Definitions: From the National Center for Cultural Competence

Cultural awareness: Being cognizant, observant and conscious of similarities and differences among cultural groups.

Cultural sensitivity: Understanding the needs and emotions of your own culture and the culture of others.

Cultural competence:

Cultural competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency or among professionals and enable that system, agency or those professions to work effectively in cross-cultural situations (Cross, et al, 1998).

The term cultural competence means services, supports or other assistance that are conducted or provided in a manner that is responsive to the beliefs, interpersonal styles, attitudes, language and behaviors of individuals who are receiving services, and in a manner that has the greatest likelihood of ensuring their maximum participation in the program (US Dept of Health and Human Services, 2000).

Cultural competence (National Center for Cultural Competence, 1998) 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 diversity and the cultural contexts of communities they serve.
- Incorporate the above in all aspects of policy-making, administration, practice and service delivery, systematically involve consumers, families and communities.

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 the cultural competence continuum.

NCCC Glossary [http://www.ncccurricula.info/glossary.html](http://www.ncccurricula.info/glossary.html)

NCCC Definitions of Cultural Competence [http://www.ncccurricula.info/culturalcompetence.html](http://www.ncccurricula.info/culturalcompetence.html)
Conceptual Frameworks / Models, Guiding Values and Principles

The NCCC embraces a conceptual framework and model for achieving cultural and linguistic competence based on the work of Cross et al. (1989).

The NCCC uses this framework and model to underpin all activities.

- Cultural Competence: Definition and Conceptual Framework
- Culturally Competent Guiding Values and Principles
- Linguistic Competence: Definition
- Guiding Values and Principles for Language Access

Cultural Competence: Definition and Conceptual Framework

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 diversity and the cultural contexts of the communities they serve.
- incorporate the above in all aspects of policy making, administration, practice, service delivery and involve systematically consumers, key stakeholders and communities.

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 the cultural competence continuum. (adapted from Cross et al., 1989)

Culturally Competent Guiding Values & Principles

Organizational

- Systems and organizations must sanction, and in some cases mandate the incorporation of cultural knowledge into policy making, infrastructure and practice.*
- Cultural competence embraces the principles of equal access and non-discriminatory practices in service delivery.*

Practice & Service Design

- Cultural competence is achieved by identifying and understanding the needs and help-seeking behaviors of individuals and families.*
- Culturally competent organizations design and implement services that are tailored or matched to the unique needs of individuals, children, families, organizations and communities served.*
- Practice is driven in service delivery systems by client preferred choices, not by culturally blind or culturally free interventions.*
- Culturally competent organizations have a service delivery model that recognizes mental health as an integral and inseparable aspect of primary health care.

Community Engagement

- Cultural competence extends the concept of self-determination to the community.*
- Cultural competence involves working in conjunction with natural, informal support and helping 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).*
- Communities determine their own needs.**
Community members are full partners in decision making.**
Communities should economically benefit from collaboration.**
Community engagement should result in the reciprocal transfer of knowledge and skills among all collaborators and partners.**

**Family & Consumers**
- Family is defined differently by different cultures.***
- Family as defined by each culture is usually the primary system of support and preferred intervention.***
- Family/consumers are the ultimate decision makers for services and supports for their children and/or themselves.***

Linguistic Competence: Definition

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, individuals with disabilities, and those who are deaf or hard of hearing. Linguistic competency requires organizational and provider capacity to respond effectively to the health and mental health literacy needs of populations served. The organization must have policy, structures, practices, procedures, and dedicated resources to support this capacity.

Goode & Jones (modified 2009). National Center for Cultural Competence, Georgetown University Center for Child & Human Development.

Click here for the full text definition of linguistic competence.

Guiding Values and Principles for Language Access

- 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.
- Interpretation and translation services comply with all relevant Federal, state, and local mandates governing language access.
- Consumers are engaged in evaluation of language access and other communication services to ensure for quality and satisfaction.

Footnotes
* Adapted from Cross, T. et al, 1989
*** "Other Guiding Values and Principles for Community Engagement" and "Family & Consumers" are excerpts from the work of Taylor, T., & Brown, M., 1997, Georgetown University Child Development Center, (GUCDC) University Affiliated Program, and

Click on Resources and Tools for checklists that reflect these values and principles in policy and practice.
PROMOTING CULTURAL DIVERSITY AND CULTURAL COMPETENCY

Self-Assessment Checklist for Personnel Providing Services and Supports to Children with Disabilities & Special Health Needs 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 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 and families served by my program or agency.

_____ 3. When using videos, films or other media resources for health education, treatment or other interventions, I insure that they reflect the cultures of children 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 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 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 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 who have limited English proficiency.

_____  9. I use bilingual staff or trained/certified interpreters for assessment, treatment and other interventions with children who have limited English Proficiency.

_____ 10. I use bilingual staff or trained/certified interpreters during assessments, treatment sessions, meetings, and for or 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:

_____  * limitations in English proficiency is in no way a reflection of their level of intellectual functioning.

_____  * their limited ability to speak the language of the dominant culture has no bearing on their ability to communicate effectively in their language of origin.

_____  * they may or may not be literate in their language of origin or English.

12. When possible, I insure that all notices and communiqués to parents 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:

_____  * apply them within my program or agency.

_____  * advocate for them within my program or agency.

15. I understand the implications of health literacy within the context of my roles and responsibilities.

16. I use alternative formats and varied approaches to communicate and share information with children and/or their family members who experience disability.
VALUES AND ATTITUDES

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 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 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 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 medical treatment, health and mental health care, and special education 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 accept that religion and other beliefs may influence how families respond to illnesses, disease, disability and death.

30. 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.
__31. I understand that traditional approaches to disciplining children are influenced by culture.

__32. I understand that families from different cultures will have different expectations of their children for acquiring toileting, dressing, feeding, and other self-help skills.

__33. I accept and respect that customs and beliefs about food, its value, preparation, and use are different from culture to culture.

__34. 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.

__35. 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 and families served by my program or agency.

__36. 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 competence.

**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 with disabilities or special health care needs and their families.
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:

   * limitations in English proficiency are in no way a reflection of their level of intellectual functioning.
   * their limited ability to speak the language of the dominant culture has no bearing on their ability to communicate effectively in their language of origin.
   * they may or may not be literate in their language of origin or English.

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:

   * apply them within my program or agency.
   * advocate for them within my program or agency.

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.