



---

**CULTURAL AND LINGUISTIC COMPETENCE**  
**TECHNICAL RESOURCE GROUP**  
**DRAFT WORKPLAN**

## **I. INTRODUCTION AND JUSTIFICATION**

### A. Introduction

There is extensive evidence that racial and ethnic groups have less access to mental health services and are more likely to receive lower quality care. The provision of mental health care in a cultural and linguistic competent manner is fundamental in any effort to ensure appropriate access to and engagement in appropriate services by all population groups and especially unserved, underserved and inappropriately served communities. Improving access to and quality of mental health services for historically underserved communities and the reduction of mental health disparities across racial, cultural and ethnic groups are key goals of the Mental Health Services Act.

The primary role of Cultural and Linguistic Competence Technical Resource Group (CLCTRG) is to ensure the Mental Health Services Oversight and Accountability Commission (MHSOAC) has access to experts in the three core principles of the Act: [(1)] cultural and linguistic competence to reduce disparities, [(2)] inclusive of multicultural client and family involvement in shaping MHSOAC policy, and [(3)] outcomes accountability. The CLCTRG serves at the pleasure of the Commission [and] will consist of individuals with expertise in a systems approach to cultural and linguistic competence, mental health stigma and discrimination reduction, and the reduction of disparities in access to, quality of, and mental health outcomes among unserved, underserved and inappropriately served communities in California.

### B. The Charge of the CLCTRG

The CLCTRG is charged with ensuring that the MHSOAC has an ongoing focus on [reducing and eliminating] disparities in the area of access, quality, and outcomes in mental health service provision to unserved, underserved and inappropriately served communities. Historical disparities are found and consistently continue to exist among California's racial-ethnic populations including African-Americans, Latinos, Asian Pacific Islanders (API), and Native Americans [as these groups have demonstrated evidence of historical disparities, in access and appropriateness of care in mental health systems. [Therefore,] any other population group(s) [that may be] targeted by a county must be clearly defined with demonstrated evidence and supporting data to target them as having documented disparities in mental health services. [See Appendix for other frameworks discussed

## **II. PRIMARY ROLES [AND BENCHMARKS] OF THE CLCTRG**

### A. Committee Action Items and Timelines

1. Provide information and technical assistance to the Commission to assist them in achieving their goal of reducing disparities in access to, quality of, and outcomes of mental health services.

- a. Provide the MHSOAC staff and Commissioners with assistance in the development of a vision for disparities elimination, as well as a plan with benchmarks to work toward the reduction of disparities.

Recommendation to be made to the MHSOAC to consider adopting a policy statement regarding Cultural and Linguistic competency and elimination of disparities at a meeting/workshop/retreat. Winter or spring 2008.

Develop and adopt a mission statement for the Cultural and Linguistic Competency Technical Resource Group. February. 2008

Mission Statement submitted for Consideration:

It is the mission of the CLCTRG to ensure that the MHSOAC has an ongoing focus in the area of access, quality, and outcomes disparities in mental health service provision to unserved, underserved and inappropriately served communities with historical disparities.

- b. Provide MHSOAC Staff and Commissioners with advice and counsel to ensure MHSOAC meetings demonstrate cultural honoring, cultural responsiveness, and cultural humility.

Provide periodic reports and presentations to MHSOAC regarding progress toward meeting cultural and linguistic competency in Commission activities twice yearly in June and January.

2. Assist Commissioners in creating accountability mechanisms for reduction of disparities.

- a. Assist the Commissioner in recognizing that the responsibility and charge for creating culturally and linguistically competent mental health services is not limited to this committee and is the responsibility of all committees.

Provide orientation and periodic reports to Commissioners and all committees once a year and/or as needed.

Provide recommendations and guidance for creating culturally and linguistic competent participants for Commission committees and programs.

- b. Assist Commissioners in developing strategies to ensure counties and the state are accountable for reduction of disparities in their quality of mental health care for historically unserved, underserved and inappropriately served cultural, racial and ethnic populations.

Assist Commissioners in developing strategies and protocols in partnership with Department of Mental Health for increasing the reduction of disparities in their

quality of mental health care for historically unserved, underserved and inappropriately served cultural, racial and ethnic populations satisfying these core questions:

- ✓ What have you done?
- ✓ Why have you done it?
- ✓ What were the results?

Including the integrated plan and other components of the MHSA. Year 2008-2009.

- c. Assist Commissioners to develop their capacity to implement culturally appropriate outreach and engagement models for California's historically unserved, underserved and inappropriately served communities.

Provide data on progress towards improving cultural and linguistic competency to MHSOAC via the annual independent review referenced below.

Respond to Commissioner's requests for resources related to cultural and linguistic competency within 90 days.

Seek further direction to support the efforts of the MHSOAC.

- d. Assist the MHSOAC in the development of mechanisms that provide historically unserved, underserved and inappropriately served populations a path to involvement in mental health policy development.

Recommendation to be made to the MHSOAC at a meeting/workshop/retreat. Winter or spring 2008.

Seek an annual independent review of county plans to obtain baseline data. Regarding whether unserved, underserved and inappropriately served communities were involved in mental health policy development. Results may be forwarded to MHSOAC Measurement and Outcome Committee.

- e. Educate Commissioners on the disparities in the mental health system.

Provide periodic data to the MHSOAC on the types, impact and extent cultural and linguistic disparities that exist in California.

Respond to Commissioner's request for resources related to cultural and linguistic competency with in 90 days.

3. Ensure that county defined historically unserved, underserved and inappropriately served communities have increased their capacity to be involved in the development of health policy.

Annually county plans will report the participation of unserved, underserved and inappropriately served communities in program planning, policy development, evaluation and other components of the MHSA.

Monitor and annually report to the MHSOAC on the effectiveness of outreach procedures. *Date to be determined*

4. Provide a Public Forum where unserved, underserved and inappropriately served in California's public mental health system.
  - a. Serve as a referral source for Commissioners when issues related to disparities are identified at MHSOAC meetings.

Provide a forum and process where stakeholders can communicate issues and concerns. February 2008

Report on progress/resolution on concerns raised by stakeholders to the MHSOAC within 90 days.

- b. Serve as an access point to the MHSOAC, if desired by communities, where historically unserved, underserved and inappropriately served communities can identify concerns related to MHSA planning or implementation.

Provide a forum and process where stakeholders can communicate issues and concerns. *Date to be determined*

Report on progress/resolution on concerns raised by stakeholders to the MHSOAC within 90 days.

- c. Supporting engagement of historically unserved, underserved and inappropriately served communities and encourages their participation at MHSOAC meetings, particularly when there are agenda items related to reducing disparities in California's mental health service system.

Request collaboration with stakeholders to determine meetings locations by November 2007.

### III. CLCTRG MEMBERSHIP

The CLCTRG will at a minimum consist of individuals with knowledge and experience in the mental health field and include stakeholders from California's diverse populations including but not limited to; the Department of Mental Health , Office of Multicultural Services (DMH, OMS), the California Institute for Mental Health, Center for Multicultural Development (CIMH, CMD), the California Mental Health Directors Association, Cultural

Competence/Ethnic Service Managers (CMHDA, CC/ESM), the University of California, Davis, Center for Reducing Health Disparities (UCD, CRHD), and California Network of Mental Health Clients (CNMHC), the Mental Health Association in California (MHAC), the National Alliance on Mental Illness (NAMI), United Advocates for Children and Families (UACF) and Community Based Organizations (CBOs). Efforts will be made to have representatives from different ethnic, racial, and cultural groups. CLCTRG members will serve a two-year rotating term

#### **IV. MEETING SCHEDULE**

Develop an annual meeting schedule at the first meeting of the calendar year. The meeting schedule may be amended by the Chair and/or Committee based on unique or anticipated needs

#### **V. PROCESS/RESOURCES**

In order to assist MHSOAC Commissioners, the CLCTRG will seek and collaborate with experts and the public through public testimony and presentations. It is the goal of the CLCTRG to have meetings and hearings in locations that are representative of unserved, underserved, and inappropriately served communities throughout the state of California.

Staff will initiate the planning and design of necessary meetings and/or public hearings and will ensure that the CLCTRG is informed prior to establishing a final CLCTRG work plan for the MHSOAC. Staff will keep CLCTRG members informed and solicit input and participation in such meetings and/or public hearings in an effort to achieve participation from a wide range of sources

#### **VI. CLCTRG APPENDIX**

##### **Historical Disparities Adopted Definition**

Historical disparities have been consistently found in and continue to exist among California's racial-ethnic populations including African-Americans, Latinos, Asian Pacific Islanders (API), and Native American. Any other population group(s) targeted in a county plan must be clearly defined with demonstrated evidence and supporting data to target them as having historic disparities in unserved, underserved and inappropriately served in mental health services.

##### **Cultural and Linguistic Competence**

Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among consumer providers, family members,

and professionals that enable that system, agency or those providers to work effectively in cross-cultural situations. (Source: Adapted from Cross, T.L., Bazron, B.J. Dennis, K.W., Issacs, M.R. and Benjamin, M.P. (1989). Towards A Culturally Competent System of Care, (Vol) Washington, D.C.

### **Cultural Humility**

A process that requires individuals to continuously engage in self-reflection and self-critique as lifelong learners and reflective practitioners. It requires health providers to acknowledge and address the power imbalances that exist in the dynamics of provider-client communication by using client-focused interviewing and care, and it is a process that requires humility to develop and maintain mutually respectful and dynamic partnerships with communities. The cultural humility approach enhances patient care by effectively weaving an attitude of learning about cultural differences into patient encounters. Additionally, this approach cultivates self-awareness by encouraging health practitioners to acknowledge the belief systems and cultural values they bring to patient encounters.

### **Other Frameworks**

The CLCTRG discussed several framework themes that could be used for the unserved, underserved and inappropriately served population definition:

- a. Those populations that have not been historically provided access to mental health services.
- b. Those groups that are not represented in treatment data equal to their distribution in the general population.
- c. Those that are receiving some level of assistance but not adequate to deal with their mental illness.
- d. Those that are not represented in data systems reporting treatment for mental illness.