Spring 2012 SPOTLIGHT ON CULTURE

The Organizational Journey toward Cultural and Linguistic Competency: Part One

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This is the beginning of a four-part series on the organizal domains that support the delivery of culturally and linguistically competent services to diverse groups of children and families who have experienced trauma. Part one focuses on how child-serving professionals can come to understand the cultural characteristics of those they are serving.

Part One: Who Do You Serve? Identifying Your Service Population

The delivery of culturally and linguistically competent services begins with knowledge of the characteristics of the population being served.

Whether an organization serves a specific, geographically-defined catchment area or is open to the public at large, it should periodically capture data about the children and families who come (and do not come) through its doors, said Vivian H. Jackson, PhD, a member of the NCTSN Advisory Board and a faculty member at the National Center for Cultural Competence at Georgetown University Center for Child and Human Development. Neighborhoods and communities are often in flux, Jackson noted, and strategies for helping a traumatized child who recently arrived from El Salvador, for example, are not interchangeable with strategies that may have been in use for years for helping African American children. “As populations move out and new populations come in,” she said, “approaches to service delivery must be reevaluated.”

External, Internal Sources of Information

There are many external data sources for assessing the characteristics of a service population. A quick scan of the addresses of current clients will help to identify their communities, the demographics of which can be researched through United States Census Bureau information or from enrollment data from local school systems. If the population is comprised of recipients of Medicaid or state mental-health funds, the state or local departments of these programs may supply additional demographic information. Some local jurisdictions furnish more detailed neighborhood profiles (for example, Citywide Vital Signs, compiled by the Baltimore Neighborhood Indicators Alliance). Online databases (see Additional Resources pg. 3) offer information about spoken languages, religious/faith adherents, and other key demographic data. With the information it collects, the agency can design services to better fit the social contexts of the people it serves and make appropriate decisions regarding outreach and collaboration.

Internal client data allow an organization to compare its own demographics with that of the community it serves. These data also serve as the baseline from which the organization can identify strengths and challenges in the provision of quality services. At minimum, the CLAS (National Standards on Culturally and Linguistically Appropriate Services) standards suggest that data on race, ethnicity, and language be collected. (A revision of the CLAS standards will be released later in 2012.)

In October of 2011, in compliance with the Affordable Care Act, Section 4302, the Department of Health and Human Services released guidelines that require collection of race and ethnicity data at a more specific, "granular" level. Collection of language, gender, and disability data is also required on all HHS-sponsored health surveys. Such granular-level data can make a difference. A study that used the terms Mexican-American/Chicano(a), Puerto Rican, and Cuban instead of the umbrella terms Latino or Hispanic was able to show that diabetes-related mortality was twice as high in Mexican-American and Puerto Rican patients as it was in Cubans (Smith & Barnett, 2005).

As electronic health records gain in use, data capture affects how organizations gather information and structure their services. Jackson pointed out that organizations working toward cultural and linguistic competency should actively encourage the inclusion of demographic fields that will allow them to uncover disparities in care in areas such as service utilization, diagnostic patterns, rates of participation and satisfaction, and clinical and functional outcomes.

Data on primary language and literacy levels, in both the mother tongue and English, are also important. (See www.lep.gov for federal guidance on language access.) An analysis of language needs can help guide the organization in developing a language access plan. The plan, in turn, will help the organization make decisions about multilingual staffing, interpreters, and telephone interpreting services; determine which materials require translation into which languages; and select facility signage to include in languages other than English. Assessing literacy levels will also guide decisions on the degree to which symbols and other plain language methods need to be incorporated in the organization's work.

Understanding Communities

Clinicians should be attuned to what is happening in their clients' worlds. Jackson offered examples from Washington, DC, where Haitians were deeply affected by the earthquakes in their homeland, and Trinidadians closely followed the elections in their home country. As they seek to help children and families heal from traumatic events, agencies can collaborate with key community partners, cultural brokers, and advocacy groups to help them stay apprised of these types of contextual family factors. "If you're not making connections about the level of tension in the household and how that is also influencing this child," Jackson said, "then you've missed a big opportunity to be helpful to the family."

Delivering culturally and linguistically competent services is a holistic process that takes place over time and evolves on a continuum (Cross, et al., 1989). The process may appropriately be led by organizational executives, board members, program managers, and others with the authority to make decisions about policies and resource allocation. However, "No one has to wait for the call from an organizational executive to begin to champion the issues of cultural and linguistic competence," Jackson said. Organizational change can start with leadership from any place within the organization. Any individual can begin to ask and answer these questions: Who do we serve? Who do we not serve, and why? How does the culture of our clients influence their experience of trauma? How does their sociocultural context contribute to their distress and to their healing? Who do we serve well? Who do we not serve well, and why? And finally, What organizational changes do we need in order to make a difference?

Additional Resources

- The Modern Language Association's Language Map Data Center offers a survey of spoken languages, broken out by state, county, or zip code. Visit http://www.mla.org/map_data&dcwindow=same
- The Migration Policy Institute offers estimates of foreign-born residents in a given geographic area, as well as current political and historical background and refugee information.

Visit www.migrationinformation.org

- The Association of Religion Data Archives offers demographic maps of religious affiliation and identification, customized according to geographic area. Visit http://www.thearda.com/DemographicMap/
- The Health Research and Education Trust offers a free toolkit on how to collect race, ethnicity, and primary language information from clients. Visit www.hretdisparities.org
- The Institute of Medicine's report on Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement can be accessed at http://www.iom.edu/Reports/2009/RaceEthnicityData.aspx
- The Office of Minority Health supplies templates for collection of language, race, gender and disability information. Visit http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=208

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