.ppsi.iastate.edu/>
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