MARYLAND DEPARTMENT OF HEALTH
Behavioral Health Administration

FY 2019-2020
CULTURAL AND LINGUISTIC COMPETENCY STRATEGIC PLAN

A RECOVERY AND RESILIENCE-ORIENTED SYSTEM OF CARE

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"The services and facilities of the Maryland Department of Health (MDH) are operated on a non-discriminatory basis. This policy prohibits discrimination on the basis of race, color, sex, or national origin and applies to the provisions of employment and granting of advantages, privileges, and accommodations."

"The Department, in compliance with the Americans with Disabilities Act, ensures that qualified individuals with disabilities are given an opportunity to participate in and benefit from MDH services, programs, benefits, and employment opportunities."

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DEPUTY SECRETARY'S MESSAGE

In his 1999 report on mental health, Surgeon General David Satcher concluded that all Americans do not share equally in the hope for recovery from mental and behavioral illnesses or in reasonable access to treatment services and supports.[1] He posits that in order for issues of access and quality of care to be improved, the field must provide services within the cultural and linguistic competence context of the people being served. This requires that each of us continue to embark upon a learning journey that provides us with the knowledge, skills and abilities to effectively work cross-culturally.

Culturally competent care is quality care. Some of the factors for consideration in the delivery of culturally competent care include:

- Understanding that we each view the world through our own cultural lens. This impacts the manner in which we engage people into treatment, deliver services, and define treatment compliance. We must put our own cultural bias aside and partner with our clients to learn what strategies work best within their cultural context.
- Recognizing that the assessment and inclusion of formal and informal observations of cultural parameters influencing individuals and families—however "family" is defined by the client—is essential for service planning and delivery. Cultural parameters include: strength of racial/ethnic identity; level of acculturation and assimilation; values orientation; immigration/migration experience; current socio-economic status; cultural beliefs and practices; use of informal networks and ethnic-specific institutions; language and communication processes; views about discrimination and racism; influence of religion/spirituality on belief systems and behavioral patterns and cultural beliefs regarding behavioral health and behavioral health care.
- Recognizing "structural racism" is a major characteristic of American life. This refers to a system in which public policies, institutional practices, cultural representation and other norms work in a variety of ways to perpetuate racial group inequity. There are inherent and deeply engrained inequities in American society that shape how we structure services, define customers and determine how resources are allocated. Efforts must be made to restructure services such as they are acceptable to communities of color.
- Programs should be community-based and easily accessible to the target population. This means that we may wish to co-locate services in health clinics, family resource centers or other community settings to reduce stigma.
- The importance of coordinated service linkages and relationships in recognition of the multiple needs of the diverse individuals and families we serve should be underlined. Care management is a core function of programs.

Let's all work together to create an integrated system of care that is inclusive of the unique needs of all members of our community.

Best regards,

[1]U.S. Department of Health and Human Services. (1999). *Mental Health: A Report of the Surgeon General*. Rockville, MD: Department of Health and Human Services. Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institute of Health, National Institute of Mental Health.

EXECUTIVE SUMMARY

The Maryland Department of Health (MDH), Behavioral Health Administration (BHA) is committed to establishing and maintaining an integrated behavioral health system that fosters continuous development of cultural and linguistic competence. Through ongoing community partnerships and stakeholders' collaboration, BHA strives to accomplish this commitment by cultivating a system that recognizes and values the delivery of culturally and linguistically competent behavioral health services to Marylanders.

This Cultural and Linguistic Competency Strategic Plan (CLCSP) was developed to:

- Establish and maintain statewide culturally and linguistically competent behavioral health services;
- Work toward the elimination of internal and external stigma, negative stereotyping, and discrimination against individuals or members of particular groups based on mental health or substance use disorder (SUD) status, age, disability, ethnicity/race, gender, religion/spirituality, sexual orientation, socio-economic status and membership in a particular social group;
- Foster the implementation of data driven decision making practices that result in the formation of culturally and linguistically appropriate policies, provisions, and infrastructures;
- Support the usage of evidence-based practices to address the unique behavioral health needs of individuals served in Maryland's Public Behavioral Health System (PBHS); and
- Advocate for and institute ongoing workforce development programs in cultural and linguistic competence reflective of Maryland's diverse population.

BHA believes that culturally and linguistically appropriate services lead to meaningful and sustainable outcomes reflective of enhanced quality of life, health, safety, and wellness for all Marylanders. BHA also recognizes that cultural and linguistic competence is a continuously evolving process that is critical to creating and maintaining an integrated system of care equipped to assess the effectiveness of behavioral health service delivery to Maryland's diverse populations. Thus, BHA is committed and pledges to collaborate with internal and external partners to promote continuous improvement, implementation, and expansion of an integrated, recovery oriented and culturally and linguistically competent behavioral health system of care that addresses the needs of individuals served in Maryland's PBHS.

THE BEHAVIORAL HEALTH ADMINSTRATION (BHA)

VISION STATEMENT

"Improved health, wellness, and quality of life for individuals across the life span through a seamless and integrated behavioral health system of care."

MISSION STATEMENT

"The Maryland Department of Health Behavioral Health Administration will develop an integrated process for planning, policy, and services to ensure a coordinated quality system of care is available to individuals with behavioral health conditions."

"The BHA will, through publicly-funded services and support, promote recovery, resiliency, health and wellness for individuals who have or are at risk for emotional, substance related, addictive, and/or psychiatric disorders to improve their ability to function effectively in their communities."

ACKNOWLEDGMENTS

This CLCSP has been developed in consultation with the Maryland's Behavioral Advisory Council's Cultural and Linguistic Competence Committee, BHA's Division of Data/IT, and the Applied Research and Evaluation Unit as well as the Maryland Office of Minority Health and Health Disparities. BHA has also reviewed research materials on cultural and linguistic competence, national behavioral health cultural and linguistic competence plans and standards; and adopted the National Culturally and Linguistically Appropriate Services (CLAS) Standards as well as some of the evidence-based best practices applicable to Maryland's context.

Special thanks go to the Cultural and Linguistic Competence Committee (CLCC), which was created under the Maryland's Behavioral Health Advisory Council (BHAC). The CLCC's mission and objective statements are as follows:

MISSION

The CLCC will generate recommendations and concepts that will facilitate the development of cultural and linguistic competence and culturally responsive services important for the behavioral health system, providers, and communities across the state. The target population will be those who have cultural or linguistic differences from the mainstream or dominant culture or language. The CLCC will also look at issues related to gender, sexual orientation, gender identity, homelessness, and disability, which will be used to shape and inform strategies that are part of state, federal, and local planning and funding processes.

We are grateful to all the members of the CLCC who contributed ideas and devoted their time and energy in shaping and reviewing this Strategic Plan. Special thanks goes to CLCC members representing the deaf and hard of hearing community. Their knowledge on the communication and cultural challenges deaf and hard of hearing clients are facing when seeking behavioral health services, and their invaluable inputs to this CLCSP are much appreciated.

INTRODUCTION

Cultural and linguistic competency refers to the ability of health care providers and health care organizations to understand and respond effectively to the cultural and linguistic needs presented by the client within the health care encounter. SAMHSA defines cultural competence as being respectful and responsive to the health beliefs and practices and the cultural and linguistic needs of diverse population groups. Developing cultural competence is an evolving, dynamic process that takes time and occurs along a continuum.[2]

Maryland is the 7th most diverse state in the United States of America. In Maryland, 46.2% of the state's total citizenry is composed of racial and ethnic population groups. This population is estimated to grow to 50% by 2019.[3] As Maryland grows more racially and ethnically diverse, BHA must ensure that behavioral health services along the continuum of care are not only accessible but are also culturally and linguistically competent and reflective of the individuals we serve.

BHA also recognizes that a lack of culturally and linguistically appropriate services contributes to health disparities not only among ethnically and racially diverse populations but other minority groups. Healthy People 2020 defines a *health disparity* as "a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion."[4] BHA has prioritized the development and implementation of a statewide CLCSP as one of its many efforts to improve equitable access to and delivery of quality services throughout the continuum of care for all individuals at risk of or with emotional, substance use related, addictive, and/or psychiatric disorders, to improve their ability to function effectively in their communities.

This Plan offers guidance for the implementation and infusion of initiatives that will increase levels of diversity and inclusion in behavioral health programs. These FY2019-2020 initiatives set forth by BHA will also increase awareness and understanding of how specific values, norms, beliefs, attitudes, and behaviors associated with different cultural groups influence the delivery of BH services.

There are federal and state laws, statutes, and regulatory provisions that mandate programs, services, government entities, hospitals, academic institutions, etc., to provide culturally and linguistically competent care and conduct non-discriminatory practices. Some of these are:

- American with Disabilities Act 42 U.S.C. § 12101 (July 26,1990)
- Maryland Health Improvement and Disparities Reduction Act of 2012 (SB234)
- Medicaid, State Children's Health Insurance, and Medicare
- Presidential Executive Order No. 13166, 65 FR 50121 (August 11, 2000)
- Title VI of the Civil Rights Act of 1964 (42 U.S.C. § 2000d et seq.)
- U.S. Department of Health and Human Services Title VI regulations (45 CFR part 80)
- U.S. Department of Health and Human Services, Title VI, 68 FR 47311 (August 8, 2003)

[2]SAMHSA. (2016, November 10). *Cultural Competence*. Retrieved from http://samhsa.gov
[3]American Community Survey. (2012); Maryland Department of Planning (2014); Retrieved from: https://health.maryland.gov/mhhd
[4]U.S. Department of Health and Human Services. (2008, October 28). *The Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2020. Phase I report: Recommendations for the framework and format of Healthy People 2020*. Retrieved from: https://www.healthypeople.gov

STRUCTURE OF THE BEHAVIORAL HEALTH ADMINISTRATION CULTURAL AND LINGUISTIC COMPETENCY STRATEGIC PLAN

This CLCSP is a result of collaborative efforts among various internal and external stakeholders, including BHA staff, various community representatives through the CLCC, and the Maryland Office of Minority Health and Health Disparities; and a review process of numerous in-house documents, data, research materials, and national culturally and linguistic competence plans and standards. An analysis of statewide demographic and PBHS data was conducted. The existing data offers population estimates by ethnic, racial and other distinct minority population groups throughout Maryland's 24 jurisdictions as well as the number and percentage of individuals from minority backgrounds served in Maryland's PBHS. Understanding the distribution of users of Maryland's PBHS provided the insight needed to develop strategic goals and the National Culturally and Linguistically Appropriate Services (CLAS) self-assessment tool described in Parts 2 and 3 of this CLCSP, which will inform the publicly funded mental health and SUD services across the lifespan and throughout the continuum of care at the state and jurisdictional levels. The strategic goals and self-assessment tool will also serve as blueprints for BHA, the local mental health and SUD authorities known as Core Service Agencies (CSAs), Local Addictions Authorities (LAAs) and Local Behavioral Health Authorities (LBHAs), and their governing bodies in shaping future policies, plans and programs, and allocating resources.

PART 1: Demographic and Service Utilization Data

In this section, various demographic and service utilization data are presented. Understanding population estimates and the needs of Maryland's minority population served in the PBHS is essential to the effective design and development of a statewide CLCSP behavioral health initiatives that would potentially increase the cultural and linguistic competence of behavioral health services. These strategic initiatives are part of BHA's ongoing effort to implement an integrated system of care based on data driven planning and decision making processes. We must ensure that our system of care recognizes how specific values, norms, beliefs, attitudes, and behaviors associated with different minority groups influence the delivery of behavioral health services as well as implement appropriate strategies to address long-standing health disparities and inequities.

PART 2: FY 2019-2020 Cultural and Linguistic Competency Strategic Plan Goals

The five goals contained in this section are intended to be used by Maryland's behavioral health systems both at the state and local levels in the planning, development, implementation, evaluation and monitoring of culturally and linguistically appropriate behavioral health services. As Cross et al., rightly indicated "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 professionals to work effectively in cross-cultural situations. A culturally competent system of care acknowledges and incorporates—at all levels—the importance of culture, assessment of cross-cultural relations, vigilance towards the dynamics that result from cultural differences, the expansion of cultural knowledge, and the adaptation of services to meet culturally-unique needs."[5] Thus, these goals will be guided by BHA staff, state policymakers, caregivers, consumers, and other interested stakeholders and community partners.

[5] Cross T.L., Bazron B.J., Dennis K.W., & Isaacs M.R. (1989). *Towards a culturally competent system of care*: Vol. I. Washington, DC: National Technical Assistance Center for Children's Mental Health, Georgetown University Child Development Center.

PART 3: **Implementation of the National CLAS Standards**

Data results reveal that among individuals served in Maryland's PBHS, a significant percentage are ethnic, racial and other minorities. The CLAS self-assessment tool contained in this document would become a part of the annual local mental health and SUD authorities (CSAs/LAAs/LBHAs) plan review process. Data collected from the self-assessment tool during the FY 2019 annual plan review process will be analyzed and used to guide future policies and practices to improve and increase culturally appropriate services statewide. The data will also serve as benchmarks and indicators for BHA's progress and performance toward eliminating long-standing health disparities and inequities. BHA's "goal is to support the delivery of high-quality, culturally and linguistically appropriate, person-centered behavioral health experiences in a timely manner, regardless of which "door" a person enters the system."[6]

[6]Maryland Department of Health Behavioral Health Administration. (July 2018*). Local Systems Management Integration Plan Brief Summary*.

PART 1: DEMOGRAPHIC AND SERVICE UTILIZATION DATA

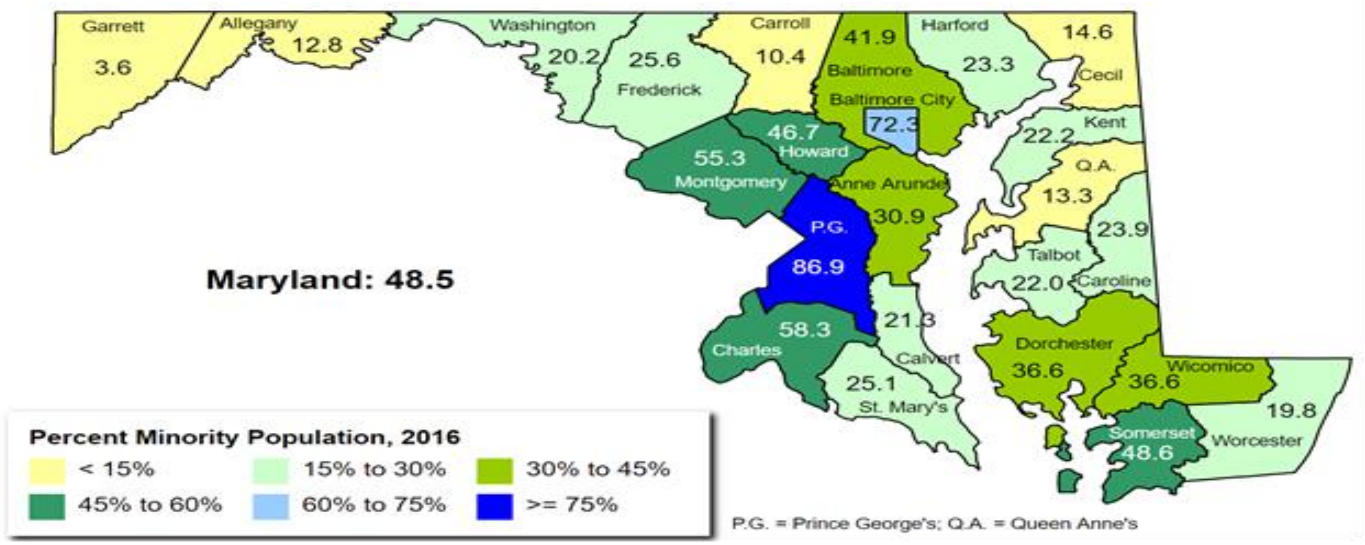
BHA recommends using a data driven, decision making approach to contribute to the formation of culturally and linguistically appropriate services, policies, and practices. This section presents data on Maryland's diverse population. The tables and figures in this section illustrate the ethnic and racial distribution of the state's general population across Maryland's 24 jurisdictions, the proportion of minorities and the breakdown by ethnicity/race, age and gender of those receiving public behavioral health services. Additionally, the data shows patterns of use and access to the PBHS by special population groups with unique cultural needs.

BHA recognizes that continuous data analysis is a vital part of improving the quality and effectiveness of a strong culturally and linguistically competent system. Thus, it will continue to explore ways to positively apply data driven decision making approaches to enhancing the cultural and linguistic competency of services throughout the PBHS.

Diversity in Maryland

Maryland's population is ethnically and racially diverse. State-level demographics that describe Maryland's minority population are used to identify cultural and linguistic groups and their service utilization rates. According to a Maryland Minority Health and Health Disparities Report, Maryland was the 7th most diverse state in the United States, with a 46.2% of the population from ethnic and racial minority groups, and was estimated to be 48.5% in 2016 (see map below). The percentage of Maryland's minority population is expected to rise to 50% by 2019. Only six other states (including the District of Columbia) had a higher percentage of minorities in their population: Hawaii (77.2%), District of Columbia (64.7%), California (60.8%), New Mexico (60.3%), Texas (55.7%), and Nevada (47.3%). [7]

Map 1:
Maryland's Ethnic and Racial Minority Population by Jurisdiction



***Data Source**: US Census estimated population data for July 1, 2016, Maryland Department of Planning.*

[7]Maryland Office of Minority Health and Health Disparities, *Minority Health Highlights*; 2017. Retrieved from https://health.maryland.gov/mhhd/Pages/Health-Equity-Data.aspx

Data Summary and Analysis

Maryland is a culturally and linguistically diverse state with a population of just over six million. Based on 2016 population estimates, ethnic and racial minorities represented nearly one-half (48.5%) of the state's population.[8] Minorities are defined as everyone other than the "non-Hispanic White" population. African Americans account for nearly one-third (30%) of the state's population and 61% of the minority population. Individuals of Asian and Hispanic or Latino origin account for 6.1% and 9.2% of the population respectively (*American Community Survey, 2016*)[9].

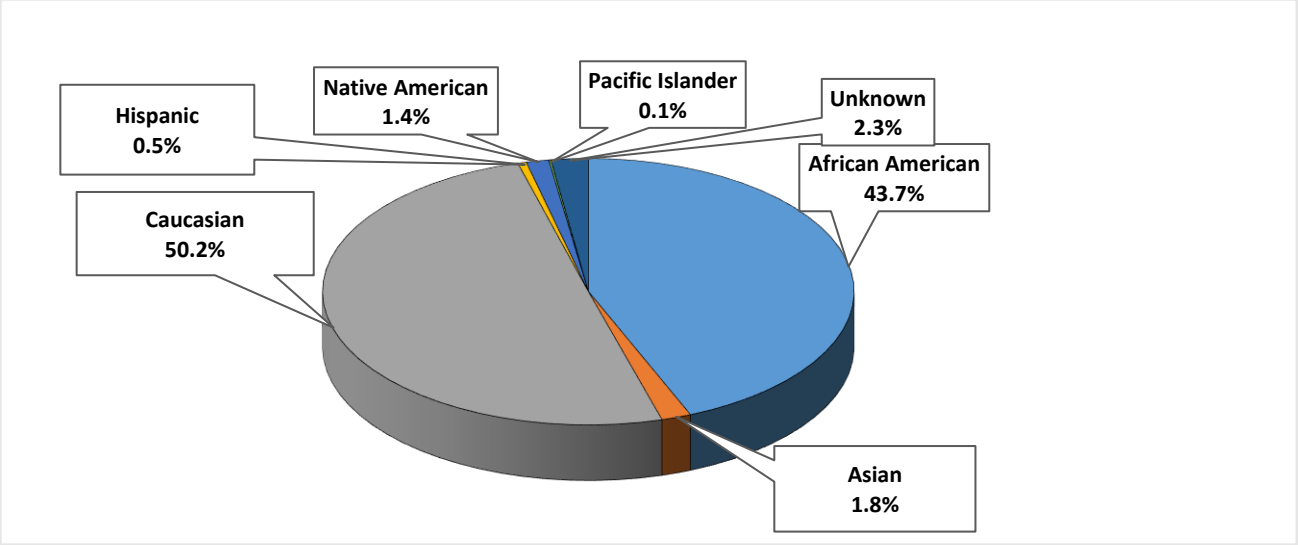
As shown in Map 1, the proportion of minorities varies substantially across the state's 24 jurisdictions, ranging from a low of 3.6% in Garrett County to a high of 86.9% in Prince George's County. Baltimore City and those jurisdictions bordering the Baltimore and Washington metropolitan areas have the highest concentration of minorities.

Ethnic and Racial Minority Users of Maryland's PBHS

Maryland's PBHS provides a comprehensive array of mental health and SUD treatment and support services to adults, children and adolescents experiencing behavioral health challenges. In Fiscal Year (FY) 2017, a total of 262,701 individuals received PBHS services in Maryland at a total cost of $1.3 billion dollars[10]. Individuals from minority backgrounds accounted for nearly one- half (46%) of the total population served in the PBHS as well as the behavioral health expenditures.

Figure 1:

Ethnic and Racial Distribution of Individuals served in the PBHS, FY 2017



African American	Asian	Caucasian	Hispanic	Native American	Pacific Islander	Unknown	Total
114,876	4,739	131,843	1,361	3,609	348	5,925	262,701

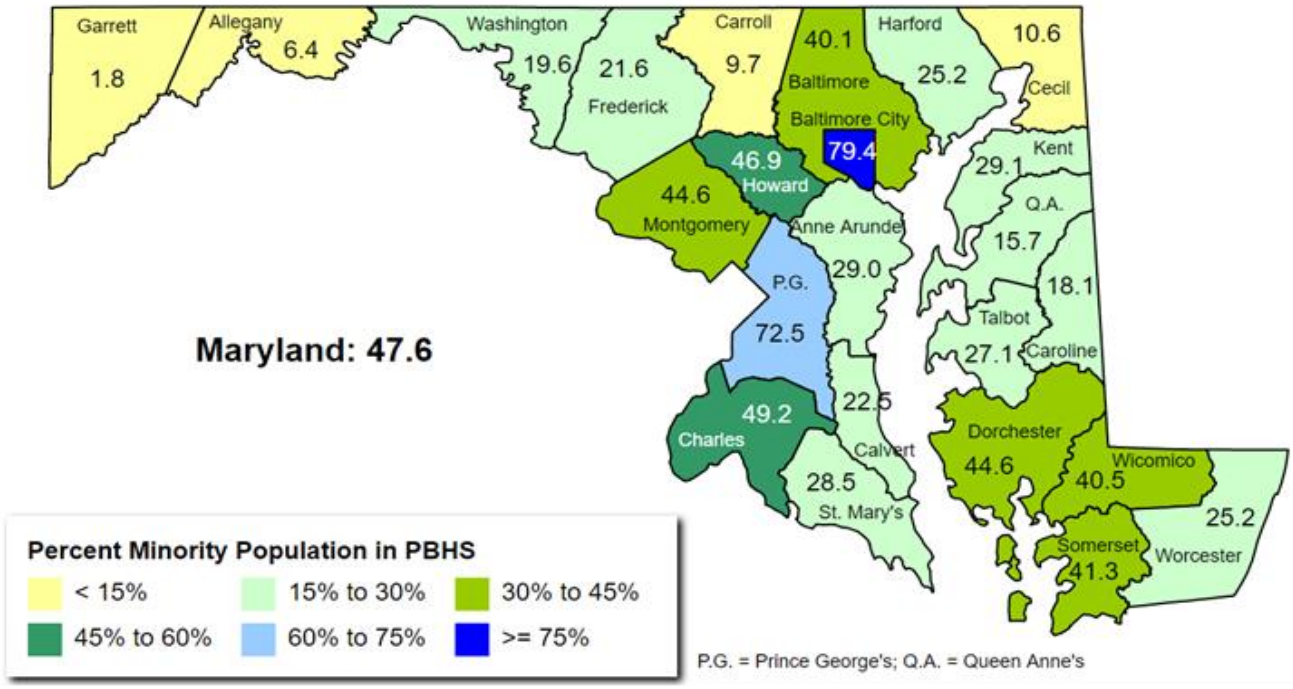
Data Source: *FY 2017 behavioral health service claims data. Data based on claims paid through March 31, 2018.*

[8]Department of Legislative Services (2018). Overview of Maryland Local Government: Finances and Demographics; Annapolis, MD. Retrieved from http://dls.maryland.gov/pubs/prod/InterGovMatters/LocFinTaxRte/Overview-of-Maryland-Local-Governments-2018.pdf

[9] American Community Data. Retrieved from https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=CF

[10]The amount and data reported may not contain the absolute total since providers have up to 12 months from time of service to submit their claims for payments. It is likely that not all claims data may have been included here as a result of delayed claims.

Map 2:
Percentage of Minority Individuals served in the PBHS by Jurisdiction, FY 2017



Data Source: *behavioral health service claims paid through March 31, 2018. FY 2017.*
Note: *The number of individuals served by the PBHS for FY 2017 are not final as providers have up to 12 months from time of service to submit claims.*

Data Summary and Analysis
Similar to the distribution in the general population in Maryland, ethnic and racial minorities represent nearly one-half (47.5%) of the individuals who received PBHS (mental health or SUD) services (see Figure 1), with African Americans accounting for the vast majority (92%) of the PBHS minority population. Compared to the overall Maryland population, minorities served in the PBHS were more likely to be African American and less likely to identify as Hispanic or Asian. The PBHS also had a relatively higher proportion of Native Americans who received services compared to their proportion in the general population as a whole.

As shown in Map 2, the proportion of minorities served in the PBHS varied substantially across Maryland's 24 jurisdictions. Based on 2016 population estimates (see Map 1), the Baltimore/Washington metropolitan areas (Baltimore City, and Baltimore, Charles, Howard, Montgomery and Prince George's counties) and three counties on the Eastern Shore of Maryland (Dorchester, Somerset and Wicomico) had the highest minority concentrations and provided behavioral health services to a higher numbers of minority individuals compared to the rest of the state (see Table 1 and Map 3). Four jurisdictions, including: Baltimore City, and Baltimore, Montgomery and Prince George's Counties accounted for 77% of the racial minorities served in Maryland's PBHS (see Table 1).

Table 1:
Ethnic and Racial Distribution of individuals served in the PBHS by Jurisdictions, FY 2017

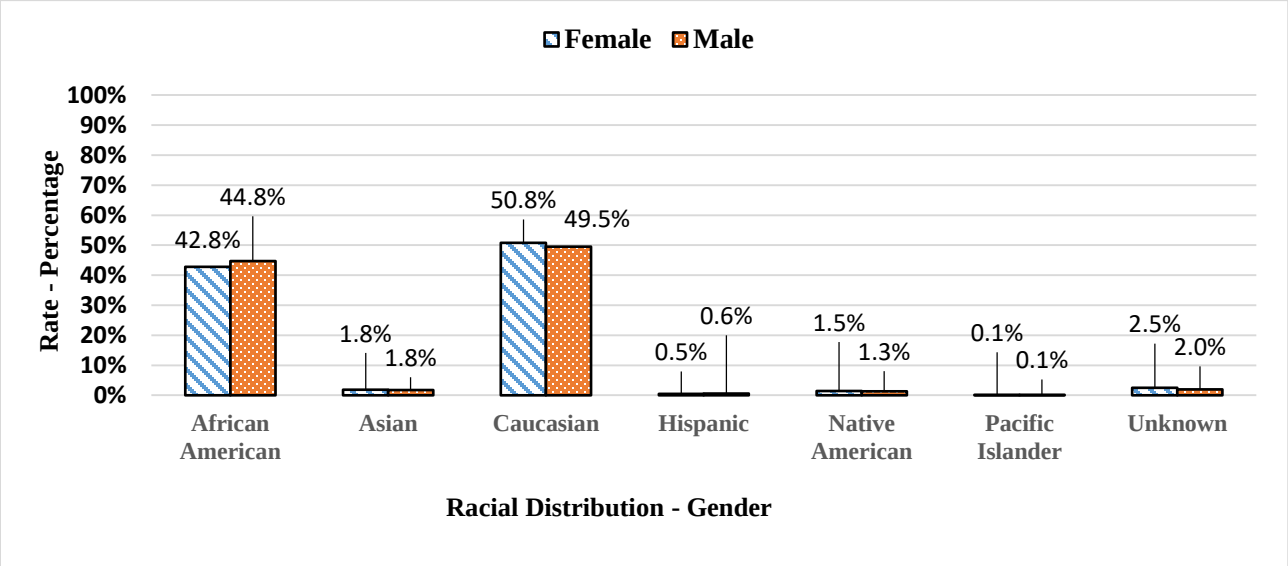
Jurisdiction	African American	Asian	Caucasian	Hispanic	Native American	Pacific Islander	Unknown	Total Minority	Total By Jurisdiction
Allegany	326	21	5,622	8	33	2	65	390	6,077
Anne Arundel	5,156	320	13,875	56	308	42	559	5,882	20,316
Baltimore City	54,115	595	13,605	166	790	57	857	55,723	70,185
Baltimore County	13,512	802	21,602	113	567	60	877	15,054	37,533
Calvert	727	27	2,676	3	43	6	95	806	3,577
Caroline	372	23	1,865	6	13	4	22	418	2,305
Carroll	420	52	5,059	14	66	3	114	555	5,728
Cecil	656	38	6,469	24	57	6	155	781	7,405
Charles	2,278	93	2,446	12	102	8	128	2,493	5,067
Dorchester	1,269	24	1,635	13	33	4	36	1,343	3,014
Frederick	1,465	143	6,262	51	111	11	187	1,781	8,230
Garrett	20	6	1,735	0	5	1	23	32	1,790
Harford	2,313	130	7,568	24	132	19	188	2,618	10,374
Howard	2,323	400	3,081	31	114	10	174	2,878	6,133
Kent	318	2	800	1	13	1	16	335	1,151
Montgomery	6,377	1,303	10,012	507	499	33	833	8,719	19,564
Prince Georges	15,220	484	5,419	219	368	49	779	16,340	22,538
Queen Anne	251	14	1,537	3	20	3	31	291	1,859
Somerset	796	14	1,186	10	26	2	21	848	2,055
St. Mary	1,161	50	3,083	6	60	4	132	1,281	4,496
Talbot	416	23	1,277	9	27	5	15	480	1,772
Washington	1,864	73	8,444	56	105	10	188	2,108	10,740
Wicomico	2,741	72	4,148	27	79	5	145	2,924	7,217
Worcester	727	28	2,326	2	38	3	49	798	3,173
Out of State	53	2	111	0	0	0	236	55	402
State Total	**114,876**	**4,739**	**131,843**	**1,361**	**3,609**	**348**	**5,925**	124,933	**262,701**

Data Source: *FY 2017 behavioral health service claims paid through March 31, 2018.*
Note: *The number of individuals served by the PBHS for FY 2017 are not final as providers have up to 12 months from time of service to submit claims.*

Demographic Characteristics by Race/Ethnicity, Age and Gender

Maryland's PBHS aims to ensure that all populations have equal access to quality care regardless of ethnicity, race, gender, geographical location, nationality, sexual orientation, disability or socio-economic status. Understanding the distribution of PBHS services in Maryland (by ethnicity/race, age and gender) is essential to effectively evaluate and address potential issues concerning access to and quality of behavioral health services. Data provides the foundation for sound decision-making and serves as a guide to the design and implementation of appropriate strategies to address quality of care and equal access to the PBHS.

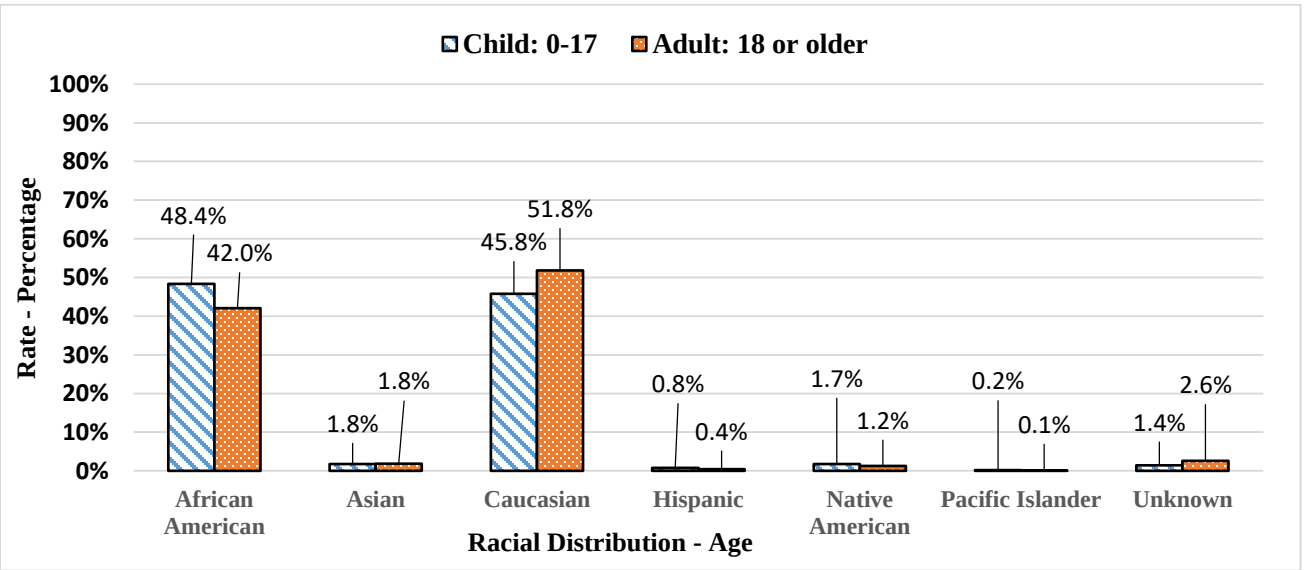
Figure 2:
Percentage of Individuals Served in the PBHS by Race and Gender, FY 2017



Gender	African American	Asian	Caucasian	Hispanic	Native American	Pacific Islander	Unknown
Female	58,770	2,522	69786	626	1,992	205	3,435
Male	56,105	2,217	62055	735	1,617	143	2,490

Data Source: *FY 2017 behavioral health service claims. Data reflect claims paid through March 31, 2018.*

Figure 3:
Percentage of Individuals Served in the PBHS by Race and Age, FY 2017



Age	African American	Asian	Caucasian	Hispanic	Native American	Pacific Islander	Unknown
Child: 0-17	33,751	1,224	31,933	538	1,214	119	977
Adult: 18+	81,125	3,515	99,910	823	2,395	229	4,948

Data Source: *FY 2017 behavioral health service claims. Data reflect claims paid through March 31, 2018.*

Note: *Both for figures 2 and 3, the number of individuals served by the PBHS for FY 2017 are not final as providers have up to 12 months from time of service to submit claims.*

Data Summary and Analysis

Figures 2 and 3, display the ethnic and racial characteristics of individuals served in the PBHS categorized by gender and age. As shown in Figure 2, the ethnic and racial breakdown among females and males was similar. Among both females and males served in the PBHS in FY2017, African-Americans were the largest minority group, accounting for 42.8% and 44.7% of the female and male population respectively.

The racial distribution of individuals served in the PBHS categorized by age shows that children and adolescents (Birth to 17 years) were slightly more likely to be from minority backgrounds compared to adults (18 years and older). Minorities accounted for 52.9% of children and adolescents and 45.5% of adults respectively (see Figure 3).

Limited English Proficiency (LEP) Individuals served in the PBHS in FY 2017

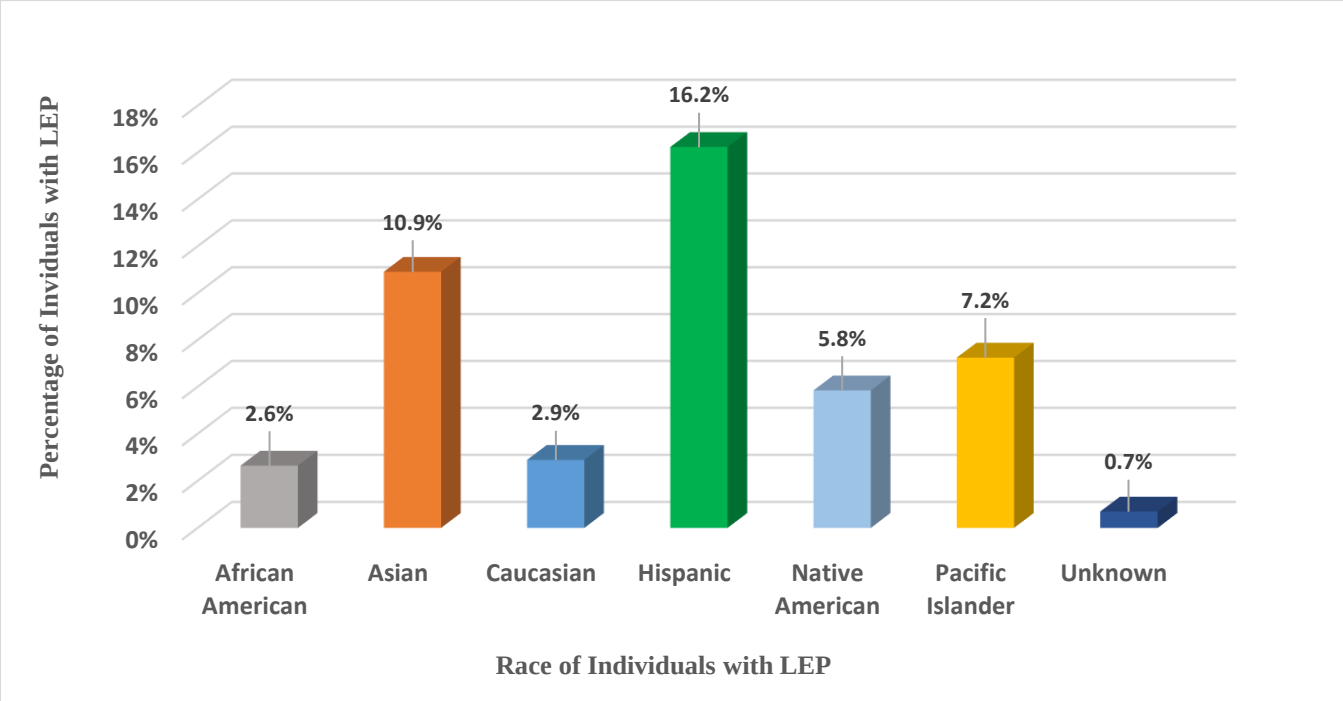
MDH, in accordance with applicable State and Federal law, seeks to make programs, services, and benefits accessible to all eligible individuals, including those with LEP due to national origin and/or ancestry. The efforts to make programs and services accessible to LEP persons is in line with the obligations outlined in Title VI of the Civil Rights Act of 1964 and Annotated Code of Maryland State Government Article, §§10-1101—10-1105[11].

In Maryland, the Baltimore Metropolitan Region, which comprises Baltimore City, Anne Arundel, Baltimore, Carroll, Harford and Howard counties, is where the majority of individuals who speak a language other than English at home and who speak English at a level considered less than "very well" mostly reside compared to the entire state. As recipients of federal funding, MDH and BHA are required by law "to take reasonable steps to create meaningful access to information and services provided[12]" for LEP persons living in Maryland. Based on data from the Baltimore Metropolitan Council (BMC), about four percent (3.93%) of individuals ages five and over indicate they speak English less than "very well" at home in the Baltimore Metropolitan Region.[13]

Determining reasonable steps to be taken to provide behavioral health services to the LEP population involve four factors: 1) the number and proportion of individuals identified as LEP persons in the eligible PBHS service area, 2) the frequency with which LEP persons come in contact with the PBHS programs, 3) the importance of the PBHS services provided to the LEP population, and 4) the resources available to the LEP recipients of PBHS services.[14]

[11]Maryland Department of Health (2016). *Limited English Proficiency Policy*- Office of Equal Opportunity Programs; Policy # 01.02.05.
[12]Ibid.
[13] Baltimore Regional Transportation Board (2015). *Language Assistance Program and Limited English Proficiency Plan*. Retrieved from www.baltometro.org/BRTB/BRTBRes16-5.pdf
[14] Ibid.

Figure 4
Percentage of Individuals with LEP served in the PBHS by Ethnicity and Race, FY 2017



LEP	African American	Asian	Caucasian	Hispanic	Native American	Pacific Islander	Unknown	Total
PBHS – Total	**114,876**	**4,739**	**131,843**	**1,361**	**3,609**	**348**	**5,925**	**262,701**
LEP – PBHS	3,041	517	3,811	221	211	25	41	7,867
LEP-Proportion	2.65%	10.91%	2.89%	16.24%	5.85%	7.18%	0.69%	2.99%

Data Source: *FY 2017 behavioral health service claims. Data reflect claims paid through March 31, 2018.*
Note: *The LEP proportion is based on the LEP number (LEP-PBHS) divided by total served in the PBHS-Total by each Race category. The number of individuals served by the PBHS for FY 2017 are not final as providers have up to 12 months from time of service to submit claims.*

Data Summary and Analysis

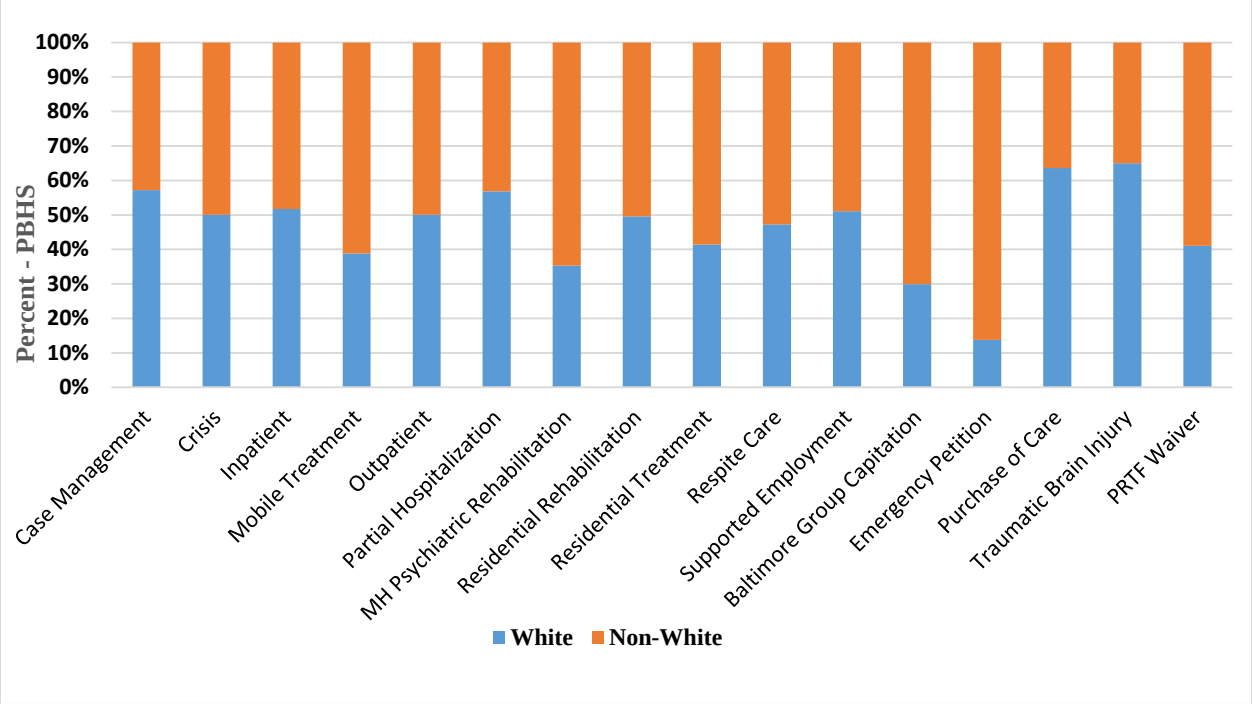
Figure 4 displays the ethnic and racial distribution of individuals who received services in the PBHS in FY 2017 and who reported LEP. Overall, about three percent (2.99%) of the total population served in the PBHS reported having LEP, which is not substantially different from the proportion of those in the general population who self-identified as having LEP in the greater Baltimore metropolitan area, which is about 3.9%.[15] Of those served in the PBHS, individuals with LEP were more likely to be of Hispanic (16.2%) or Asian (10.9%) origin compared to other minority groups. Overall, African Americans (2.6%) and Caucasian/White (2.9%) individuals were the least likely to report LEP.

[15]Ibid.

Behavioral Health Service Utilization and Expenditures

Figure 5:

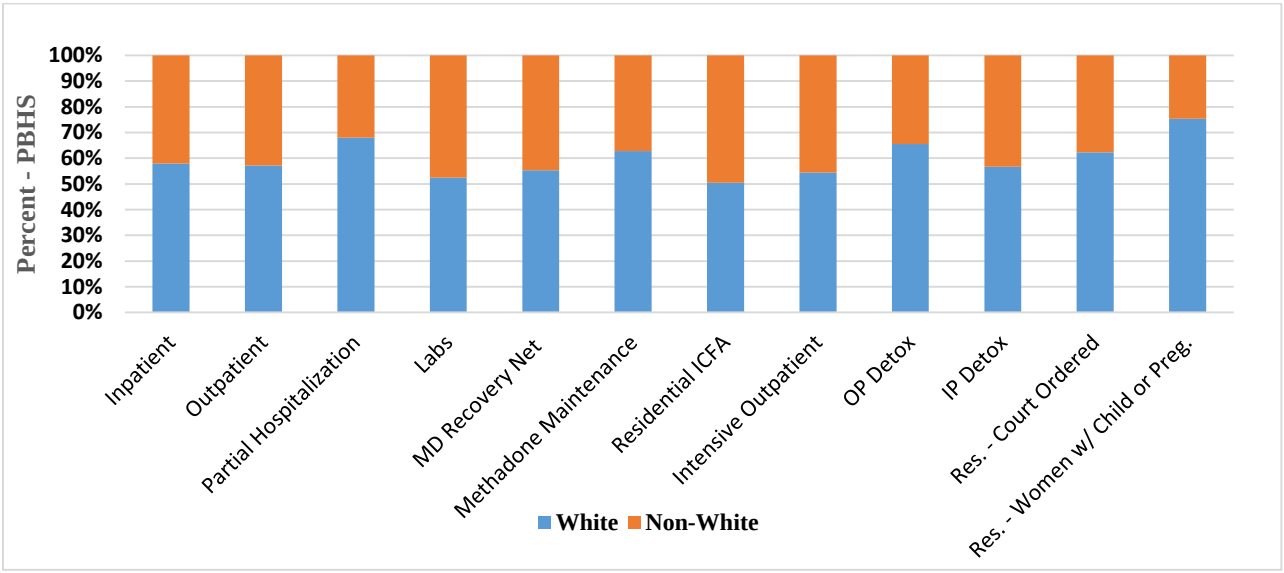
Percentage of White and Non-White Individuals served in the PBHS by Mental Health Service Categories



Data Source: *PBHS claims data, FY 2017 which include claims paid through March 31, 2018.*

Figure 6:

Percentage of White and Non-White Individuals served in the PBHS by SUD Service Categories



Data Source: *Public behavioral health service claims data, FY 2017. Data reflect claims paid through March 31, 2018.*
Note: *The number of individuals served by the PBHS for FY 2017 are not final as providers have up to 12 months from time of service to submit claims.*

Data Summary and Analysis

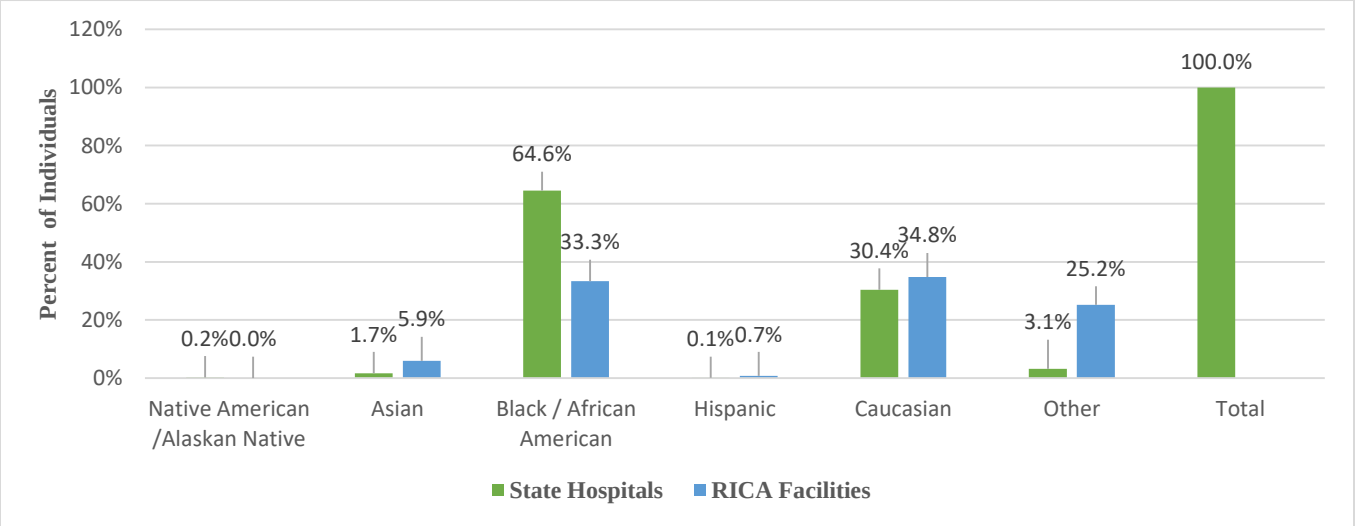
Figures 5 and 6 display mental health and SUD service utilization by racial categories. A review of the behavioral health service use patterns by racial categories (Figure 5) revealed that individuals from racial minorities (Non-White) were more likely to use mental health services, especially Psychiatric Rehabilitation (64%) Mobile Treatment (61%), Waiver (59%) and Residential Treatment (58%) services compared to Caucasian (White) individuals. Additionally, minority populations were more likely to be emergency petitioned (86%) and to also use the Baltimore City Group Capitation program services (70%), which serve individuals who have not benefited from traditional mental health service programs. Compared to Caucasian (White) individuals, racial minorities were less likely to use Partial Hospitalization, Purchase of Care, Case Management, and Traumatic Brain Injury services (See Figure 5).

Figure 6 displays utilization of SUD services by racial category. Overall, Caucasian (White) individuals were more likely to use SUD services compared to racial minority (Non-White) populations. As shown in Figure 6, individuals from racial minority groups were nearly as likely as Caucasian (White) to use Intensive Care Facilities for Addictions (ICFA). The percentage of use among Whites is 50% and 49% for the Non-White population. However, Caucasian/White were more likely to use Intensive Outpatient (54%) and MD Recovery Net services (55%), Inpatient (58%), Methadone Maintenance (62%), Partial Hospitalization (68%) and Women with Children Residential Services (75%) compared to Non-White individuals.

State Psychiatric Facilities: Minority Populations

Maryland operates five state psychiatric hospitals, and two Regional Institutes for Children and Adolescents (RICAs). In fiscal year 2017, 1,138 individuals were served in the five state hospitals and 135 children and youth were served in the two RICAs.

Figure 7:
Ethnic and Racial Distribution of individuals served in State Hospitals and RICAs



Facility	Native American /Alaskan Native	Asian	Black / African American	Hispanic	Caucasian	Other
State Hospitals	**4**	**27**	**1,055**	**1**	**496**	**51**
RICA	**0**	**8**	**45**	**1**	**47**	**34**

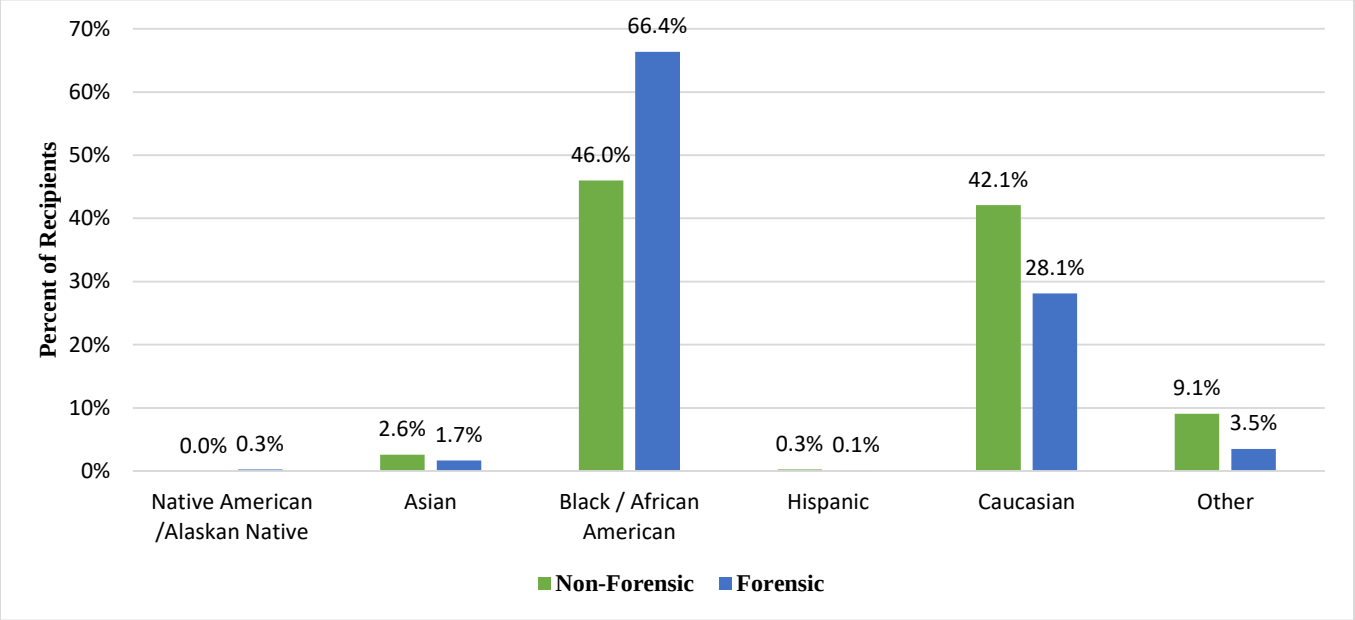
Data Source: *FY 2017 Hospital Information Management System (HIMS).*

Data Summary and Analysis

As shown in Figure 7, more than two-thirds (66.6%) of the individuals who received treatment in State hospitals were from racial minority backgrounds. Black/African Americans accounted for the largest proportion of individuals served in State psychiatric facilities (64.6%) and nearly of all the minority population (97%). Two-thirds (68%) of the children and adolescents who received treatment in RICAs were either Black/African American (33.3%) or Caucasian/Whites (34.8%) with the remaining one-third (32%) being from Asian and other backgrounds (32%).

Figure 8

Percentage of Individuals served in State Psychiatric Facilities by Ethnicity/ Race and Forensic Status



Facility	Native American /Alaskan Native	Asian	Black / African American	Hispanic	Caucasian	Other
Non-Forensic	0	10	177	1	162	35
Forensic	4	25	998	1	423	53

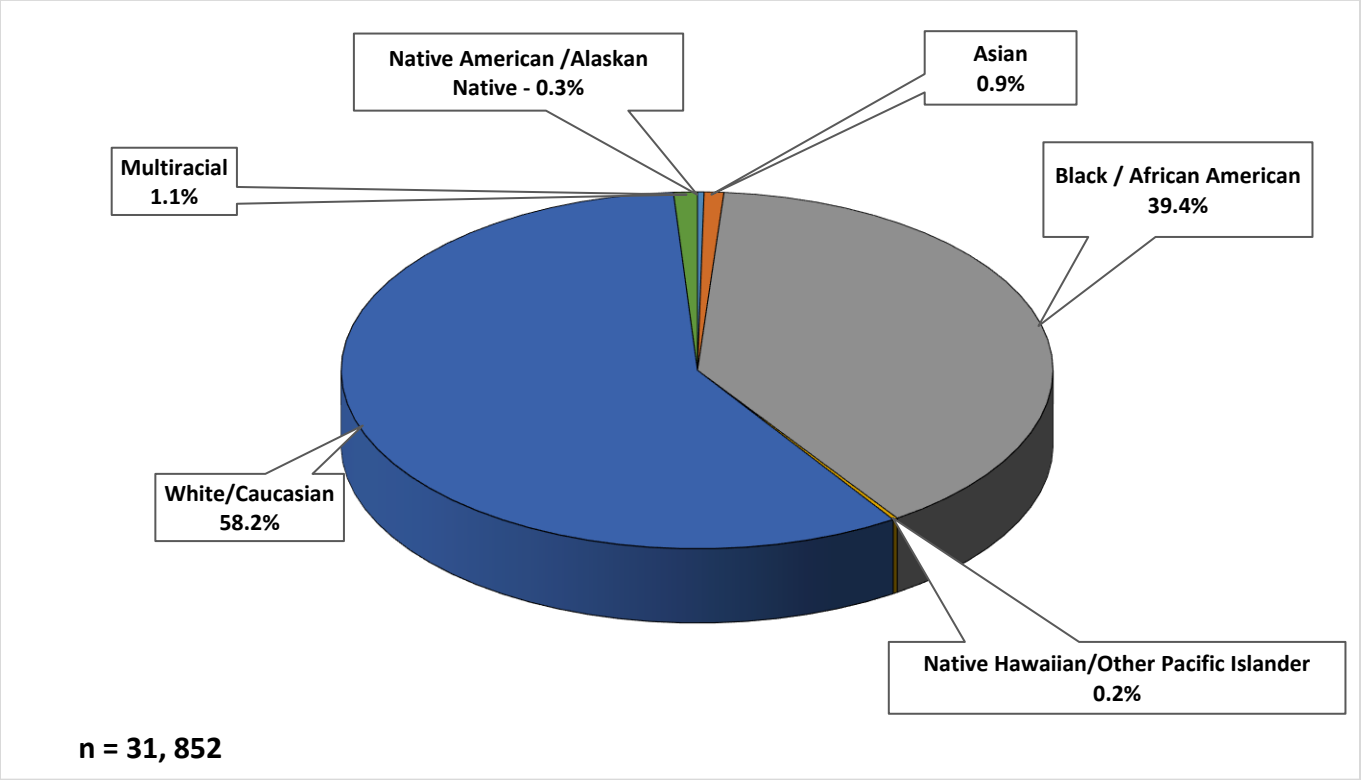
Data Source: *FY 2017 HIMS.*

Data Summary and Analysis

Figure 8 displays the distribution of ethnic and racial minorities served in State facilities by forensic and non-forensic status. As shown here, among all the ethnic and racial groups, Black/African Americans were more likely than Caucasian/Whites and/or the other minority groups to have been forensically admitted to a State psychiatric facility. Other than Asians and those identified as "Other," none of the other minority groups (Native-American, 4 and Hispanic, 1) had a substantial number of individuals with forensic involvement admitted into State psychiatric facilities. Compared to Black/African Americans who accounted for two-thirds (66.4%) of forensically involved individuals, only slightly more than one-quarter (28.1%) of Caucasian/Whites were forensically involved.

Recovery, Resilience and Outcomes

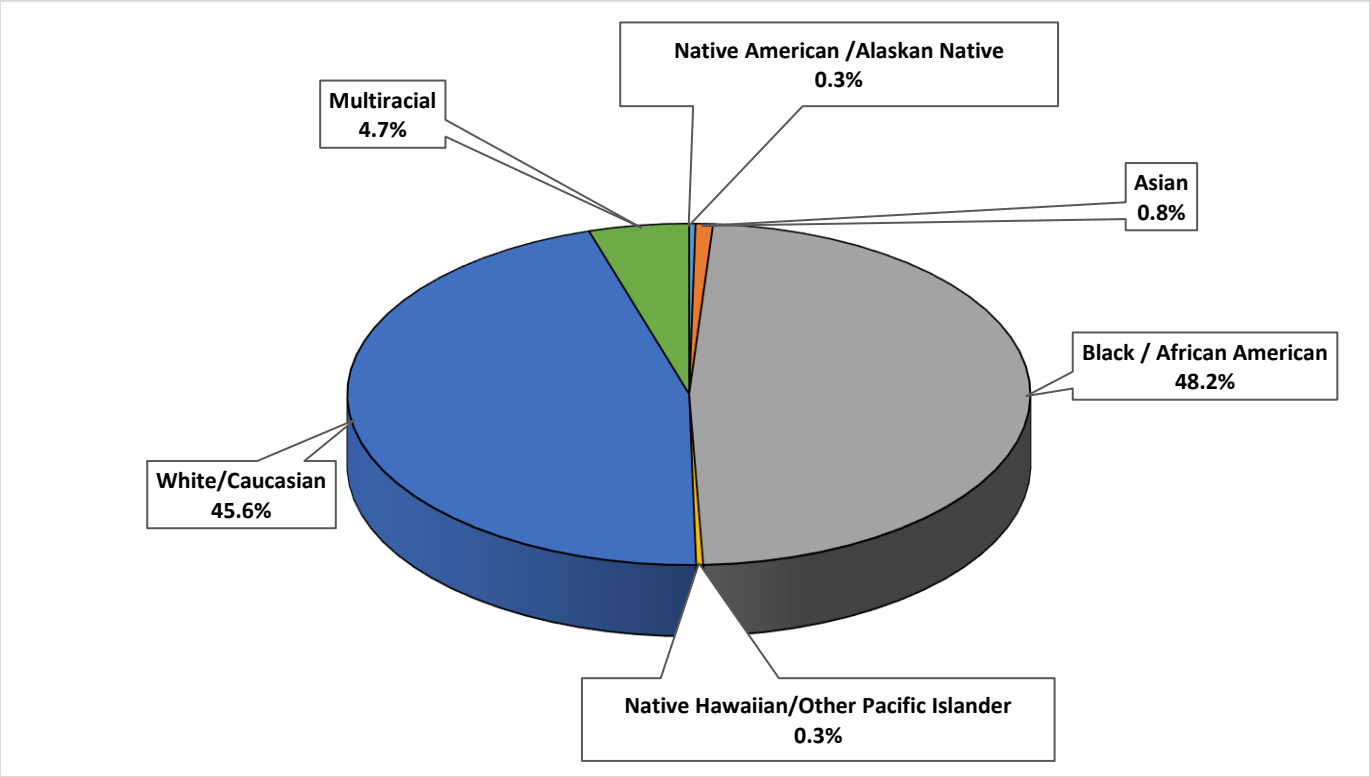
Figure 9:
Satisfaction with Recovery among Adults served in the Outpatient PBHS reported in Outcomes Management System (OMS), FY 2017



Race	Native American /Alaskan Native	Asian	Black / African American	Native Hawaiian/Other Pacific Islander	Caucasian/White	Multiracial
Satisfaction	94	284	12,534	70	18,526	344

Data Source: *OMS, FY 2017. PBHS outpatient services (e.g., Outpatient Mental Health Clinics, Federally Qualified Health Centers, Hospital Based Mental Health Clinics and Level I SUD Services).*
Note: *Percentages reflect the number of adults served in the PBHS Outpatient Services and who reported either "very much" or "quite a bit" to the OMS question, "Overall, how satisfied are you with your recovery?" and not all those served in the PBHS.*

Figure 10:
Experience of Resilience (Hopefulness) among Children and Adolescent served in the Outpatient PBHS reported in the OMS, FY 2017



Race	Native American /Alaskan Native	Asian	Black / African American	Native Hawaiian/Other Pacific Islander	White/Caucasian	Multiracial
Resilient	20	55	3226	22	3050	317

Data Source: *OMS, FY 2017. PBHS outpatient services (e.g., Outpatient Mental Health Clinics, Federally Qualified Health Centers, Hospital Based Mental Health Clinics and Level I Substance Use Disorder Services).*
Note: Percentages reflect the number of children and adolescents served in the PBHS Outpatient Services and who reported either "very much" or "quite a bit" to the Outcome Management System (OMS) question, "I am hopeful about the future?" and not all those served in the PBHS.

Data Summary and Analysis

Among adult recipients of PBHS OMS outpatient services, there were differences in those who reported satisfaction with their recovery. As shown in Figure 9, adult recipients of PBHS OMS outpatient services who identify as racial minorities were less likely (41.2%) to report satisfaction with their recovery compared to White/Caucasian individuals, with about 58.2% reporting satisfaction with their recovery. Among racial minority groups reporting satisfaction with their recovery, African Americans were the single largest minority group accounting for 94% of those from minority backgrounds. Individuals from multi-racial and Asian backgrounds accounted for an additional two percent of adults who reported satisfaction with their recovery.

As shown in Figure 10, children and adolescents from racial minority groups compared to Caucasian/White who received services in the PBHS OMS outpatient services were more likely to report being hopeful about the future, with slightly more than one-half (54.4%) of children/adolescents from minority groups reporting that they were "very much" or "quite a bit" hopeful about the future.

In addition to ethnic and racial minorities, the Maryland PBHS serves special population groups with unique cultural needs. These groups include the deaf and hard of hearing, veterans and the homeless population.

Deaf and Hard of Hearing

Lack of funding and access to behavioral health services as well as the limited availability of local, culturally competent mental health providers who are fluent in American Sign Language (ASL), have been a growing concern for providers to deaf and hard of hearing individuals. To help close the gap and increase direct mental health services provided by providers who are culturally and linguistically competent, the Governor's Office of the Deaf and Hard of Hearing (GODHH) worked closely with the Department of Health in FY 2016 to increase the availability of mental health providers who are fluent in ASL to deaf and hard of hearing individuals through telehealth. Medicaid participants usually would have to travel to use telehealth services with a culturally competent provider fluent in ASL. Medicaid only reimbursed for psychiatrists despite the fact that there are no psychiatrists in the state of Maryland who know ASL. [16]

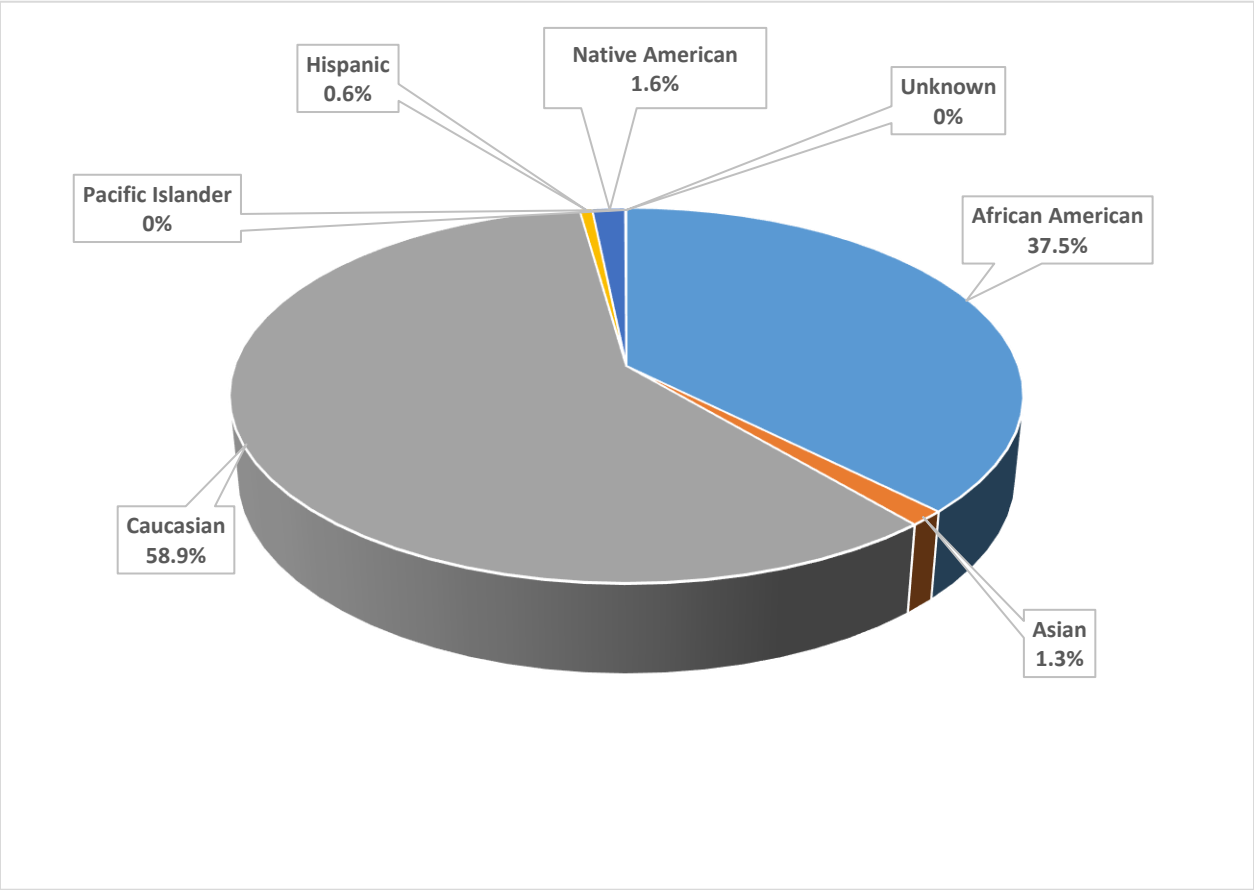
GODHH and MDH drafted changes to regulations in the Code of Maryland Regulations (COMAR 10.09.49 Telehealth Services) and in FY 2017, the changes were proposed and adopted. Maryland is now the first state where Medicaid specifically permits and reimburses qualified providers such as psychologists and social workers who are fluent in ASL for clinically appropriate telehealth services for deaf and hard of hearing Medicaid participants. Furthermore, the GODHH serves on the Behavioral Health Advisory Council and Co-Chairs the Cultural and Linguistic Competency Committee, which works on promoting and advocating for a culturally competent and comprehensive approach to Maryland's PBHS.

GODHH also actively connects individuals in need of behavioral health services to local providers, organizations, and resources, and also helps connect community organizations with appropriate state entities to ensure that treatment is accessible and funding is available.[17]

[16] Governor's Office of the Deaf and Hard of Hearing, Annual Report, Fiscal Year 2017, July 1, 2016-June 30, 2017. Retrieved from https://odhh.maryland.gov/wp-content/uploads/sites/13/2017/12/ODHH-FY2017-Annual-Report.pdf

[17] Ibid.

Figure 11:
Deaf and Hard of Hearing Individuals served in the Outpatient PBHS by Race reported in the OMS, FY 2017



Total	African American	Asian	Caucasian	Hispanic	Native American	Pacific Islander	Unknown
3,517	1,319	46	2,074	21	55	1	1
Percentage	37.5%	1.3%	58.9%	0.6%	1.6%	0%	0%

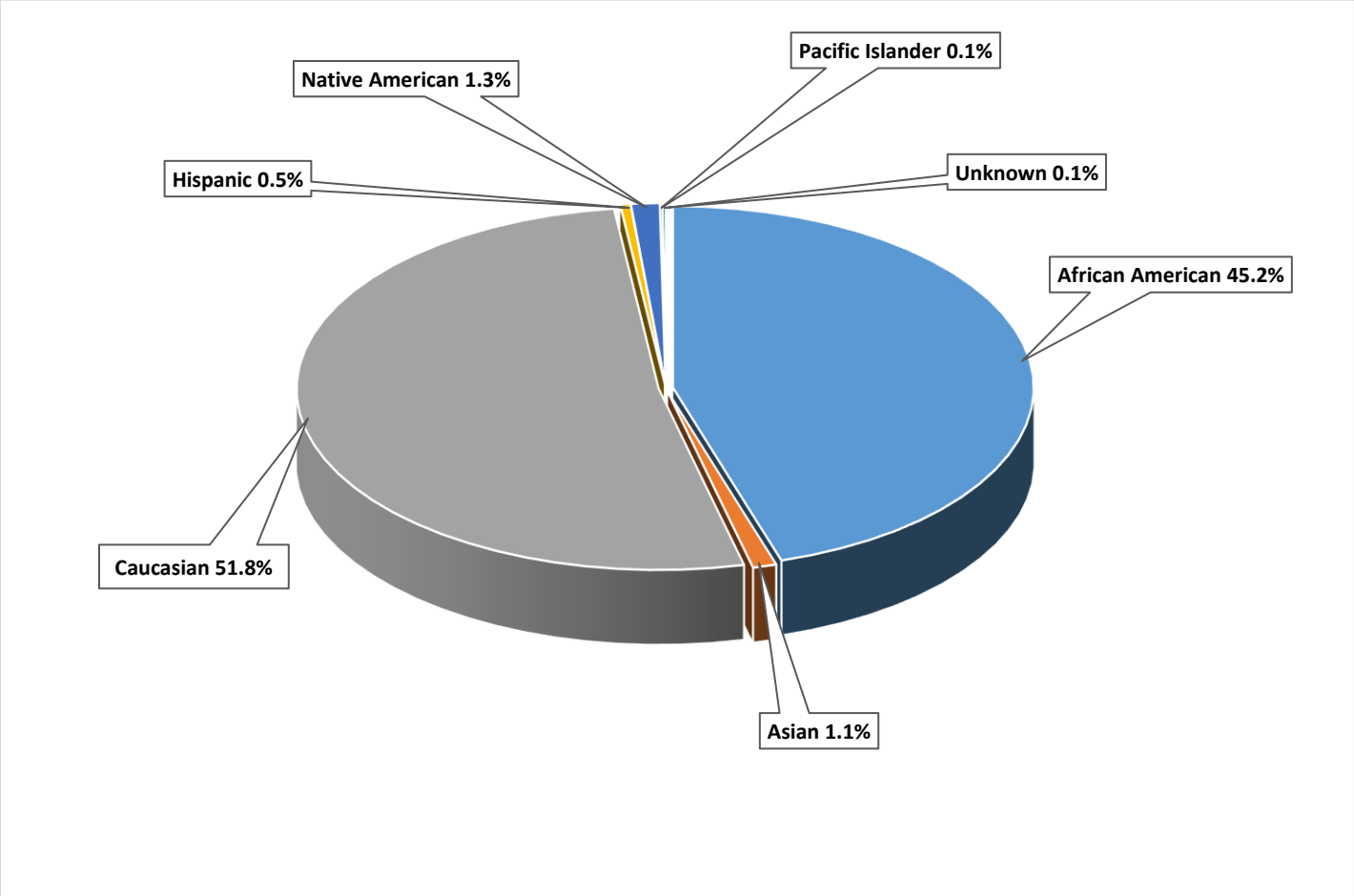
Data Source: *OMS, FY 2017. PBHS outpatient services (e.g., Outpatient MH Clinics, Federally Qualified Health Centers, Hospital Based MH Clinics and Level I SUD Services).*

Data Summary and Analysis

As shown in figure 1, there were a total of 3,517 deaf and hard of hearing individuals who received behavioral health services in FY 2017 of whom almost 60% were Caucasian, followed by 37% African Americans. Although there were no significant observation made among the other racial/ethnic minority populations, it is important to note that the data on the Deaf and Hard of Hearing is based solely on individual responses in the OMS and does not represent the entire Deaf and Hard of Hearing population served in Maryland's PBHS.

Veterans

Figure 12:
Veterans served in the PBHS Behavioral Health Services by Race, FY 2017



Total	African American	Asian	Caucasian	Hispanic	Native American	Pacific Islander	Unknown
5,965	2,694	63	3,090	27	76	7	8
Percentage	45.16%	1.06%	51.80%	0.45%	1.27%	0.12%	0.13%

Data Source: *FY 2017 behavioral health service claims data. Data based on claims paid through March 31, 2018.*

Data Summary and Analysis
Figure 12 shows the racial distribution among veterans served in the PBHS. At almost, 52% Caucasians are the predominant group served in Maryland's PBHS followed by African Americans at 45%. The percentage of other ethnic minority veterans who seek public behavioral health service are less than 3%, and the largest percentage among these groups are those who identified themselves as Native Americans (1.3%) and Asians (1.1%).
The number of veterans who have received behavioral health services from 2015 to 2017 has increased by 17%. Veterans make up 2% of the total number of individuals who received behavioral health service in fiscal years 2015 thru 2017.

Table 2:
Number of Veterans who received Behavioral Health Services (Mental Health or SUD), FY 2015-2017

Year	2015	2016	2017
Number of Veterans	5,092	5,592	5965

Data Source: *Behavioral health service claims data*

Homelessness

For FY 2017 the estimated count of individuals experiencing homelessness in Maryland was 31,095. From 2016 to 2017 Maryland's homeless count of individuals who are homeless increased by 4.8% and this was a 12% increase since 2015 (see Table 4). The cost of living in Maryland has risen in the last two years, increasing from the eleventh highest to eighth among the 50 states and District of Columbia.[18] The majority of homeless individuals counted in FY 2017 were residents of Baltimore City, Baltimore County, Montgomery County and Prince George's County (see Table 3 below). [19] The largest number of individuals served who are homeless were in Baltimore City for all 3 consecutive years. Table 3 gives a glimpse into the number of homeless counts for the four Maryland jurisdictions with the largest homeless population. Males make up the majority of this population and 60% were African American. Seven percent of the counted homeless were veterans. This was 0.5%, or 2,165 of the projected total number of Maryland veterans.

Table 3:
Maryland's Four Jurisdictions with the Largest Homeless Population Count

Counties	Total HC (FY 2015)	Total HC (FY 2016)	Total HC (FY 2017)
Baltimore City	11,144	11,807	12,868
Baltimore County	3,628	3,648	3,763
Montgomery County	3,189	2,798	2,661
Prince George's County	1,263	1,921	2,128

Source: Partially adapted from the 2017 Annual Report on Homelessness. (2017). Maryland Interagency Council on Homelessness.

[18] Maryland Interagency Council on Homelessness (2017). *Annual Report on Homelessness*. Retrieved from https://dhcd.maryland.gov/homelessservices/documents/2017annualreport.pdf
[19] Ibid.

Table 4:
Maryland's Count of Individuals who are Homeless

Counted Homeless in Maryland July 1, 2015- June 30, 2016		
COUNT		
2015	27,764	
2016	29,670	
2017	31,095	
SHELTERED VS UNSHELTERED	**FY2016**	**FY2017**
Sheltered	6,594	5,511
Unsheltered	1,798	1,736
TYPE	**FY2016**	**FY2017**
Shelter Beds	4,749	4,662
Transitional Units	2,953	2,865
Permanent	7,689	8,478
FAMILY SIZE	**FY2016**	**FY2017**
Singles	4,389	5,071
Families	2,556	2,176
GENDER	**FY2016**	**FY2017**
Male	61%	61%
Female	39%	38%
Transgender	.05%	.05%
AGE	**FY2016**	**FY2017**
Children under 18	1,720	1,370
Youth 18-24	440	422
Adults over 24	5,210	5,455
RACE	**FY2016**	**FY2017**
African American	58%	60%
Caucasian	34%	34%
Latino or Other	8%	6%
VETERANS	**FY2016**	**FY2017**
Counted	520	536
Served		2,165

Source: 2016 Annual Report on Homelessness, October 1, 2016. Prepared by Maryland's Interagency Council on Homelessness; 2017 Annual Report on Homelessness, November 7, 2017. Prepared by Maryland's Interagency Council on Homelessness.

Summary of Demographic and Service Utilization Data

The above data do not cover all the various groups in Maryland and are by no means exhaustive. However, they do provide some insight into the cultural and linguistic diversity found in the State. Also, most individuals fall into more than one of these groups. For instance, a young woman who is a college graduate, black, gay, veteran and homeless with mental illness and a substance use disorder, cannot just be classified by race, gender and level of education. We also encounter sub-groups within a particular group. For example, homelessness can occur due to varying circumstances such as; loss of income, domestic violence or substance use disorder. These and other factors have to be taken into account to understand diversity and disparities.

In order to keep moving towards a PBHS that is a culturally and linguistically competent system of care, BHA has established five goals and accompanying strategies for FY 2019-2020 based on the National CLAS Standards outlined in Part 2 of this Plan. In addition, efforts at the State and local levels will include the use of a CLAS self-assessment tool to ensure the implementation and evaluation of culturally and linguistically appropriate behavioral health services. This is discussed subsequent to the Goals.

PART 2: FY 2019-2020 CLCSP GOALS

The overarching goal of this CLCSP is to ensure Maryland's behavioral health services are culturally and linguistically competent and meet the expressed needs of all individuals and families served in the PBHS.

GOAL 1:
ESTABLISH AND MAINTAIN CULTURALLY AND LINGUISTICALLY COMPETENT BEHAVIORAL HEALTH SERVICES.

STRATEGIES	OUTCOME MEASURES
Ensure organizational commitment to cultural and linguistic competence.	Mission and Vision statements reflect and convey organizational commitment to cultural and linguistic competence.
Adopt the National CLAS Standards and infuse strategies on cultural and linguistic competence in annual plans.	CLAS standards are used in the planning, resource allocation, implementation and evaluation of services. All goals and strategies include cultural and linguistic competence action plans.
Provide the necessary resources to support the implementation of cultural and linguistic policies and programs.	Financial and human resources are allocated and resource materials provided to improve and implement organizational policies and practices.

GOAL 2:
ELIMINATE CULTURAL AND LINGUISTIC BARRIERS TO ACCESS OF BEHAVIORAL HEALTH SERVICES.

STRATEGIES	OUTCOME MEASURE
Raise awareness on internal and external stigma, negative stereotyping, and discrimination against minority groups and underserved population with behavioral health issues.	Anti-stigma messages on behavioral health issues are developed and shared within the PBHS and Maryland communities.
Increase awareness on culturally and linguistically appropriate verbal and non-verbal communication styles.	Identify and promote the use of tools to improve culturally and linguistically appropriate communication skills in the provision of services.
Create a welcoming environment in which all individuals and families served in the PBHS feel valued.	PBHS have instituted policies and practices that recognize, value and respect the diverse cultures of the individuals and families served.
Improve public awareness on available culturally and linguistically competent behavioral health services.	Information on culturally and linguistically effective behavioral health services are widely disseminated.

GOAL 3:
CREATE A SYSTEM OF DATA DRIVEN DECISION MAKING PROCESSES THAT RESULT IN THE FORMATION OF CULTURALLY AND LINGUISTICALLY COMPETENT POLICIES AND PRACTICES.

STRATEGIES	OUTCOME MEASURES
Identify the needs of minority and underserved groups served in the PBHS and institute services that meet their expressed cultural and linguistic needs.	Needs assessments are conducted and culturally and linguistically appropriate programs that meet the expressed needs of minority and underserved groups are designed and implemented.
Ensure that behavioral health services have sufficient capacity to meet the cultural and linguistic needs of the minority and underserved groups served in the PBHS.	Evaluate existing services, identify gaps and provide evidence that supports the need to build organizational capacity to address the expressed cultural and linguistic needs of minority and underserved groups served in the PBHS.
Evaluate and monitor progress through the collection, analysis and utilization of data.	Action plans are developed and quality improvement measures are put in place based on collected and analyzed data.

GOAL 4:
SUPPORT THE USAGE OF EVIDENCE-BASED PRACTICES TO ADDRESS THE UNIQUE NEEDS OF INDIVIDUALS SERVED IN MARYLAND'S PBHS.

STRATEGIES	OUTCOME MEASURES
Establish structures and processes to facilitate implementation of evidence-based practices.	Changes are made and resources are identified and allocated to reflect organizational commitment to the implementation of evidence-based practices.
Identify priority service areas that can benefit from culturally and linguistically competent evidence-based practices.	Priority service areas are identified and action plans are developed to implement evidence- based practices.
Ensure that evidence-based practices yield the desire outcomes.	Evaluation measures are put in place to assess and improve program effectiveness.

GOAL 5:
ADVOCATE FOR AND INSTITUTE CULTURALLY AND LINGUISTICALLY COMPETENT WORKFORCE DEVELOPMENT PROGRAMS REFLECTIVE OF MARYLAND'S DIVERSE POPULATION.

STRATEGIES	OUTCOME MEASURES
Build a culturally and linguistically competent workforce that can effectively address the behavioral health needs of a diverse population.	Measures are put in place to recruit, promote and support a culturally and linguistically diverse workforce.
Increase workforce capacity through ongoing training programs that address the cultural and linguistic needs of individuals and families served in the PBHS.	Resources are allocated and ongoing cultural and linguistic competency training programs are provided to staff at all levels within the PBHS.
Institute cultural and linguistic competency training programs that incentivize staff at all levels of the workforce to learn about and address the cultural and linguistic needs of the individuals and families they serve.	Training programs effectiveness in engaging and motivating staff are reflected in staff performance to meet the expressed needs of the individuals and families they service.

PART 3: IMPLEMENTATION OF THE NATIONAL CLAS STANDARDS

BHA and local mental health and SUD authorities (CSAs/LAAs/LBHAs) will use the National CLAS Standards as guidelines for the development of their FY 2020 behavioral health plans and progress reports. A commitment to address the cultural and linguistic needs of all individuals and families served in the PBHS should be reflected in the Mission and Vision statements of behavioral health governing bodies, BHA and all jurisdictional public behavioral health plans. Strategies on cultural and linguistic competency should be infused throughout administrative, budget, communication, financial and human resources allocation, prevention, treatment, and recovery services goals.

CLAS SELF-ASSESSMENT TOOL

The following checklist will serve as a self-assessment tool for BHA, the local mental health and SUD authorities and behavioral health providers participating in the PBHS to rate leadership and organizational commitment and level of cultural and linguistic competency on a scale of 0-3. The meaning of the competency levels in the checklist are as follows:

- 0 – no competency
- 1 – low level competency
- 2 – medium/moderate level competency
- 3 – high level competency

The self-assessment tool will be part of the annual BHA guidelines for the local jurisdictions CSAs/LAAs/LBHAs FY 2020 plan development and FY 2019 progress reporting processes. Although some of the statements in the self-assessment tool are slightly modified, each statement refers to one of the 15 standards of the CLAS. BHA will support the local jurisdictions in their efforts to implement the National CLAS Standards in the PBHS and will monitor implementation based on program plans and progress made.

NATIONAL CLAS STANDARDS SELF-ASSESSMENT TOOL

GOAL 1: ESTABLISH AND MAINTAIN CULTURALLY AND LINGUISTICALLY COMPETENT BEHAVIORAL HEALTH SERVICES		**LEVEL**			
1	Our Mission and Vision statements reflect organizational commitment to cultural and linguistic competence. (Standard 1)	0	1	2	3
2	We have established culturally and linguistically appropriate goals, management accountability, and infused them throughout the organization's planning and operations. (Standard 9)				
3	Our organizational governance and leadership promote and use CLAS standards in policies, practices and allocation of resources. (Standard 2)				
4	We have created conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints. (Standard 14)				
5	We communicate our organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public. (Standard 15)				
GOAL 2: ELIMINATE CULTURAL AND LINGUISTIC BARRIERS TO ACCESS OF BEHAVIORAL HEALTH SERVICES					
1	We offer language assistance to individuals who have limited English proficiency and/or other communication needs including individuals who use American Sign Language, at no cost to them, to facilitate timely access to behavioral health services. (Standard 5)				
2	We inform all individuals of the availability of verbal, signing and written professional language assistance services in their preferred language or form of communication. (Standard 6)				
3	We ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided. (Standard 7)				
4	We provide easy-to-understand print and multimedia materials and signage in the languages commonly used by individuals in our community. (Standard 8)				
GOAL 3: CREATE A SYSTEM OF DATA DRIVEN DECISION MAKING PROCESSES THAT RESULT IN THE FORMATION OF CULTURALLY AND LINGUISTICALLY COMPETENT POLICIES AND PRACTICES					
1	We conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of the community we serve. (Standard 12)				
2	We collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery. (Standard 11)				

GOAL 4: SUPPORT THE USAGE OF EVIDENCE-BASED PRACTICES TO ADDRESS THE UNIQUE NEEDS OF INDIVIDUALS SERVED IN MARYLAND'S PBHS		**LEVEL**			
		0	1	2	3
1	We conduct ongoing assessments of our organization's CLAS-related activities and integrate CLAS-related quality improvement and accountability measures into program activities. (Standard 10)				
2	We partner with the community to design, implement and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness. (Standard 13)				
GOAL 5: ADVOCATE FOR AND INSTITUTE ONGOING WORKFORCE DEVELOPMENT PROGRAMS IN CULTURAL AND LINGUISTIC COMPETENCE REFLECTIVE OF MARYLAND'S DIVERSE POPULATION					
1	We recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the community we serve. (Standard 3)				
2	We provide orientation and training to new and existing members of our governing body, leadership and staff on culturally and linguistically appropriate policies and practices on a regular basis. (Standard 4)				

Acronyms

ASL	American Sign Language
BHA	Behavioral Health Administration
BHAC	Behavioral Health Advisory Council
BMC	Baltimore Metropolitan Council
CLAS	Culturally and Linguistically Appropriate Services
CLCC	Cultural and Linguistic Competence Committee
CLCSP	Cultural and Linguistic Competency Strategic Plan
CSA	Core Service Agency
EP	Emergency Petitioned
FY	Fiscal Year
GODHH	Governor's Office of the Deaf and Hard of Hearing
HIMS	Hospital Information Management System
ICFA	Intensive Care Facilities for Addictions
LAA	Local Addictions Authority
LBHA	Local Behavioral Health Authority
LGBTQ	Lesbian, Gay, Bi-sexual, Transgender, Queer/Questioning
LEP	Limited English Proficiency
MCV	Maryland's Commitment to Veterans
MT	Mobile Treatment
OMS	Outcomes Measurements System
PBHS	Public Behavioral Health System
PRP	Psychiatric Rehabilitation Program
PRTF	Psychiatric Residential Treatment Facilities
RICA	Regional Institutes for Children and Adolescents
RRP	Residential Rehabilitation Program
SAMHSA	Substance Abuse and Mental Health Services Administration
SUD	Substance Use Disorder

Definitions

1. **Behavioral health**: The concept of "behavioral health" expands the term "mental health" to include substance use, behaviors, habits, and external forces that contribute to mental or emotional well-being. Retrieved from https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2015/01/28/14/58/support-for-social-determinants-of-behavioral-health
2. **Competence**: having the capacity to function effectively. Retrieved from https://files.eric.ed.gov/fulltext/ED330171.pdf
3. **Cultural Bias**: the tendency to judge people in terms of one's own cultural assumptions. Retrieved from: https://www.tutor2u.net/psychology/reference/issues-debates-culture-bias
4. **Cultural Competence**: 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 professionals to work effectively in cross-cultural situations. Retrieved from https://files.eric.ed.gov/fulltext/ED330171.pdf
5. **Culture**: the integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, or social group. Retrieved from https://files.eric.ed.gov/fulltext/ED330171.pdf
6. **Health disparities**: differences in the health status of different groups of people. Some groups of people have higher rates of certain diseases, and more deaths and suffering from them, compared to others. Retrieved from https://medlineplus.gov/healthdisparities.html
7. **Health equity**: the fair distribution of health determinants, outcomes, and resources within and between segments of the population, regardless of social standing. Retrieved from https://www.cdc.gov/nchs/ppt/nchs2010/41_klein.pdf
8. **Linguistic Competence**: 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, and individuals with disabilities. Linguistic competency requires organizational and provider capacity to respond effectively to the health literacy needs of populations served. Retrieved from https://gucchd.georgetown.edu/products/DefinitionLinguisticCompetence.pdf
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