

Tips for Working in a Culturally Competent Manner



September 2008

Preface

This document provides a basic overview of what it takes to develop cultural competence. It can be used to guide your thinking related to inter-cultural contact. Cultural competence cannot be developed simply by attending trainings or reviewing “cultural profiles.” It is a process with no end point, as it is impossible to learn all there is to know about another culture or fully understand the worldview of another individual. What is key is an open mind, respect for that which is different, a commitment to understanding ourselves and those around us, and acknowledgement of systemic barriers that lead to disparities in health and other conditions among certain groups. The most effective way to develop this capacity is to engage and interact with people who see the world differently. It also is important to engage in these interactions outside of the provider role by attending cultural festivals, getting to know your neighbors, etc.

This document was developed by the Association for the Study and Development of Community for nonprofits and public agencies in Howard County, Maryland, to supplement a summit about the practice of cultural competence in the county. The contributors to this document include: Marjorie Nemes, Kien Lee, and Cara Chervin. We also would like to thank Elisa Montalvo for her input, as well as members of the summit’s planning committee for their review.

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SECTION 1: QUESTIONS TO PONDER ABOUT CULTURE AND CULTURAL COMPETENCY

Things to Ask Yourself

If someone asked you, what is “culture,” what would you say?

Would you say that people from the same culture behave the same way? Why or why not?

How similar or different is your behavior and the decisions you make to that of other people from your racial/ethnic/cultural group? Why do you think it is similar? Why do you think it is different?

How do you know someone has done something because of their culture, personality, life experience, or circumstance?

Do you think you’ll ever know everything there is to know about your culture, or any other culture? If you can’t know everything there is to know, then what do you think is most important for you to know?

What are some of the things people say about the group(s) you identify with or the group(s) others believe you belong to? Can you pinpoint the source of these beliefs? Would you say these are legitimate, sound, and/or scientific sources?

Can you think of a time when you found yourself challenging negative ideas or beliefs someone expressed to you about a particular racial/ethnic/cultural group?

Where were you educated or trained to provide the services you provide? Have you found that you have had to adapt what you were taught to treat or provide information to certain clients?

What is culture?

There is no agreed upon definition of “culture.”

In research and lay discussions, “culture” is commonly left undefined and used interchangeably with race, ethnicity, nationality, and religion.

Some definitions of culture:

- The shared knowledge and schemes created by a set of people for perceiving, interpreting, expressing, and responding to the social realities around them (Lederach, 1995).
- The collective programming of the mind which distinguishes the members of one group from another (Hofstede, 1984).
- A configuration of learned behaviors and results of behaviors whose component elements are shared and transmitted by the members of a particular society (Linton, 1945).

Where Do You Begin?

There is so much to learn about other cultures, and even then you don't know if people are behaving a certain way because of their culture, personality, life experience, or circumstance. The migration process itself can add an additional layer of influence on behavior. For example, limited English proficiency can cause some individuals to lack the confidence to engage others, express their thoughts, or actively participate in group processes. As a service provider, how are you supposed to approach your interactions with people from different racial/ethnic/cultural backgrounds?

The following are initial considerations across different racial/ethnic/cultural groups that require careful inquiry before determining what services are appropriate and how to provide the services. It would be impossible to cover all the considerations that one should keep in mind during human interactions. We simply hope to give you an idea of what not to assume and how to ask respectfully.

Power relations and dynamics in a family, network, or organization. Providers need to respectfully ask who the decision-makers are in a family, organization, or community, and not assume that the person with whom they are interacting has the ability to commit to a decision. The answer has implications for who needs to be part of the intervention or treatment process in order for the process to work. For example, in some nations/cultures members are taught to hold profound respect for elders and authority figures. This means that the members may be reluctant to commit to an intervention or treatment without consulting the elder in their family or community. Questions to ask may include:

- Who do you usually go to when you need help with...?
- Before making a decision is there someone in particular you need to consult or is there someone in your family I should speak to about this situation?
- Is there someone in your family or community that people go to for help or advice? For what things do people go to this person?

- Are there consequences if you or anyone else does not follow the decision-maker's instructions?

Gender roles are defined differently and may vary in rigidity. This may have implications for the gender match between the service provider and the individual, and its impact on an individual's comfort level. This may go as far as the need for a gender match between service provider and client/patient when in situations perceived by the client/patient as compromising or sensitive (e.g., physical exam). Questions to ask may include:

- Have you found that your responsibilities as a woman or man have changed since relocating to the US? How would you say this has impacted your family or community?
- What are the typical responsibilities of men in your family and community?
- What are the typical responsibilities of women in your family and community?
- What are the consequences if you or anyone in your family or community does not follow the expectations for men and women?

Inequity between men and women is found in most, if not all, countries and cultures; however, the manifestation and tolerance for this type of inequity varies. Women may or may not participate in certain decision-making situations and not be provided the opportunities afforded to their male counterparts (e.g., an education).

Perspective on health and illness. Every nation has a particular approach to the treatment and understanding of health and illness. Differences are found across Western nations, let alone Eastern and Southern nations.

According to Cecil Helman (2001) the culture or nation in which we are raised teaches us how to perceive and interpret the many changes that can occur over time in our own bodies and in the bodies of others. We learn how to differentiate...a sick body from a healthy body, a fit body from a disabled one; how to define a fever or a pain... how to perceive some parts of the body as public, and others as private...

How people express they are not well across cultures is particularly nuanced. We all have mental maps of the human body's anatomy and its function, which is influenced by culture. Anthropologists have found that certain cultures or nations will somaticize through particular organs or areas of the body (Helman 2001). Helman (2001) posits that people's perceptions or understanding of their inner body structure has implications for how they present bodily complaints and their responses to treatment. Helman provides the example of a young English woman who decides not to take antacid medication to treat her heartburn, because during her examination the doctor had not assessed her heart, and hence his treatment was not accurate in her mind.

The most widespread understanding of the human body's function is that which originated in humoral theory. Humoral theory is based on the notion of balance between two or more elements or forces within the body, and is believed to have its origins in ancient China and

India. The extent to which these elements (e.g., blood, phlegm, yellow bile, and black bile) are believed subject to external environment or supernatural forces came to differ across cultures. Today we still see traces of this understanding in folk sayings in Western nations, though it is no longer considered a “legitimate” practice; however, this understanding has evolved over time in some cultures and is still at the root of people’s lay understanding of the human body’s functions (Helman 2001).

Most, if not all nations, have been exposed to some aspect of Western medicine; however, Western medicine is usually out of the reach of most people, and, most importantly, not in line with their own understanding of health and illness. This has several implications for service providers: 1) clients/patients may prefer to turn to traditional healers and/or spiritual leaders for advice, 2) clients/patients may explain their symptoms in psycho-somatic terms, 3) clients/patients may not comply with their intervention or treatment plans, and 4) clients/patients may take traditional medicine even while taking the medicine prescribed by the doctor. Questions to ask a person about his/her orientation towards the concept of health and illness include:

- When you feel sick, what do you do? Is this different from what you would have done in your home country? Why?
- What do you do to prevent getting sick?
- Which diseases do you think are treatable and which ones do you think are not? Why?
- What type of Western medication would you be willing to take or not take? Why?

Prevention practices are also not necessarily common in some countries. Preventive practices can be considered a luxury for immigrants who come from rural and low-income areas. Annual visits to the dentist, for instance, are neither accessible nor affordable.

Communication with authoritative figures. Most people, regardless of culture or religion, recognize and respond to authority; however, some nations and religions try to instill in their citizens or followers a greater sense of acquiescence and apprehension in the challenging of authority. Cross-cultural research has also found that there can be differences across cultures in how much people will tolerate inequity and/or the imbalance of power. Consequently, some individuals may be more accustomed to challenging the ideas and/or orders of someone who is perceived to be in an authoritative position, while others are not and may be less inclined to voice their thoughts and opinions. Some people may smile and nod even if they do not agree or understand what is being said. For service providers, this means 1) taking the time to ask a question in more than one way to check for consistency, 2) not assuming that a nod means agreement, and 3) working closely with the client/patient to break down the steps or instructions. Questions to ask a person about his/her handling of authoritative figures include:

- Who do you consider to be someone knowledgeable, an expert in certain things in your home country?
- If you did not agree with this person what would you do? Why?

- Do you feel the same way about that type of figure or person in that role here in the United States? Why or why not?

In most countries, teachers and doctors are revered and their authority is seldom questioned. Therefore, it is difficult to get immigrants to engage in their children's schooling because they see that as impinging on the teacher's authority. Similarly, patients do not question their doctor or healer's instructions.

Concept of time. Concepts and attitudes toward time can vary across nations/cultures. Time in some cultures is an opportunity to experience, not necessarily something to be measured or experience anxiety over. Sometimes it is a dimension for telling a story or recounting a life journey; instead of describing the past in terms of months or years, the person describes it in terms of the birth of a grandchild or a marriage. It is best to allocate some extra time for clients/patients, and explain to them in a kind way how long a meeting will last and avoid too much rushing or abruptness when beginning or ending a meeting.

Rituals surrounding life transitions (e.g., birth, marriage, death). Every culture recognizes phases in the human life cycle. There are cultural events that mark certain milestones in people's lives. Birth, entry into adulthood, marriage, and death typically have certain meanings and are accompanied by certain practices that mark the transition in a person's responsibilities and/or role within a community or home. In some cultures, the mourning period for death can be as long as one to several months and during that time, family members may or may not follow a set of rules to demonstrate their grief. As service providers, it is useful to know this information when planning events or when asking clients/patients to follow certain instructions; the clients/patients may not be able to follow those instructions because of the rules around these life events. Questions to ask include:

- What do you do when there is a birth, marriage, or death in your family or community?
- Are there restrictions about what you can or cannot do during that time? What are those restrictions?
- Are there specific events that mark entry into adulthood? What are they? What can the child do or not do during that time?

Social networks. Every group of people relies on a particular network for social support. These could include networks based on professional interests, religion, ethnicity, language, region, etc. These networks change at both the individual and community level during the migration process; some are lost, some are transformed, and most of the time new ones must be developed. The community level social networks that are developed can operate out of someone's home or an office. These networks are tapped for all types of assistance, from funds for a funeral to cultural education. For service providers, these networks are useful for disseminating information and engaging the community's leaders.

Questions to ask to find out about social networks include:

- Who do you turn to for help, whether to find a job, teach your child about his/her native language, or financial help?
- When your community wants to organize an event, how does it get the word out?
- Is there someone or several people who must give permission? Who?
- Is this different from how things were in your home country? Why or why not?
- What is the best way for me to distribute information to the people in your community?

What is Cultural Competence?

Cultural competence is defined in a number of ways. The following was adapted by the National Center for Cultural Competence at Georgetown University from Cross et al. (1989):

Cultural competence is a developmental process that evolves over an extended period. Both individuals and organizations are at various levels of awareness, knowledge, and skills along a cultural competence continuum.

Cultural Competence involves developing:

- An understanding that other people see the world differently, they have the right to see the world differently, and they deserve your respect regardless of their world view.
- The necessary skills (analytic and communication), knowledge of self and others, and engaging in inter-cultural experiences in order to be able to interact with people effectively who are not from your culture/ethnicity/race.

The “Other Side” to Cultural Competence

The other side to being culturally competent is becoming aware of the stereotypes you carry and not applying them when interacting with people of other cultural/ethnic/racial groups.

Cultural competence involves developing an awareness of the stereotypes you have learned about the behaviors and intentions of people from other groups (e.g., racial/ethnic, gender, sexual preference, religious), whether positive or negative, and making sure:

- You do not assume someone identifies with a particular group, and

- You do not apply the stereotype(s)/belief(s) you have come to learn about the group they identify with when you interact with them.

It is critical to examine your personal biases, preferences, and/or thoughts about the communities you serve. If you do not examine your biases, you will limit your ability to serve communities effectively. By identifying your biases and getting correct information, you can begin to move towards providing effective services.

Things to Ask Yourself

Can you think of anyone that works with you, a family member, or friend that you believe is culturally competent?

- Why do you think they are culturally competent?
- Are you culturally competent? Why do you think so? How do you know?

What difference do you think it makes whether or not you do your work in a culturally competent way?

What steps have you taken to improve your knowledge and understanding of your clients who are from a different racial/ethnic/cultural group from your own?

What can you do to become as culturally competent as possible?

What Can Service Providers Do?

Service providers should:

- Become familiar with the culture of the people they serve. This includes learning about help-seeking behaviors, language/literacy needs, beliefs, values, and attitudes related to the service being provided, as well as whether or how the service was provided in the country of origin.
- Develop an understanding of how they are perceived by the different communities they serve (e.g., perceived as a person of privilege within a particular community, which makes it difficult for people of this particular community to trust or open up to).
- Work with their organization/agency to adapt treatment models and services with the ultimate goal of improving the well being of clients in a culturally appropriate manner. In addition, consider how language/word choice, symbols, and ideas underlying the

treatment, intervention, and/or prevention strategies may be misinterpreted or perceived as inappropriate across cultures.

SECTION 2: CULTURALLY AND LINGUISTICALLY COMPETENT ORGANIZATIONS

Things to Ask Yourself

How do you know that you have walked into a culturally competent organization?

How do you know that an organization provides services that are culturally competent?

How would a culturally competent organization make you feel?

Would you accept or want help from an organization with providers that you believed were not culturally competent?

What steps has the organization you work for taken to ensure that you are knowledgeable about the clients the organization serves that are of a different ethnic/racial/cultural group from your own?

Culturally Competent Organizations

According to the National Center for Cultural Competence at Georgetown University, cultural competence requires that organizations:

- Define a 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 diversity and the cultural contexts of the communities they serve;
- Incorporate the above in all aspects of policy making, administration, practice, and service delivery and involve systematically consumers, key stakeholders, and communities.”
- Identify and understand the needs and help-seeking behaviors of individuals and families.

- Must have systems and sanctions, and in some cases mandate the incorporation of cultural knowledge into policy making, infrastructure, and practice.
- Embrace the principles of equal access and non-discriminatory practices in service delivery.
- Design and implement services that are tailored or match the unique needs of the individuals, children, families, organizations, and communities served.
- Service delivery systems are driven by client preferred choices, not by culturally blind or culturally free interventions.
- Have a service delivery model that recognizes mental health as an integral and inseparable aspect of primary health care.

According to the National Center for Cultural Competence at Georgetown University, a culturally competent organization:

- Works in conjunction with natural, informal support and help networks within culturally diverse communities (e.g., neighborhood, civic and advocacy associations; local/neighborhood merchants and alliance groups; ethnic, social, and religious organizations; and spiritual leaders and healers).
- Allows communities to determine their own needs.
- Treats community members as full partners in decision making.
- Should ensure communities benefit economically from collaboration.
- Should ensure community engagement results in the reciprocal transfer of knowledge and skills among all collaborators and partners.

Linguistic Competence

Linguistic competence is an obvious and key component of an organization's cultural competence, though some organizations struggle to build their capacity to provide translation and interpretation. However, Title VI of the Civil Rights Act of 1964 states that "No person in the United States shall, on the grounds of race, color, or national origin, be excluded from

participation in, be denied benefits of, or be subjected to, discrimination under any program or activity receiving Federal financial assistance.”

According to the Department of Health and Mental Hygiene,

“The federal government has promulgated policies prohibiting national origin discrimination against persons with limited English proficiency. (See Presidential Executive Order 13166, issued August 11, 2000, and U.S. Department of Health and Human Services–Office of Civil Rights Policy Guidance published in the Federal Register on August 30, 2000 [pp. 52762-52774] and August 8, 2002 [pp. 47311 to 47323]). In essence, these policies require federal fund recipients to take reasonable steps to create meaningful access to information and services provided at the State and local levels (to learn more please review the attached LEP Factsheet).”

According to the National Center for Cultural Competence at Georgetown University, **linguistic competence** is the capacity of an organization and its personnel to communicate effectively, and convey information in a manner that is easily understood by diverse audiences, 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.
- An organization must have policy, structures, practices, procedures, and dedicated resources to support this capacity.
- Services and supports are delivered in the preferred language and/or mode of delivery of the population served.
- Written materials are translated, adapted, and/or provided in alternative formats based on the needs and preferences of the populations served.
- Consumers are engaged in the evaluation of language access and other communication services to ensure quality and satisfaction.

References

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Lederach, J.P. (1995). *Preparing For Peace: Conflict Transformation Across Cultures*. Syracuse, NY: Syracuse University Press.

Linton, R. (1945). *The Cultural Background of Personality*. New York.

The National Center for Cultural Competence at Georgetown University
<http://www11.georgetown.edu/research/gucchd/nccc/index.html>

SECTION 3: EXAMPLES OF CULTURAL COMPETENCY STANDARDS ADOPTED BY NONPROFITS AND PUBLIC AGENCIES

Cultural Competence Checklist for Success

This section contains a checklist of considerations for ensuring cultural competency. This information was adapted from two resources:

1. Empowering Linguistic Access in Health Care Settings: Legal Rights and Responsibilities. Published by the Henry J. Kaiser Family Foundation, January 1998.
2. National Center for Cultural Competence, Georgetown University Child Development Center

Physical Environment. Culturally and linguistically friendly interior design, pictures, posters, and art work make your senior centers and nutrition sites more welcoming and attractive to the participants. Providing services in a comfortable setting enhances program participation for all.

Training and Professional Development. Staff development is essential to both cultural and linguistic competence. It is also important to provide informal opportunities like “Brown Bag” lunches for staff to explore their attitudes, beliefs, and values. Specialized training for staff involved in the interpretation process is often overlooked. There is an assumption that if you are bilingual you can interpret. Training bilingual staff in interpreter skills enhances their ability to effectively communicate in both directions.

Communication Strategies. Communication strategies have to capture the attention of your audience. This means not only using the language and dialect of the people you are serving; it means using communication vehicles that are proven to have significant value and use by your target audience. Multilingual brochures and other written materials do not help those persons who cannot read no matter what language they are written in. In addition to traditional pathways such as television, radio, and print media consider "moving" information through e-mail, internet, and mass transit advertisements, as well as less traditional channels, such as the bulletin board in the ethnic restaurant or grocery store. Also remember that people can act as communication vehicles because of their ability to move through communities and connect with your target audience. Keep the following points in mind when developing and using communication vehicles:

- Develop publications in the language of the population you are targeting. Have an individual from the same ethnic group you are trying to reach review any publications you intend to use for outreach. This will help to ensure the materials are both meaningful and do not include potentially offensive passages.
- Avoid literal translations of existing material as they lose their meaning when syntax and vocabulary are not within cultural contexts.
- In publications, use pictures including the targeted group to promote identification of the issue as "being important to people like me."
- Explore the use of community-based media outlets (such as ethnic newspapers and magazines, local ethnic-based radio stations, cable television programs, etc.) and use prepared public service announcements, sample articles, flyers, and posters as ways to get information out to diverse populations.
- Find places that your target audiences frequent. Identify places that are natural sites for presentations, brochures, flyers, and posters. Take your information and presentations to areas where you find a high volume of "people traffic," including hair salons, barber shops, day spas, laundromats, dry cleaners, video stores, grocery stores, libraries, and restaurants.
- Arrange for staff to conduct outreach in targeted churches, communities, sororities, clubs, and even people's homes. Community service announcements during religious services may be an excellent way of attracting interest for after service discussion groups, depending on the religion (some religions are more cautious about restricting their involvement to spiritual and faith issues only, and not community and other issues).
- Identify key information web sites as a way of educating younger caregivers and the growing population of elder website users.

- Exhibit information and educate culturally diverse caregivers through professional meetings, conferences, and publications. There are national associations of immigrant physicians, nurses, media professionals, attorneys, etc. that hold regular meetings, produce publications, and seek to educate their memberships through association activities.

Community/Consumer Participation. Community can be defined in several different ways. It can refer to the people who live within a geographic boundary. It can refer to those who are served by a certain agency or program. It can also refer to a group of people who have similar beliefs, a similar culture, or shared identity and experiences. Getting to know the community, its people, and its resources will help you identify useful strategies for service delivery. If the church is an important institution in a particular community, developing a preventive health partnership with the church may help you reach a group of people that you are trying to serve.

Establish partnerships and relationships with key community resource people. Put accurate information and adequate print materials into the hands of people who can actively promote your interests. Try to report back the results or outcomes of your initiatives to any groups or individuals that help you in the process. People will feel more vested in initiatives when they know about outcomes that they have helped to achieve and will be more likely to assist you again. Keep the following points in mind:

- Use traditional data sources like the Census to identify counties and neighborhoods with high concentrations of immigrant groups, or identify other sources of aggregate data from community planning agencies, social service departments, school district planning offices, and services for new immigrants. Use this data to identify locations where special outreach could be focused and concentrate outreach efforts in these areas.
- Assist immigrant representatives to make contacts and plan events for outreach in their communities. They are the most knowledgeable about the best way to reach community members.
- Learn who are the most effective resource people in immigrant communities (such as local neighborhood government advisory group representatives, religious committee chairs, local business owners, restaurateurs, booksellers, musicians, funeral planners, teachers, and school administrators) and enlist their support for your program.
- Have volunteers or staff, who speak the same language as the population you are trying to reach, conduct outreach presentations for your program.
- Ask faith leaders to identify principal people in the congregations who are motivators for their activities. Invite them to become volunteers, conduct informal outreach in their communities, and distribute information about your programs. For example, the church may be an appropriate site to convene a family support group for those whose family members are residents of long term care facilities.

- Seek bilingual and immigrant volunteers from established volunteer organizations, such as AmeriCorps and Retired Seniors Volunteer Program (RSVP) to enhance your immigrant outreach efforts.
- Team up with the local affiliates of disease-specific groups that focus on immigrant health risk factors. Consider partnerships for outreach with organizations such as the American Diabetes Association and the American Heart Association.

Principles of Interpreter Services. Unless the staff is thoroughly fluent and effective in the target language, a qualified interpreter should be used.

- Do not use family members or friends to interpret unless the resident knows of the option of having a qualified interpreter and prefers to use a family member or friend.
- Never use young children or youth to interpret.
- Do not rely on untrained health care workers or employees of the provider to interpret.
- Use qualified interpreters, who have passed qualification standards and who complete continuing interpreter education programs. Meet with interpreters regularly to assess services.
- Minimize the use of telephone language lines to those occasions when it is absolutely necessary.

Examples of Sector-specific Policies and Practices

This section contains examples of policies and practices published by different organizations and agencies.

Elements of Diversity Characterizing Older Adults

Reference: Aging and diversity: An Active Learning Experience (Tried and Mehroatra, 1998).

Retrieved online 2-28-07:

http://72.14.205.104/search?q=cache:wUh50tEdeFEJ:www.n4a.org/datoolkit/Elements_of_Diversity.pdf+elements+of+diversity&hl=en&ct=clnk&cd=1&gl=us

Elements of diversity characterizing older adults are many and varied. Among the most prominent of these factors are:

- Cohort (persons born at about the same time)
- Income (size and sources of personal finances)
- Social roles (parent, widow, retiree)

- Gender (based on gender, people may learn to perceive the world differently and be perceived differently)
- Sexual orientation (heterosexual, bisexual, homosexual)
- Ethnicity (a shared sense of identity that includes a set of cultural meanings based on national origin, religion, language, and/or race)
- Race (a social construct that people may use to categorize themselves or others)
- Cultural identification (values or behaviors shared with a group based on national origin, language, religion, or occupation)
- Friendship patterns (persons with whom people choose to socialize and the frequency of the interactions)
- Religion, spirituality (practice of an organized religion; a personal set of spiritual values)
- Value system (belief system regarding behavior and life goals)
- Language (spoken at home and in the community)
- Community (size, region)
- Work status (employed full time or part time, volunteer, unemployed)
- Occupation (present or former)
- Family composition (marital status, children)
- Formal education (years of schooling, diplomas, degrees)
- Living arrangements (live alone, with adult children, congregate housing)
- Health status (healthy, frail, disabilities, chronic illnesses)
- Functional independence (degree of ability to take care of personal needs, presence of cognitive or physical disabilities)
- Generation as an American (first generation, etc.)
- Degree of acculturation (traditional, bicultural, assimilated)
- Personal interests (preferred activities, hobbies, attitudes)
- Personality (temperament, characteristic style of adaptation, patterns of relation to others)
- Dietary practices (preferred foods)
- Time (historical time, time in one's life)

Health Promotion in Higher Education

Reference: Samsha's National Mental Health Information Center. Cultural Competence Standards in Managed Care Mental Health Services: Four Underserved/Underrepresented Racial/Ethnic Groups. 2001. Retrieved online 2-28-07:

<http://mentalhealth.samhsa.gov/publications/allpubs/sma00-3457/ch3.asp>

Services shall be provided irrespective of immigration status, insurance coverage, and language. Access to services shall be individual- and family-oriented (including client-defined family) in the context of racial/ethnic cultural values. Access criteria for different levels of care shall include diagnosis, health/medical, behavior, and functioning. Criteria shall be evaluated in six areas: psychiatric, medical, spiritual, social functioning, behavior, and community support. The Health Plan shall:

1. Include specific procedures to ensure comparability of access and receipt of benefits across populations. Racial/ethnic Mental Health Specialists shall be involved in the development and ongoing implementation and evaluation of these procedures;
2. Ensure that gatekeeping, service authorization, and critical service junctures for consumers from the four groups shall be performed by or under the supervision of a culturally competent mental health professional;
3. Ensure that restrictive placements for consumers from the four groups shall be made only with prior cultural consultation. Restrictive placements include inpatient, residential, and involuntary treatment;
4. Ensure that access is decentralized and facilitated through multiple outreach and case-finding approaches. These approaches shall include strategic co-location within racial/ethnic community organizations, social service agencies, community action agencies, health centers, churches, mosques, schools, and neighborhood locales which are accessible through public transportation and in-home, in-community, and mobile care. They shall be publicized by culturally and linguistically appropriate information which allows client choices;
5. Ensure that agencies have the flexibility of providing services to consumers from the four groups who may not reside in the agency's geographic service area, when this is in the best interest of the clients;
6. Provide that access to traditional healers and self-help services shall be covered by the benefits package;
7. Ensure that the use of telephone numbers (e.g., 1-800) for access shall not be exclusive of other points of entry for 24 hour crisis service and shall be accompanied by education of consumers from the four groups in the use of such access procedures;
8. Ensure that legal documentation for immigrant groups is not a requirement for service and does not serve as a barrier to service access (Legal status shall not be confused with sponsored and unsponsored status);
9. Ensure that confidentiality requirements, by incorporating the values of consumers, including family decisions about services when appropriate, do not serve as a barrier to care;
10. Ensure equal availability of telephone and other communication means of access for consumers and families from the four groups. Staff who provide telephone access services shall be culturally and linguistically competent, and have access to racial/ethnic mental health professional staff for consultation;
11. Ensure that programs serving consumers and families of the four groups provide culturally inviting environments (e.g., decor, ambiance) as measured by consumer satisfaction surveys;
12. Provide to all consumers, families, and providers a culturally based and linguistically complete orientation and ongoing education about access to managed care; and
13. Ensure that ability to pay is not a barrier to accessing services in a managed health care environment.

Mental Health

Reference: Samsha's National Mental Health Information Center. Cultural Competence in Serving Children and Adolescents with Mental Health Problems.

Retrieved online 2-28-07:

http://mentalhealth.samhsa.gov/_scripts/printpage.aspx?FromPage=http%3A//mentalhealth.samhsa.gov/publications/allpubs/CA-0015/default.asp

At the Policymaking Level, programs that are culturally competent:

- appoint board members from the community so that voices from all groups of people within the community participate in decisions;
- actively recruit multiethnic and multiracial staff;
- provide ongoing staff training and support, developing cultural competence;
- develop, mandate, and promote standards for culturally competent services;
- insist on evidence of cultural competence when contracting for services;
- nurture and support new community-based multicultural programs and engage in or support research on cultural competence;
- support the inclusion of cultural competence on provider licensure and certification examinations; and
- support the development of culturally appropriate assessment instruments, for psychological tests, and interview guides.

At the Administrative Level, culturally competent administrators:

- include cultural competency requirements in staff job descriptions and discuss the importance of cultural awareness and competency with potential employees;
- ensure that all staff participate in regular, in-service cultural competency training;
- promote programs that respect and incorporate cultural differences; and
- consider whether the facility's location, hours, and staffing are accessible and whether its physical appearance is respectful of different cultural groups.

At the Service Level, practitioners who are culturally competent:

- learn as much as they can about an individual's or family's culture, while recognizing the influence of their own background on their responses to cultural differences;
- include neighborhood and community outreach efforts and involve community cultural leaders if possible;
- work within each person's family structure, which may include grandparents, other relatives, and friends;
- recognize, accept, and, when appropriate, incorporate the role of natural helpers (such as shamans or curanderos);
- understand the different expectations people may have about the way services are offered (for example, sharing a meal may be an essential feature of home-based mental health services; a period of social conversation may be necessary before each contact with a person; or access to a family may be gained only through an elder);

- know that, for many people, additional tangible services--such as assistance in obtaining housing, clothing, and transportation, or resolving a problem with a child's school--are expected, and work with other community agencies to make sure these services are provided;
- adhere to traditions relating to gender and age that may play a part in certain cultures (for example, in many racial and ethnic groups, elders are highly respected). With an awareness of how different groups show respect, providers can properly interpret the various ways people communicate.

Police Department

Reference: Hillsboro Oregon Police Department. Cultural Competency Plan. 2006.page 3-4.
Retrieved online 3-1-07:
<http://www.ci.hillsboro.or.us/Police/documents/HPDCulturalCompetencyPlan.pdf>

The guiding principles of the Hillsboro Police Department's Cultural Competency Plan are based on fundamental attributes set forth in a department document entitled "Our Expectations." It is the expectation of all department members to treat all people with fairness, courtesy, impartiality, and respect. This document, in conjunction with our policies and procedures, sets forth the moral and ethical standards that govern our organization. They motivate us to provide competent, appropriate, and effective services to those individuals and families and to foster enduring relationships with our community partners.

Principle 1: Diversity and cultural competence are valuable assets given high priority by HPD.

Principle 2: The Cultural Competency Plan will be developed and integrated into the organization with representation and participation from all levels and entities of HPD.

Principle 3: Cultural competence will be an integral part of every employee's performance evaluation. These will be evaluated through the core competencies outlined in the Employee Evaluation and Career Development Process sections of 'Quality Service' and 'Respect and Community'.

Principle 4: The Plan will provide meaningful, legitimate opportunities for members of the community to share their concerns and ideas in the development of the department's strategic plan and their input will be used to develop programs and enhance procedures that will contribute to the quality of life within our community.

Principle 5: Every member of HPD will be accountable for the success of the Plan. A critical element in the success of the Plan is to have culturally competent staff members who demonstrate a willingness to work with culturally, ethnically, and socially diverse populations.

Principle 6: The Plan will be integrated into all aspects of any future strategic planning process.

Principle 7: In consultation with the Cultural Diversity Committee, HPD management will be responsible for monitoring the implementation of the Plan.

Community Justice

Reference: Multnomah County Department of Community Justice. Making Differences Work: Intercultural Strategies for Community Justice. 2003. Retrieved 3-1-07: www.co.multnomah.or.us/dcj/intercultural_strategies.pdf.

- **Principle 1:** Our society is diverse, with people of different ages, genders, races, ethnic backgrounds, physical abilities, religions, sexual orientations, and family situations. This diversity is of value to our society and an integral part of our organization.
- **Principle 2:** Cultural competency is fundamental to all aspects of our business. It affects how we provide services, work with our employees and the community, make decisions, and solve problems.
- **Principle 3:** This intercultural strategies document will be developed, integrated into the organization, and updated with representation and participation from all levels and work units of DCJ.
- **Principle 4:** This document will offer guidelines for improving the way DCJ provides services. To meet the needs of youth, families, and the community, the document will ensure cultural competency at every level of DCJ.
- **Principle 5:** As DCJ increases its culturally competency, our services and sanctions will assist us in addressing the issue of overrepresentation of certain ethnic groups within the justice system and under-representation of those groups in the workforce.
- **Principle 6:** Cultural competency will be an integral part of every employee's performance evaluation. We will not only evaluate and monitor the performance of our staff; we will also evaluate and hold accountable our service providers and community partners. DCJ will collectively determine the criteria for measuring cultural competency and incorporate those criteria into the intercultural strategies document.
- **Principle 7:** DCJ will provide meaningful, legitimate opportunities for the individuals, families, and communities we serve to respond to and engage in a dialogue with DCJ. This could include customer satisfaction surveys and having staff designated to follow up on comments. DCJ will use the results of that dialogue and input from other stakeholders to improve its decision-making process and effectiveness.
- **Principle 8:** Every member of DCJ will be accountable for understanding these guiding principles and contributing to the success of this document. Success will require culturally

competent staff members who demonstrate a willingness to work with any member of our culturally, ethnically, linguistically, religiously, and socially diverse society.

- **Principle 9:** This intercultural strategies document will be considered and integrated into all aspects of future strategic planning at DCJ.

- **Principle 10:** In consultation with the Cultural Competency Steering Committee, DCJ management will be responsible for monitoring the implementation of this document and updating department staff on progress toward its goals.

Comprehensive Workforce Development Plan

(These standards were developed as part of comprehensive workforce development plan for the District of Columbia).

- One-Stop Centers should ensure that data on Limited-English Proficient (LEP) individuals and persons with disabilities served by the centers is collected, disaggregated by age and gender, publicly disseminated, and periodically updated through their information systems.
- One-Stop Centers should implement a strategy to recruit, retain, and promote at all levels a diverse staff and management who are representative of the LEP and disability populations served. The staff hired should be culturally and linguistically competent.
- One-Stop Centers should ensure that staff and management receive ongoing training on diversity and on providing culturally and linguistically appropriate services for LEP and disability communities, and on assisting these communities to enter high-wage occupations.
- One-Stop Career Centers must provide training to all frontline and managerial staff on providing employment services to persons with disabilities.
- The One-Stop Center System must ensure that appropriate and certified language assistance services (i.e., translation, interpretation, and accessible formats) are available to LEP individuals and persons with disabilities at all points of contact during hours of operation, and in a timely manner.
- One-Stop Centers must make a conscious and ongoing effort to ensure that LEP individuals and persons with disabilities are informed about their right to receive language assistance services and are aware of and feel encouraged to use these resources and programs at the One-Stop System.
- One-Stop Centers must increase the number of people with disabilities and LEP individuals placed in high-wage, quality employment by working with local CBOs to both job seekers and employers until each party finds a job or finds their candidates, respectively.

- One Stop Centers must ensure accessibility to services and resources by making the facility physically accessible and providing reasonable accommodations to access other core services.
- One Stop Centers must ensure accessibility to training programs and services by verifying that current and new contractors can deliver employment-related services to persons with disabilities.
- One-Stop Centers must coordinate with partner agencies to provide job-related supports and improve work outcomes for persons with disabilities.