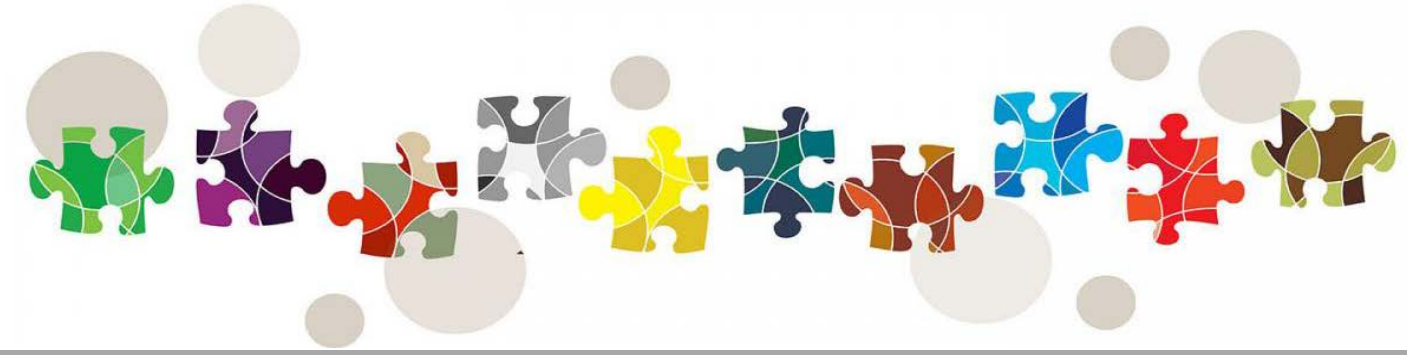
County of San Diego Behavioral Health Services

Promoting Cultural Diversity Self-Assessment (PCDSA) Biennial Report: 2018



Introduction

One of the quality improvement strategies in the County of San Diego Behavioral Health Services (SDCBHS) Cultural Competence Plan is to survey all programs to assess for culturally competent service provisions. Accordingly, all County and County-contracted programs are required to complete the Promoting Cultural Diversity Self-Assessment (PCDSA). In February 2018, the SDCBHS Quality Improvement unit requested each contracted Mental Health Services (MHS) and Substance Use Disorder (SUD) program manager to distribute the survey to their organization and complete the survey. A total of 2,672 respondents completed the survey: 2,195 for MHS and 477 for SUD. The program level data was distributed to the Programs/COR in October 2018.

The PCDSA supports the SDCBHS' commitment to a culturally competent workforce and upholds the guidelines described in the Cultural Competence Plan and Handbook. These documents can be located in the SDCBHS Technical Resource Library at www.sandiegocounty.gov/hhsa/programs/bhs/technical_resource_library.html.

For more information contact the Quality Improvement, Performance Improvement Team at BHSQIPIT@sdcounty.ca.gov.

Background and Method

The PCDSA was developed by Georgetown University's National Center for Cultural Competence. The assessment's goal is to heighten the awareness and sensitivity of program staff to the importance of cultural diversity and cultural competence.

The PCDSA is administered to all staff of County-operated and County-contracted mental health and substance use disorder programs in February every two years. A Google survey was distributed to all program managers on February 14, 2018 and they were asked to ensure that all program staff receive a copy of the link to complete the survey.

What does the data mean?

The PCDSA results show the providers and their organizations' awareness and understanding of the diverse cultural groups in the County, and may reveal opportunities to provide better communication and access to treatment for diverse populations. As this is the first PCDSA assessment conducted by BHS, the results would also provide a baseline for subsequent assessments. The survey data shows that the providers' self-reported Values and Attitudes are in general, attuned to the diverse populations they serve. The most opportunity for improvement is in the area of sites' Physical Environment, Materials, and Resources. Additional efforts to ensure physical elements in the sites reflect the various cultural and ethnic groups of their clients could be considered as a step towards enhancing cultural competence.

NOTE: Percentages in this report may not add up to 100% due to rounding.

Demographics

Key findings:

Female staff survey respondents outnumber males 3 to 1, compared to the FY 2016-17 Systemwide client population which shows males (57%) outnumbering females (43%).

Gender (MHS & SUD)	Staff Survey Respondents		FY 2016-17 Clients	
	Count	%	Count	%
Female	2,023	76%	31,783	43%
Male	594	22%	42,383	57%
Other gender	4	0.1%	164	0.2%
Prefer not to state	51	2%	N/A	N/A

Gender (MHS)	Staff Survey Respondents		MHS Clients FY 2016-17	
	Count	%	Count	%
Female	1,703	78%	26,452	45%
Male	445	20%	32,006	55%
Other gender	4	0.2%	148	0.3%
Prefer not to state	43	2%	N/A	N/A

Gender (SUD)	Staff Survey Respondents		SUD Clients FY 2016-17	
	Count	%	Count	%
Female	320	67%	5,331	34%
Male	149	31%	10,377	66%
Other gender	0	0%	16	0.1%
Prefer not to state	8	2%	N/A	N/A

Key Findings (Race and Language):

- The providers' self-reported race distribution closely reflects the self-reported race distribution of clients served in FY 2016-17.
- Majority of staff survey respondents (52%) speak English only.
- Spanish is the second most prevalent primary language among staff survey respondents (37%).
- Less than 1% of staff survey respondents speak Vietnamese as a primary language, and the same is true for primary speakers of American Sign Language.

Race (MHS & SUD)	Staff Survey Respondents		FY 2016-17 Clients	
	Count	%	Count	%
White	1,119	41.9%	26,435	38%
Hispanic	792	29.6%	23,345	33%
African-American	229	8.6%	8,147	11.7%
Multirace/Mixed	227	8.5%	2,735	4%
Asian/Pacific Islander	212	7.9%	3,084	4%
Unknown	33	1.2%	5,579	8%
Other	25	0.9%	N/A	N/A
Native American	24	0.9%	588	0.8%
African	4	0.1%	N/A	N/A
Latino	3	0.1%	N/A	N/A
Caucasian	2	0.1%	N/A	N/A
Latino non-Hispanic	1	0.0%	N/A	N/A
Mexican-American	1	0.0%	N/A	N/A

Primary Language	Count	%
Only English	1,382	52%
Spanish*	979	37%
All Other Languages	133	5%
Tagalog*	59	2%
Arabic*	41	2%
Farsi*	29	1.1%
Vietnamese*	25	0.9%
American Sign Language	24	0.9%

Second Language	Count	%
No Second Language	2,532	95%
All Other Languages	99	4%
Spanish*	17	1%
American Sign Language	11	0.4%
Tagalog*	11	0.4%
Farsi*	2	0.1%

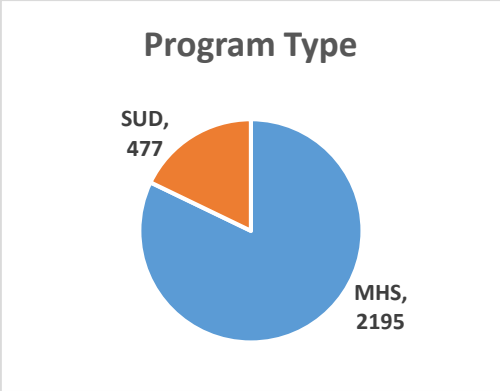
*Threshold languages

Education Level (MHS & SUD)	Staff Survey Respondents	
	Count	%
High School Diploma	412	15%
Associate's Degree	284	11%
Bachelor's Degree	695	26%
Master's Degree	1,115	43%
Doctorate/MD/PhD/PsyD	126	5%

Key Findings:

Education levels among staff survey respondents are diverse, with majority holding a Master's degree (43.2%).

Programs



Key findings:

- There are 477 SUD Staff that responded to the survey, compared to 2,195 Mental Health Services Staff.
- Peer Support Specialists/Youth Support or Family Support Partners make up 15% of MHS staff survey respondents, compared to 6% in the same category for SUD.

Staff Position	Staff Survey Respondents					
	MHS		SUD		Combined (MHS & SUD)	
	Count	%	Count	%	Count	%
Direct Service Provider	1,220	56%	256	54%	1,476	55%
Indirect/Support Services	258	12%	89	19%	347	13%
Manager/Supervisor	269	12%	75	16%	344	13%
Peer Support Specialist/Youth Support Partner/Family Support Partner	323	15%	28	6%	351	13%
Program Director or Other Senior/Executive Level Staff	125	6%	29	6%	154	6%

Years in Service	Staff Survey Respondents					
	MHS		SUD		Combined (MHS & SUD)	
	Count	%	Count	%	Count	%
0-1 year	278	13%	59	12%	337	13%
2-5 years	885	40%	160	34%	1,045	39%
6-10 years	422	19%	107	22%	529	20%
10+ years	610	28%	151	32%	761	28%

Key findings:

- The majority of respondents (39%) reported having been in service at the program for 2-5 years.
- The second highest number of respondents have been in service with the program for 10+ years.

Staff Survey Answers

Key findings:

- The majority of staff survey respondents answered "Things I do occasionally" or "Things I do frequently".
- Section 1, questions 1 to 5 (pertaining to Physical Environment, Materials, and Resources) reflect the greatest need overall.
- Question 4 (pertaining to offering food that is unique to the community's ethnic group) shows the most need - 12% of respondents answered "Did not occur to me".
- The greatest disparity between MHS and SUD staff responses is reflected in the results for Question 37 (pertaining to awareness of cultural-specific healing methods). A total of 3% of MHS respondents answered "Did not occur to me" compared to 29% of SUD respondents. The same proportion of MHS respondents (30%) answered "Things I do occasionally" to this question.

Legend: MHS | SUD | Combined

	1 - Did not occur to me	2 - Things I do rarely or never	3 - Things I do occasionally	4 - Things I do frequently	5 - Not applicable to my program
I. Physical Environment, Materials and Resources					
1. I display pictures, posters and other materials that reflect the cultures and ethnic backgrounds of communities served by my program or agency.	8%	20%	22%	50%	0%
	0%	7%	21%	71%	0%
	9%	**19%**	**31%**	**41%**	**0%**
2. I ensure that magazines, brochures, and other printed materials in reception areas are of interest to and reflect the different communities served by my program or agency.	4%	16%	27%	52%	0%
	0%	14%	0%	86%	0%
	8%	**18%**	**25%**	**49%**	**0%**
3. When using videos, films, CDs, DVDs, or other media resources for Behavioral Health outreach, prevention, treatment, or other interventions, I ensure that they reflect the cultures of communities served by my program or agency.	3%	20%	22%	55%	0%
	7%	14%	7%	71%	0%
	7%	**16%**	**25%**	**53%**	**0%**
4. When offering food, I ensure that meals provided include foods that are unique to the cultural and ethnic backgrounds of the communities served by my program or agency.	12%	26%	26%	35%	0%
	7%	14%	50%	29%	0%
	12%	**28%**	**26%**	**33%**	**0%**
5. I ensure mediums and modalities in reception areas and those, which are used during program services, are representative of the various cultural and ethnic groups within the local community and the society in general.	9%	13%	29%	50%	0%
	7%	14%	0%	79%	0%
	8%	**18%**	**26%**	**48%**	**0%**
II. Communication Styles					
6. For people 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 interactions.	1%	3%	37%	56%	0%
	0%	0%	43%	57%	0%
	3%	**10%**	**30%**	**57%**	**0%**

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Legend: MHS | SUD | Combined

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II. Communication Styles (continued)					
7. I attempt to determine any cultural expressions used by communities served that may impact interactions and services.	3%	6%	26%	65%	0%
	0%	21%	21%	57%	0%
	2%	**7%**	**28%**	**63%**	**0%**
8. I use visual aids, gestures, and physical prompts in my interactions with those who have limited English proficiency.	1%	8%	26%	66%	0%
	7%	7%	21%	64%	0%
	2%	**7%**	**26%**	**64%**	**0%**
9. I use trained bilingual or multilingual staff (or appropriate interpreter services) during assessments, treatment sessions, meetings, and for other events for families who would require such level of assistance.	1%	10%	15%	74%	0%
	0%	7%	0%	93%	0%
	4%	**11%**	**14%**	**71%**	**0%**
10.1 When interacting with people 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.	0%	2%	3%	96%	0%
	0%	0%	0%	100%	0%
	1%	**2%**	**6%**	**92%**	**0%**
10.2 When interacting with people who have limited English proficiency, I always keep in mind that 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.	1%	1%	6%	92%	0%
	0%	0%	0%	100%	0%
	1%	**2%**	**7%**	**90%**	**0%**
10.3 When interacting with people who have limited English proficiency, I always keep in mind that they may or may not be literate in their preferred language or English.	4%	2%	8%	86%	0%
	7%	0%	7%	86%	0%
	3%	**4%**	**14%**	**79%**	**0%**
11. I ensure that all notices and communication to service participants are available in threshold languages.	1%	12%	23%	64%	0%
	7%	7%	29%	57%	0%
	3%	**10%**	**22%**	**65%**	**0%**
12. I understand that it may be necessary to use alternatives to written communications for some communities receiving information.	2%	5%	28%	65%	0%
	0%	14%	21%	64%	0%
	3%	**7%**	**26%**	**64%**	**0%**
13. I understand the value of linguistic competence and promote it within my program or agency.	1%	4%	24%	71%	0%
	0%	0%	36%	64%	0%
	3%	**7%**	**23%**	**67%**	**0%**
14. I understand the implications of health care and behavioral health literacy within the context of my roles and responsibilities.	1%	3%	13%	84%	0%
	0%	7%	21%	71%	0%
	1%	**3%**	**15%**	**80%**	**0%**
III. Values and Attitudes					
15. I use alternative formats and varied approaches to communicate and share information with those we serve who experience disability.	1%	2%	15%	83%	0%
	0%	7%	14%	79%	0%
	2%	**5%**	**21%**	**72%**	**0%**

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Legend: MHS | SUD | Combined

	1 - Did not occur to me	2 - Things I do rarely or never	3 - Things I do occasionally	4 - Things I do frequently	5 - Not applicable to my program
III. Values and Attitudes (continued)					
16. I avoid imposing values that may conflict or be inconsistent with those of cultures or ethnic groups other than my own.	1%	1%	11%	87%	0%
	0%	0%	0%	100%	0%
	2%	**2%**	**11%**	**85%**	**0%**
17. In delivering program services, I discourage participants from using derogatory slurs (e.g., racial, ethnic, sexist, homophobic, transphobic, etc.) by helping them understand that certain words can hurt others.	0%	2%	15%	83%	0%
	0%	0%	14%	86%	0%
	1%	**4%**	**14%**	**81%**	**0%**
18. I screen books, movies, and other media resources for negative stereotypes before sharing them with those served by my program or agency.	6%	15%	17%	62%	0%
	7%	21%	21%	50%	0%
	7%	**14%**	**19%**	**60%**	**0%**
19. I intervene in an appropriate manner when I observe other staff within my program or agency engaging in behaviors that show cultural insensitivity, bias, or prejudice.	1%	7%	27%	65%	0%
	7%	21%	29%	43%	0%
	3%	**11%**	**26%**	**60%**	**0%**
20. I understand and accept that family is defined differently by different cultures (e.g., extended family members, godparents, family of choice).	0%	0%	9%	91%	0%
	0%	0%	0%	100%	0%
	1%	**1%**	**7%**	**91%**	**0%**
21. I recognize and accept that people from culturally diverse backgrounds may desire varying degrees of acculturation into the dominant or mainstream culture.	2%	1%	8%	90%	0%
	0%	0%	7%	93%	0%
	1%	**2%**	**11%**	**85%**	**0%**
22. I accept and respect that gender roles and expression of gender identity in families may vary significantly among different cultures.	1%	1%	8%	91%	0%
	0%	7%	0%	93%	0%
	1%	**1%**	**8%**	**90%**	**0%**
23. 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 man in families).	0%	0%	7%	93%	0%
	0%	0%	7%	93%	0%
	1%	**2%**	**10%**	**87%**	**0%**
24. 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.	1%	2%	11%	63%	23%
	0%	0%	7%	64%	0%
	1%	**1%**	**8%**	**63%**	**27%**
25. I recognize that the meaning or value of behavioral health outreach, prevention, intervention, and treatment may vary greatly among cultures.	0%	1%	11%	88%	0%
	0%	0%	0%	100%	0%
	1%	**1%**	**8%**	**90%**	**0%**
26. I recognize and understand that beliefs and concepts of emotional well-being vary significantly from culture to culture.	0%	0%	6%	94%	0%
	0%	0%	0%	100%	0%
	1%	**1%**	**8%**	**90%**	**0%**
27. I understand that beliefs about mental illness, substance use, and emotional disability are culturally-based. I accept that responses to these conditions and related services are heavily influenced by culture.	2%	1%	11%	86%	0%
	0%	0%	7%	93%	0%
	1%	**1%**	**9%**	**89%**	**0%**

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Legend: MHS | SUD | Combined

	1 - Did not occur to me	2 - Things I do rarely or never	3 - Things I do occasionally	4 - Things I do frequently	5 - Not applicable to my program
III. Values and Attitudes (continued)					
28. I understand the impact of stigma associated with mental illness, substance use, and behavioral health services within culturally diverse communities.	0%	2%	5%	93%	0%
	0%	0%	7%	93%	0%
	1%	**1%**	**6%**	**92%**	**0%**
29. I accept that religion, spirituality and other beliefs may influence how people respond to mental or physical illnesses, disease, disability, and death.	0%	0%	8%	92%	0%
	0%	0%	0%	100%	0%
	1%	**1%**	**6%**	**92%**	**0%**
30. I recognize and accept that cultural and religious beliefs may influence a family's reaction and approach to a person diagnosed with a physical/emotional disability or special health care needs.	0%	0%	9%	91%	0%
	0%	0%	7%	93%	0%
	1%	**1%**	**7%**	**91%**	**0%**
31. I understand that traditional approaches to disciplining children are influenced by culture.	1%	2%	13%	85%	0%
	7%	0%	7%	86%	0%
	2%	**2%**	**12%**	**84%**	**0%**
32. I understand that people from different cultures will have different expectations for acquiring self-help, social, emotional, cognitive, and communication skills.	0%	0%	8%	92%	0%
	7%	0%	7%	86%	0%
	1%	**1%**	**7%**	**91%**	**0%**
33. I accept and respect that customs and beliefs about food, its value, preparation, and use are different from culture to culture.	1%	1%	12%	86%	0%
	0%	7%	7%	86%	0%
	1%	**2%**	**9%**	**88%**	**0%**
34. Before visiting a home setting, or providing services in the community, I seek information or acceptable behaviors, courtesies, customs, and expectations that are unique to specific cultures and ethnic groups served by my program or agency.	6%	15%	20%	60%	0%
	7%	21%	14%	57%	0%
	6%	**15%**	**27%**	**53%**	**0%**
35. I seek information from family members or other key community leaders that will assist in service adaptation to respond to the needs and preferences of culturally and ethnically diverse community members served by my program or agency.	3%	13%	20%	64%	0%
	7%	14%	36%	43%	0%
	4%	**12%**	**27%**	**58%**	**0%**
36. I promote the review of my program's or agency's mission statement, goals, policies, and procedures to ensure that they incorporate principles and practices that promote cultural diversity and cultural and linguistic competence.	2%	8%	28%	62%	0%
	7%	14%	14%	64%	0%
	3%	**9%**	**21%**	**67%**	**0%**
37. I am aware of cultural specific healing methods, particularly as they pertain to the communities served by my program or agency.	3%	9%	30%	58%	0%
	29%	14%	0%	57%	0%
	4%	**11%**	**29%**	**56%**	**0%**
38. I contribute to and/or review current research related to cultural disparities in behavioral health, health care, and quality improvement.	6%	12%	29%	53%	0%
	0%	21%	36%	43%	0%
	4%	**15%**	**33%**	**48%**	**0%**
39. I accept that many evidence-based outreach, prevention, and intervention approaches will require adaptation to be effective with culturally and linguistically diverse groups.	2%	3%	17%	78%	0%
	14%	0%	14%	71%	0%
	2%	**4%**	**16%**	**78%**	**0%**