



Making Children's Mental Health Services Successful

Creating a Front Porch:

Strategies for Improving Access to Mental Health Services

A Monograph by

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This publication was produced by *Study 5: Accessibility of Mental Health Services: Identifying and Measuring Organizational Factors Associated with Reducing Mental Health Disparities* of the Research and Training Center for Children's Mental Health. This study investigates how the concept of cultural competence can be operationalized and implemented within systems of care to improve access to services and supports and reduce mental health disparities.

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Louis de la Parte Florida Mental Health Institute Publication #240-3
Tampa, Florida

Recommended citation:

Callejas, L. M., Nesman, T., Mowery, D., & Hernandez, M. (2008). *Creating a front porch: Strategies for improving access to mental health services (Making children's mental health services successful series, FMHI pub. no. 240-3)*. Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, Research & Training Center for Children's Mental Health.

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The Center is jointly funded by the National Institute on Disability and Rehabilitation Research, U.S Department of Education and the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration under grant number H133B040024. The opinions contained in this document are those of the authors and do not necessarily reflect those of the U.S. Department of Education or Substance Abuse and Mental Health Services Administration.



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1. Introduction

This monograph aims to increase awareness of the impact of culture on access to mental health services with the goal of reducing the burden of care for culturally/racially diverse families (Hernandez, Nesman, Isaacs, Callejas, & Mowery, 2006; Huang, 2002).

Access is a first step toward receiving needed mental health services and can be seen as the “front porch” of services where people can be linked to services without being identified as a “client.” As on welcoming front porches in communities throughout this country, people feel comfortable spending time together, listening and learning, and building relationships of trust. In these intimate community gathering places, communication often crosses cultural, linguistic, and other barriers. Creating a front porch for mental health requires organizational commitment to the implementation of policies and practices such as flexible funding, increased human resources, and family support that do not depend on billable hours.

This monograph identifies strategies to increase access as part of a broader conceptual model that addresses the community context in which services are delivered, the characteristics of populations served, and the overall organizational infrastructure through which services are delivered. Access strategies were identified through interviews conducted with personnel from selected organizations that met criteria for providing culturally competent services and supports for racially/ethnically diverse children and families. This monograph is part of a series of monographs outlining successful strategies for increasing Access, Availability, and Utilization of services at the organizational and direct service levels.

The findings presented in this monograph were derived from a larger study (Research and Training Center for Children’s Mental Health, 2004) that focused on identifying organizational practices used to improve access to mental health services and reduce disparities. For the larger study, a review of child and family mental health research literature was conducted that identified strategies that direct service personnel have used successfully to increase access to mental health services for diverse children and their families (Hernandez, et al., 2006). A review of cultural competence assessment measures was also conducted to determine: (1) how results of such measures have been used to improve services; (2) the effectiveness of existing protocols used to measure cultural competence; and (3) whether cultural competence does indeed lead to improved mental health outcomes for ethnically and racially diverse populations (Harper, Hernandez, Nesman, Mowery, Worthington, & Isaacs, 2006).

The purpose of this monograph is to increase awareness of the impact of culture on access to mental health services with the goal of reducing the burden of care for culturally/racially diverse families.

Characteristics of the community include the influence of culture, ethnicity, race, socioeconomic status, and other social factors on help-seeking and the ways in which different populations interact with organizations and systems.

Conceptualizing Cultural Competence

Following completion of the literature and protocol assessment reviews, a cultural competence model that identified important domains related to cultural competence was developed (Hernandez & Nesman, 2006). Figures 1 and 2 provide an illustration of this model and its various components. Figure 1 illustrates the relationships between a community’s populations, organizational structures, direct services processes, and the overall community context. The box labeled community context (1) highlights the notion that mental health organizations and systems function within larger community, state, and national contexts that affect their efforts to serve local populations. Next, the model points out the important role of a *target population’s cultural and linguistic characteristics* by showing its relationship to the organization (2). In this case, characteristics of the community include the influence of culture, ethnicity, race, socioeconomic status, and other social factors on help-seeking and the ways in which different populations interact with organizations and systems. Figure 1 also highlights the importance of an *organization or system’s combined policies, structures, and processes* (3). These characteristics of the organization influence the ways in which it interacts with the community’s populations, and are also influenced by the populations’ characteristics as well as the overall community context. The level of compatibility between a target population’s cultural and linguistic characteristics and the organizational or system infrastructure influences the organizational cultural competence (4). Increasing compatibility can result in outcomes such as reduced mental health disparities (5).

Figure 1
Conceptual Model of Organizational Cultural Competence:

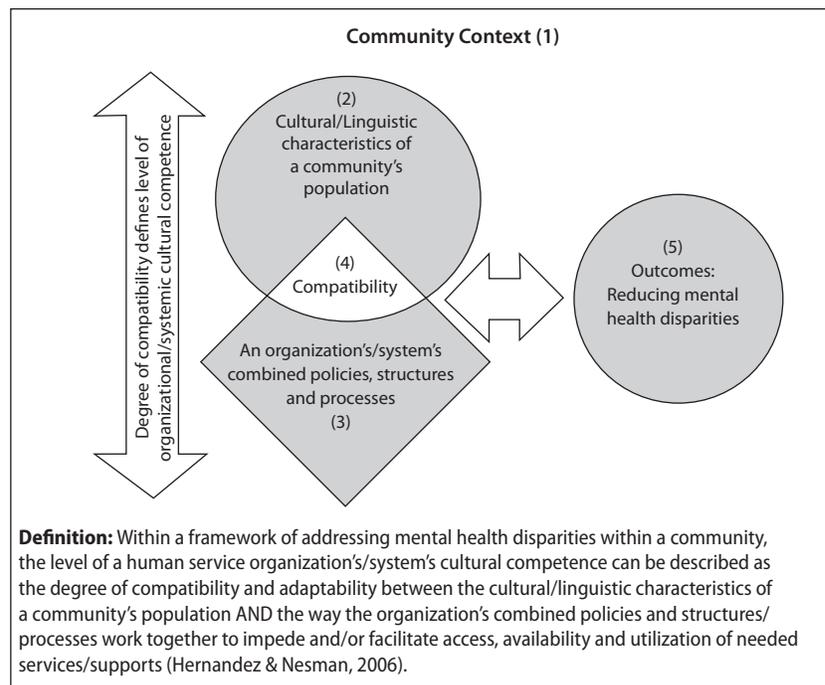
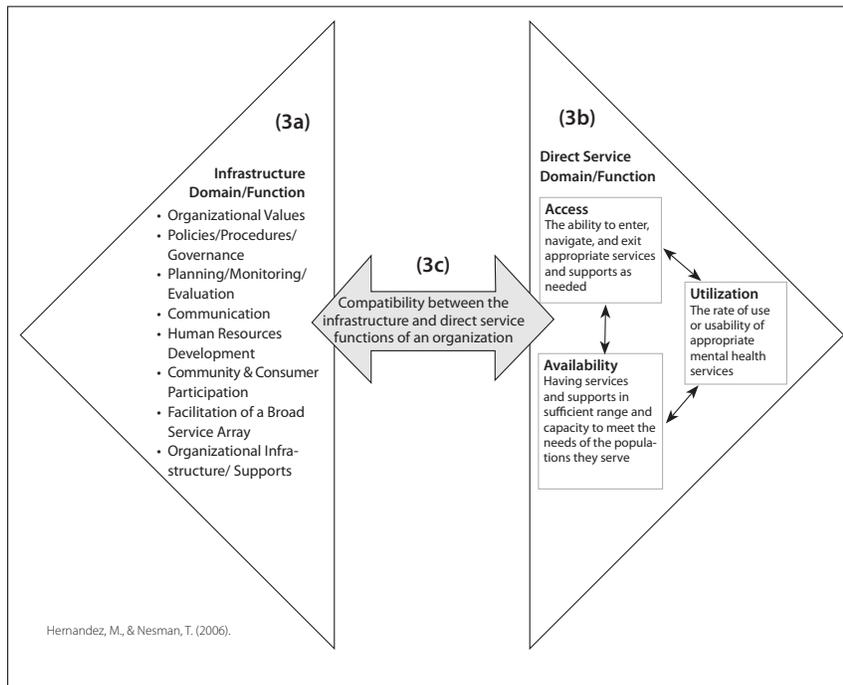


Figure 2 illustrates in more detail the components of the Infrastructure and Direct Service domains of an organization. The *infrastructure domain* is made up of multiple functions that are typical of organizations, each of which must be adapted for cultural competence (3a). For example, the domains of Values, and Policies/Procedures/Governance can be adapted to include wording that addresses the population's unique characteristics as well as community issues such as insurance coverage or immigration status. The *direct service domain* includes functions related to service accessibility, availability, and utilization (3b), each of which is also influenced by the organization's characteristics and the population's characteristics. As shown, *compatibility* is needed between infrastructure and direct service domains, as well as with the target population (3c) in order for culturally competent service to occur. This compatibility must be maintained through reciprocal knowledge development and communication between the target population and the organization in order to ensure an appropriate and acceptable continuum of services.

The model suggests that accessibility to mental health services by diverse children and their families can be increased through the development of compatible, or culturally competent, practices at both organizational and direct service levels. Access is shown as influencing and being influenced by availability and utilization of services (shown as two-way arrows in 3b) indicating that compatibility with the population involves adaptations in all three service domains. These three domains cover the continuum of service delivery from prevention to problem

The model suggests that accessibility to mental health services by diverse children and their families can be increased through the development of compatible, or culturally competent, practices at both organizational and direct service levels.

Figure 2
Conceptual Model of Organizational Cultural Competence:
Organizational Infrastructure and Direct Service Domains



For the purposes of this monograph,

access to mental health services is defined as the direct service and organizational mechanisms that facilitate a person's ability to enter into, navigate, and exit the appropriate services and supports as needed.

identification and help seeking, to assessment, treatment, and follow up. Access is seen as the “front porch” of this continuum in mental health service delivery. That is, the first step in developing a positive relationship between families and providers that can result in linkages to needed services. The front porch is built through outreach activities in the community, reciprocal linkages with community services and people, and creation of a welcoming and accepting reception area in an agency. For the purposes of this monograph, access to mental health services is defined as *the direct service and organizational mechanisms that facilitate a person's ability to enter into, navigate, and exit the appropriate services and supports as needed*. Availability is defined as *having acceptable services and supports in sufficient range and capacity to meet the needs of the target populations*. Utilization is defined as *the rate of use of services or their usability for target populations* shown by measures such as length of time in service, retention, and dropout rates.

This monograph focuses on key practices that were reported to increase accessibility of mental health services for underserved populations in the organizations studied. Although there may be overlap in practices that impact each direct service domain (i.e., access, availability and utilization) this monograph focuses on practices that were clearly linked to increased access by the respondents in this study. Separate monographs in this series focus on key practices that were linked to increased availability and utilization of mental health services. The section that follows outlines the identified direct service practices and organizational strategies used within the study sites to increase accessibility to services.

This monograph is structured as follows. First, there is an overview of the methods used in this study including selection criteria, data collection techniques, and analysis procedures. The following section outlines the identified direct service practices and organizational strategies used within the study sites to increase accessibility to services. It includes a description of each of the target populations served by the participating study sites, as well as information about the history and context of, and general service delivery information for each organization. (For more detailed descriptions of each participating organization see the Appendix). The final section provides a discussion of lessons learned throughout this process, limitations of this study, and directions for future research.

2. How We Identified Key Strategies

Site Selection

Mental health organizations or systems were selected for participation in this study through a national search. Sites were identified as “exemplary” by a panel of researchers, practitioners, and family advocates who work in the areas of cultural competence and disparities in mental health. Sites were identified using the following criteria:

- Have strategies for increasing access for an underserved population
- Serve one or more of the targeted populations (African American/Black, Asian/Pacific Islander, Latino, and Native American)
- Proactively address cultural competence at the organizational level
- Proactively address language and cultural barriers
- Provide evidence that targeted populations value and use their services
- Demonstrate matching strategies to targeted groups and identify appropriate outcomes for those groups
- Show evidence of sustainability

Nominated sites participated in an initial semi-structured screening interview and a document review (e.g., evaluation reports, annual reports, websites, etc.). Organizations were invited to participate in either a site visit or multiple phone interviews if they met the study criteria. Those participating in site visits were selected based on strong evidence of impact in the community, well articulated strategies to reach targeted populations, and national or community level recognition of quality services that had been sustained and adapted over time. Sites that participated in phone interviews also demonstrated impact in the community but generally had a shorter history of involvement with the target population and were still developing their strategies or were not able to commit the resources needed to host a site visit.

Data Collection

Two versions of semi-structured interview protocols (one for organizational personnel and one for family members receiving services) were developed, piloted, and revised for use during interviews. Multidisciplinary interview teams included multilingual/multicultural researchers who were trained to administer the interview protocol. Interviews focused on identifying specific strategies and/or practices that were used to increase service access, availability, and utilization for one or more of the racial/ethnic populations targeted by the study.

Organizations participating in site visits were selected based on strong evidence of impact in the community, well articulated strategies to reach targeted populations, and national or community level recognition of quality services that had been sustained and adapted over time.

A total of 151 interviews were conducted with a variety of stakeholders, including administrators, direct service personnel, funders, evaluators, and/or family representatives.

Analysis Procedures

Interview responses with each site were coded using ATLAS.ti version 5.2, qualitative analysis software (Scientific Software Development, 2006). The coding process included identification of practices and strategies related to improved access, availability, and utilization of mental health and support services, relevant community and organizational characteristics, and conceptualizations of cultural competence. Similarities and differences in practices and concepts used across sites were identified through the coding and theory-building process. Once specific practices/strategies were coded, they were collapsed into code “families,” or larger categories that corresponded to specific components of the conceptual model of organizational cultural competence (Hernandez & Nesman, 2006) or were identified as having relevance across multiple model domains.

Findings from the literature review revealed a number of practices that were deemed to be of basic importance in addressing accessibility to mental health services and supports for ethnically and racially diverse children and families. These strategies were:

- addressing transportation needs;
- providing flexible scheduling for services;
- providing alternative and more convenient service locations;
- providing flexible payment options;
- providing culturally and linguistically appropriate materials;
- recruiting and hiring bilingual and bicultural personnel whenever possible; and
- increasing support and training for staff working with diverse communities (Harper et al., 2006; Hernandez et al., 2006).

These practices were used to develop initial codes for classifying responses across the study sites, based on strategies identified in the literature review and preliminary evidence of strategy implementation during initial screening interviews. Responses that did not conform to these identified codes were analyzed to identify emergent themes that were later used to develop additional codes.

Sample

Twelve sites were selected based on the study criteria and agreement with each site to participate in the study. Seven organizations hosted site visits, during which site personnel and other stakeholders were interviewed, and representatives from another five organizations were interviewed by phone. A total of 151 interviews were conducted with a variety of stakeholders, including administrators, direct service personnel, funders, evaluators, and/or family representatives.

Table 1 provides a general overview of the organizations selected for site visits and phone interviews. The table indicates the population group(s) served, as well as the general geographic location of the organization or system, a general description of the services offered, and the number of years each site has been in operation. The organizations are ordered in the table by *Organizational Type* thereby providing an overview of the various organizational forms represented. The organizational type encompasses a number of infrastructure components such

as organizational policies and procedures, funding requirements and constraints, and the types of services offered. The table begins by listing an organization that began as a grassroots neighborhood-based effort by community residents to combat discrimination and inadequate services, and which later developed into a Community Development Corporation¹ (CDC). The table moves from similar grassroots or community-based organizations to agencies or organizations that are more traditional in origin and are affiliated with System of Care grant communities or public behavioral/mental health departments or systems.

Table 1: Description of Study Sites

Study Site	Population Served	Geographic Region	Organizational Type	Service Type	Est.
01 Visit	Latino (90% Mexican descent); Native American	Southwest	Community Development Corporation (CDC); originated as grassroots, neighborhood based non-profit	Variety of social and human services, economic development, housing, and mental health	1969
02 Visit	Latinos (about 70% Mexican descent; various indigenous ethnic groups, majority P'urhépecha)	Pacific Northwest	Neighborhood-based, non-profit providing services; originated as grassroots organization	Variety of children's, family, and community development programs; information & referral to specialty services	1991
03 Visit	Native American (105 different tribes/ethnic groups served)	West Coast	Community-based non-profit with culturally-specific focus on service provision; countywide services	Variety of educational, family, economic, and community development programs; mental health	1974
04 Phone	African American primarily, 90%; growing populations of Haitian and African immigrants, Latinos	Midwest	Community-based non-profit with culturally-specific focus on service provision	Chemical dependence treatment, mental health, and family preservation	1975
05 Visit	Asian & Pacific Islander, 75%	Pacific Northwest	Community-based non-profit providing services countywide; originated as grassroots organization	Variety of social services, including, Aging & Adult, naturalization, vocational services, mental health across lifespan	1973
06 Phone	Latinos 70% (Puerto Rican, Central & South American); 30% African American	Northeast	Community-based non-profit organization with culturally-specific focus on service provision	Variety of health and human services, including HIV/AIDS, Head Start; mental health	1960
07 Phone	50% Latinos; 20-25% Native American; 20% White; some African American	Southwest	Community-based non-profit organization	Variety of traditional, spiritually-oriented, and alternative mental health services	2001
08 Phone	Latino (about 60%; various ethnic groups); African American (about 30%); Filipino (7%); small percentages of East African immigrants and Whites	West Coast	Community-based non-profit	Variety of social services, mental health, and family preservation	1975
09 Visit	Multi-ethnic; African American; Haitian; Cape Verdean immigrants; small percentages of Latinos, Whites	Northeast	State-wide non-profit organization	Mental health services across lifespan, elderly services, developmental disabilities service, information & referral	1975
10 Visit	Multi-ethnic; 35% Latino (various ethnic groups); 15% Asian and Pacific Islander (various ethnic/cultural groups)	West Coast	Children and Youth Services Division/Cultural Competence Department; county mental health system	Variety of mental health services for children with behavioral, emotional, or mental disorders	1999
11 Phone	60% African American; also serve White; bi/multi-racial; Latinos	South	System of Care grant site; public mental health system	Variety of family and mental health services focused on serving children with SED	1999
12 Visit	71% African American; 20% White; 6% Latino; 3% identified as "Other"	Midwest	Managed care program operated by county behavioral health division	Variety of mental health and family preservation services (court ordered referrals)	1995

¹ Community Development Corporations are broadly defined as non-profit organizations that provide programs and services at the community or neighborhood level and usually focused around housing and workforce development (National Congress for Community Economic Development, 2005).

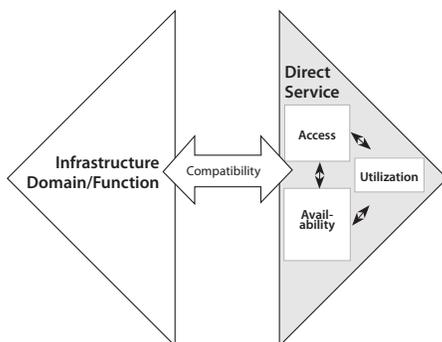
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3. Key Strategies Used to Increase Accessibility for Diverse Populations

This section presents findings related to the service delivery strategies used within participating organizations that increase service accessibility for racially and ethnically diverse children and families. Overall strategies were identified through interviews with personnel, funders, community partners, and family members at each of the 12 study sites. For the purposes of this study, a strategy is defined as a service delivery practice or series of related practices designed to increase service use for a specific population based upon that population's cultural and linguistic characteristics, history, and worldview. The findings are presented in a way that highlights how these strategies were tailored to meet the needs of the following service use populations: African Americans/Blacks, Asian and Pacific Islanders, Latinos, and Native Americans. Findings for each population are followed by a discussion of how these strategies compare across sites.

The strategies associated with the direct service domain of the cultural competence model (See Figure 2) address barriers whose impacts are most often encountered by children and families seeking services. Such strategies are most often implemented by direct service personnel, including outreach workers, case managers, and therapists, and often involve immediate interaction with children and families. The Direct Service Strategies used to successfully increase mental health service accessibility that were identified and described through this study are:

Figure 2
Conceptual Model of Organizational Cultural Competence:
Organizational Infrastructure and Direct Service Domains



Direct Service Strategies

- Broad Referrals and Connections
- Simplified and Accessible Intake Process
- High Level of Responsiveness and Engagement
- Supportive Family Focus
- Flexible, Individualized/Culturally-Specific Services
- System Navigation
- Outreach to Community
- Addressing Stigma/Mental Health Terminology

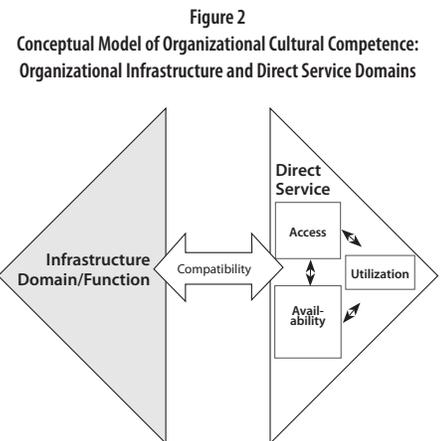
This study also identified and described a number of strategies that are implemented or developed at an administrative level within organizations or systems—one that does not usually involve direct interaction with children and families needing services. These strategies, which were associated with the organizational

infrastructure domain of the cultural competence model (See Figure 2), are most often implemented by administrators, working closely with funders and policy-makers. Such strategies are frequently reflected in mission statements, established governance policies, human resources procedures, and other components associated with the infrastructure of an agency. However, implementation of these Organizational Infrastructure Strategies can shape whether and how direct service strategies are used to address the needs of racially/ethnically diverse children and families. The Organizational Infrastructure Strategies that were identified and described through this study are:

Organizational Infrastructure Strategies

- Flexible Financial Arrangements
- Multiple Reciprocal Relationships
- Expanded Array of Services
- Staff Characteristics
- Staff Training and Development

It is important to note that the strategies presented as part of this study do not exist in isolation of the other domains of the cultural competence model. That is, implementation of a direct service strategy designed to increase access to services for a particular population should be supported at the organizational level through specific governance procedures, creative and flexible funding of services, and other strategies that will support direct service personnel in their efforts. Further as Figure 2 makes clear, compatibility between the organizational infrastructure and direct service domains is as important as the larger compatibility between an organization (or service system) and the target population(s) within a community (See Figure 1). In addition, since the direct service components (accessibility, availability, and utilization) within an organization are also interrelated, it is difficult to isolate strategies designed to increase accessibility from those that address utilization or availability of services. Despite these noted interrelationships, it is easier for the purposes of analysis to classify strategies within a single domain of the cultural competence model. Based on this rationale, the focus of this monograph is primarily on strategies that improve access, while availability and utilization strategies will be addressed in separate monographs. Findings related to interrelationships and compatibility among domains will be discussed in the closing sections of this monograph.



African American/Black Populations

Staff at these organizations reported that they recognized the cultural differences among multiple Black populations and African Americans and described ways that they try to respect the cultural differences within their respective user populations.

Increasing Accessibility for African American/Black Populations

Four of the 12 sites studied served a majority of African American or Black populations, and these differed by organizational type: Site 04 is a community-based ethnic specific organization, Site 09 is a statewide non-profit organization, Site 11 is a federal System of Care grantee, and Site 12 is a managed care program (See Table 1). Two of these sites hosted visits by the study research team (Sites 09 and 12), while staff from the other two was interviewed by phone. The types of services delivered by these organizations were quite diverse, including substance abuse treatment, mental health services, family preservation, elderly services, developmental disability services, information and referral, and services designed for children with serious emotional disturbance (SED) and their families. Some sites provide services on a referral basis only. A description of each organization is available in the Appendix.

History and Context of African American/Black Populations Served

The African American or Black populations served by the organizations that participated in this study were culturally diverse with different social circumstances and mental health needs. Two of the study sites were located in the Midwest, one in the Northeast, and one in the South. Three of these sites report that 60% to 95% of their service population can be identified as African American or Black. This category can include one or more of the following: African Americans (native U.S. born) and immigrants from or descendants of Haiti, Nigeria, Somalia, and other African nations, as well as bi-racial or multiracial children. In some cases, bi-racial/multiracial children were being raised by White grandparents seeking more information on how to raise their grandchildren in an environment that was respectful to all of their grandchildren's cultures.

Staff at these organizations reported that they recognized the cultural differences among multiple Black populations and African Americans and described ways that they try to respect the cultural differences within their respective user populations. As one direct service respondent mentioned when discussing his work with adolescents who are at risk or have SED:

We try to do our best to be aware of the cultural differences and... not try to step on their toes or their family or cultural values. We try to work close with the families to make sure that we carry out their values outside of the house. If they don't let the kids do something in the house, we try not to let the kids do it outside, when they're out with us. That way there's no confusion or misunderstanding (personal communication, interview participant, Site 09).

Respondents at sites with high or growing proportions of immigrants also noted that language barriers made it especially difficult for parents to find services for children with mental health or other needs. When discussing beliefs and views about mental illness and other needs, respondents who served Black immigrant children and families noted that parents often consider emotional or behavioral disturbances as “disciplinary problems,” or that children need to be disciplined more for “improper or inappropriate behavior” rather than a specific condition or symptoms that may need to be addressed by professionals or practitioners.

Respondents also noted that there was often resistance on the part of parents who felt that mental illness was shameful or would stigmatize the family or child.

Respondents who served primarily African American populations often noted the importance placed on family ties and spirituality in many of the families with which they worked. However, these respondents also noted that family members should be treated with respect and that service providers should not assume to know the cultural and spiritual preferences of African American families and individuals. As one administrative respondent noted,

People think because they read in [a] book about a particular culture—because of course they have books on every single culture and how to do effective therapy with African American culture—aha, I know how to deal with African Americans (personal communication, interview participant, Site 04).

Another direct service respondent noted that it was even important to ask families how they prefer to be identified to let family members know that their input is respected: “Sometimes it’s the difference between African American and Black” (personal communication, interview participant, Site 12). Various respondents who discussed the strengths of African American families also identified resilience in African American individuals, families, and communities as a major factor in surviving and overcoming the hardships faced by African American/Black populations throughout this country’s history.

The issues addressed by the organizations participating in this study who served African American children and youth, include: serious emotional disturbance, mental health diagnosis, involvement in the juvenile justice and child welfare systems, truancy, runaway, and gang involvement. A number of respondents noted that the majority of the families they served were poor and had limited access to transportation. Respondents at various sites also noted that domestic violence and anger management were important issues affecting families that might negatively impact children’s mental health. One site in particular (Site 04), offers domestic violence and anger management services with an emphasis on acknowledging historical trauma in African American populations (Williams, Neighbors, & Jackson, 2003), as well as a positive emphasis on “Black Identity and the Black Experience.” According to respondents at this site, their programs allow individuals and families to place mental health and other issues in context—for instance, anger expressed on the part of families might be related to frustrations related to how discrimination and racism exacerbate the difficulties of poverty, which many families have experienced for generations.

Strategies Used to Increase Access for African American/Black Children and Families

Organizations working with African American/Black children and families identified culturally-specific strategies they employed to ensure compatibility with their clients. These organizations emphasized the importance of accommodating specific logistical issues as well as developing trust and engaging the family and children in the service planning and assessment of its effectiveness.

Respondents who served primarily African American populations often noted the importance placed on family ties and spirituality in many of the families with which they worked.

At site 04, respondents reported that therapists and counselors were often used to conduct intake with families to help families feel that they are receiving the services that they need as soon as possible.

Direct Service Strategies

Simplified and Accessible Intake Process

Direct service respondents at various sites that serve a high proportion of African American/Black children and families noted that intake procedures often serve to begin the process of collecting information about a family's cultural and other preferences with regard to services and treatment. A direct service respondent at Site 09 noted the importance of recognizing family input during personnel's earliest interaction with them:

[The families] are usually very straightforward. "This is what we want." They ask questions with regard to parental preferences for how to work with their children related to curfew, requirements before recreational activities. We try to talk to the parents one-on-one and try to get a feel of what is acceptable (personal communication, interview participant, Site 09).

At site 04, respondents reported that therapists and counselors were often used to conduct intake with families. This practice is used intentionally to help families feel that they are receiving the services that they need as soon as possible, and avoid discussion of "personal" or "private" information with personnel not participating specifically in treatment. This finding appears to corroborate similar findings in the research literature (Flisher, Kramer, Grosser, Alegria, Bird, Bourdon, Goodman, Greenwald, Horwitz, Moore, Narrow, & Hoven, 1997; Gong, Gage, & Tacara, 2003; Kramer, Kwong, Lee, & Chung, 2002; Sue, 1994).

Increased Engagement and Responsiveness

Staff at Site 04 reported that they had begun using incentives to engage youth involved in the juvenile justice system or in substance abuse programs more successfully in services. Most often gift certificates are used to reward demonstrated progress in group therapy and regular attendance to meetings. According to one respondent, the agency uses incentives to motivate change within their user population and reinforces the use of a technique known as "motivational interviewing," which focuses on "eliciting behavior change by helping clients to explore and resolve ambivalence" through a client-centered, directive counseling approach (Rollnick & Miller, 1995). Further, personnel also make it a point to have youth and families meet with their therapists informally before intake and before they start therapy so that "they feel engaged by the therapeutic process and don't feel as if they have to share all of their personal information with other staff who will not be treating or addressing issues" (personal communication, interview participant, Site 04). During interviews, the use of incentives and innovative approaches to therapy were further characterized as a way to "to get away from confrontation in therapy with Black families." These efforts highlight the importance of understanding community context and preferences with regard to trust-building and rapport that can strengthen the relationship between providers and family members.

Maintaining a Supportive Family Focus

All of the sites visited during this study illustrated use of this strategy as a conscious way to build upon rapport and engagement with families by identifying family strengths and including the family in the care and treatment of children and youth. Much of this emphasis on family strengths is illustrated by the ways in which direct service personnel work with families—especially those sites which employ Wraparound Services and/or Family Team Meetings, where family members play an integral role in directing service plans. Many of the African American serving organizations who participated in this study reported encouraging family involvement in treatment/services in different ways. For instance, Site 11, which serves high rates of African Americans, provides peer support services to families of children and youth who have been referred for mental health services. These peer support workers help family members better understand the mental health service system, child and family rights, and how to advocate for those rights. Personnel at Site 04, by contrast, reported developing programs that incorporate a family's particular historical context and experiences with discrimination. Site 12, which provides services through court-ordered referrals, instituted a program where family members are asked to critique services, internal personnel, and personnel at partner agencies through a confidential system that does not require identifying individuals making complaints or seeking changes in service delivery. Respondents credited this system with improving service delivery by taking family comments seriously and addressing issues in a timely manner.

Community Outreach

A majority of the sites working with this population reported use of outreach strategies to increase knowledge of their agency and services within their target communities. Respondents at two of the sites reported that they did not conduct outreach activities with communities because services were available to a restricted target population. One site, in particular, noted that they did not “advertise” services beyond their target population, which are referred by court order only. However, data collected from this site indicate that this organization does conduct outreach activities to families involved in their programs, including education about mental illness and available services, as well as providing similar information at meetings with representatives from other service systems, policymakers, and funders. Various respondents at all four of these sites identified a number of different activities designed to provide information about their agencies and services to the local community. Activities reported include attending community health fairs, hosting informational tables at local community events, making presentations, and connecting with local leaders and/or important community organizations.

All of the sites visited during this study illustrated use of this strategy as a conscious way to build upon rapport and engagement with families by identifying family strengths and including the family in the care and treatment of children and youth.

Currently, the agency is seeking licensing as a community mental health provider, in order to provide in-house specialty services, including general counseling and grief therapy.

Organizational Infrastructure Strategies

Flexible Financial Arrangements

As a managed care program, Site 12 receives funding from diverse sources, including the state bureau of child welfare, various county divisions (e.g. mental health, delinquency, and court services), and Medicaid. The agency pools all of these funds to ensure the highest degree with regard to flexibility of funding for programs. As a result, Site 12 is able to avoid capitation rates for particular services. As one administrator noted:

[T]he flexibility is entirely with [us] to use that funding in the ways that best meets the needs of the child. We don't set a cap rate, say X% is for mental health outpatient hospital and X% is for therapy and X% is for substance abuse and X% is for hospital inpatient. That's entirely left up to the program based on the individual service plan and the needs of the child. So I would say there's complete flexibility there (personal communication, interview participant, Site 12).

Administrators at Site 12 also meet yearly to establish rates for services, and these are established according to the overall budget received by the agency. While administrative respondents indicated that budgetary changes and issues are discussed informally throughout the year, the yearly meeting serves to set rates and assist in identifying services or programs that will need funding in the following year.

Site 09 uses funding from diverse sources to develop and sustain distinct programs. For instance, funding specified for child welfare was used to develop an intensive case management program that addresses the needs of children at-risk of being removed from their homes. Funding from the state division of mental health that requires addressing the cultural needs of families has been used to develop and sustain a peer support program that promotes leadership and knowledge of mental health among ethnically and racially diverse parents. Participation in one program does not necessarily preclude a child or family from participation in another.

Expanded Array of Services

Administrators at Site 04 discussed efforts that they had made over the past decade to increase mental health services for African Americans, especially given high rates of incarceration and lack of services in the community. Currently, the agency is seeking licensing as a community mental health provider, in order to provide in-house specialty services, including general counseling and grief therapy. These programs would be open to service users in substance abuse programs, as well as to the community at large. In this vein, they are also seeking licensing to provide therapeutic support services for children. Once licensing is secured in these and other areas, additional funding for programs would become available to expand their current service array. The ultimate goal, according to administrators would be for Site 04 to open a mental health clinic which would provide a wide range of specialty services.

Another initiative that Site 04 administrators would like to develop in conjunction with their expanding mental health services is establishment of a psy-

chological residency program that would specifically recruit applicants of color that represent the largest groups in the community. The proposed program was described in the following manner:

[W]e hope to be opening what we're affectionately calling a Brown Clinic which would be for residents, I'm saying psychiatric and psychological residents to do fellowships from the diverse communities here in [state], which is generally Hispanic/Latino, African American, African which is Somalian, (we're probably the biggest Somali population in the country), and Native American. And the vision around that is that once we establish this Brown Clinic that we would collaborate with those communities to bring their residents and psychologists in for a year to not only study but complete their residency or licensure requirements [here]. That's a big growth initiative and also I think something that is hopefully going to be a model type of program for working with diverse communities (personal communication, interview participant, Site 04).

Staff Development and Training

Administrators at Site 04 discussed the importance of providing continual cultural competence training to their personnel, even though the majority of their staff are members of the local community. They also reported emphasizing cultural competence during clinical case consultation with providers. One of the more innovative aspects related to their training of staff relates to the material that administrators and others have compiled to train staff regarding the provision of culturally competent services to African Americans. The training program focuses on historical trauma in Black populations and was described in this manner:

We have a home-grown clinical curriculum that is generally introduced in almost all of our programs around the construct of Black emotional pain, and that is something that all of our programs refer to a little bit or use a little bit of in one form or another as a way to help African Americans coming into treatment to be able to acknowledge how to go about being African American and where they're at with their identity and the community and if there's things that they feel oppressed about. So we generally introduce that to all of our staff (personal communication, interview participant, Site 04).

Strategies that increased access for African American/Black families at the organizations participating in this study highlight the need for organizations and their staff to work toward understanding the history of the community and to develop a positive relationship with the community based on trust. Appropriate adaptations of intake processes, knowing how to engage families, and providing adequate support for their efforts in seeking help for their children are all dependent upon understanding the specific beliefs and experiences that have served as barriers in the past. These strategies need to be developed in addition to the fundamental strategies described in the previous section, and are not adequate without them. For example, depending on the presence of diverse staff to ensure compatibility with the community is not sufficient to develop community trust or fully engage families in services.

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Asian and Pacific Islander Populations

Examples of specific populations

served include Mien, Hmong, Mandarin or Cantonese Chinese, Cambodian, Filipino, Sikh Indian, Laotian, Korean, Japanese, Thai, Samoan, Punjabi, and Taiwanese.

Increasing Accessibility for Asian and Pacific Islander Populations

Two of the 12 organizations in this study served a substantial number of Asian and Pacific Islanders (API). Site 05 is a community-based ethnic specific organization, and Site 10 is a public county behavioral health provider (See Table 1). Both of these sites hosted visits by the study research team. Services delivered by Site 05 covered a wide range of social, medical, educational, legal, and mental health needs for 30 different API ethnic populations of all ages. Site 10 was responsible for overseeing and providing the county's public health and behavioral health services for all ages and populations, including a large Vietnamese community, and had integrated cultural competence into many services through the influence of a cultural competence department. This site contracts with regional clinics and community-based providers and co-locates clinicians at these sites. A more detailed description of each organization is available in the Appendix.

History and Context of Asian and Pacific Islander Populations Served

Organizations in this study serve API populations from a variety of backgrounds, experiences, and age groups including immigrants, refugees, and American born. For example, at Site 05 clients speak over 30 languages and dialects. Examples of specific populations served include Mien, Hmong, Mandarin or Cantonese Chinese, Cambodian, Filipino, Sikh Indian, Laotian, Korean, Japanese, Thai, Samoan, Punjabi, and Taiwanese. There are also a growing number of families comprising a variety of ethnicities, both Asian and non-Asian, and different levels of acculturation. Some families have lived in the United States for several generations and have many connections in the community, but many are first generation immigrants who are socially and linguistically isolated.

Site 05 serves over 1,300 children, youth, and their families annually. Among those served 85% are from low-income households and 88% are youth of color, of which 75% are API. The population of children and youth served by Site 05 is also described as at risk and low income, with many single parent families or two parent families in which both parents work for low wages. Many clients depend on Medicaid, but some immigrant families do not have any insurance. Children who are referred to Site 05 are most often children of immigrants or refugees, although some youth have been refugees themselves. Children who are born in the United States are highly acculturated and bilingual, while parents often speak another language, which results in generational and cultural clashes with their children. Although the expertise and language capacity of Site 05 is targeted to serve those who identify as API, the agency's culturally competent and holistic service model has been helpful to those from other immigrant and refugee backgrounds, most recently those from East Africa and Eastern Europe. Children and youth are referred to Site 05 for a range of issues including low school attendance, depression, selective mutism, eating disorders, destructive behaviors, low school achievement, and getting into fights. Referrals may also relate to family issues such as divorce, poverty, dysfunction related to cultural factors, serious domestic violence (including homicide), sexual assault, and gambling. The most common mental health problems across all clients include schizophrenia, depression/anxiety, and chronic pain associated with Post Traumatic Stress Disorder (PTSD).

At Site 10 the API population makes up a smaller percentage of the clients served (14%) but includes the largest community of Vietnamese in the country. Respondents reported that the agency's evaluation of local penetration rates showed API populations access services at substantially lower rates compared to White populations. The agency identified language and stigma as major barriers to access. Emerging populations such as Iranian, Korean, and Cambodian have also been identified through the agency's ongoing monitoring and data collection. In response to identified needs, agency forms have been translated into Spanish, Vietnamese, Farsi, Korean, and Cambodian languages.

Strategies Used to Increase Access for Asian and Pacific Islander Children and Families

Organizations working with API populations emphasized the importance of addressing the varied needs of a highly heterogeneous population in ways that were not stigmatizing in order to increase access. Developing compatible services with the population involved addressing needs related to acculturation levels of children and parents, being responsive to emerging community problems such as violence or gambling, and advocating for community support of mental health services. The following themes describe specific strategies employed by these organizations.

Direct Service Strategies

High Level of Responsiveness and Engagement

Site 05 uses task force committees to identify pressing community issues and needs. In the examples discussed during interviews, personnel mentioned the recent development of a program following identification of problems with teen gangs, sexual assault of young women, and high suicide rates among Asian teens. In this case, need identification and program development required substantial input at the administrative level, although direct service personnel were also involved in development and oversight of a peer advocate program for teens that resulted from the task force findings. Through this prevention program, staff members identify potential leaders from among high school students and train them to work as peer leaders and mentors for middle school students. Studies reviewed by the task forces and cited by direct staff during interviews indicated that among Asian teens, problems with gangs, sexual violence, and/or suicide would be discussed with peers rather than family members. In this case, direct service respondents indicated that they used their knowledge of the community—cultural preferences and characteristics related to help-seeking among teens—to shape the program and make it a success. An unanticipated outcome of this program was that some of the peer leaders have gone on to study social work in college and continue to work in the area of prevention.

Another service recently added to Site 05 was the placement of therapists with knowledge of the target communities at an elementary school with a high API population. At the invitation of the school principal, therapists keep weekly office hours at the school in order to reach API children and families that would not access services at the agency's main location. According to respondents from Site 05, this strategy appears to be successful in reducing the

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“shame factor” that prevents families from seeking help for mental health issues outside of the family or trusted agents such as schools. The organization's ability to respond quickly to the request for assistance from the school principal was an important factor in initiating this collaborative effort, and the ability of staff to communicate and gain the trust of families has maintained support for the program. An interview conducted with a school partner highlighted the importance of using knowledge about a family's culture in order to engage them in needed services:

Language is a big issue, but also trust. It's difficult for a lot of families to ask for help just because the shame factor is so huge in the Asian Pacific Island communities that they are really hesitant to ask for help unless they know the person that is going to be helping them. And [that] they feel a connection at the school where they can meet a counselor who they can trust is important because then they can begin telling their stories and what's happening at home. A lot of our families think that they can deal with things as a family, and they depend on the extended family so much for resources that when they meet another person that speaks their language it allows them a comfort that they can trust (personal communication, interview participant, Site 05).

Site 05 has also developed programs in collaboration with middle schools and high schools that include school based support groups and on-site case management. These services provide an opportunity for youth to discuss issues they face in a non-stigmatizing environment and open the door for referrals to other Site 05 or community services.

At Site 10, evaluators and administrators regularly analyze agency data to make recommendations for program changes. The cultural competence department staff works collaboratively with their information technology department to develop the needed data collection procedures. Client characteristics are tracked for each region served, including diagnosis, primary language, and age of client. Staff characteristics that are tracked include bilingual capacity, ethnicity, proficiency in reading/writing in another language, training received, and staff survey results. The Department also monitors the Cultural Competence Plan for all divisions and provides recommendations for updated plans each year based on data collected. Information reported in the Cultural Competence Plan includes county demographics, Medicaid eligibility, and specialty mental health services utilization by ethnicity, primary language, and age of beneficiary. The Cultural Competence Plan is also revised based on other research conducted by the cultural competence department. For example, in 2003 the plan was updated to include a requirement for all physicians, nurses, and clinicians at Site 10 to participate in ongoing cultural competence training as a part of their Continuing Education Units (CEU). This strategy was developed based on research that found very few post-grad programs include cultural competence in their training.

Flexible, Individualized/Culturally-Specific Services

One of the most unique practices identified during the course of this study was found at Site 05, where certified staff members were paid to serve as cultural consultants who could meet with other providers and address the cultural preferences and needs of diverse API children and families seeking services. The role of cultural consultants in this case is unique because it goes beyond translation and helps providers understand key concepts and preferences that may shape a treatment encounter. Agencies that determine they do not have such cultural expertise in-house are able to contract with Site 05 for cultural consultation services that are covered by funds made available through the county mental health system. County mental health administrators have found that this strategy has actually reduced the costs of serving diverse families within the system. Specific rules were developed to guide the development and implementation of this practice. For providers, this includes a stipulation that translation and cultural consultation services be provided by contract, which has led many mainstream agencies to work with Site 05. A direct service respondent at this site described the program in this manner:

If you are [a] mainstream agency with no understanding of the culture, they can consult with a particular ethnic minority specialist for cultural competency consultation. We do have consultants who give on-going consultation to mainstream organizations. And we charge them, too. The provider will meet on a particular case. It's case by case consultation. To qualify for that you have to be a Mental Health Professional, usually that will take a Master's level [course] and you go to 100 hours of training for ethnic minority specialist. That's one way of getting it, through continuing education with universities, certificate programs (personal communication, interview participant, Site 05).

Over time, the use of cultural consultants has also shaped the way the service system responds to culturally diverse individuals, as it established a basis for giving weight and importance to cultural characteristics in *addition* to linguistic differences. Through their work with cultural consultants, mainstream providers were given the opportunity to learn about key *cultural* differences within API populations that they may not have noticed, even if they were aware of differences in language. Maintaining a pool of cultural consultants also provided Site 05 with a key opportunity to establish and maintain relationships with universities and other certifying agencies that could provide the necessary training for future consultants. A clinician who works closely with Site 05 described the cultural consultation services in this manner:

(O)f course the language and the cultural consultation is enormous... It is... How could we have this appointment without a translator? And then having someone who can help me know what will likely happen if I talk about ADHD in the culture, or depression, so just having some consultation about what would be the most culturally congruent way to discuss the symptoms, or to tell me about how they might take care of it in their culture of origin. I think all of that is really important (personal communication, interview participant, Site 05).

Over time, the use of cultural consultants has also shaped the way the service system responds to culturally diverse individuals, as it established a basis for giving weight and importance to cultural characteristics in *addition* to linguistic differences.

Direct service staff also

regularly volunteer their time by participating in community events and giving presentations at public events in the community, which they feel increases awareness and comfort with approaching the agency for help.

Community Outreach

According to study respondents, Site 05 increases access through emphasizing staff and organizational outreach to individual clients and their families, as well as to the community at large. The organization allows flexibility in staff schedules to accommodate time spent in the community to reach API populations. At both Site 05 and Site 10 direct service personnel are involved in community events, while Site 05 is also involved in sponsorship and advocacy efforts for the API community. At Site 05 outreach is carried out on every level of the organization, from the executive director and Board, to direct service staff. For example, the director is involved in partnership meetings with program directors from around the state, and a variety of staff are involved in community coalitions and partnering with other ethnic-serving organizations. The director and staff were also involved in advocacy to increase non-Medicaid funding, which would fund services for many API families. Site 05 was directly involved in meeting with legislators and facilitating the attendance of clients at a state legislative event during which they spoke with legislators and expressed their concerns. Direct service staff also regularly volunteer their time by participating in community events and giving presentations at public events in the community, which they feel increases awareness and comfort with approaching the agency for help.

Addressing Stigma/Mental Health Terminology and Translation

According to respondents at Site 05, the ability to offer services beyond mental health services that meet the practical needs of the community opens a way for clients to access Site 05 without the stigma that might be associated with visiting an identified mental health clinic.

We offer not only the mental health piece, but we also offer the practical, the useful things that families do need. And we don't just sit in our office and wait for our people to come to us, we go out into the community, we go out to see the families, we go out to see the schools, we're everywhere and the parents appreciate that. And especially refugee and immigrant populations, they're so reluctant to trust, and if we can help them it's always a good way for us to get in (personal communication, interview participant, Site 05).

Asian staff members at Site 10 participated in a recent effort by the cultural competence department that examined agency forms to identify terms that had not been translated well. During this process it was found that some words were actually translated in a way that could have very negative effects on efforts to increase API participation in needed services. A review of some forms noted that the word “psychiatrist” was translated as “witch doctor.” In addition, the document review found that terms were not used consistently across forms prompting personnel to establish preferred translations, which were then incorporated into all forms used within the agency.

Organizational Infrastructure Strategies

Flexible Funding Arrangements

Respondents who worked at API-serving agencies and organizations described numerous creative ways in which they generate and use funding to provide services at affordable costs. However a number of respondents highlighted the difficulty in serving uninsured families, especially those from undocumented populations. This difficulty was most often faced by larger and more traditional organization where funding streams from the federal government can be restrictive. In such cases, families were referred to community-based agencies and organizations, including churches where such services may be provided at low or no cost and/or with no insurance or documentation requirements.

Respondents at Site 10 indicated that their sub-contracts with community-based organizations require that they deliver services to a predetermined number of children and families who are either uninsured or had no available funding for mental health services. Site 10 has also developed contracts with agencies that are already working with Asian monolingual populations to co-locate clinicians. Specific training is offered for all staff based on populations served (e.g., PTSD and intergenerational issues for Vietnamese youth). Personnel at Site 05 noted that they try to be flexible when scheduling appointments to help clinicians build relationships with children and families. Through participation in a county mental health system partnership, Site 05 has been able to advocate for cost differentials for culturally-specific service accommodations (e.g. longer intake and counseling sessions, more flexible lengths of treatment including allowances for periods of inactivity, and use of cultural interpreters). Site 05 has worked with other ethnic specific providers in the community to advocate with county mental health to identify the time, expertise, and effort required to provide such culturally appropriate interventions. As a result, cost differentials were developed for culturally-specific services and language interpretation provided by trained individuals and agencies that have contracts with the county.

Multiple Reciprocal Relationships

Both Site 05 and Site 10 developed strong partnerships with universities and/or professional organizations to increase opportunities for health professionals to gain internship experience in serving API populations. Site 10 works with local universities and community-based clinics and other contracted providers to provide clinical training and supervision opportunities with API populations for graduate interns. In this way, they were able to expand mental health services to children and families, as well as provide new learning opportunities for emerging mental health professionals. Over time, this relationship has resulted in numerous clinical placements and credentialing opportunities for professionals interested in working with racially and ethnically diverse populations. Site 05 is one of six training sites across the nation to implement “Growing Our Own,” a project of the National Asian and Pacific Islander Mental Health Association that trains masters- and doctorate-level interns to develop cultural competency in working with API clients.

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Site 10 has sought to integrate cultural competence into services through development of a Cultural Competency and Multi-Ethnic Services Department within the agency.

Staff Training and Development

As a countywide provider, Site 10 has sought to integrate cultural competence into services through development of a Cultural Competency and Multi-Ethnic Services Department within the agency. In order to increase its impact, the Cultural Competence and Multi-Ethnic Services Director's position was established at the middle management level, and reports directly to the Medical Director. Early and continued top administration buy-in has allowed the department to become an integral part of the agency, including regular identification and reporting of cultural competence needs, and development of training or other resources to fill these needs. The creation of a department also included a substantial investment in staff that is able to focus on cultural competence activities without additional clinical responsibilities. Services provided by staff include consultation, training on cultural competence, training on strategies to improve access and penetration rates, interpreting data on changing demographics and service utilization patterns, and developing recommendations for addressing gaps in services. Although the Department is located in and funded by the Behavioral Health Division, it is also used as a resource throughout the organization and by other public sector partners including hospitals, schools, social services, and juvenile justice.

Strategies that increased access for Asian and Pacific Islander children and families were developed based on specific populations served by organizations in this study. Appropriate adaptations of services depended upon how recently a child or family member has migrated to this country, refugee status, and the acculturation levels of parents and children, as well as their nation of origin. In order to ensure compatibility with API populations it is important to consider variations within the population and changing characteristics over time as acculturation occurs. Organizational strategies are needed that support a diversity of linguistic and cultural backgrounds among staff members, as well as a diversity of issues that might need to be addressed within various API populations. Challenges to meeting these staffing needs continue, but efforts to increase the eligible pool are being developed by participants in this study.

Increasing Accessibility for Latino Populations

Five of the 12 sites studied served a majority of Latino populations, and all of these were classified for this study as community-based organizations, although two of these organizations did not provide mental health services as a primary part of their service array (See Table 1). One of these sites (Site 01) was identified as a Community Development Corporation, a non-profit organization that provides a wide range of housing and social services at the neighborhood level. The other organization (Site 02) that did not provide specialty services, did offer support groups for women who were victims of domestic violence, child/youth prevention programs, as well as information and referrals to partner mental health clinics. Sites 06 and 08 are non-profit organizations that provide a variety of mental health and family support programs in the Northeast and West Coast, respectively. Site 10, is a department within a county behavioral health division on the West Coast that serves a number of diverse populations, of which 35% are Latino. Services provided by these organizations, included therapy and counseling for individuals and families, intensive day treatment for adolescents, family support and intensive case management, partial hospitalization, residential programs, child care and Head Start programs, after school programs, family preservation services, system navigation, and family education services. Two of the sites (Site 01 and Site 02) highlighted in this section hosted visits by the research study team, while staff from the other three sites were interviewed by phone. A more detailed description of each organization is available in the Appendix.

History and Context of Latino Populations Served

The Latino populations served by the organizations that participated in this study were culturally diverse with different social circumstances and mental health needs. Two of the study sites were located in the Southwest, one on the West Coast, one in the Pacific Northwest and one in the Northeast. All of these sites reported that between 50% and 95% of their service population can be identified as Latino. This category can include descendants or immigrants of one or more of the following nations of origin: Mexico, Puerto Rico, Dominican Republic, Ecuador, Nicaragua, and other nationalities from the Caribbean, Central and South America, as well as indigenous groups from Mexico for whom Spanish is a second language. In many cases, English was not the primary language for the populations served by these organizations, making language an important barrier to services for children and families. The lack of fluency in English was characterized by respondents at each of the sites highlighted in this section, as a prime factor in the lack of knowledge about available services within the target Latino communities served. A number of sites also noted serving a significant number of undocumented families or individuals, and that funding/legal restrictions often made it difficult to serve this population adequately.

Respondents at each of these sites noted differences between particular populations based on different national and cultural traditions. For instance, respondents at Site 06 noted differences in the way Spanish is spoken in different countries of Latin America and the Caribbean—especially with regard to particular words that may be acceptable in one country or region and vulgar in

Latino Populations

The lack of fluency in English

was characterized by respondents as a prime factor in the lack of knowledge about available services within the target Latino communities served.

Generalized cultural characteristics that they felt were important for service providers to recognize when working with Latino populations included generating trust and creating an atmosphere that was variously identified as “informal,” “personable,” “comfortable,” or “familiar.”

another. Respondents at various sites also noted cultural differences with regard to communication styles—some groups were characterized as being “introverted,” whereas other groups were characterized as being more deferential to doctors and other professionals and less likely to vocalize concerns in public or professional settings. Differences in cultural norms and communication styles were noted by personnel at Site 02 as being more pronounced within populations of indigenous Mexicans, who were identified as unwilling to share concerns or problems with neighbors and/or multiple staff members. Rather, indigenous family members preferred to work with one staff member, and often worked with that person exclusively. A respondent at Site 01 discussed the importance of recognizing the cultural differences within the larger Latino population. As an example, he noted that the term “family,” itself, is a cultural concept that is defined differently even among members of the same cultural group or population. He noted that Hispanic families include nuclear families where men assume a dominant and central role, families that include grandparents living within the home, single-parent households, and nuclear families where women have a great degree of independence and decision-making power. Therefore, he cautioned, against placing individuals in conceptual “boxes” defined solely by their cultural heritage.

A number of respondents also highlighted generalized cultural characteristics that they felt were important for service providers to recognize when working with Latino populations. The first of these is the importance of generating trust and creating an atmosphere that was variously identified as “informal,” “personable,” “comfortable,” or “familiar” within interviews. To illustrate, a respondent at Site 06 described the relationship that his organization’s staff has with the individuals and families that use their services:

We have the same backgrounds. We share the common experience of being immigrants [and] that helps us relate to clients. We have this warmth ingrained in treatment and services. [The agency] reproduces culture, [because] the secretary smiles and is not distant, [and] she knows patients by name. She asks them about it when they miss [an appointment] and shows that she worries about them. She promotes mental health, too, not just the counselors. There is a community in the office...it becomes like a family...there’s familiarity and we’re not anonymous (personal communication, interview participant, Site 06).

Respondents at other organizations provided similar responses with regard to their service delivery practices and noted that they maintained very flexible hours, accepted walk-ins, and in one case, allowed individuals to “hang out” in the offices socializing with other community residents and/or direct service staff. Respondents also noted the importance that service users placed on family support and encouraged the participation of family members in treatment when possible. Respondents from various sites reported that individuals who did not have support from family members were often the individuals who faced the greatest challenges with regard to improvements in recovery.

A number of respondents identified barriers to access related to social and cultural factors. For example, respondents mentioned stigma as a barrier among

the Latino populations they served with regard to mental health and behavioral issues. It was noted that parents were often resistant to receiving mental health services because they felt that mental illness was shameful or would identify the child or family as “crazy.” Respondents at multiple sites also reported that parents often considered emotional or behavioral disturbances as “disciplinary problems” that required more/harsher discipline for their children. However respondents at Site 02, in particular, reported discussing the mental, behavioral, and emotional needs of children with caregivers as a challenge that needed to be addressed in order to ensure the child’s educational success. In this way, direct service staff appealed to Latino parents’ desire to help their children succeed in school, as well as help parents feel that they were complying with school and other institutional regulations. A number of respondents also noted that the majority of the families they served lived below the Federal Poverty Level, with limited access to transportation, which hindered their ability to access the services for which they were referred. Respondents also emphasized the barriers that exist for undocumented families or individuals, which including hesitancy in seeking help for problems or issues even when they acknowledge needing them, because of fear of arrest or deportation.

The issues addressed by the organizations participating in this study who served Latino children and youth, include: serious emotional disturbance, mental health diagnosis, persistent mental illness, involvement in the juvenile justice and child welfare systems, gang involvement, domestic violence and violence in the community.

Strategies Used to Increase Access for Latino Children and Families

Organizations working with Latino children and families have developed culturally-specific outreach and engagement strategies that are compatible with the linguistic and cultural characteristics of their clients, including immigration and acculturation differences. In spite of variation within Latino populations, all organizations emphasized the importance of maintaining a professional yet welcoming atmosphere that built personalized relationships with their clients. Working with families in a holistic and respectful manner was also important, and was carried out by either meeting needs directly or connecting families to known contacts in other agencies. It was also important to be considered a part of the community and to reduce the emphasis on “mental health” in order to increase willingness to seek services.

Direct Service Strategies

Broad Referrals and Connections

Most of the organizations that served majority Latino populations were characterized in interviews by personnel as being the only organization in their respective community or city that provides culturally sensitive mental health and family support services. Because of this, they noted, a number of the individuals and families that they serve were referred to them by other providers who did not maintain bilingual/bicultural staff. However, staff at some of these organizations also reported developing relationships with a variety of providers in the commu-

In spite of variation within Latino populations, all organizations emphasized the importance of maintaining a professional yet welcoming atmosphere.

They also emphasized the importance of having an intake process that takes less than an hour and limits the number of intrusive questions during the initial contact with parents and caregivers.

nity to help increase access to a broad array of services for their target population. Maintaining relationships with direct service personnel working in other agencies allowed them to personalize the process for the children and families that they serve by establishing a point of contact in the receiving organization. At Site 08 respondents described a specific agency policy that supports their efforts to meet the needs of clients through connections with other organizations.

The other thing we do is here is something called, we call it, 'No Wrong Door,' which means that if you come to us and you don't fit the criteria, if we can't help you, we will sit down and find somebody who will. We will make the phone calls. We'll make the referral. We'll contact somebody and make that connection. We don't just turn somebody away and say, 'Sorry, you know what, we can't help you.' And that is something that we have always made an effort to do, and we follow up After you get so many doors slammed in your face, it really gets discouraging [for families]... (personal communication, interview participant, Site 08).

Further, direct service staff use relationships with staff at other organizations to facilitate the referral process for Spanish-speaking service users. Respondents emphasized the importance of making introductions and explaining services in a culturally and linguistically appropriate manner when connecting clients to other organizations. According to respondents, these efforts at helping families connect to services are needed to address not only linguistic barriers, but also a lack of familiarity with services and reluctance to seek formal mental health services. The lower acculturation levels and shorter lengths of residence in the United States of families served by organizations in this study were named as important contributors to the development of these referral practices. These practices correspond to help-seeking strategies of ethnically/racially diverse and immigrant families that have been reported in the literature (Gong, Gage, & Tacara, 2003; Hernandez et al., 2006; Kramer, Kwong, Lee, & Chung, 2002; McMiller & Weisz, 1996; Sue, 1994).

Simplified and Accessible Intake

Direct service respondents at various sites that serve a high proportion of Latino families stressed the importance of conducting intake at times and locations that were convenient to the family. For instance, personnel from Site 08 reported doing intake during a parent's lunch hour in an effort to accommodate family members' schedules. For less acculturated families and those with lower incomes this was especially important because of limited flexibility in their jobs or transportation options. They also emphasized the importance of having an intake process that takes less than an hour and limits the number of intrusive questions during the initial contact with parents and caregivers, giving them some time to warm up to direct service staff before addressing topics that may be considered shameful, frightening, or associated with stigma. Respondents at a variety of sites, including this one, noted that for families of color, information about family problems, mental health issues, and children's behavioral issues, among others, is often seen as "private" and not to be discussed with individuals outside of the household.

High Level of Responsiveness and Engagement

Respondents at Site 02 reported that they relied heavily on satisfaction surveys that families are asked to complete regularly while participating in programs or services. Direct service workers reported conducting short interviews with family members (whom they are not serving directly for purposes of confidentiality) to assess satisfaction with services. During these interviews, personnel also solicit information or suggestions that might lead to new programs or adaptations to existing programs. An innovative program that promotes literacy in parents and introductory reading for toddlers in tandem was developed from such suggestions in this case. When a staff member asked a parent for input on how to increase support within the home for children's reading and education, the parent responded that only if adults knew how to read and recognized the value of this skill would parents support reading in their children. Further, a program that would allow parents to stay with their children was thought to be more appealing to Latino families, another important factor identified through interviews. As a result of these suggestions, direct service staff created the dual literacy/reading readiness program to address this identified need. Respondents indicated that this level of responsiveness to parent-identified needs creates "more buy-in" on the part of families who are then more likely to continue with services and/or increase their trust in direct service personnel. Further, parents who felt that an organization was responsive to their needs were more likely to tell others about an agency or its programs. Respondents at all of the Latino-serving sites identified "word of mouth" as being an important way in which the community learned about their services.

Direct service staff created the dual literacy/reading readiness program to address this identified need. Respondents indicated that this level of responsiveness to parent-identified needs creates "more buy-in."

Flexible/Individualized/Culturally-Specific Services

Respondents at Site 07 emphasized the importance of maintaining flexibility when serving Latinos and other populations of color. According to an administrative respondent at this site, providing individualized services that respond to a child or family's needs is of utmost importance. This respondent compared Site 07 with other agencies in the area:

There are a lot of agencies that provide services similar to what we provide, but the one thing that I think that we uniquely bring to the service delivery system is that we are the least structured place. In other words, a lot of places provide cookie cutter treatment. If you have problem A, you're going to do B, C, and D to solve that problem. What we do is we try to uniquely match our services with the client and then try to allow them to have a dominant role in deciding what their treatment will include. And that is unique. Nobody else does that (personal communication, interview participant, Site 07).

The respondent went on to note that the agency is flexible in allowing service plans to remain open during periods when there is low participation—for instance, one visit per month—to demonstrate commitment to the family with the goal of engaging them in services even if it takes a longer period of time.

Direct service and administrative personnel at most of these sites reported addressing their outreach activities toward the important community networks that circulate information about services and other aspects of the service system to community residents.

System Navigation

Respondents at Site 02 reported that they accompany families to appointments with other providers or agencies. However, in this case the practice of accompanying parents to other services is not associated with a formal organizational policy. Although the ability to follow families through the service system and assist them in making meaningful connections at additional agencies requires administrative support, the personnel at Site 02 do not identify a specific organizational policy with this practice. Rather, the environment at this site is flexible enough to allow direct service personnel to implement strategies and practices that they identify as being effective in meeting the needs of children and families they serve. Administrators at this site reported providing support for this and other strategies through regular meetings and communication with staff. They also reported having a sense of confidence in the decision-making skills of their direct service staff because of the knowledge and experience their staff have through their work with the target population, or because direct service staff were recruited from the target communities and may have been service recipients in the past. Although implementation of this strategy at Site 02 was largely identified as occurring under the purview of direct service personnel, development of a supportive environment in which these relationships can thrive requires support at the organizational level.

Outreach to Community

Respondents at Site 01 defined outreach to the community broadly, including any instance where staff at any level could represent the organization by communicating a consistent message highlighting their knowledge of target populations and their success in working with these. Further, administrative respondents at this site reported hiring specific personnel to develop marketing strategies for programs and consistency in logos, publication materials, and all communication to the public. Other respondents at sites serving high proportions of Latinos also discussed their use of outreach strategies designed to increase referrals and interest in their programs within Latino communities. Further, direct service and administrative personnel at most of these sites reported addressing their outreach activities toward the important community networks that circulate information about services and other aspects of the service system to community residents.

Addressing Stigma/Mental Health Terminology

A number of direct service respondents discussed their efforts to address sensitively the issue of mental health with Latino families. They indicated knowledge of beliefs related to mental health within their target populations and reported using terms and concepts that are more compatible with families' own conceptions about mental health and illness. Direct service personnel at Site 02, which serves a high proportion of Mexican descent and indigenous Mexican families, indicated that they rarely used terms such as "mental health," "mental illness," and even "domestic abuse" when working with families. As one direct service respondent noted,

We can't come and talk to them about "mental health," it will scare them. And I think this is the problem when [agencies] develop a program, that we use terms the people don't understand and in that way we don't engage them (personal communication, interview participant, Site 02).

A number of direct service respondents at this site also noted the importance of using vocabulary that can be easily understood by family members, and avoiding medicalized jargon when describing their issues or problems. For example, discussing parents' concerns about a child in terms of problems at school, reactions to parental discipline, or changes in eating or sleeping patterns. Mental health services might be described as an opportunity to talk to someone who will listen carefully and work with the parent to help them figure out what is happening with the child, and helping the parent deal with stressors that affect the family's well-being. At Site 06 respondents mentioned the importance of explaining to parents the difference between the severity of conditions associated with mental illness in Latin America and the broader continuum of mental health conditions and services that are provided in the United States.

Responses from direct service personnel at other sites serving large populations of Latinos noted similar reactions to services labeled as "mental health" or treatments for specific conditions, such as depression. Another respondent noted, "Despite the fact that the term mental health may be foreign to a lot of communities, the idea of mental health is not" (personal communication, interview participant, Site 06). A respondent at Site 01 noted that domestic violence centers that were being established in the near future would be called "Family Centers" to avoid any negative connotation related to seeking services for domestic violence issues.

For respondents at Site 02, the way in which they discuss symptoms, problems, treatments, and services focuses on addressing specific behaviors or the consequences, as when a child is having behavioral problems at school resulting in more frequent contact with parents to address a child's issues. In such cases, direct service personnel reported that they would talk about the behaviors and how parents feel about being contacted by the school and teachers and whether they would like to find a solution for their child. Emphasizing behaviors (which can be changed), as well as the difficulties resulting from classroom disruptions for both the child and the parent would result in more responsive action on the part of parents, according to these direct service workers. Use of such a strategy appears to corroborate findings that suggest that Latino families are more likely to seek mental health services when a child's problems result in disruptive behavior, especially at school (Alegria, Canino, Lai, Ramirez, Chavez, Rusch, & Shrout, 2004). However as Alegria et al. (2004) also noted, direct service personnel must also work with families to address internalizing symptoms or problems that may not be as clearly evident or disruptive as problem behaviors. Such work requires even more attention to stigma and the use of terminology that is supportive to the child and family.

Mental health services might be described as an opportunity to talk to someone who will listen carefully and work with the parent to help them figure out what is happening with the child, and helping the parent deal with stressors that affect the family's well-being.

The organization has adopted a strategy of developing relationships with funders and policymakers and communicating clearly to them what they have to offer the community through a “branding” process and annual fundraising events.

Organizational Infrastructure Strategies

Flexible Financial Arrangements

Respondents at every site in this study discussed the ways in which their agencies use different funding streams to develop a broad service array. The funding options available to study sites differed by organizational type. For instance Site 01, a statewide CDC that provides a variety of economic and community development services in addition to other social services, is able to generate profits from some services. Because they are able to implement a number of programs that generate a profit, such as housing and property rental, they are able to use accumulated funds in other areas of the organization to develop needed mental health programs and services. The administrative structure of this site is corporate in nature and much attention is paid to the growth and economic strength of the organization in order to continue serving underserved Latinos and other populations within their state. The organization has adopted a strategy of developing relationships with funders and policymakers and communicating clearly to them what they have to offer the community through a “branding” process and annual fundraising events. Site 01 has also increased its development efforts with an emphasis on media coverage and strategic approach to developing compatible services for various racially/culturally diverse communities.

Staff Characteristics

Although many of the study sites placed an emphasis on hiring staff members from within their target population(s), respondents at Site 02 also identified specific characteristics and skills that were important for staff members to possess— especially at the direct service level. Two of these characteristics were mentioned by respondents at various sites—persistence and tolerance—as being of particular importance when working with communities of color. Although respondents didn’t always use these terms to describe desired characteristics among direct service staff, in particular, they did note the importance of maintaining efforts on behalf of families despite any difficulties that might arise during the service delivery process. With regard to tolerance, a number of respondents underscored the importance of hiring and developing staff to work with families in a way that identified cultural and other strengths, as well as understanding and accepting different cultural and family beliefs without judgment or in ways that could increase stigma to mental illness and treatment or services. While direct service respondents at Site 02 characterized working with families in this way as being motivated by kindness, more often, they qualified “kindness” as a way of working with families in a manner that respected their culture and language.

Latino serving organizations emphasized the importance of demonstrating respect in all actions, including with clients, among staff, and between administration and staff. The personalized nature of services also called for organizational flexibility in ensuring that scheduling and funding of these services was possible. This meant that organizations sought multiple sources of funding for which requirements for eligibility and billing varied. The ability to build and maintain strong relationships and a good reputation in the Latino community were key to the organization’s outreach, hiring, and service delivery approaches.

Increasing Accessibility for Native American Populations

Three of the 12 sites in this study served substantial numbers of Native Americans, and all of these were classified for this study as community-based organizations (See Table 1). One site (Site 03) serves Native Americans almost exclusively and is located in a large urban county on the West Coast. At this organization, a centrally located facility houses a wide range of mental health, prevention, family preservation, and health services. A second site (Site 01), which is located in the Southwest, is a Community Development Corporation that provides for-profit housing and community development services as well as a variety of social and behavioral health services. In this organization the services offered to Native Americans include parenting programs, a continuum of mental health services, and substance abuse residential treatment. The third organization (Site 07), which is also located in the Southwest, provides a variety of treatment and support services for mental health and substance abuse issues that include traditional and non-traditional indigenous approaches. Two of the sites (Site 01 and Site 03) highlighted in this section hosted visits by the research study team, while staff from the third site were interviewed by phone. A more detailed description of each organization is available in the Appendix.

History and Context of Native American Populations Served

Site 03 targets all Native Americans in a large urban West Coast county, which includes representatives from approximately 105 different tribes. According to the 2000 Census the American Indian and Alaska Native population was over 76,000, or 0.8% of the population in the county. The American Community Survey identifies only 49,164 as American Indians and Alaska Natives, but a total of 104,236 are identified as having some Native American heritage. Tribal groups with the largest numbers identified by the ACS include Cherokee (3,447), Chippewa (230), Navajo (4,310), and Sioux (494), but many others are also represented in the overall count, including those who also identify with another ethnic/racial group. About 40% of American Indians and Alaska Natives reported speaking a language other than English at home and among those over 25 years of age only 59% were high school graduates or higher, compared to 75% for the general population. The median household income for American Indians and Alaska Natives in 1999 was \$36,201, representing only 70% of the median income for the entire county population (\$51,315). The number of individuals below poverty level was estimated as 15,096, or 20%.

Children and families served by Site 03 vary in their acculturation and length of residence in the county. Some have lived in the area all of their lives, while others have moved recently from reservations or travel back and forth between their reservations and the area. Some are very traditional and speak tribal languages, while others “know that they are Indian, but they may not be as traditional...[for which] the identification isn’t as strong” (personal communication, interview participant, Site 03). Most families served by Site 03 speak English or are bilingual, but a few older adults speak their tribal language primarily. In these cases translation might be required, but staff report that “we talk it out. Generally it’s not a barrier.” Although some families moved to the area by their own choice, there are

Native American Populations

Children and families

served by Site 03 vary in their acculturation and length of residence in the county. Some have lived in the area all of their lives, while others have moved recently from reservations or travel back and forth between their reservations and the area.

The best locations for satellite sites were identified through a community needs assessment process that looked at geographic distribution of Native Americans along with recommendations given in focus groups.

also many whose ancestors were forcibly removed from traditional lands, or relocated from other parts of the United States by the government. Most families are aware of or personally experienced placement in boarding schools and have had negative experiences with research and social programs that promised improvements in services but did not deliver on these promises. These experiences have resulted in high levels of distrust in this community.

The majority of children currently served by the system of care (about 80%) at Site 03 are in out of home placement foster care and are referred through a unit that focuses on Native Americans at the Department of Children and Family Services. Referrals are also increasing from schools and juvenile probation. Common reasons for referrals are related to child abuse and neglect. The majority of child diagnoses include attachment disorders, depression, behavioral problems, anxiety, PTSD, and substance abuse (methamphetamines for children and women, alcohol for men). For women and girls, sexual abuse and domestic violence are issues in addition to other social and economic issues. For some of the children (particularly children with substance abuse) their family members or communities are also dealing with substance abuse issues. Children and youth who enter through probation are primarily referred for truancy and theft. Most who are truant have run away from home and are on the streets, stealing to get by, and getting involved in substance abuse.

Site 03 provides countywide services through a centrally located downtown facility but has found that satellite clinics are needed because of the distance and challenges of traffic in a large city. Long distances across the county make it difficult for families to attend appointments during the day due to lack of child care facilities nearby. Although case managers do conduct home visits, this is not always appropriate when there are other family members present. Some therapists also provide services in the schools but the types of services are limited. Site 03 has addressed these challenges through locating services at satellite sites closer to where Native Americans live. The best locations for satellite sites were identified through a community needs assessment process that looked at geographic distribution of Native Americans along with recommendations given in focus groups. In spite of being a challenge for some clients, having a central location for all services and functions of Site 03 has facilitated access for many families, especially those who need multiple services. The agency created a single service location for multiple services in order to reduce the challenges of having to travel to various locations to obtain services. Having a single main location also makes it easier for other providers to make referrals for families with multiple needs. One respondent at Site 03 described the advantages of a single location as follows:

We wanted to create a one-stop place for our children and parents. For example, parents would say that the system had so many requirements for them to get their children back. ... It's [the system is] almost set up for failure. They don't know where to go or what to do, and once they start failing they just go back to alcohol or drugs and just give up. At our agency for our community, is to be able to have as much services available as we can for the community (personal communication, interview participant, Site 03).

Staff at Site 03 describes issues faced by Native American children and families as too complex and difficult to limit to a single diagnosis. Common issues identified by staff include domestic violence, child abuse resulting in out of home placement, lack of “balance” or knowledge about “who they are as American Indians,” low graduation rates, and behavior problems. Staff also identified “multigenerational trauma” as a major or important issue, which has led them to emphasize working with both child and family. For example, there may be co-occurring substance abuse and mental health issues for both child and parent and little support from traditional extended family or tribe due to geographical separation. In addition, low SES often impacts families’ ability to provide basic necessities such as food and shelter, and limits transportation options to get to the downtown facility or participate in activities. Many adults also have low educational levels and some have criminal histories, which limit job opportunities and the ability to “get ahead.” Staff takes SES into consideration when arranging service appointments or inviting children to events, and includes making arrangements for transportation if needed. Access to services is also limited by lack of knowledge among children and families about where to go for help and lack of knowledge on the part of mainstream providers about the Native Americans in the county. Many providers are unaware of the existence of Native Americans in the county, have little knowledge of cultural issues that need to be considered, and do not know about culturally appropriate services that are available. Children and family members often describe themselves as being the only native person at their job site or school and have little support or connection with other native people. For these reasons respondents described the Native Americans in the county as an “invisible population.”

Although the primary populations served by Site 01 and Site 07 are Latino (90% and 50% respectively), the organizations also serve substantial numbers of Southwestern Native Americans. At Site 01 a recent expansion to providing statewide services has increased the number of Native Americans served in the northern regions, which include primarily Navajo and Hopi communities near reservations. The total Native American population reported by the ACS for the state served by Site 01 is 328,340, which includes those of mixed race as well as major tribal groups such as Cherokee, Chippewa, Navajo, and Sioux. A few Native Americans are also served in the urban areas through the continuum of services provided in low to moderate income communities. Services are provided in English, Spanish, Navajo, and Hopi, based on the needs of the community. Issues faced by Native American populations served by Site 01 tend to reflect complex combinations of depression, substance abuse, limited jobs, and low levels of education, and poverty, which contribute to child neglect or abuse. Staff reported that substance abuse is often related to child abuse and “cycles of abuse” that are perpetuated from one generation to the next. Site 07 provides a number of innovative and progressive services in an urban setting, including traditional Native American healing practices. The Native American population identified by the ACS in this county is 31,160. Native American clients from urban and surrounding rural areas are referred to Site 07 for mental health and substance abuse problems through a county referral process. Site 07 provides access to a variety

Staff takes SES into consideration when arranging service appointments or inviting children to events, and includes making arrangements for transportation if needed.

Organizations serving Native Americans

emphasized the importance of understanding and valuing both commonly held cultural and spiritual values and respecting individual family preferences.

of contracted clinicians from diverse ethnicities and professional backgrounds. Client match with providers is emphasized, based on the individual and family's cultural and therapeutic preference.

Strategies Used to Increase Access for Native American Children and Families

Organizations serving Native Americans that participated in this study emphasized the importance of understanding and valuing both commonly held cultural and spiritual values and respecting individual family preferences. The variety of tribes served and their isolation from either mainstream services (rural populations) or from other Native Americans (urban populations) required constant vigilance to avoid overgeneralization and promote both individual and collective Native identities. The strategies described below addressed these issues through outreach activities with various Native communities as well as outreach to partner agencies to increase knowledge about serving Native Americans. In addition, awareness of the impact of historical trauma was key to direct service approaches, which included cultural assessments and culturally adapted counseling approaches, as well as organization-wide strategies such as maintaining a supportive family atmosphere for staff.

Direct Service Strategies

Broad Referrals and Connections

According to respondents, accepting referrals from a wide variety of sources—both within and outside of an agency, as well as walk-ins or self-referrals—is an important aspect of providing services to Native American populations. All sites serving Native Americans have built multiple connections with other agencies in the community, including Indian Health Services (IHS) and/or between programs within their own organizations. Site 07 participates in a community-wide intake and referral process, and receives many referrals from schools. Site 01 depends upon its knowledge of available resources statewide to be able to connect families in rural Native American communities with the services they need. Site 03 is known both locally and statewide for the services, trainings, and resources that they provide. Staff members at Site 03 report that many departments call them because of the information, resources, and services they can use to provide or connect Native American families. These respondents also report that they have worked hard at building good relationships with both Native and non-Native providers in order to both receive and send referrals, including the courts, probation, and child welfare, from whom they receive a majority of referrals. Because the organization is a provider of residential services for the entire state it also maintains connections with providers across the state to be able to refer children back to their home communities.

Partnerships are sought with mainstream providers in order to broaden the services that clients can access at Site 03. Staff at Site 03 report building these partnerships by regularly identifying new contacts and visiting agencies, as well as making presentations and providing training on culturally competent ways of serving Native American families. According to interview responses, such work

has resulted in an increase of Memoranda of Understanding (MOU) between Site 03 and other providers, with a total of about 50 MOUs reported. Such agreements provide sources of referrals, as well as resources to which Native American clients can be referred. The trainings that are provided by Site 03 for non-Native organizations, in many cases required by the MOUs they develop with partners, increases the number of providers in the county who are able to work with Native American families.

High Level of Responsiveness and Engagement

Site 03 engages Native American children and families by emphasizing the importance of developing trusting relationships between families and the staff as well as the organization. Trust in the organization at Site 03 has been built over time through hiring staff from the community, hiring former clients, sponsoring community activities, and engaging the community in research. Former experiences with researchers who did not share findings with the community has resulted in a high level of distrust, which was addressed by training Native American community members and staff in conducting research and reporting results back to the community. Staff at Site 03 also engage clients by meeting immediate needs such as food or shelter, being friendly, demonstrating patience, providing quality services, and making sure that concerns they have voiced are being addressed. Site 03 staff point out that patience is especially needed in engaging families who are referred for services by the courts since families are not accustomed to seeking help outside the family or tribe and may be overwhelmed by the service system. Staff report that therapists need to exercise patience, attending to beliefs and needs of clients, and remaining alert to cultural influences that might slow down the engagement process. As one clinician put it,

Relationship and trust is the core of it and that's where word of mouth comes in. If you are providing good services and you have good staff that knows how to develop that relationship and trust, then the word gets out there and other people come to you and you keep reciprocating that. We are one of the only organizations in [this] county that is targeting American Indians so we have to provide the best services that we can for this community because they are not getting the services elsewhere. They are not even being identified. So that's really the goal- whatever we can do to developing that relationship is very important (personal communication, interview participant, Site 03).

Supportive Family Atmosphere

Agencies working primarily with Native American families require both knowledge of the population's history and general cultural traits, and awareness of the variability that might exist within families. For instance, while various agencies may offer natural supports and cultural or spiritual resources in mental health treatment, some individuals may feel uncomfortable and/or dislike participating in alternative treatments. Therefore, direct service personnel generally advise learning more about the individuals. As one respondent at Site 03 noted:

The trainings that are provided for non-Native organizations increase the number of providers in the county who are able to work with Native American families.

Site 03 provides a sense of community, sense of family, spirituality, and inter-connectedness.

...Just because a person is native you wouldn't make them participate in a sweat [ceremony]. Part of being sensitive or culturally competent is looking at what the value system or belief system is for that particular family (personal communication, interview participant, Site 03).

Generally services for children attempt to address common issues for Native Americans including intergenerational trauma and cycles of substance abuse. Site 03 works with the entire family to increase awareness of how abuse is passed on and examine the family history of abuse or other issues. Families are also provided with information about how to break the cycle and given support in doing so. Staff also focuses on strengths such as spiritual and cultural heritage (e.g., language, tribal ways, or dance). Including these aspects in service delivery is linked to an increased sense of belonging, feeling valued, and being supported, which reduces the likelihood of returning to substance abuse or other negative behaviors. Support is also built by tapping into the extended family support systems, bringing in traditional practitioners and spiritual/cultural advisors from the family's tribe, or connecting youths/families with native groups, organizations, and events.

The environment created by staff and leadership at Site 03 is also important to increasing access for Native American families. The organization is described as "family oriented," meaning the organization is a resource for them and their families if they need assistance. Direct service personnel have access to traditional healers or may participate in any programs such as substance abuse or mental health counseling. Wellness programs and health fairs are also provided for staff and talking circles are held to reduce stress. Staff is supported by an executive director who acts as a mentor as well as a good leader, demonstrating respect for people at all levels and giving each an equal voice in the organization. This is observed in the equal value placed on staff contributions from case managers to psychologists, and viewing traditional medicine and Western medicine as equally important. Each staff member is seen as having a valuable role in working with families and territoriality is discouraged as a deterrent to serving the community. These characteristics of the staff and leadership are considered to be advantages of having an "Indian program," which provides an opportunity for Native Americans to take care of themselves, their families, and their community. As described by one respondent, Site 03 provides a sense of community, sense of family, spirituality, and inter-connectedness. It is a place where people come to socialize and connect with other Native people as well as for services. This environment is supported and maintained by staff at all levels of the organization.

Flexible/Individualized/Culturally-Specific Services

All sites serving Native Americans provide culturally appropriate activities and services along with more traditional services to meet the preferences and needs of children and families. Sites 01 and 07 provide a variety of services to urban Native Americans that address key issues such as substance abuse, abuse and neglect, and mental health. At Site 07 services include traditional mainstream services as well as cultural healing practices such as talking circles, sweat lodges, and group or individual sessions with Native practitioners. Clients are also matched with providers or treatments based on self-identification of preferred cultural

and therapeutic elements. Similarly, Site 01 provides a continuum of social and behavioral health services in urban areas that employ staff with training in indigenous practices. Site 03 emphasizes giving equal importance to Western medicine (psychologists, case managers, doctors, nurses) and traditional (spiritual) services delivered in ways that respect individual child and family preferences. Services fit within a holistic framework that balances mental, physical, spiritual, and emotional aspects, and recognizes the critical importance of community and spirituality. Site 03 periodically brings in Native practitioners from different tribes to meet with clients or perform specialized rituals or ceremonies. For example, at a residential facility for girls a psychologist and psychiatrist are on staff but there are also Native dance workshops, cultural group sessions, and sweat lodges. In addition, a Spiritual/Cultural Advisor is included on staff to ensure that Native aspects are integrated throughout the entire treatment process. Intake assessments include questions to identify cultural or spiritual issues, level of interest in ceremonial participation, and level of connectedness to the Native community. Treatment plans are developed based on this information and are assessed in case discussions to ensure clients are linked to preferred types of services and supports. The following excerpt describes this process:

We look at each individual or family to determine what type of treatment we will use and try to give the best combination of Western and traditional treatment. In terms of case discussions, we are always looking at building that sense of cultural identity and pride for our clients in terms of spirituality and other cultural issues. Exposing kids to beading, traditional dance workshops, and to other native youth is an important strategy. That's an important component that we include in our assessment and in our treatment plan and in the overall care of our youth and their families (personal communication, interview participant, Site 03).

According to respondents at Site 03, therapists work with clients in ways that blend professional training with their Native values and beliefs, thus reducing the “sterile” nature of the process and forming more personalized relationships. Clients also have access to traditional practitioners from various tribes and youth/families from other native groups or organizations so that young people are able to increase their knowledge and appreciation for native cultures and languages. For example, a Coming of Age ceremony held at a girl’s home at Site 03 was conducted by Hopi and Navajo practitioners blending traditions from both groups. Respondents commented that this experience increased the interest in learning more about other tribes and traditional dances, and increased the girl’s pride in being Indian. According to respondents, the cumulative effect of exposure to other Native Americans and Native ways was observable improvement in child functioning.

According to study respondents, case management at Site 03 is also tailored to the complex and unique needs of Native American families, including a de-emphasis on a single diagnosis and identifying other needs of the family. Case managers reported that they emphasize building relationships with families and letting the family feel connected with them in addition to offering whatever support might be called for in coordinating services. Respondents also noted that case managers and therapists work closely together to understand the needs of

A Spiritual/Cultural Advisor

is included on staff to ensure that traditional aspects are integrated throughout the entire treatment process.

Case managers have often found themselves acting as role models and cultural teachers for children who are isolated from their tribes and in many cases have been removed from their families and placed into non-Native foster homes.

the family and make sure their needs and goals are being met. The case manager might conduct home visits, visit the child's school, participate in other events in the community with the child or family, and assist the child and family with accessing other services. As therapeutic needs arise, the case manager refers them back to the therapist and informs the therapist of emerging issues. According to respondents, the commitment of case managers and the personal nature of their work with families help to engage families in seeking recommended services and keep them connected to the agency. Finally, some respondents at Site 03 reported that case managers have often found themselves acting as role models and cultural teachers for children who are isolated from their tribes and in many cases have been removed from their families and placed into non-Native foster homes.

Community Outreach

At Site 03, outreach to families is extremely important to develop trust in services. Staff regularly attend powwows and pass out information about programs offered. The organization has even created a position that is designated for powwow outreach, which sets up an informational booth at all the powwows in the county. However, there are also many Native Americans in the county that do not participate in these events, so staff also attend other events or host their own events. For example, the organization sponsors an annual Sobriety Dance at a local park that includes lunch, a variety of activities hosted by each agency department, and booths from other agencies. A large National Indian Day event is also held, with invitations sent to all clients registered with the agency. Programs such as an after school club house also conduct outreach through family events that include traditional foods and transportation and offer opportunities to meet other Native Americans. At all community events staff are personally involved in handing out information and talking to community members in order to develop one-on-one relationships. The goal of outreach efforts is to get Native Americans talking about the agency, increasing knowledge and awareness of services, and spreading information by word of mouth.

Organizational Infrastructure Strategies

Multiple Reciprocal Relationships

All three sites working with Native American communities emphasized the importance of forming and maintaining reciprocal relationships with other agencies, funders, and the community. At Site 03 the predominant focus is on the Native American community, and this places them in the role of advocating for their clients with partner providers to promote culturally sensitive service provision and to develop referral sources. Communication with partner providers includes letting them know what services are available and how to identify Native clients. Site 03 invests in these relationships with other providers because there is such a great level of need that they know they alone cannot meet. Their goal in partnering is to develop the capacity of their partners in order to increase access for all Native Americans in the county. In addition, staff sees their role as not only providing direct services but also getting out and educating the different systems their clients are involved with. The organization as a whole also develops relationships and advocates for needed policy changes at the city, county, and state level with the goal of increasing awareness of American Indian issues.

Site 03 also works at coordinating services and sharing information with other Native American organizations. There is a history of turmoil and hostility among Native organizations due to competition for funding, which has limited use of services across agencies. Site 03 identified this issue through its early research efforts and created an advisory board that included individuals from other Native organizations as community members rather than as representatives of their organizations. Other organizations were also eventually invited to community meetings, research symposia, and events designed to unify the Native organizations. The effort was successful in building a bridge that resulted in the major organizations uniting to hold traditional dance classes so that they were accessible to the broader community. Site 03 also initiated collection of data to document needs and track demographic changes for Native Americans in the county. Historically, data were not available on Native American clients because Native agencies did not collect it and county departments often misclassified Native American clients. When Site 03 received grant funding to conduct research it was used to build the agency's and community's capacity to do research rather than paying outside researchers. One result has been that the American Indian Children's Council has taken many of the research findings and implemented them in the community.

Staff Training

All organizations serving Native Americans provide periodic training in cultural competence for their staff. In addition, Site 03 provides training focused on Native American cultures for staff, foster families, and other providers with whom they work. Training for other providers was developed in response to several situations in which Native American children's behavior was misinterpreted. In one case a Native American boy who lived in a non-Native foster home was placed in jail for supposedly smoking marijuana when he was actually burning sage while praying. Site 03 had to send a traditional advisor to court to explain this situation to the judge and subsequently developed training for foster families to increase their knowledge of Native American practices that might be carried out by the children in their care. Site 03 also holds a Healing American Indian Nations Conference annually that is available for providers throughout the community. Regular biweekly training for staff at Site 03 covers both mainstream and Native aspects of care as well as Native American history. Training is also provided for interns and new staff to promote key aspects of care such as addressing complex issues rather than focusing on single diagnoses. Non-Native staff also receive training on traditional cultural ways, which assists them in understanding both client and agency practices. Teaching about Native American values that are held in common is balanced with information about the great variability within the population, and key questions to ask families to determine where they fit into the spectrum of Native Americans. Traditional practitioners and cultural advisors are available for training on specific groups or practices with which staff might not be familiar.

In addition to formal training, staff at Sites 03 and 07 rely on the diverse staff within their organizations to educate each other on the specific groups served and various treatment options. At Site 03 weekly staff meetings include discussion of what is working or not working with various clients with an emphasis on listen-

Their goal in partnering is to develop the capacity of their partners in order to increase access for all Native Americans in the county.

Participation in community activities such as the Sobriety Run has been made mandatory for non-Native staff as a way to get to know the community and become better known by community members.

ing to staff in a way that creates a safe environment to bring up difficult issues. Supervisors also bring up cultural issues in meetings to make sure these are being considered and listen for areas of training needs among staff. Site 01 and 03 also rely on cultural/spiritual advisors who can consult with staff on an informal basis. And, although all staff members at Site 03 are supported in attending community events, this is also seen as a learning experience for non-Native staff. At Site 03, participation in community activities such as the Sobriety Run has been made mandatory for non-Native staff as a way to get to know the community and become better known by community members.

The strategies developed by organizations serving Native Americans illustrate the importance of paying attention to the cultural and spiritual preferences of families. Developing compatible services depended upon being involved in the community and being willing to learn from community advisors. The wide variation in ethnic backgrounds among Native American communities and scarcity of providers who know how to serve Native communities are challenges addressed through sharing knowledge and building collaborative partnerships. The organizations also suggest that non-Natives can effectively serve Native populations if they are willing to learn, connect with the community, and employ specific direct service strategies to engage families.

4

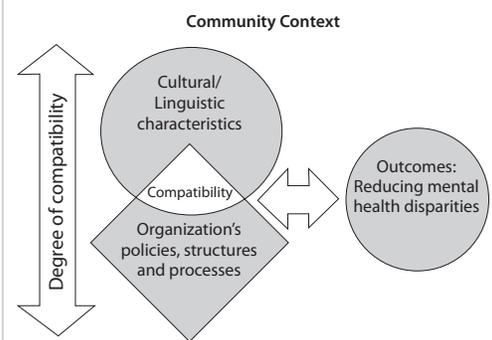
4. Tying It All Together

The strategies presented here illustrate the importance of compatibility between a service organization or system and the community it serves, as presented in the organizational cultural competence model (Figure 1). The strategies that increase service accessibility for ethnically/racially diverse populations can be broadly construed as relating to responsiveness at a very personal level on the part of agency personnel working with diverse children and families and responsiveness and flexibility within a given organization. The strategies identified within the 12 study sites reflect this responsiveness on the part of direct service staff and at a larger organizational level, beginning with the fundamental strategies that require concrete changes in an agency's service hours, fee structure, and other basic operating practices.

As noted in the study methods section of the monograph (p. 5), the literature and protocol reviews conducted for this study identified a number of strategies that encourage very specific changes to organizational operations and service delivery practices that most often address barriers whose impacts are experienced in a first-hand way by children and families (Harper et al., 2006; Hernandez et al., 2006). For instance, maintaining flexibility in the scheduling of services or increasing the payment options available to families addresses immediate difficulties that can inhibit service use by children and families. Nearly all of the study sites provided evidence of implementing these operational practices as a first step in increasing access to the services they provide. This first step has been described in this monograph as the “front porch” of service systems. Some of the specific practices identified in the literature (Hernandez, et al., 2006) can serve as supports for the front porch strategy, including: addressing transportation needs; providing flexible scheduling for services; providing alternative and more convenient service locations; providing flexible payment options; providing culturally and linguistically appropriate materials; recruiting and hiring bilingual and bicultural personnel; and increasing support and training for staff working with diverse communities.

Examples of *direct service strategies* that were identified during interviews for this study highlighted the importance of building and maintaining relationships with children and families as well as with other providers. This aspect of services is the defining characteristic of a “front porch” strategy, which allows for the development of relationships and leads to linkage to needed services. An integral part of these relationships involves intensive communication with family members that demonstrates mutual respect and genuine concern for family needs and preferences, which can then be incorporated into service delivery planning. Direct service personnel

Figure 1
Conceptual Model of Organizational Cultural Competence



The strategies that increase service accessibility for ethnically/racially diverse populations can be broadly construed as relating to responsiveness at a very personal level on the part of agency personnel working with diverse children and families and responsiveness and flexibility within a given organization.

Strategies that enhance the existing organizational infrastructure can be characterized as setting a foundation of culturally competent practice.

also must communicate with their counterparts at other agencies, in order to establish and maintain professional relationships that facilitate the provision of system navigation and other needed services for families. Such practices operate best when implemented in an open and flexible environment that allows personnel to use their close knowledge of ethnically and racially diverse communities to further develop strategies and practices for engaging families and responding to their needs.

As illustrated by examples from the organizations that participated in this study, access barriers must also be addressed at the *organizational level*. Despite their best efforts, direct service personnel, on their own, can not fully increase service accessibility. Barriers to mental health service access must also be addressed by practices or strategies that originate and/or occur within the infrastructure of an agency or system, for instance through the development of a more targeted mission statement, governance documents, or the establishment of policies and procedures that address access barriers, disparities in service accessibility, or particular community needs. Strategies that enhance the existing organizational infrastructure through targeted staff training and other supports are also important in this regard. Such strategies can be characterized as setting a foundation of culturally competent practice that direct service personnel can build upon through their more personal “front porch” interactions with children and families seeking services. As suggested by study respondents, maintaining a front porch requires support through resources that are not dependent on billable hours. These *organizational infrastructure strategies* build organizational capacity, improving the ability of mental health systems to serve diverse families, and advocating for needs at a variety of levels, child and family needs, and organizational needs. Further, such strategies set the stage for an organization to develop a broad service array that can address specific needs as they emerge and that can be tailored to those needs by trained staff, which are able to implement the mission and vision of their organization and have the flexibility to make decisions that will further address the needs of diverse children and families. Organizations that make this investment in their agencies and staff were considered to be illustrative of the importance of *compatibility* between the direct service functions and the organizational functions of a given agency or service system, as shown in Figure 2.

Participants in this study also provided information about *outcomes* resulting from the implementation of direct service practices and organizational infrastructure strategies to increase access for the ethnically/racially diverse populations that they serve. In some cases, respondents may not have linked outcomes to specific and intentional practices but described *resulting scenarios* following implementation of a complex of strategies or adaptations to service delivery practices. Examples of such scenarios included increasing an organization’s reputation in the community, improving the overall cultural and linguistic sensitivity of the larger service system, and serving as a bridge between various organizations/systems and the community or population being served. The *resulting scenarios* reported by study participants point to the importance of maintaining connections with the particular populations served, service provider partners, and the community at large. In the same way that a front porch can become a welcoming meeting place in a neighborhood, organizations in this study implemented strategies that attracted families from their

target populations and, in most cases, from other underserved communities as well. Further as a result of this increased attention within the community, they were often able to attract funding and influence policy related to disparities for these populations. The ongoing attention that these organizations paid to community needs, resources, and context, as well as the alignment of their services and infrastructure with these community characteristics was a key factor in producing positive impacts in the populations they served. The following themes summarize the types of resulting scenarios described by study participants.

Increasing Organizational Reputation Within the Community

Respondents at most of the study sites identified their agency or organization's "reputation in the community" as being linked to their success in improving accessibility of mental health services for the diverse populations they serve. Many said their organizations were known and respected within local communities—either for their history of serving the target population, service delivery efforts, and/or continued participation in the community (especially with regard to organizations that began as grassroots efforts). These respondents further noted that the community often used services because of prior knowledge about a specific organization. When discussing this topic, respondents described the reputation of their respective organizations as having developed over time after maintaining positive relationships with children and families arriving for services or seeking information from them and continued implementation of outreach activities within target communities. Employment of bilingual staff was often a key component associated with an organization's reputation because it distinguished such organizations from others who did not. However, respondents most often emphasized the importance of maintaining bicultural staff—personnel that were hired from within a target population and/or know a great deal about that population's strengths and cultural characteristics, and who work with children and families in a way that respects their differences and preferences.

According to many of the respondents in this study, outreach activities were also linked to an agency's reputation, because they provide a key way to increase visibility within the community. This point was particularly important for sites that did not develop out of a grassroots movement and/or to advocate for a particular community or neighborhood. This sort of visibility facilitates the development of relationships with community residents and potential service users. A number of the sites highlighted in this section noted that they were able to expand the use of services following implementation of such activities. For the culturally-specific sites, outreach activities provide a means for helping the community discuss mental health and reduce the level of stigma in identifying needs or problems and the benefits of service use in a culturally responsive manner. A number of sites also work to engage policymakers and leaders by discussing community needs and involving them in their organizational leadership, whenever possible.

Improving the Cultural and Linguistic Sensitivity of the System

Another outcome reported by respondents relates to the positive influence that they felt their organizations had on the larger mental health service system and in increasing the cultural and linguistic sensitivity of various child serving

Respondents described

the reputation of their respective organizations as having developed over time after maintaining positive relationships with children and families arriving for services.

When organizations advocate for increased knowledge about community needs or funding to meet specific needs or programmatic gaps, they often serve as catalysts within the larger service system.

systems. A number of sites used specific and purposeful strategies designed to make positive changes in these areas at various levels, including the areas of public policy, organizational administration, and funding of services. However, some respondents felt that improvement of the larger service system emerged as a result of past efforts on the part of their respective organizations, especially the implementation of strategies designed to increase mental health service accessibility for populations of color. According to these respondents, such work requires that staff assume an advocacy role when addressing the mental health needs of a target population to wider audiences.

Administrative respondents at Site 04 discussed the importance of testifying before the State Legislature and other governing bodies about the wider African American experience in this country and the relationship between historical trauma (Williams, Neighbors, & Jackson, 2003) and substance abuse when advocating for changes in existing drug policies. In this case, administrators strongly felt that sharing the historical context in which African American populations have developed would help persuade policymakers to support innovative and culturally-specific programs that would be more readily accepted and utilized by community members. At Site 05, respondents discussed their organization's emergence as a leader within the larger community *and* among providers and policymakers, as a result of their longstanding work with various Asian and Pacific Islander populations. They noted that their agency has been identified as an expert in cultural competence, and as such, agency representatives participate in regular county mental health partnership meetings between providers and county level decision-makers. Such participation also increases Site 05's visibility within a much larger community and often generates opportunities for training personnel at mainstream providers, as well as interest in the cultural consultation services they provide. Respondents at both sites noted that efforts aimed at increasing the cultural competence of mental health services for children—even at the direct service level—can eventually help improve the cultural and linguistic sensitivity of service systems.

Serving as a Bridge

The organizations that participated in this study often came to serve as a “bridge” between the communities and populations they serve and the wider service system. This relationship is akin to the one that is developed at the individual level by direct service staff who provide system navigation and family support. When organizations advocate for increased knowledge about community needs or funding to meet specific needs or programmatic gaps, they often serve as catalysts that increase the knowledge of communities and responsiveness to their needs within the larger service system—especially if they provide services within a larger network of providers that are linked through referrals and/or case management (See Provan & Milward, 1995). Although an organization's basic type and infrastructure can often shape the way accessibility strategies are implemented, the larger agencies or mental health departments and systems that participated in this study developed close working relationships with community-based organizations and advocacy groups to increase personalization of service delivery.

According to study respondents, the advocacy role that often emerged as a consequence of their efforts to improve the cultural and linguistic sensitivity of the overall service system resulted in their emergence as a key cultural broker between mainstream providers and policymakers and the larger communities they serve.

Conclusion

Taken together, the strategies, or adaptations to service delivery practice(s), identified through this study can help mental health systems and organizations increase their level of cultural competence in working with ethnically and racially diverse children and families. Specifically, they are recommended for mental health systems and organizations that are interested in increasing accessibility to mental health services for African American, Asian American and Pacific Islander, Latino, and Native American populations, which have been shown to suffer disparities in access to appropriate mental health services and supports (President's New Freedom Commission, 2003; U.S. Department of Health and Human Services [DHHS], 1999). The findings of this study underscore the importance of developing organizational/systemic awareness of and responsiveness to diverse communities and cultures in efforts to increase cultural competence, as noted in the research literature (Cauce, Domenech-Rodriguez, Paradise, Cochran, Shea, Srebnik, & Baydar, 2002; President's New Freedom Commission, 2003; U.S. DHHS, 1999; Yeh, McCabe, Hough, Dupuis, & Hazen, 2003; Yeh, McCabe, Hurlburt, Hough, Hazen, Culver, Garland, & Landsverk, 2002). This awareness and responsiveness can be translated into strategies that serve as the "front porch" of mental health services.

These strategies, whether used at the organizational infrastructure or direct service level, build upon awareness of community and family preferences, history, and context. At the direct service level, responsiveness is often demonstrated through interpersonal interaction, through the development of relationships and rapport with families. Such relationship-building allows direct service personnel to learn continually about particular communities, the diverse cultural groups they include, and changing contexts over time. At the organizational level, responsiveness is most often reflected in practices that are designed to build an organization's (or system's) capacity to serve the needs of racially and ethnically diverse families. When organizations provide staff with cultural competence training and support direct service efforts to work with families in a way that is respectful and seeks family and community input in all aspects of service delivery, they create an atmosphere that demonstrates a commitment to serving families. As noted throughout, organizational type and community preferences often dictate how specific strategies are implemented. This study shows that there are a number of strategies that can be used to enhance mental health service accessibility for ethnically and racially diverse children and families. However, such strategies do not work in isolation. In order for such strategies to be successful, they must be implemented in ways that take into account larger organizational and community contexts to ensure adequate funding and other resources.

The strategies identified during this study have been determined to yield positive results based on interview findings that showed consensus across stakeholders

Taken together, the strategies, or adaptations to service delivery practice(s), identified through this study can help mental health systems and organizations increase their level of cultural competence in working with ethnically and racially diverse children and families.

and continued use of services by the targeted communities over time. Although the effectiveness of these strategies has reached a level of acceptance by the organizations that participated in this study and the communities they serve, this has not been measured empirically. Moreover, study sites did not generally collect empirical data on disparities in service access or utilization among specific populations, and therefore this study did not allow for testing the degree to which use of these strategies can ultimately be tied to a demonstrated decrease in disparities in mental health service access, as suggested by the conceptual model presented in this monograph. Additional research is recommended to further operationalize and measure the effectiveness of these “front porch” strategies to improve service accessibility for African American/Black, Asian and Pacific Islander, Latino, and Native American populations. The relative costs and benefits of implementing these strategies also needs to be analyzed. Further, additional research is needed to determine the extent to which access facilitation strategies are linked to improved mental health outcomes in these populations.

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6. Appendix: Descriptions of Study Sites

Site 01

Site 01 is a statewide organization founded in 1969 in the Southwest to address a variety of social problems affecting the Mexican American population. The organization traces its origins to the grassroots efforts of family members and community leaders protesting discrimination and unfair treatment of Chicano students in public schools. Following a three-month boycott of public schools to address these conditions, the leaders of this grassroots movement incorporated to address other important social issues identified in the community. Since that time Site 01 has become a Community Development Corporation which provides a variety of for-profit and non-profit services to address issues faced by low to moderate income communities. Site 01 has over 100 contracts to provide services such as dropout prevention and education, after school, Head Start, cultural development, mental health, domestic violence, substance abuse, parenting, leadership development, elder services, housing, economic development, and subsidiaries (including credit unions, and a mortgage company). Site 01 includes a staff of over 600 that provides services to a primarily Mexican/Mexican American population (90%), but is currently expanding to areas that are primarily Native American. The history and longevity of the organization have contributed to the organization's reputation and stature within

the Mexican American community and throughout the state. In order to maintain a direct connection with community needs and issues, 51% of Board members are community residents. Many staff members are long-term employees and/or community residents who have received services from the organization. Some staff have returned to work at the organization after completing college or graduate studies and/or working elsewhere. Funding is varied, with over 290 funding partners, and is based on a "33% rule" for the organization, which limits funding from any source. Types of funders include federal agencies (ACYS, SAMHSA, HUD), the state Governor's office and specific state agencies (Department of Economic Security, Health Department, Transportation, Public Safety), local contracts with cities, foundation grants, and the United Way. The agency maintains an emphasis on integrating culture, heritage, and ethnicity in the planning, execution, and implementation of programs and services. Other agencies, funders, and the state look to Site 01 as a guide and expert on Latinos, but also as an innovator that is not afraid to incorporate culturally relevant practices as it learns about the needs of other populations, such as Native Americans. Site 01 maintains its roots in the Latino community and is able to draw upon this as a resource for implementing new services with Native Americans and other underserved populations.

Site 02

Site 02 is a non-profit agency founded in 2000 in small city in the Pacific Northwest. The organization started as a partnership between teachers and social service providers who were concerned about high failure rates among local elementary school students. In an effort to increase academic achievement among these students, teachers worked to establish a tutoring program in a low-income housing complex where many of these students lived. The program, which grew into the current organization, is unique to this study sample in that it is site-based and provides services to low-income residents who live in targeted housing areas. The organization established offices within three apartment complexes and has become an integral part of the communities of focus. Staff at Site 02 described their organization as a “cultural bridge” between the user population and various service systems. Site respondents estimate that their service user population is about 70% Latino. The organization does not provide specialty mental health services but partners with community-based clinics and other mental health agencies to which it refers children and families. Services offered include support groups, after school programs, information and referral, and system navigation services. For this study, the research team conducted a site visit within the apartment complex occupied primarily by immigrants from Mexico, some of whom are indigenous Purhépecha from the Mexican state of Michoacán. Often, these residents do not speak Spanish or English, but speak the unwritten Purhépecha language. A number of services are provided free of charge, and the agency is flexible enough to

allow people to walk in without an appointment whenever they need help from translation of letters to system navigation. The organization also tends a community garden which is harvested by the children and families of the community. Direct service personnel are most often hired from within the user population and are trained as “natural helpers” (lay health outreach workers). Site 02 receives funding from the city, the county, and other sources to increase the array of services offered.

Site 03

Site 03 serves Native Americans in a large urban West Coast county by providing a wide range of services that are culturally-specific. The organization began as a homeless outreach program in the downtown area and has developed into a one-stop service center providing mental health services and programs focusing on wellness, substance abuse prevention and treatment, workforce development, suicide prevention, and general health. Site 03 also has on-site programs to assist with transportation, food, and housing needs and partners with satellite sites to better serve the Native American populations across the county. Key aspects of their services include offering Western medical and mental health services in combination with traditional spiritual elements, and an emphasis on social and cultural connections among Native Americans. Site 03 conducts a summer camp program each year that is used to build leadership skills in young people and trains them for future involvement in the community. Diverse sources of funding include SAMHSA, Indian Health Services, and inter-tribal health board and county and state funds that are used to provide services to both tribally enrolled and non-

enrolled clients. The large geographic area and dispersed target population creates challenges for Site 03 to reach all Native Americans in the county, therefore training is provided for partnering agencies to build their capacity to work with Native American families that access their services. Site 03 brings Native Americans together for programs at their center and includes culture elements in the décor to create an environment that promotes Native American identity and belonging. Site 03 also participates in traditional ceremonies and events in the community and advocates for services for Native Americans at the state and local level in order to reduce client distrust and unfamiliarity with the system, and increase provider awareness of the presence and needs of Native Americans.

Site 04

Site 04 is a community-based non-profit organization, founded in 1975 in the U.S. Midwest, to provide services to chemically dependent people in a culturally-specific context. Over the years, Site 04 services have expanded to encompass other issues that are often found to co-occur with chemical dependency, such as family counseling, family violence, crisis intervention and home-based services. In 1995, Site 04 became an umbrella name for an organization that houses three divisions that address three distinct service areas: chemical dependency treatment, family counseling with a special emphasis on domestic violence and anger management, and culturally-specific mental health services for youth, with a special emphasis on dual diagnosis disorders. Some of the services that Site 04 provides to community residents are court mandated. The majority (90%) of the population

served by Site 04 is African American (both child and adult), but there is an increase in the number of other populations served. Site 04 staff estimate that 99% of the families receiving services are at or below Federal Poverty Guidelines levels. The largest growing population in the area is Haitian and various African immigrant populations, although Site 04 does serve small populations of Hispanics, Asians, and Middle Easterners. Some of the main issues identified for the population served by Site 04 personnel, include homelessness, truancy, domestic violence, and child protection. Site 04 staff also identified the following barriers that affected access to mental health services for the African American population they serve: lack of affordable, public transportation and lack of information regarding navigation of available services. The underlying principle of Site 04, as identified by the staff interviewed, is that the Black experience in this country must be understood fully in order to appreciate the challenges faced by many members of the African American population, especially with regard to mental health and related issues. Further, the strengths of African American communities must be identified and nurtured in order to successfully address ongoing mental health and chemical dependency issues. According to one Site 04 administrator, their culturally-specific programs that incorporate history and traditions, exhibit outcomes that are 50% more successful than those for programs that do not take culture into consideration.

Site 05

Site 05 is a nationally recognized non-profit organization offering a broad array of human services and behavioral health programs to Asian and Pacific

Islander populations in the Pacific Northwest. Established in 1973, the mission of Site 05 is to promote social justice, well-being and empowerment of API individuals, families, and communities by providing and advocating for innovative community-based multicultural and multilingual services. Site 05 provides a variety of programs designed to serve Asian Americans and offers a variety of payment options. With an annual budget of \$8.1 million, a staff of more than 160, and a volunteer base of over 350, the organization serves more than 18,000 clients annually through 11 different social services for individuals and families of all ages. In addition to mental health counseling and case management, there are day programs for the elderly, early childhood programs, children and youth programs in the schools, domestic violence interventions, nutrition and food bank programs, substance abuse treatment, legal and naturalization services, and vocational and employment services. Site 05 also provides cultural consultation, interpretation, and education for other providers in the area. Site 05 began serving Chinese, Japanese, and Filipino clients with social work interns who were ethnically matched with the community. When Vietnamese refugees began arriving in 1976, two Vietnamese workers were hired with funding from the office of refugee and resettlement. Additional programs were initiated based on identified needs, including a vocational and substance abuse outreach program in collaboration with other agencies such as the Center for Addictions. The most recent programs that have been initiated respond to identified community wide issues such as domestic violence, problem gambling, gangs, and sexual assault on young Asian women. The organiza-

tion is currently located in a district of the city where many API families live or do business. The main building is entered through a well-landscaped courtyard designed according to feng sui principles. On the ground floor is a primary care facility run by Community Health Services, which has co-located services in order to increase access for Site 05 clients and other low income Asian American clients. Based on input from Site 05, the clinic was designed with large examination rooms to accommodate family members, an interpreter, and the physician. Eastern modalities are integrated with western medicine, such as acupuncture and Chinese medicine. A dental clinic is also located on the first floor, and there is an on-site lab and pharmacy. On the opposite side of the courtyard from the medical clinic is an early childhood education center and an assisted living facility for low income elderly with a common room for joint programs such as oral history (elders tell their life stories to the children), and a meal room for elders overlooking the children's playground. Due to its exemplary relationship with the communities it serves, Site 05 has been nationally recognized as a model for the delivery of culturally and linguistically competent services. A major factor which staff attribute to its success is that it is "not just a social service agency, and not just a clinic, it's a social justice organization." Social justice is considered to be a core element of cultural competency. For example, the organization addresses racial disparities and works toward equity through involvement in issues such as deportations and anti-immigrant policies, which are important to the community it serves.

Site 06

Site 06 is a nonprofit organization that provides family orientated mental health and family support programs in the Northeast region of the United States. The organization began in 1960, as a volunteer effort on the part of social workers of Puerto Rican descent who wanted to help recent immigrants from Puerto Rico experiencing a variety of social and health needs in overcoming linguistic and other barriers as they settled in the city. Following its incorporation two years later, Site 06 began recruiting families who had adjusted well to immigrant life to help in the delivery of services to other individuals and families in the local community. The organization's current mission is to prevent family disintegration and enhance the self-sufficiency of the Latino community. The majority of the population served by Site 06 is about 70% Latino, representing various national origin groups, although they also serve a high proportion of African Americans (about 30%), and Whites. (The proportion of each ethnic group served varies within each of the program areas). Site 06 offers a variety of services, including individual and family counseling, intensive treatment for severely emotionally disturbed adolescents, family preservation services, Head Start programs, intensive case management, short-term hospitalization, and residential treatment programs. According to Site 06 staff and organizational documents, they are one of the only organizations in New York that provides mental health services and printed information in Spanish. Site 06 also employs staff that speak French and Haitian Creole. The organization emphasizes the communication of respect for cultural identity

in all interactions with individuals and families served by the organization, regardless of ethnic background.

Site 07

Site 07 is described by its staff as an "alternative healing center," was founded in 2001 in a major city in the Southwest, and provides services at several locations countywide. The organization provides individual, family, and group therapy, including Cognitive Behavioral Therapy, Jungian oriented therapy and counseling and support groups that address anger management, domestic violence, divorce/custody issues, parenting, substance abuse, relapse prevention, and culture bound syndromes. In addition, they provide a number of innovative and progressive services, which they identify as "cutting edge therapeutics," including traditional/cultural healing, Tai Chi, Reiki, other massage therapy, hypnosis, massage therapy, art therapy, and pet therapy. Site 07 staff reported that at least 50% of the population they serve is Hispanic, followed by 20-25% Native American, 20% White, and some African Americans. They offer therapy in Spanish and Polish, and intake forms are provided in Spanish. While staff reported observing the importance of an individual and family's culture, they also reported a preference for letting individuals identify themselves on their own terms and acknowledging those preferences throughout the service delivery process. According to an administrative respondent, the organization "[tries] to uniquely match our services with the client and then try to allow them to have a dominant role in deciding what their treatment will include."

Site 08

Site 08 is a non-profit agency founded in 1975 by residents of a community within a large West Coast city. Founders included a local psychologist and school principal, who collaborated to create a prevention program for adolescents at risk of entering the juvenile justice system. Since then, the organization has grown to include almost 700 employees and offers a diverse array of programs countywide. These programs include counseling and therapy for children, youth, and families, licensed childcare programs, a youth hotline staffed by teens, after school services, a community youth center, and family support and advocacy services. This study focused primarily on the Parent to Parent Program component of the agency, which targets disadvantaged families of color who have children with mental health challenges, and provides support, training, and information for parents raising children with emotional and behavioral needs. About 70% of families served by this program component are Latino, with the remainder reported to be African American (25%) and a very small percentage of White families; all of the target families were identified as poor. Parent to Parent programs are run by families and offer three culturally-specific programs in the Southeastern section of the city: the Family Guide Project, which provides parent support, navigation services, and Wraparound services for families with children involved in multiple service systems; the Trauma Treatment Program, which focuses on helping children, youth, and their families cope with traumatic experiences related to neighborhood and family violence, and the City Arts after school program,

an after school creative arts program for children and youth that have been expelled from other programs due to emotional and behavioral challenges. Parent to Parent staff includes six paid Parent Partners, who work directly with families in providing supportive services, a part-time psychiatrist who is also a parent of special needs youth, volunteers from the community, and the program director. Funding for Parent to Parent Programs is obtained primarily through small grants from private foundations and through the county. At the time this study was conducted, Site 08 was working to qualify for Medicaid reimbursement.

Site 09

Site 09 is a state-wide organization with the goal of “bringing people and services together.” It was incorporated in 1975 and is currently one of the largest Minority Non-Profit Organizations in the state it serves. Site 09 programs include family stabilization services, counseling, education, outreach and public health, developmental disabilities, mental health, elderly services, and information and referral resources. The Wraparound Family Services division at Site 09 serves a small northeastern community that includes families who are African American, Haitian, Cape Verdean, Vietnamese, Latino, South Asian Indian, and White. Approximately 1,540 youth and their families are served annually. Most families are referred by the Departments of Mental Health (DMH), Mental Retardation (DMR), Social Services (DSS), and Youth Services (DYS). Children’s issues range from autism, to emotional and/or behavior challenges and learning disabilities, while family needs include

severe poverty, lack of health insurance, lack of affordable transportation, unemployment, immigration issues, limited English speaking ability, and literacy and educational challenges that Site 09 staff characterize as affecting level of knowledge about service systems and resources. Innovative programs are developed and provided by staff that is diverse in cultural/linguistic and educational backgrounds. Programs include the Parent Information Network, which provides peer consultants who educate parents on family and children’s rights, provide support and empowerment, conduct workshops and training, and provide insurance information; Coordinated Family Focused Care (CFFC) and the Family Resource Mobilization Unit (FRMU), which provide case management, therapy and counseling, referrals, family and youth support services such as mentoring, and flexible funding; and the After-School Enrichment Program, which provides therapeutic after school activities funded by the Department of Mental Health.

Site 10

Site 10 is located in a large county on the West Coast. About 35% of the population is of Hispanic or Latino origin and 15% is Asian (of which 33% is Vietnamese). Nearly 30% of the population is foreign born. Large populations of Spanish-speaking and Vietnamese speaking families are located in distinct communities. The Vietnamese population is reportedly the largest outside of Vietnam. Mental health services are provided by the Behavioral Health Division of the organization, which is administered by the county and serves primarily Medicaid recipients. A cultural compe-

tency department has been in existence since 1999 to provide consultation, training on cultural competence and access, monitor demographic and service utilization data, and develop recommendations for services across the organization. Children are referred for services by schools, social services, and juvenile justice. A majority of referrals are for children/youth with ADHD, substance abuse, affective disorders, and youth transitioning to adult services. Services are offered through 26 outpatient sites in targeted locations and include consultation, evaluation, therapy, medication, referrals, and wraparound services for parents/families. Both non-traditional and traditional services are offered for API individuals and families in order to reduce stigma and increase trust. Non-traditional services were developed through community engaged planning processes and include full service partnerships and a training program for lay health promoters. The linguistic needs of populations have been addressed through translation of all agency forms to Vietnamese and Spanish using a process that verified the appropriateness of mental health terms. Funds are derived from a variety of sources including state and federal grants, county funds, Medicaid, and state funding for county mental health services. Clients with private insurance are not accepted, but fee-for-services options exist.

Site 11

Site 11 is a not-for-profit statewide parent support and advocacy organization for families with children who have emotional, behavioral, and/or mental health issues. It is the state chapter of Federation of Families and was founded in 1990. Site 11 provides

information, referrals, advocacy, and support groups, along with the opportunity for families, professionals and other interested state and community representatives to speak with each other about the needs of children with emotional problems. According to staff interviewed, up to 60% of the children served by Site 11 are African American. The remaining proportion of families served were identified as White, biracial, and Hispanic. Site 11 programs are funded through a variety of federal and state funding streams and assist parents and caregivers in addressing their children's mental health issues. These services include a statewide information and referral service network, child care training and consultation in three areas of the state, an early identification and treatment program for teens, family support services for families with children at-risk of being placed in child welfare, and a program that provides services to uninsured and underinsured children.

Site 12

Site 12 was founded in 1995 and is operated by the Behavioral Health Division of the County Department of Health & Human Services in a Midwestern state. Site 12 serves families living in the county who have a child with serious emotional or mental health needs, is referred through the child welfare or juvenile justice systems, and is at immediate risk of placement in a residential treatment center, juvenile correctional facility, or psychiatric hospital. Their services were designed to reduce the use of institutional-based care such as residential treatment centers and inpatient psychiatric hospitals while providing more services in the com-

munity and in the child's home. Site 12 utilizes a wraparound approach to service delivery, which focuses on strength-based, individualized care. Site 12 was named an exemplary program by the President's New Freedom Commission on Mental Health in 2004. Seventy-one percent of children and youth served by Site 12 are African American, followed by 20% White, 6% Hispanic, and 3% of youth with ethnicity identified as "Other." Site 12 offers a variety of services including group homes, care coordination, residential treatment, foster care, psychological assessments, intensive in-home therapy, crisis 1:1 stabilization, medication management, day treatment, discretionary/flex funds, life skills, support services, transportation, alcohol and drug abuse services, inpatient, mentor/support, outpatient mental health, parent support, and respite.