SYMPOSIUM: UNLOCKING DISPARITIES FROM PROVIDER AND COMMUNITY PERSPECTIVES

USING EXPLORATORY DATA TO PROMOTE CULTURAL AND LINGUISTIC COMPETENCE

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Introduction

- One of the goals of systems of care is to extend services to previously underserved groups, including members of minority, cultural or marginalized groups
- Historically, these groups often face barriers to effective mental health care
- Barriers include disparities related to health care access and quality, cost of services, appropriateness of services, racism and discrimination

Culture and Mental Health

- An individual's cultural background influences:
  - how they express and manifest their symptoms, how they cope, the types of supports they have available/need, and their willingness to seek treatment
- The culture of a clinician/practitioner or the service system influences:
  - how diagnosis, treatment and service delivery are applied

U.S. Department of Health and Human Services (2001). Mental health: Culture, race and ethnicity– A supplement to mental health: A report of the Surgeon General. Rockville, MD: DHHS

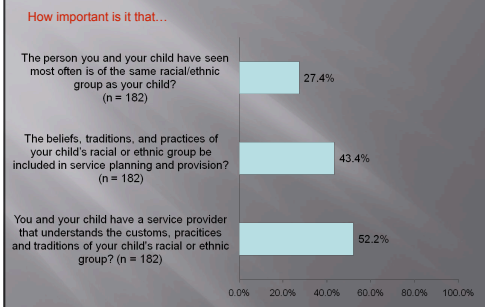
CLC and Disparities

- Consumer level barriers
  - Access to mental health care
  - Stigma
  - Racism & discrimination
- Provider level barriers
  - Cultural knowledge
  - Inadequate skills and practices
  - Language insufficiency
- System level barriers
  - Lack of CLC policies and procedures
  - Insufficient/inadequate training
  - Lack of diverse workforce

Comprehensive Community Mental Health Services for Children and their Families Program

- Funded by the Center for Mental Health Services of the Substance Abuse and Mental Health Services Administration (SAMHSA)
- Largest children's mental health services initiative to date (over $1.06 Billion)
- 126 grants and cooperative agreements funded to date
- Each system of care community funded for 6 years
- 30 communities funded in FY 2005 and 2006

How Important is the Provision of Culturally Competent Care to Caregivers?*



*Data reported were collected using the Cultural Competence and Service Provision (CCSP) Questionnaire. Data include cultural competence in the 6 months prior to data collection. Percentages reported combine the responses "Very Important" and "Extremely Important." This report is based on data submitted through November 10, 2007 for communities funded in FY 2005 – 2006.

According to the National Center for Cultural Competence at the Georgetown Center for Child and Human Development:

Cultural competence requires that organizations:

- have a defined set of values and principles, and demonstrate behaviors, attitudes, policies and structures that enable them to work effectively cross-culturally;
- have the capacity to value diversity, conduct self-assessment, manage the dynamics of difference, acquire and institutionalize cultural knowledge, and adapt to diversity and the cultural contexts of the communities they serve;
- incorporate the above in all aspects of policy making, administration, practice, service delivery and involve systematically consumers, key stakeholders and communities.

Cultural and Linguistic Competence Implementation Substudy (CLCIS)

- The first of three substudies conducted for the national evaluation of the Comprehensive Community Mental Health Services for Children and Their Families Program[1]
- The CLCIS is a qualitative exploration of the cultural and linguistic contexts of four communities funded in FY 2005 and how they inform the implementation of their systems of care. It also examines how the cultural and linguistic needs of children and their families are being met.
- The CLCIS addresses these questions:
  - What are each community's efforts to develop culturally and linguistically appropriate systems of care at the infrastructure and service delivery levels?
  - What are the facilitators and barriers to implementing culturally and linguistically competent practices? What efforts at resolving these barriers have been implemented?
  - What are consumers' and other respondents' perceptions of how these efforts meet the diverse cultural and linguistic needs of children and families?

[1]The other two substudies are the Cultural Competence Implementation and Outcomes Self-Assessment Substudy and the Culturally Competent Evidence-Based Practices Substudy to be conducted in 2009 and 2011 respectively.

Domains and Protocol Development Process

- Step 1: The study team developed a protocol and determined domains using SAMHSA's Managed Care Cultural and Linguistic Standards as a guide.
- Step 2: The domains were refined through a three-step process. First, a literature review was conducted; second, the team collaborated with an expert panel to develop the domains; and third, input was sought from community representatives.
- Step 3: The team began developing the protocol questions by creating a list of key informant participant types. The list represented a broad category of representatives and partners in systems of care.
- Step 4: The study team, guided by feedback from the CLC Expert Panel and the communities, developed a list of questions for each key informant category based on the eight domains of inquiry.
- Step 5: The study team submitted the protocols and study procedures to the Institutional Review Board for review. Upon receipt of approval, the study team contacted the selected communities to coordinate community visits and schedule interviews.

Community Selection Process

Selection criteria included:
1. Communities must be delivering services to at least 10 children and families

2. Communities meet at least one of the eligibility criteria including having:
   - Significant experience with cultural and linguistic initiatives
   - Limited experience and knowledge with CLC initiatives
   - Community has limited resources
   - Multiple ethnic or cultural group foci
   - Single ethnic or cultural group focus
   - Faith-based influence on the emerging system of care
   - Specific language needs

3. Communities must agree help plan the site visits by recruiting interview and focus group respondents, coordinate scheduling, proving the space and arranging interpretation services and transportation services, and partnering on future presentations and listening sessions at conferences.

Community	1	2	3	4
Community Type	Urban	Rural	Rural	Urban
Population	3,900,000	170, 471	215,881	730,807
Median Household Income	$41, 922	$27,126	$34,891	$46, 412
% Who Live Below Poverty	16.8%	24.1%	21.4%	13.1%
% With Language Other Than English Spoken at Home	36.2%	3.5%	12.5%	12.1%
% Foreign-Born Persons	22.2%	1.2%	7.7%	7.3%
% Under 18 Years of Age	28.9%	27.0%	21.4%	23.3%
Special Characteristics	○ Percentage of African Americans enrolled (59%) is higher than the county as a whole (18%) ○ About 200,000 victims of hurricanes Katrina and Rita settled in the county	○ Three of the four counties have a much higher African-American population and a higher percentage of people who are living below the Federal poverty level than the rest of the State as a whole (15.7%)	○ Program serves predominantly ethnic families compared to overall demographics of the county	○ Large lesbian, gay, bisexual, transgender, questioning, interseved, and two spirit (LGBTQI2S) community. ○ County has migrant, refugee, and some Native American populations

Data Collection and Analysis

- Step 1: Each community identified a team leader and a core team to coordinate data collection for the CLCIS and the study team assigned a team member to each community to help coordinate site visits.
- Step 2: Community core teams and team members collaborated to identify data collection methods for each respondent category.
- Step 3: The teams and communities jointly reviewed the protocols that were customized for each community. The team members tailored the interviews and focus groups accordingly.
- Step 4: At the conclusion of each visit, the site visitors conducted a debriefing with key staff. The study team analyzed the data through an iterative process of aggregation and categorization by domains and produced a site visit report for each community.
- The study team completed all site visits by August 2007, within six months of commencing the study; 24 focus groups and 37 interviews were conducted across all four sites with system-level, service-level, and consumer respondents and included project directors, cultural coordinators, youth coordinators, service providers, clinical directors, evaluation team staff, governance board members, family members, and youth.

Results

- **Reducing disparities at consumer level:**
  - **Collaboration and Outreach:** Strengths included collaboration at service agencies, family support centers, faith-based organizations. Recruiting staff, racial divisiveness, lack of translated written materials, language barriers and challenges engaging emerging populations emerged as challenges across all communities.
  - **Diverse Populations**: Most communities reported that few (if any) efforts have been made to identify the LGBTQI2S population and serve their needs. There is a lack of assessment of the culture of poverty and the differential needs of poor families and youth.
  - **Culturally Competent Practices and Interventions:** Consumers expressed several needs including increased transportation options, more activities for youth, fewer restrictions on service eligibility, better collaboration between schools and other agencies, and more effective and efficient transitioning out of services.

Results

- **Reducing disparities at provider level:**
  - **Culturally Competent Practices and Interventions:** Strengths included using intake process to collect information about culture. Respondents indicated that lack of time, long paperwork processes, lack of opportunities for youth and families to provide feedback, limited school-based services, limited awareness of service availability, and language barriers were additional challenges.
  - **Training and Workforce Development**: Most communities did not have a CLC training plan, though all communities provided an overview CLC training. Respondents want training topics to be expanded to include working with LBGTQIS2 youth, information on Hispanic culture and culture of poverty, and cultural awareness training

Results

- **Reducing disparities at the system level:**
  - **Continuous Quality Improvement:** Strengths include collection of data on family's culture. Evaluation processes do not always include an assessment of training activities, policies, and procedures related to CLC, or the differential needs of diverse populations, including those of lower socioeconomic status. Lack of adequate language translation staff resulted in a labor intensive, multi-step data collection process for one community.
  - **Governance:** The diversity of the governance boards does not always match the diversity of the service populations. Getting members to attend governance board meetings is challenging.
  - **Planning and Management:** Strengths include the infusion of CLC plan into strategic plan. Planning is difficult without an accurate portrait of the community's current CLC status and the funds to manage needed changes. CLC may be difficult to achieve unless it has a line item in the budget. Planning and management require active participation from all stakeholder groups throughout the strategic planning process.
  - **Training and Workforce Development**: Most of the communities displayed a strong awareness of the need for linguistically and ethnically relevant hiring of staff, and lamented the difficulties they have faced. Rural communities find it especially difficult to hire therapists who speak other languages or who reflect their growing ethnic populations.

Results

- **Reducing disparities at the system level:**
  - **Policies and Procedures:** Strengths include the creation of the system's logic model by program staff, youth, families and community members. Each of the four communities is examining the needs of its program to develop policies and procedures that support the implementation of CLC. Concrete expectations for CLC are generally not in place. Many grantees wait until the second or third year of their grant to create a CLC plan. Some communities have been spending considerable time in the beginning stages of this process, and are trying to be inclusive of diverse groups by recruiting representative members, to help inform this process, while at the same time educating those who may not be familiar with the concept. Where the goal of CLC is made clear, the development of effective plans and policies is often still painful and laborious for those involved.

Conclusion and Next Steps

- These systems of care exist within larger cultural, political, and historical contexts, all of which are not easily altered.
- Findings show that system-level engagement of diverse groups may promote CLC within systems of care and is helpful in reducing disparities.
- One way to deliver culturally and linguistically appropriate care is to work from a bottom-up, individual- and family-level approach, rather than laboring to first change the perceptions and behaviors of the entire community. This approach can reduce disparities among the groups receiving this focused attention.
- The CLC Study has proposed two additional substudies. It is increasingly clear that each substudy needs to address the topic of institutionalized racism. The study team will work with the CLC Expert Panel to modify the study plans to meet this need.