



Oregon State
Children's Mental Health Initiative

Initial Review of Cultural Competence

Executive Summary and Narrative Only

C. H. "Hank" Balderrama
Human Services Consulting, LLC
September 2005

Acknowledgements

This document was prepared with contributions from a number of people. Thanks to Madeline Olson, Ralph Summers and Kathy Seubert, of the Oregon Office of Mental Health and Addiction Services (OMHAS) who have provided guidance in understanding Oregon State's public mental health system and have contributed numerous suggestions that have improved the clarity and focus of this report.

Appreciation goes to the people from around the state who agreed to be interviewed and shared their knowledge of cultural competence within the OMHAS service system.

Rita Shaefer contributed statistical calculations, preparation of tables and guided the format of the report.

TABLE OF CONTENTS

Children's System Change Initiative
Cultural Competence Review
C. H. Hank Balderrama
September 2005

Executive Summary

In summer 2004, The Oregon Department of Human Services (DHS) Office of Mental Health and Addiction Services (OMHAS) began to implement the Children's Systems Change Initiative. Community stakeholders requested a cultural competence review of the public mental health system.

In response, OMHAS released a request for proposals (RFP) in late 2004 to engage a consultant to conduct a strength-based cultural competence review of the Oregon mental health system's service delivery capacity. The contract was awarded to C. H. "Hank" Balderrama. The RFP required the development of a baseline of cultural competence in several areas: 1) population and language demographics; 2) service provider capacity to deliver specialized services; 3) service delivery data for indicators of who were served and what services were provided; 4) interviews with key informants to begin to identify existing and emerging culturally competent services.

As a result of the review, a set of recommendations were developed. They are intended to complement and expand upon the work already in progress at OMHAS and within the state. A list of general recommendations is presented immediately following this Executive Summary and at the end of each section of the report. Implementation Strategies, which expand upon the recommendations, are presented by section in this report.

The results of the review indicate that there are number of efforts to develop and deliver culturally competent services across the state already in progress.

Organizations have established cultural competence plans. Agencies have implemented specialized service approaches for target populations. Community specific traditional practices are being used. Efforts to develop bilingual and bicultural staff capacity to deliver mental health and substance abuse services are in progress. Work is conducted to document program structures and outcomes. OMHAS has revised the initial standards for evidence based practices as a step towards assuring culturally competent practices are available and recognized in the near future.

These state and localized efforts serve as the foundation for an intentional approach to building statewide capacity to deliver linguistically and culturally competent services for children and adults. Participants in the key informant survey consistently looked to OMHAS to formulate policy, set standards and assist and support efforts to develop cultural competence service capacity.

The need for OMHAS to do so is underscored by the passage of Oregon Senate Bill 267, which requires five state agencies, including OMHAS, to incrementally increase the level of state funds spent on evidence based programs annually. By July 1, 2009, OMHAS shall spend at least 75 percent of state moneys that it receives for programs that are evidence based.

This baseline review of information concludes that additional work must be conducted that will result in incremental expanded capacity to meet the needs of an increasingly diverse general population within the state. Among the most critical findings is that there are few, if any, programs and practices in use across the state that were reported to qualify as one of the 37 OMHAS approved evidence based practices (EBPs).

Current service capacity is not considered sufficient to meet existing and increasing service needs. Approved EBPs for the most part have not been standardized for special populations. Local emerging specialized practices are not generally recognized. The ability to increase culturally competent service capacity in Oregon will need to continue to provide for adaptation of approved practices to meet the needs of special populations and to recognize and approve emerging practices used by specialized providers.

The following general recommendations to the Office of Mental Health and Addiction Services have been formulated in light of the baseline descriptive information gathered. They are intended to provide a framework for increased capacity to serve various ethnic minority groups in a culturally competent manner, within the requirements of state and federal laws and regulations.

- Balance legislatively mandated implementation of evidence based practice with existing and emerging practice to assure adequate service access and results for racial/ethnic minorities.
- Establish a goal of comparable access to service and comparable outcomes across age and racial/ethnic groups.
- Provide leadership by setting policy and standards, supporting their attainment, and establishing a range of acceptable performance.
- Formulate indicators of access and outcomes across racial/ethnic groups.
- Set standards for linguistic service capacity and competence.
- Establish qualifications for Minority Mental Health Specialists, their utilization, and standards for practice and consultation.
- Provide leadership in additional development of service capacity in collaboration with stakeholders to:
    - Support emerging practices,
    - Assist in the dissemination of successful local efforts, and
    - Encourage cooperative ventures among mental health and substance abuse providers with allied partners

LIST OF RECOMMENDATIONS
BY SECTION

DEMOGRAPHICS

- Establish a base population from which comparisons of access to service and related outcomes may be established among fifteen population groups composed of children, adults and elders who are African Americans, American Indians/Alaska Natives, Asian/Pacific Islanders, Caucasians and Hispanics.
- Document factors that enable accurate determinations of the numbers of recent immigrants and refugees, by location, to promote reasonable projections of their service needs.
- Develop and implement indicators of access to and results from service that will enable determinations of comparable access and outcomes.
- Establish and enforce a policy that requires service to limited English proficient individuals to be provided by qualified staff or interpreters and which prohibits use of family members or friends in place of qualified staff or interpreters.
- Translate vital documents such as client rights, consent to treatment and release of information into Spanish and other languages as provided for in federal guidelines.
- Develop or access a method to determine the proficiency of bilingual direct service staff and interpreters, and assure that it is implemented.

SERVICE ACCESS

- Adopt a policy to ensure comparable access to services and outcomes from service are achieved across age and racial/ethnic groups.
- Define and adopt measures of service access and outcomes by March 31, 2006 in collaboration with stakeholders, MHOs and provider agencies.
- Phase in a range of acceptable performance levels in providing service access and outcomes by age and racial ethnic groups in contract among service providers over a four year period, beginning July 1, 2006 through June 30, 2010.
- Establish a method to include language in data collection elements as an additional measure of comparable service access and outcomes.
- Establish a method to determine whether qualified staff and interpreters are serving limited English proficient individuals.
- Adopt and phase in more detailed or focused measures of service access and outcomes in contract beginning July 1, 2008.

- Provide technical assistance and support the implementation of access and outcome standards by identifying and disseminating information about practices that will lead to comparable access and outcomes.
- Develop and publicize regular progress reports, by MHO and county groupings to encourage accountability and collaboration among all service providers.

PROVIDER SERVICE CAPACITY

- Establish qualifications for Minority Mental Health Specialists.
- Establish a policy which provides that racial/ethnic minorities served in the public mental health system will be served by a person who qualifies as a Minority Mental Health Specialist or by a person who receives consultation from such a specialist at critical treatment junctures.
- Provide support and assistance to contractors and sub-contractors in the implementation of the proposed standard for use of Minority Mental Health Specialists.
- Create a standard report, in an electronic format for all reporting entities to use when submitting their service practitioner information to enable determinations of levels of specialized service expertise.
- Review service practitioner reports annually, by MHO, and use them as a guide to target development of further specialized expertise.

KEY INFORMANT SURVEY

- Continue to work with legislative, community and provider organization stakeholders to address the need to carry out legislative mandate to implement evidence based practices and still preserve and promote culturally and specific practices that produce positive outcomes but are not yet demonstrated to meet best practice standards.
- Take a leadership role in documenting efforts that are being made to develop capacity to serve racial/ethnic and linguistic minorities by county and by MHO.
- Promote the development of evidence based practices by identifying specialized practices being used, encouraging collaboration among MHOs and provider agencies and assisting in the engagement of resources to establish emerging, promising and best practices.
- Promote additional development of service capacity by disseminating information about successful strategies to develop linguistic and cultural competency.
- Establish additional state level capacity to provide support and assistance to MHOs and provider agencies in establishing cultural competence capacity enhancement plans through assignment of qualified staff and/or contractual arrangements.

This report recognizes that there are many positive factors already in place within the mental health and addiction services system of care throughout state. The recommendations at the end of each section of the report are intended to be complementary of one another and to serve as a broader foundation to extend culturally competent care.

These recommendations put forth ways that OMHAS can increase or develop expectations and accountability in contract and in administrative rules that will provide for comparable access to services for people across age and racial/ethnic groupings. They also provide for the office to guide further development of specialized services through shared responsibility with its provider network and others.

OMHAS has the capability to use its role as regulator and payer to create and refine standards related to cultural competency. It also has capacity to continue to provide leadership by providing guidance and technical assistance to its service network and others that will support and enhance adaptations and innovations in the use of best practices from mainstream and minority communities.

I. Project Description

The Oregon Department of Human Services (DHS), Office of Mental Health and Addiction Services (OMHAS) heard concerns from community stakeholders in late summer 2004. Some stakeholders expressed the opinion that the statewide mental health system did not have sufficient expertise and capacity to adequately serve children from racial/ethnic communities.

In response to those concerns, OMHAS released a request for proposals (RFP) in fall of that year. The RFP solicited a contractor to conduct a strength-based assessment of the current level of the Oregon mental health system's service delivery capacity to serve various ethnic minority groups in a culturally competent manner. It requested a review of general population data and service statistics. A survey of a variety of knowledgeable individuals throughout the statewide was required, as was a review of information about staff composition and specialized expertise to provide culturally competent mental health services.

The results of the project called for written recommendations for strategies to increase the mental health system's capacity to provide culturally competent care. Objectives were to be identified, using results of the strength-based assessment to promote increased capacity on an incremental basis.

The successful bidder to review mental health services for children and others from a culturally competent perspective was C. H. "Hank" Balderrama. He has more than 25 years experience in promoting cultural competence at the community, state and national levels. He founded and directed two private non-profit organizations, has served as a senior administrator in the Washington State Mental Health Division and has participated on national level panels on cultural disparities and cultural competence. He has consulted independently on numerous projects, which includes work with Multnomah County Mental Health and Addictions Services Division and Cascadia Behavioral Health's Project Respond between 2001 and 2005.

This assessment of cultural competence is a descriptive study. It includes a compilation and a review of demographics by county, mental health organization (MHO) and state population groupings. Demographic tables were developed that afford the ability to determine where various racial/ethnic groups are concentrated. This informs where culturally competent services by specific groups are likely to be needed.

Information about language spoken at home, an indication of language fluency, was documented. This serves as an indicator of need for services by limited English proficient individuals and will assist in projection of additional language capacity needed among mental health service staff.

A measurement of access to service was developed. It is referred to as Comparable Access (CA) ratios. The percentage of sub-groups of people in the general population is compared to their percentage in the service population.

Management information was compiled by three types of services: crisis, outpatient and inpatient hospitalization, for both community and state hospitals. This is intended to afford an initial look at service access by age and ethnicity across broad service types. A review of these three services helps to identify whether some groups are in more restrictive care and higher cost services at rates higher than others. It is also an indicator of other possible disparities.

While use of CA ratios is a gross measure of access, it serves to:

- promote establishment of baseline measures of comparable access,
- serve as a useful indicator of potentially undesirable service patterns and,
- indicate where additional review needs to be concentrated.

This method is a promising foundation on which to base initial impressions about comparable access to services and comparable service outcomes across age and racial-ethnic groupings.

Provider service qualifications, to the extent available, were reviewed. OMHAS requires MHOs to submit annual mental health practitioner reports that document various characteristics of direct service providers. The potential value of a review of service practitioner qualifications information is to assess the current level of specialized service capacity in relation to indicators of service need and access to service. The future objective will be the ability to project sufficiency of staff service capacity in comparison to projected need for age, linguistic and culturally specific competent services.

The final assessment step incorporates interviews with a diverse group of key informants throughout the state. OMHAS staff assisted in the identification of key informants throughout the state. A relatively small but representative group of consumers, consumer advocates, direct service providers, program managers, MHO administrators and OMHAS staff were interviewed. One or more people were interviewed from each MHO. There was a mix of racial-ethnic diversity among participants.

Key informants were asked about their knowledge of demographics within their service areas. They were requested to describe their understanding of service needs among local residents. They were asked about barriers to services, how the barriers might be addressed and who is responsible to do so. In addition, they were asked to state what their agency and others are doing to address service barriers.

Informants were encouraged to project how one might know or measure whether and when sufficient capacity to meet service needs has been met. Finally they were invited

to identify any culturally specific emerging, promising or best practices being developed or in practice either locally or elsewhere.

The purpose of the informant survey was to gather additional information about service needs and capacity to meet it. It also was useful as an indicator about the collective level of knowledge among key people contributing to policy making and operations of the public mental health system.

In summary, this review of cultural competence within the state mental health system is intended to address a number of questions.

- Who are potential service recipients?
- What services do they need?
- Who is serving them?
- What do we know about progress in meeting their service needs?
- How might we better prepare service providers to meet the needs?
- How should we measure our progress?

The following sections of this report provide details about each area of review. Each of the specific areas of this review contains information about what was examined and how the results might be used locally. Appendices provide supporting details and facilitate additional review of state, county or MHO level data.

Recommendations are listed at the end of each section. A list of recommendations resulting from this review is provided immediately following the Executive Summary on pages 3 and 4 of this report.

Tables and graphs in this report have been compiled at the state, Mental Health Organization and county level for the most part. Information is presented consistently from state to MHO to county levels. This affords an opportunity to identify patterns at the highest level and to view detailed information at the local level.

A set of graphs begins on page 80 of this report. The graphs illustrate at state and MHO levels Comparable Access (CA) ratios for minority groups, by age. Following the graphs are tables that provide detailed information. The tables present general and service population demographics by number, percent and CA ratio by age group.

Supporting information is provided for each section of this report in the appendices.

II. DEMOGRAPHICS

Data Examined

Several sets of data from multiple sources were examined. Census and language information for the general population of Oregon was compiled from the U.S. Census Bureau Internet web site. Census tables SF 3- PT 10 and SF 4-PT 38 were major sources of data.

OMHAS provided a copy of "Racial & Ethnic Diversity in Oregon: State, County & Census Tract Diversity Pyramids, Maps, Charts and Tables", by Evans, Stickler and Kelly, Oregon Department of Human Services, 2002. This manual is an excellent comprehensive set of tables that enabled statewide and local pictures of information related to the characteristics of the residents of the state of Oregon.

The methodology used in this cultural competence review distinguishes among Hispanic and non-Hispanic groups. U.S. Census data collection methodology does not consider Hispanics to be a racial group. Census procedures list basic groups of Caucasian (White), African American, American Indian-Alaska Native, Asian-Pacific Islander and mixed race categories. Once an individual selects a racial group, an option to identify as Hispanic is also available. There are sub-sets of Hispanics an individual may select such as Cuban, Mexican American, Puerto Rican and others.

For purposes of this study, Hispanics were grouped together. Thus there are five major racial/ethnic groups reported in this review. They are four non-Hispanic groups of Whites, African Americans, American Indians/Alaska Natives, and Asian/Pacific Islanders. There are also Hispanics, who may have reported themselves as one or more of the racial categories, including "Other"

There are at least two emerging populations groups in Oregon that are not readily detailed from U.S. Census Bureau data. Each of those groups is known to be present in Oregon, but Census Bureau procedures do not readily lend themselves to identification of them. Alternate sources of reliable data were not examined. There is, however, readily acknowledged presence of northern African and former Soviet Union and eastern European immigrants in Oregon.

U.S. Census Bureau data on languages spoken within the state is an indirect indicator of the presence of these two population groups. It is not, in itself, a sufficient data source to determine numbers of Soviet, eastern European and northern African Immigrants by local areas. Reliable sources of information will need to be consulted for details about the presence of these groups in future reviews.

Demographic information was compiled for 15 population groups: children, adults and elders by five racial/ethic categories. Data was compiled for county, mental health organization and state levels.

Specific information about numbers and percentages of population groups is contained in Appendices A and B.

Language information also was documented. Data tables at the state level provide information about numbers of people who speak a language other than English in broad categories. Data at the MHO level provides information specific to particular languages. Information at the county level indicates, by age group, ability of people to speak various languages. One may reasonably project where staff capacity should be developed and prioritized for development by reviewing data presented.

Language data presented at the MHO level is grouped only by youth and adults, including older adults. This is due to the fact that separate information for adults and older adults was not available through Census data.

Rationale for Review of Population and Language Data

Use of U.S. Census Bureau data, while subject to limitations, is the nationally accepted standard for population information. It is important to determine potential service populations in order to project service need. Census information has been used in this report to examine age, racial/ethnic and language needs of potential service recipients as a step towards quantification of needed cultural and linguistic service capacity. Federal requirements and guidelines establish the responsibility to meet unique needs.

Assumptions

This review assumes that the need for mental health services is relatively equal among all population groups. Various stressors may tend to increase the need. Factors include lower socio-economic status, lack of access to housing and health care services, recentness of immigration, post traumatic stress and various other variables.

This review also assumes that recipients of federal and other public funds have an obligation to assure equal access to services and similar results. Federal regulation at 42 CFR 438.207 requires that a state must ensure, through its contracts, that each managed care organization gives assurances to the State and provides supporting documentation that demonstrates that it has the capacity to serve the expected enrollment in its service area. People who must demonstrate eligibility for services are primarily affected.

The Federal Register: August 8, 2003 (Volume 68, Number 153) issued, "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition against National Origin Discrimination Affecting Limited English Proficient Persons. This applies to any potential recipients of services. Eligibility is not a consideration.

The guidance indicates that some actions will be considered strong evidence of compliance with a federal funding recipient's written-translation obligations. Those actions include:

> The federal funding recipient provides written translations of vital documents for each eligible LEP language group that constitutes five percent or 1,000, whichever is less, of the population of persons eligible to be served or likely to be affected or encountered. Translation of other documents, if needed, can be provided orally.
>
> If there are fewer than 50 persons in a language group that reaches the five percent trigger the recipient does not translate vital written materials but provides written notice in the primary language of the LEP language group of the right to receive competent oral interpretation of those written materials, free of cost.
>
> These provisions apply to the translation of written documents only. They do not affect the requirement to provide meaningful access to LEP individuals through competent oral interpreters. Oral interpretation of documents may not substitute for translation of vital written documents.

Vital documents are summarized as those which are critical to informed participation in services. They may include, for instance, intake, consent and complaint forms, any forms with potential for important health consequences, written notices of eligibility criteria, rights, denial, loss, or decreases in benefits or services, actions affecting parental custody or child support, and other hearings, notices advising LEP persons of free language assistance, written tests that do not assess English language competency, but test competency for a particular license, job or skill for which knowing English is not required, or applications to participate in a recipient's program or activity or to receive recipient benefits or services.

Limitations of the Data

U.S. Census Bureau data is collected each ten years, the last being in 2000. The demographics of any given geographic area of Oregon and other states are fluid. Population information becomes dated soon after the nationally accepted data is compiled and reported. Population data examined in this report is for the general population. Seasonal farm workers and other populations that will influence the level of need for services are not included in this descriptive review.

Census bureau data does not contain sufficient information to accurately identify characteristics that are important in a study of service need. One may not determine whether a person is a recent immigrant or a refugee. Ability to speak a language is determined by self-report, which, in itself, is influenced by the knowledge and understanding of the person being interviewed.

Caveats

OMHAS is, in essence, a safety net for people without other resources. A decision will need to be made about whether another population base should be used instead of the general population to project service needs. One alternative is the group of people at or below 200% of federal poverty level.

Information about recent immigration, refugee and migrant season worker status has not been documented, although these are important factors to be considered. To increase reliability of projections, alternate reliable sources need to be included in future reviews.

Findings

Statewide totals and percentages of race/ethnic groups are as follows:

Population Group	Total	Percent
White, non-Hispanic	2,584,969	78.64%
African American, non-Hispanic	51,123	1.56%
American Indian/Alaska Native, non-Hispanic	40,604	1.24%
Asian, non-Hispanic	90,686	2.76%
Hispanics	275,314	8.38%
Hawaiian/Pacific Islander, non-Hispanic	7,442	0.23%
Other, mixed race, non-Hispanic	236,791	7.2%
Total	3,286,929	100.00%

Within the state, 78.6% of the people are Caucasian or White. The total of other population groups is 21.4%. The 2000 census is the first census that provided a choice of citing mixed race status. In the 1990 census count, approximately 47% of Hispanics reported they were of White race; approximately 48% reported they were of "Other" race; the remaining 5% reported they were one of the remaining race categories. Details of the following charts are at Appendix B.

African Americans

The African American population is concentrated primarily in western, urban settings.

Counties	Population
16	Less than 200
8	200 - 500
6	500 – 1,000
4	1,000 – 5,000
Washington	5,000 – 10,000
Multnomah	40,000+

Multnomah County, with a population of 40,000 plus, represents more than half of the state's population of African Americans.

American Indians/Alaska Natives

American Indians are located throughout the state. There are nine federally recognized tribes in the state. In addition, there are significant populations of American Indians concentrated in major urban centers of the state.

Counties	Population
5	Less than 200
7	200 - 500
5	500 – 1,000
14	1,000 – 5,000
4	5,000 – 10,000
Multnomah	10,000+

The four counties that have populations of 5,000 to 10,000 American Indians/Alaska Natives have no reservations. Only Multnomah County has a population of greater than 10,000 but fewer than 25,000.

Asians

Asians also are concentrated in Western Oregon, primarily in urban centers.

Counties	Population
12	Less than 200
5	200 – 1,000
6	1,000 – 5,000
2	5,000 – 10,000
Clackamas	10,000 – 15,000
Washington	25,000 – 40,000
Multnomah	40,000+

Hispanics

Hispanics are distributed throughout the state. While they are often located in rural areas, approximately half of the populations are located in urban centers. They are a mix of first and subsequent generations. Other population groups tend to have more homogenous age distributions. Hispanics tend to have a smaller contingent of older adults and a larger contingent of single males than other groups. This suggests that there are a significant number of recent immigrants among them.

The OMHAS "Racial & Ethnic Diversity in Oregon" document notes that there are almost 100,000 migrant and seasonal farm workers in Oregon. They are located primarily in the I-5 corridor and in the near urban counties. They are not included in Comparable Access ratio calculations.

Counties	Population
5	Less than 200
6	200 – 1,000
14	1,000 – 5,000
4	5,000 – 10,000
Marion Multnomah Washington	40,000+

Hawaiian/Pacific Islanders

The Hawaiian/Pacific Islanders is the smallest identified population group, with about two-thirds, or 22, of the state's counties realizing 200 or fewer residents.

Counties	Population
22	Less than 200
8	200 – 500
Jackson	500 – 1,000
5	1,000 – 5,000

No counties are reported to have greater than 5,000 resident Hawaiians.

Demographic information was examined for Hawaiian/Pacific Islanders, but the small total number of them in the general population did not lend itself to a meaningful statistical examination of Comparable Access.

Russian, Former Soviet Union Immigrants, Northern Africans

No population statistics were readily available for these groups of people. There are anecdotal reports of significant increases population groups within the last ten to fifteen years in various parts of the state. Members of these groups have physical

characteristics similar to mainstream Americans. Their recent immigration and refugee status, language abilities and other factors make them remarkably different in their service needs and access characteristics

It is important to gather additional information about them. Alternate data sources will need to be contacted for information about these emerging populations.

Languages Spoken Other Than English

Some people may be surprised by the number of people in Oregon who speak a language other than English. A total of 428,975 people (13% of the state's population) in all age groups reported speaking a language besides English. This total is reflective of all individuals who spoke another language, irrespective of whether they spoke English very well to not at all.

Statewide there are 26,410 youth who speak English "Not Well" or "Not At All". These youth and others who speak English not well or not at all may be considered limited English proficient (LEP). Among LEP youth, Spanish is the most frequently reported language. A total of 18,432 Spanish speaking youth may be considered LEP. The remaining 7,978 LEP youth speak Indo-European, Asian/Pacific Islander and Other languages.

Among adults, 114,428 reported speaking English not well or not at all. Spanish speaking LEP individuals totaled 83,119. All other languages reported by adults totaled 31,309.

There are relatively few individuals in the older adult population of the state who may be considered to speak English on a limited basis. A total of only 9,440 people aged 65 and older were reported to speak English not well or not at all. Of those, 4,515 spoke Indo-European languages; 3,267 spoke Asian languages. This finding is consistent with the demographic finding that Hispanics in the state tend to be young adults with an emerging group of youth but relatively few elders.

In general, the presence of people who speak languages other than English is consistent with the distribution of racial-ethnic groups. Minority group members tend to reside along the I-5 corridor, especially in urban settings. The exception to this is the group of Hispanics, who also tend to reside in rural areas.

A related finding, to be addressed in the Provider Service Capacity section of this report, is that language ability of direct service providers is not tracked consistently. The personnel qualifications review seems to indicate there is insufficient capacity to provide mental health services to people in their own language. This appears to pose a significant barrier for many people. Information obtained from key informants tends to support this notion.

There is insufficient information available to determine the languages spoken by provider staff at either the professional, paraprofessional or other staff levels. There also is no consistent formal means to determine the language proficiency of staff who are responsible to communicate with LEP individuals.

The ability to determine how many staff speak a language other than English and how well they communicate in that language is an important consideration. Clearly there are many people in the state who are likely to require mental health services in an alternate language.

DEMOGRAPHICS RECOMMENDATIONS

A great deal of demographic data is available to and is used by OMHAS already. It will be important to formalize a method to track and update age and racial/ethnic data on a regular basis as a means to document the level of need for linguistically and culturally competent service capacity in light of continually increased diversity throughout the state.

- Establish a base population from which comparisons of access to service and related outcomes may be established among fifteen population groups composed of children, adults and elders among African Americans, American Indians/Alaska Natives, Asian/Pacific Islanders, Caucasians and Hispanics.
- Document factors that enable accurate determinations of the numbers of recent immigrants and refugees, by location, to promote reasonable projections of their service needs.
- Develop and implement indicators of access to and results from service that will enable determinations of comparable access and outcomes.
- Establish and enforce a policy that requires service to limited English proficient individuals to be provided by qualified staff or interpreters and which prohibits use of family members or friends in place of qualified staff or interpreters.
- Translate vital documents as client rights, consent to treatment and release of information into Spanish and other languages as provided for in federal guidelines.
- Develop or access a method to determine the proficiency of bilingual direct service staff and interpreters, and assure that it is implemented.

EXAMPLES OF IMPLEMENTATION STRATEGIES

OMHAS is responsible to provide service to Medicaid eligible people and others with limited access to services. General population data has been used in this report to

compile comparable access information. Consideration needs to be given to using an indicator of low income such as people at or below 200% of the federal poverty level.

In order to document information about people with recent immigration status, government and private agencies that specialize in serving refugees will need to be contacted. They will be able to provide accurate and reliable counts of recent immigrants, by location, who are likely to require specialized mental health services and who are often eligible for support during transition periods. Compilation of this information will be useful in projecting the level and location of projected service need.

In addition to use of comparable access ratios, by service modality, other indicators will be useful in measuring access and outcomes. Service penetration rates are used in some states. Stakeholders will have recommendations for other measurable indicators of access to service.

Washington has developed a system to test language proficiency among its social and health services and contracted interpreters that has been in place for more than ten years. Superior court systems have processes to certify interpreters for court proceedings. It is not necessary for OMHAS to establish a method to certify direct service providers or interpreters. Arrangements for testing may be made with other established agencies, and cooperative ventures are an option.

III. Service Statistics

Data Examined

The types of data sets examined in this study are:

Data Set	Source	Population Base
Outpatient Services by County	CPMS	Oregon Census Data
Crisis Services by County	CPMS	Oregon Census Data
Outpatient Services by MHO	MMIS	Oregon Census Data
Inpatient Services by MHO	MMIS	Oregon Census Data
Acute Community Hospital) by State	OPRCS	Oregon Census Data
Long Term (State Hospital) by State	OPRCS	Oregon Census Data

CPMS = Client Processing and Monitoring System

MMIS = Medicaid Management Information System

OPRCS = Oregon Patient/Resident Care system

General population data was compared to service data. The comparison process used a "Comparable Access" ratio (CA). For purposes of this review, Comparable Access ratio is defined as the comparison of a sub-population's representation in the service population to its presence in the general population. If a sub-population composes 4% of the general population in a geographic area (state, county, MHO), one might expect that the same sub-population should be approximately 4% of the service population.

Service data used in this study was provided by the Department of Human Services (DHS) Office of Mental Health and Addiction Services (OMHAS). That office also provided Oregon Census information. Comparisons or presence in the general population to presence in the service population were made among five population groups: African-American non-Hispanics; American Indian/Alaska Native non-Hispanics; Asian/Pacific Islander non-Hispanics; Caucasian or White non-Hispanics and Hispanics. Data was compiled by state, MHO, and county groupings.

Finally, data among the five major racial/ethnic groups was compared among three age groups, children, aged 0 to 17; adults, aged 18 to 64 and elders, aged 65 and over.

Rationale

For purposes of this study, three types of data were examined by age and race/ethnicity. This afforded an opportunity to compare basic access to crisis, outpatient and inpatient mental health care by age and racial/ethnic groups at county, MHO and state levels.

Basic access is defined merely as the appearance of an individual in a particular type of service, irrespective of other measures. If a person was enrolled in outpatient services, no distinction was made between attendance at one session or multiple services.

This initial review is intended to identify service patterns that bear further examination and which support the need for efforts to expand service capacity based on preliminary findings. In the future, more detailed or focused examination is merited.

Assumptions

The goal of a culturally competent system is to provide relatively equal or comparable access to services for people of all ages and backgrounds. Results of service or outcomes also are expected to be comparable among service recipients even when the methods to achieve them may vary. Achievement of comparable access and outcomes is considered to be cost effective and humane.

The "ideal" CA ratio of 1.0 is virtually impossible to achieve for any particular group. The comparison of the ratio of people in the service population to the ratio of their representation in the general population is a general indicator of service access. The CA is considered an indicator of whether one or more populations are "under-represented" in some services and perhaps "over-represented" in some services. Figures significantly above or below a CA ratio of 1.0 are considered indicators which merit further examination and serve to identify whether where additional action must be taken.

Variance in CA by age group for a particular service category is considered more acceptable than variance in the same category among racial/ethnic groups. As an example, children are likely to be physically healthier than elders. Thus it may be understandable to find a higher percentage of elders than children in restrictive settings due to infirmity or other physical considerations. That level of variation is based on characteristics that are age based.

Variation among ethnic groups in the same service category is not considered as acceptable. The finding that one group has significantly higher or lower rates of access to a given service deserves further examination.

Limitations of the Data

Only broad race/ethnicity comparisons were compiled as a result of data availability. Additional factors such as gender, detailed race/ethnicity and language ability are not included in this report.

Reliability of the data is highly dependent on the accuracy of the reporters of it. Multiple data sources were used, and there was some variability among them, depending on the data examined.

Caveats

Use of a ratio to a ratio comparison is not considered a statistically reliable calculation. One should be cautious to take into consideration CA ratios over time and the effects that smaller populations in an MHO or county service area may have on statistical calculations. The smaller the numbers involved, the less reliable the comparison becomes.

When reviewing detailed Comparable Access information presented in Appendices F through L, care should be exercised to review both percentages and numbers served. For children's crisis services, American Indian children have a relatively higher CA ratio of 2.93, but only 133 children were served. Caucasian children have a significantly lower CA ratio of 0.67, but 1,430 children were served.

Use of a CA ratio is considered a useful indicator nonetheless, inasmuch as it serves to indicate where more sophisticated measures of review need to be pursued.

Findings

Statewide CA ratios are presented for Outpatient, Crisis, Community Inpatient and State Hospital services on the next page of this report. Commonly used terms for racial/ethnic groups are used due to space considerations in the presentation. Details, including specific numbers served are found in Appendix G. CA ratios specific to MHOs are presented in Appendix I and J.

	OUTPATIENT				**COMMUNITY INPATIENT**			
	Children	Adults	Elders	All Ages Combined	Children	Adults	Elders	All Ages Combined
White	1.27	1.13	0.31	1.09	0.18	1.35	0.28	0.87
Hispanic	1.13	0.55	0.42	0.73	0.07	0.47	N/A	0.30
Asian	0.50	0.87	1.59	0.38	0.04	0.59	N/A	0.40
Indian	2.78	1.99	0.55	3.10	0.24	1.32	0.66	0.90
Black	4.50	2.71	0.80	1.22	0.63	1.33	0.83	2.82

N/A indicates none were reported.

	CRISIS				STATE HOSPITAL			
	Children	Adults	Elders	All Ages Combined	Children	Adults	Elders	All Ages Combined
White	0.67	1.50	0.33	1.09	0.36	1.50	0.62	1.05
Hispanic	0.45	0.92	0.37	0.73	0.15	0.88	N/A	0.57
Asian	0.28	0.44	0.23	0.38	0.33	1.17	N/A	0.85
Indian	2.93	3.46	0.28	3.10	0.84	2.21	N/A	1.60
Black	0.95	1.49	0.26	1.22	2.09	6.87	5.60	5.15

N/A indicates none were reported.

Statewide
Children's Intensive Treatment Services

Day Treatment 2004

Ethnic	unique served
Asian	3
African American	46
Hispanic	19
American Indian	22
Unknown	17
White	463

Residential Treatment 2004

Ethnic	unique served
Asian	3
African American	70
Hispanic	30
American Indian	72
Unknown	64
White	853
Other	1

pulled by JCC from MMIS 5/05

Only statewide data is provided. There is no appendix related to Children's Intensive Treatment services due to the fact that the small numbers of racial/ethnic minority children served make is difficult to draw reliable conclusions from the data.

In general, Caucasians as a group and by age groups were closer to the "ideal" CA ratio of 1.0 than others. Where there was significant variance from CA in a particular age group or service category, Caucasians generally remained closest to the desirable ratio.

Statewide results indicate that African Americans and American Indians/Alaska Natives tended to have high Comparable Access ratios in outpatient services, an indication that they are enrolled at rates higher than their rates in the general population. The state level results also indicate that both of those groups have high CA ratios in inpatient settings.

One might expect to see inpatient service access lower than for outpatient among these two groups, based on the assumption that effective outpatient service is expected to minimize the need for inpatient services. The finding of higher inpatient access does not, in itself, indicate that outpatient services are not effective. It does, however, indicate that African American and American Indian population groups in Oregon are being served in inpatient settings at a rate higher than others, a finding that deserves to be studied further.

Opposite indications were found for Asians and Hispanics. They tended to have low CA ratios both for outpatient and for inpatient services. This is not considered an indicator that these two groups have lower need for inpatient services. It is an indicator that they receive these two services proportionately less than others and that more needs to be done to understand this finding.

There were relatively few children and elders, by number, in state hospital and inpatient settings. The reliability of the data is affected as a result. It will be useful to examine in greater detail whether the children and elders are hospitalized primarily by one or by multiple sources and to determine what needs to be done about that.

Relatively few children statewide were reported to have used crisis services. A total of 1,430 Caucasian children were served. The next highest group, Hispanics, totaled 153. Other groups had smaller totals served. The CA ratio for American Indian children was 2.93, but the total served was 133.

Significant numbers of children of all racial/ethnic groups received outpatient services. African American (4.50) and American Indian (2.78) children had the highest CA ratios. Asian children (0.50) had the smallest CA ratio and the fewest served; there were a total of 276. Hispanic children had a CA ratio of 1.13. By comparison, the CA ratio for Hispanic adults was 0.55. This is likely due largely to eligibility for service differences, as noted among multiple key informants.

A general pattern was noted for adults. Caucasians are at or above 1.0 CA in Crisis, Outpatient, Community Inpatient and State Hospital service categories. African Americans and American Indians tend to have comparable or higher CA ratios in all service categories than Caucasians. Asians and Hispanics tend to have lower CA ratios than other groups for inpatient services.

While the total number of people served is relatively small, African American adults realized the highest CA ratio for state hospitalization. The CA ratio is 6.87, followed next by American Indians at 2.21. It will be useful to examine other service considerations such as length of stay and recidivism rates.

Older adults as a group consistently had lower CA ratios in all service categories than children and adults. Elders also totaled the fewest numbers served. With few exceptions, people 65 and older realized CA ratios of 0.50 and lower.

Statewide only 455 people age 65 and older were reported to have used Crisis Services. Of those, 431 were Caucasian.

Asian elders had a CA ratio of 1.59 in Outpatient services. Due to the small number of people served, it is possible that one program in Multnomah County that specializes in serving older Asians may have contributed significantly to the higher CA ratio. Insufficient details were available to examine that possibility.

African American elders had a CA ratio of 5.60 at State Hospitals, a finding that is consistent with other indications of restrictive care for children and adults within this major population group.

Graphs titled "Statewide Comparison of Service Access by Population Groups" are provided in Appendix H. These graphs illustrate ranges of service access by population group by MHO. A CA ratio well below 1.0 is considered an indicator that bears further examination equal to a rating well above 1.0.

Appendices G through L display CA ratios for crisis, outpatient and inpatient services. They are listed by state, MHO and county groupings

SERVICE ACCESS RECOMMENDATIONS

Service data already is compiled in a manner that will facilitate monitoring of service by age and racial/ethnic groupings. Determinations need to be made about a baseline for service comparisons. More specific performance standards and accountability measures need to be formulated and put in place to allow for determinations of comparable access to service to be made on an ongoing basis.

- Adopt a policy to ensure comparable access to services and outcomes from service are achieved across age and racial/ethnic groups.

- Define and adopt measures of service access and outcomes by March 31, 2006 in collaboration with stakeholders, MHOs and provider agencies.
- Phase in a range of acceptable performance levels in providing service access and outcomes by age and racial ethnic groups in contract among service providers over a four year period, beginning July 1, 2006.
- Establish a method to include language in data collection elements as an additional measure of comparable service access and outcomes.
- Establish a method to determine whether qualified staff and interpreters are serving limited English proficient individuals.
- Adopt and phase in more detailed or focused measures of service access and outcomes in contract beginning July 1, 2008.
- Provide technical assistance and support the implementation of access and outcome standards by identifying and disseminating information about practices that will lead to comparable access and outcomes.
- Develop and publicize regular progress reports, by MHO and county groupings to encourage accountability and collaboration among all service providers.

EXAMPLES OF IMPLEMENTATION STRATEGIES

Stakeholders will need to be consulted to formulate potential measures of access and outcomes. Base population determinations will need to be made, e.g. use of general population data or low-income population data.

Acceptable ranges of performance will need to be established. Variation in performance is to be expected, and establishment of an acceptable level of variation will be important to establish.

A performance baseline will need to be set for each individual MHO by whatever measures are adopted. If, for example, use of a comparable access ratio is the measure of access, a baseline performance is set for calendar year 2005. If an MHO realized a CA ratio of 0.25 for given population group, it is reasonable to ask that half the difference between a CA ratio of 1.0 and 0.25 or attainment of a CA ratio of 0.50 is expected within a two year period. In the following two year period, improvement by half the difference is expected again. In the third biennial period, attainment of 1.0 becomes the performance standard. Thus transition is incremental, and diversity in service is achieved during normal consumer attrition in service.

This report includes only an overview data provided to OMHAS by MHOs of service practitioners. It does not include a review of data forms used to collect

information about consumers and services they receive. If there are no methods in place to determine primary language of people served, data collection fields will need to be added to consumer service documentation forms. Likewise if there is no method to determine whether the consumer was served in the person's primary language, it will be necessary to address the need to document that also.

Future, more detailed measures of access and outcomes also will need to be developed in collaboration with stakeholders. Examples of access include: The number of contacts, by race/ethnicity, is comparable for outpatient services. The frequency of use of crisis services is not significantly higher or lower in one group as compared to others. Examples of outcomes are: The length of stay at hospitals is similar among various population groups. Use of seclusion and restraint varies only slightly. Rates of return to employment or other meaningful activities are similar among racial/ethnic groups.

IV. Review of Provider Service Capacity

Rationale for Review of Service Provider Qualifications

The intent of the review of direct service provider or service practitioner qualifications was to try to determine whether and how many bilingual, bicultural or bilingual and bicultural staff were present in each service area. The intent was also to begin to identify which direct service providers already have attained advanced credentials and specialized expertise to serve racial/ethnic and linguistic minorities. OMHAS provided available practitioner reports, as submitted by MHOs.

Assumptions

The ability to examine consistent, detailed direct service provider information will assist in a comparison of service patterns to available specialized personnel. Identification of desirable service patterns in areas where qualified staff are known to deliver services potentially is a key indicator of the utility of those personnel. The ability to establish parallel patterns between desirable service patterns in the presence of qualified staff will lead to more informed statements about where service capacity needs to be developed to address disproportionate or undesirable service patterns.

Limitations of the Data

OMHAS receives reports from Mental Health Organizations (MHOs) related to service practitioner staff and their qualifications. Reports were provided in hard copy; electronic copies were not available. Service practitioner characteristics information was available only for seven of the nine MHOs.

There is significant variance in the formatting of the reports. Accordingly there is variation in the data reported. In general, service practitioners are listed by name, by amount of time worked, by practitioner type, practitioner educational or professional designation and information related to individual specialty. Some reports appear to place more emphasis on one aspect than on others. One report contained detailed information about staff language capability; other reports did not include this information.

Caveats

There is great variation in formatting and information reported among the various MHOs. The data set available was incomplete. Consequently the attempt to

establish baseline information was abandoned. Recommendations for data to be collected in the future are provided below.

Findings

The number of service practitioner staff reported tallied in the hundreds among the seven reports provided. A simple table was created to provide an organized review of the varied reports. Review of the table did not produce sufficient comprehensive and reliable information on which to base definitive statements. The following observations were possible.

- There is consistency in identification of the practitioner, by name, and general credentials.
- There is variation in the format of the report even when submitted for separate counties within the same MHO.
- The reports usually include the number of hours worked per person and whether they are employed or on contract.
- Most reports indicate the practitioner is a QMHP or a QMHA. In cases where practitioner level is not identified, there isn't always an explanation.
- Specialty areas of practice are identified broadly and inconsistently among reports.
- A wide range of practice specialties were identified. They included children, adults and geriatrics. More specific specialties also were identified such as families, dual diagnosis, skills training, Crisis, Psycho-social Rehab, SPMI, Gambling, juvenile rehab, parenting, FSAT, Anger management, Suicide prevention, developmental disorders, eating disorders, grief and trauma.
- In cases where an MHO provided specialty practice information for staff, it wasn't always possible to determine the geographic location in which the person practices. This is a limitation particularly for multiple county MHOs.
- One agency identified language specialties. Among them were Mien, Cambodian, Bosnian, Hispanic, Vietnamese, Kurdish, Lao, Ethiopian, Somali, Russian, Chinese, Korean, Japanese, Spanish, Tagala (sic), and Farsi.

Compilation of staff qualifications is a sound practice. It is consistent with requirements in federal regulations at 42 CFR 438.207 and guidelines published in the Federal Register August 8, 2003, V. 68, No 163, to determine service capacity in relation to service needs. OMHAS is commended for gathering staff qualifications information and in moving in the direction of encouraging MHOs

and provider agencies to make informed decisions about where and to what extent they should develop staff capacity.

There is consistency in reporting among reporting organizations in the areas of professional and non-professional credentials and amount of time worked by individual practitioner. There is also regularity in reporting service practitioner specialties. One agency reported language specialties.

There was variation in reporting formatting and information reported. Reports were not available from all providers in all areas of the state.

A standardized report will serve as the foundation upon which to base comparisons of general population demographics and service population statistics.

Accordingly an informed service practitioner characteristics report will promote the ability of provider agencies, MHOs and OMHAS to identify areas where service capacity is needed.

In addition to the service practitioners characteristics fields currently collected, key fields need to be added to the report to promote knowledge of language and practice specialties. Those fields include:

- Age Specialty—children, adults or elders
- Race/Ethnicity Specialty—African American, American Indian, Asian-Pacific Islander, Hispanic and former Soviet Union, with an option to state other groups
- Language spoken with proficiency other than English
- Practice specialties such as dual diagnosis, PTSD, DBT, eating disorders and other unique practices may be gathered for use by MHOs.

The goal of the use of practitioner data is to align practice specialties with the need to address undesirable service patterns.

Note: *A person may be bicultural or bilingual but may not have practice specialty expertise. A person becomes a specialist in serving a particular group through study and practice specialization. Qualification as a specialist in serving a particular racial/ethnic group is a bona fide occupational qualification which may be achieved irrespective of a person's individual personal characteristics.*

PROVIDER SERVICE CAPACITY RECOMMENDATIONS

Information about the qualifications of practitioners already is gathered. Additional data about linguistic and cultural competencies and about staff service specialties need to be incorporated into service practitioner reports. Practice standards, competencies and methods need to be developed further. It will be important to work towards the development of linguistic and cultural competencies among service practitioners on a level that is consistent with changing demographics in order to promote comparable access to service and to set a solid foundation for comparable outcomes.

- Establish qualifications for Minority Mental Health Specialists.
- Establish a policy in which racial/ethnic minorities served in the public mental health system will be served by a person who qualifies as a Minority Mental Health Specialist or by a person who receives consultation from such a specialist at intake, at critical treatment junctures.
- Provide support and assistance to contractors and sub-contractors in the implementation of the proposed standard for use of Minority Mental Health Specialists.
- Create a standard report in an electronic format for all reporting entities to use when submitting service practitioner report information that enables determinations of levels of specialized service expertise.
- Review service practitioner reports annually, by MHO, and use them as a guide to target development of further specialized expertise.

EXAMPLES OF IMPLEMENTATION STRATEGIES

When creating an electronic service practitioner report, definitions of key terms need to be developed for standardized service practitioner reports. A basic, short set of instructions need to be provided.

Basic qualifications for Minority Mental Health Specialist need to be that the individual practitioner has an advanced degree in a mental health related field, at least one year of experience specializing in serving a specific population groups (i.e. African Americans, American Indians, Asian/Pacific Islanders, Hispanics and former Soviet Union eastern European immigrants), and a minimum of 100 clock hours of specialized training related to serving racial/ethnic minorities in general.

A practice standard for use of specialists to serve minorities or for general practitioners to consult with specialists at critical treatment junctures must be phased in over a period of five years from date of adoption.

Critical treatment junctures occur at consumer initial assessment or intake, upon usual review of consumer progress, prior to placement in restrictive care and especially when involuntary placement is involved, upon discharge and when there is a significant change in a consumer's circumstances.

Access to consultation from specialists to general practitioners needs to be prioritized for practitioners who are working to become Minority Mental Health Specialists to expand access for minority consumers and foster the development of additional specialized staff.

Support from OMHAS for implementation of the use of minority mental health specialists needs to include facilitation of the development of a training program for specialty practitioners and development of specialized assessment instruments that factor culturally specific consumer characteristics.

Practice protocols need to be developed for use in consultation between minority mental health specialists and generalists to promote improved practice and service results.

Agencies that use culturally specific interventions or intervention tools and other unique service approaches must be supported through encouragement and assistance in documenting emerging, promising and evidence based practices.

V. Key Informant Survey

Rationale for Key Informant Survey

The intent of interviewing a knowledgeable group of people throughout the state was to obtain a description of the mental health service system's current state of development through the impressions of people who are familiar with it. Key informant interviews serve to gain a basic understanding of what specialized service capacity exists already. Anecdotal reports, combined with review of available objective information, are complementary.

Method for Gathering Information

All individuals interviewed were contacted prior to the interview. The purpose of the interview was explained. Each of the people requested to participate agreed to do so; no one declined.

Survey participants were provided a copy of the survey materials in advance of the survey at their option. Most of them received materials in advance.

A set of questions was used to gather information about the respondent's knowledge of service area demographics and service needs of the various populations residing in the area. Respondents were asked to describe barriers to service and efforts to address them. Informants were also asked about how to determine sufficiency of service capacity and about their knowledge of emerging and best practice.

Respondents were informed that their individual responses would remain confidential. No responses are attributed to or are attributable to any specific respondent. All results are based upon aggregate or grouped responses.

Assumptions

Use of key informant interviews is an effective method to gather descriptive data. While the information gathered may not be statistically reliable it is still significant. General impressions are useful as indicators of baseline information and existing practice. Anecdotal reports often lead to the ability to focus efforts.

Limitations of the Data

A total of seventeen people were interviewed. At least one individual was interviewed from each of the nine MHOs in the state. Fourteen counties were represented among informants in the survey. Seven of the respondents were from eastern Oregon counties; others provided information about rural areas outside the I-5 corridor.

Twelve women and five men were interviewed. Two members of each racial/ethnic group were interviewed, except for Asians; no representatives of that group were interviewed.

Family members and advocates were approximately 25% of people interviewed. There were representatives from affiliated agency and university settings. One person was an MHO administrator. Several people were managers or administrators at provider agencies; others were direct service practitioners at both the professional and paraprofessional levels.

Caveats

The bulk of the strengths identified throughout the OMHAS service system were identified through the key informant survey. Attempts to distill them and still do justice to reporting them have been difficult.

All responses were first reviewed and summarized. Responses to questions about direct service providers were not considered sufficiently reliable to include them in this report. A significant number of informants were not able to respond with confidence about the accuracy of their statements about service practitioners. Consequently this report does not include additional service practitioner information from the interviews.

Key Informant responses were reviewed and edited for inclusion of this report. The "Detailed Summary of Selected Key Informant Responses" at Appendix N provides more details about the impressions of respondents, their responses and the remarkable amount of promising work that is taking place within Oregon.

SUMMARY OF RESPONSES

What population groups appear to be more prevalent in your service area?

Each of the respondents was able to respond to this question readily. Some of them had specific or informed estimates of the percentage of a specific group within the county or service area. Some respondents had age specific information such as the presence of unaccompanied male Hispanics resulting

from recent immigration or the percentage of White adults being significantly larger than the percentage of White children in the service area.

Several respondents mentioned emerging former Soviet Union and eastern European immigrants as well as northern African refugees and immigrant communities. Those responses came from respondents primarily in urban settings.

In general each of the respondents had a basic to advanced knowledge base about the presence of various population groups in the service area. A few appeared to have taken time prior to the interview to gain additional information and were able to respond in more detail than others. It is apparent that there is great awareness of the presence of diverse populations among key informants. It is not as apparent that the informants, as a group, have used confirmed demographic information as a base to target services to diverse populations.

What services do they need?

A full range of services were reported to be needed. Irrespective of the population group, respondents indicated that services are affected by cultural factors such as belief systems and behavioral norms that vary from mainstream practices in accessing mental health and substance abuse service.

In addition to culturally competent outpatient and crisis services, specialized services such as detoxification services for adolescents and residential treatment for Hispanic women were noted. Outreach services are needed in order to engage people in need of services but who aren't familiar with service availability or who may not relate to generalized service modalities. Peer support services were mentioned as an effective intervention.

Linguistic ability to serve people in their preferred language is a major service need frequently identified. Key informants also indicated that racial/ethnic minorities often relate better to a person from their culture or origin or at least a person who has experience working with a particular group.

Some of the respondents to the survey provided group specific responses. For example African Americans were said to need services for depression and anxiety, particularly related to life stressors such as prejudice, oppression and negative community events such as police shootings. In addition to transitional issues and inter-generational conflict among newly arrived

Hispanic immigrants and their children, domestic violence and substance abuse services were noted.

American Indian/Alaska Native people were considered to need treatment for depression and PTSD along with interventions for addictions and substance abuse. Asians were said to need crisis services because of their lower acceptance of services and greater likelihood not to access them. Eastern European and former Soviet Union people were reported to have needs for assistance in transition, be affected by stressors from being separated from traditional support systems, and require linguistic accommodations. Their access to service is affected by stigma and negative perceptions of mental health interventions.

Linkages to other services and supports were also reported to be important for all minority groups. Connections and easy access to community resources such as schools, churches, and other provider agencies were considered significant. Respite care, after school and summer school activities were reported to be needed. People were reported to need mental health, substance abuse and related services in their own language, in accordance with their cultural in a way that they can relate to them consistent with their every day lives.

What services are available?

There is a promising array of services available now and more are being developed around the state. There are four types of service delivery arrangements that were identified from the responses of the key informants.

- Use of specialized staff at mainstream agencies in general assignments

A number of mainstream agencies have hired individual or small numbers of staff with bilingual and bicultural specialized service capacity. They are employed within the general agency setting. These staff may provide in agency or outreach services. The agency is early in its stage of staff and program development to meet specialized service needs. This model appears to be found more frequently outside urban settings.

- Use of specialized staff at mainstream agencies where there is focus specifically on one or more populations

Some mainstream agencies have developed a focused program to serve one or more specific population groups. A group of staff specialize in providing outreach, crisis and other outpatient mental health services to target racial/ethnic groups within the service area. These staff may provide training

and consultation to general practitioner staff in order to expand the level of expertise available to meet service needs.

- Community based services that are provided by and within group specific communities

A few community based population specific agencies have begun to develop mental health or substance abuse intervention services. The number of staff who are available to provide services remains limited, but they do have specialized knowledge of the needs of their target populations and an understanding of how those services should be provided. Bilingual master's level practitioners and community outreach paraprofessionals are both used to engage and serve members of the target community.

- Cooperative arrangements between mainstream mental health or substance abuse agencies with community based agencies that service specific communities

Mainstream agencies also are beginning to establish working agreements with minority community based agencies that provide health and related services but haven't yet established mental health or substance abuse service capacity. Professional and paraprofessional mental health personnel are hired by the licensed local provider. The mental health providers are then out-stationed to a health clinic or social service agency that has already established itself in the local minority community.

Each of the nine federally recognized tribes around the state appears to have established mental health and substance abuse outpatient treatment services at varying levels of capacity. Residential services remain limited, and inpatient services continue to be provided outside of tribal operations. The need for services on and off reservations is considered to continue to exceed service capacity.

A number of agencies have begun to "grow their own". Staff with limited training and expertise are being hired and supported in their professional growth. Some mainstream agencies have formulated and are implementing cultural competence plans. Boards of directors have recruited members of minority communities and otherwise engaged communities to guide them in delivering acceptable and competent services.

One urban based agency has established a multi-cultural team of bilingual, bicultural staff with a specialized mission to serve all of the five major racial/ethic groups in the service area. The team members are Asian, African American, American Indian, Hispanic and eastern European in origin. They have multi-lingual abilities. Their charge is threefold.

- They provide direct intervention services on a crisis and short term basis.
- They deliver training to general practitioners to assist their understanding of the need for and value of culturally competent services.
- They are available for culturally specific consultation to generalist practitioners who are serving racial/ethnic minority consumers of service.

There is a rural based county that has mental health outpatient services available in Spanish offering intensive outpatient and residential alcohol and drug treatment.

Are there barriers to service?

All survey respondents agreed that there are barriers to service.

What are the barriers?

Among the most frequently identified barriers were:

- Stigma and difference in understanding of mental health and substance abuse treatment among racial/ethnic minorities and providers of service, including lack of familiarity with availability of services and the need to offer services such that racial/ethic people will relate to them
- Lack of eligibility for services and benefits
- Lack of linguistically competent and clinically trained practitioners to serve specialized service needs
- Insufficient community based organization capacity to deliver services and a need to increase partnerships with them to maximize the reach of established mental health and substance abuse providers
- The need to engage potential service consumers by focusing first on basic human needs such as housing, employment, and health care prior to focusing on mental health or substance abuse treatment through active outreach efforts.

What might be done of a tangible nature to address the barriers?

Responses to this question were grouped into four categories. The responses below are reflective of the solutions put forth by key informants.

Staffing

The state needs to take a leadership role to assure that there are sufficient levels of staff available to meet the specialized needs. We need to develop a work force for the future. We should develop professionals from their communities of origin.

Respondents said it is important to recruit and retain bilingual and bicultural direct service staff at provider agencies. They also said it is important to recruit and retain bilingual, bicultural staff at agency, county and state level management and administrative levels.

Students who are placed in clinical and administrative internship positions need to come from more diverse groups.

One organization pays a salary differential for staff that is culturally competent.

Administration

State and federal funding must be used to assure that linguistic and culturally competent services are available. Funding allocations should have provisions to assure equal access to service.

Agencies that know how to provide health and other human services to minority communities are not as well established in delivering mental health and substance abuse services. Mental health agencies don't have a minority community base. Cooperative arrangements need to be fostered among mental health organizations and community based agencies that already serve racial/ethnic minorities to expand the availability and acceptability of services.

The state should include geographic distance in its funding formula. There needs to be more funding for indigent services and more flexible funding in serving children.

OMHAS needs to assure that ethnic demographic and service data is reviewed at the state and local level. The data should be the basis to determine where adjustments in services need to be made.

The state needs to take more leadership in standards, training and clinical practice. Oregon Administrative Regulations ought to be examined for changes to promote better access and clinical standards. OMHAS needs to assure that policies and procedures as well as service standards are developed and put in place.

OMHAS should provide technical assistance to mainstream and community based agencies in the provision of culturally competent services. OMHAS should conduct workshops for minority community based organizations to bid on services.

Counties need to be held accountable for how funds are distributed to assure equal access to services. Mainstream providers must be accountable for serving all populations.

Performance based contracts are needed. They should promote the development of minority service programs and providers.

Clinical Approaches

Clinicians should ask about patient concepts of illness and processes of healing. There need to be culturally competent methods of accurate diagnosis. Clinicians need to be willing and able to explain variations in services to consumers on their own terms.

There should be bilingual, bicultural staff to provide services. Liaisons should be developed within communities to include working relationships with indigenous healers.

Culturally based diagnostic tools need to be developed and used. Consumer evaluation needs to include assessment of cultural and family strengths as well as community strengths.

Community Involvement

Outreach to diverse communities needs to occur. Communities should be involved in planning services they need. Mainstream providers should have guidance from culturally specific providers and professionals to serve people from specific groups.

There needs to be coalition building among the diverse communizes and shared knowledge as programs are developed.

Parent involvement should be assured and increased at every level of decision making.

Who might be responsible to address the barriers?

Policy makers are responsible to make changes.

This needs to be a multi-system approach. Purse holders have a responsibility to form standards and measurements. Provider management and boards need to commit resources and assure they are targeted.

OMHAS is responsible to address the disparities by clearly stating that counties have a mandate to provide demonstrated access and setting standards. There are no apparent staff people at OMHAS responsible to work with counties to do this.
Community leaders from respective minority groups need to participate in shaping policy and practice.

Administrators are responsible to address systemic barriers. Clinicians are responsible to learn new techniques.

Are there current efforts that your agency is making to improve service capacity for the various population groups?

A number of notable efforts are taking place around the state. Examples are listed below in no specific order, as reported by key informants.

When OMHAS offers training, they try to make sure that there are funds for minority and rural communities. OMHAS is developing distant learning opportunities.

One organization monitors the number of new clients seen on a monthly basis by age and ethnicity. The same organization matches consumers with staff who can best meet their needs.

One agency has developed a business plan to expand service capacity for racial/ethnic minorities. The plan is to have teams of community health workers and licensed clinical therapists engage the community. The same agency holds community groups that are educational in nature but which provide for assessments for mental health and substance abuse to be conducted and referrals for service to be made.

More than one agency is "growing their own". They have in-house methods to recruit and train direct service staff to meet the needs of minority consumers.

An affiliated agency, that doesn't deliver mental health services, still provides recommendations about service needs of the target population to mental health providers. Agency staff are developing continuing education programs for direct service staff that address practices changes including specialized counseling skills.

One organization makes multiple efforts. There is a cultural relations department and a strategic plan to develop cultural competence that has been endorsed by management and the organization's board of directors.

This organization has a very active cultural relations committee that monitors and implements the cultural competence plan. There is a team of cultural specialists staffed by a group of multi-ethnic mental health specialists that provide direct services, training and consultation to other staff in the organization.

The same organization employs a limited English proficient coordinator who is responsible to track and review incidents within the agency related to language and service provision.

Direct service and other personnel receive training in delivering culturally competent services. Training is specific to particular minority groups. The organization provides and supports culturally specific programming for African Americans in-house and for Latinos through a multi-agency project in the community.

The organization produces a quarterly report of ethnic clients served and ethnic staff who serve them. Goals for improvement are formulated based on results of the reports.

Another agency has used paid practicum placements to promote additional development of qualified service staff.

Still another agency has begun to establish partnerships with a community based health clinic. The mental health agency hires staff and stations them at a satellite office within the health clinic, where clients are more likely to access and accept services. The agency is also involved in using a "braided care" approach to delivery of services. Clinicians are able to access funds from various sources to provide support and assistance to mental health clients.

The number of bilingual professionals is tracked, and gradual improvement has been recognized elsewhere. Penetration rates also are monitored and have increased gradually. There are bi-monthly specialized staff team meetings.

There is an alcohol and drug abuse intensive outpatient and residential program for men in Spanish. The program has served 28 of 26 counties to date.

One agency hired an outside consultant to help them be more culturally competent and diverse. Implementation of the recommendations is pending.

What efforts are other individuals or agencies making to improve service capacity for the various population groups? What are the other efforts?

There are several specialized community based agencies in Multnomah County that target American Indian adults and youth, Hispanic, Asian, and

refugee communities for delivery of mental health and substance abuse services, all on an outpatient basis.

An urban American Indian program has developed capacity to identify employment opportunities for their target population.

Four community based social service agencies have formed an affiliation to develop Latino mental health services.

Some mental health providers are using mentoring and internships to develop staff capability.

A family to family training program was designed by NAMI and has been translated into Spanish. An affiliated agency uses a Spanish language curriculum to teach families about the dynamics of mental health.

A methamphetamine task force has been convened in one county. The task force includes faith based, corrections and treatment providers to address this drug problem. City, county and tribal goals are the same, and they are looking for coordinated solutions.

Health care clinics have developed partnerships with mental health providers and have established limited independent internal mental health service capacity.

How will your agency know whether and when sufficient service capacity has been established?

Responses to this question were grouped into three categories.

Indirect Indicators

There will be diverse representation on policy and decision making groups and governing bodies.

Recovery celebrations will have even more people participating.

When you can walk into a mental health place and know that you can get the help you need, we'll be there.

It's difficult to know when services are sufficient, because there are people who don't access services and population groups that are under-estimated.

Data Based Indicators

We will be able to know when penetration rates are comparable between mainstream and other communities. Outcome data from indicators such as high end services like crisis hospitals and jails will be comparable across groups.

Services will be sufficient when we see outcomes that are fairly equitable. If 13% of the mainstream population has favorable access and outcomes, we should expect to see comparable results for minority populations.

People will be able to tell when the methamphetamine problem is cut in half and there aren't long waiting lists for treatment services.

If hospitalization is low but alternatives to hospitalization are high, we are doing a good job.

We should expect that the service and administrative workforce should be representative of the groups in the community.

Consumer Satisfaction Indicators

If I went to minority community leadership and they indicated satisfaction with the level of service capacity, that would be a good measure.

We will know when there are no complaints from families and when people seek services on their own.

It wouldn't work just to do a satisfaction survey. People may not even be there to survey if they weren't served well in the first place. Focus groups need to be employed.

Are you aware of any culturally competent emerging or best practices?

Concepts

Some respondents were concerned about implementation of best practices. The current momentum to adopt them seems to assume that anything not identified as best practice isn't a good practice.

Best practice involves folks who are culturally aware and involve families and a broader social network like friends and clergy.

Emerging Practices

One of the respondents reported that everybody at the agency gets a cultural inventory at intake.

There is a crisis center that has services available in Spanish and bicultural staff.

A multi-ethnic team of cultural specialists has been in operation for well over two years. They provide short term and crisis intervention services, conduct training for general practitioners and offer consultation to practitioners who are serving racial/ethnic minority individuals.

At least one substance abuse provider has developed intensive outpatient and residential treatment services for men in Spanish.

One organization has a grant to document the work of their African American dual diagnosis work. The funds are specifically to establish a promising practice.

Use of Talking Circles is one effective practice, but it's not an officially recognized practice. Sweat lodges are also successful. Another is Back to the Boards, use of traditional baby boards for Native communities. Some people are using challenge courses, and others have adopted rights of passage programs that help youth come of age and be influenced and supported by their elders. At least one tribe is using the Family Unity model, where families decide what is best for them and have wraparound services.

Related and Collaborative Efforts

Use of cultural competence plans within an agency is an emerging but undocumented practice.

Some programs have begun to translate and adapt established interventions into other languages.

Collaborative efforts among community based organizations and established mental health agencies to develop and deliver services to target populations are occurring.

Placement of mental health workers at outstation locations such as health clinics and other community based sites is becoming more common.

Community Involvement

Use of NAMI translated curriculum materials is one step.

Families are working with provider staff to design individual service plans.

The state family networks put together a book on the subject of cultural competence within the last year. The subject of the statewide family network in June 2005 was cultural competence.

Is there anything else you think is important for me to know about mental health and related services to children and ethnic minority populations in your county or service area?

One of the things that would make a huge difference is for DHS to assist communities to develop real partnerships. DHS should promote, encourage and support local partnerships to increase use of limited dollars.

It's urgent that the OMHAS be taking seriously and putting priority on the needs of people in light of changing demographics. Service to minority groups has been an add-on. It needs to be part of core services even if it means cutting back services to others who have had more of an advantage.

When we think of systems of care, what do we consider to be essential elements? Does this perspective include natural helpers? That includes indigenous healers. We create systems of care with formal providers, but we don't include spiritual, recreational, socialization and meaningful employment in the equation. One of the best predictors of good health is a good job, including good benefits. We need to see that in our service delivery.

Who does the state have for advisors? Do they have a representative group of people helping to share policy?

FINDINGS

The participants in the key informant consistently look to OMHAS to set policy and standards for access and results from service.

There is general agreement that the capacity to meet the need for linguistic and cultural competence in serving racial/ethnic and linguistic minorities is insufficient.

There are pockets of excellence around the state that can serve as models for others to emulate.

There are a number of clinical and associated practices that are considered culturally competent around the state. They are traditionally based, time honored and used effectively within the respective community. Such practices are not formally documented or recognized to meet evidence based practice standards. They do, however, appear to produce positive results for minority consumers.

Evidence based practices have, for the most part, been standardized in mainstream, adult communities. Thus unrecognized culturally specific practices employed within the state are no less tested than existing EBPs for use with racial/ethnic and linguistic minorities. Accordingly EBPs have no greater demonstrated results for racial/ethnic communities than untested community specific interventions.

Significant, creative and highly promising methods to increase culturally competent service capacity exist in both urban and rural settings. These efforts appear to be taking place in relative isolation.

DISCUSSION

Oregon Senate Bill 267 requires that five state agencies, including OMHAS, will incrementally change the expenditure of state funds. By July 1, 2009, OMHAS must expend at least 75% of state moneys on evidence based programs.

Of the 37 evidence based practices or programs identified by OMHAS, none clearly indicate that they were standardized for specific cultural or ethnic groups. The approved practices have been standardized as evidence based in mainstream adult settings. As of August 2005, no practices recognized as evidence based by Oregon appear to apply specifically to racial/ethnic minorities.

There is a need to assist providers of culturally specific services in the implementation of approved evidence-based practices. This will require use of existing practices or adaptations of them for specific communities. In addition, many of these providers will need significant technical assistance to document the outcomes associated with culturally specific treatment approaches that have not yet been researched or approved as EBPs. As OMHAS takes steps to expand the use of evidence-based practice they should also assist providers to demonstrate practice based evidence of the utility of community specific interventions.

There is a need to assure that comparable access to service and comparable outcomes from service are accomplished. It appears that the existing services provided are not sufficient to engage and serve some population groups to meet the apparent need. This appears to be the case now irrespective of whether the intervention has been recognized as best practice.

A major challenge presents itself and must be accomplished in less than four years. Additional service capacity needs to be developed to meet the needs of minorities. Concurrently 75% of state funded practices need to be recognized as evidence based by July 1, 2009. The challenge is to assure that the level of culturally competent practice that meets state legislative requirements is sufficient to meet the level of service needs of Oregon's diverse population on a timely basis within limited available funding.

OMHAS already has recognized this challenge and has taken initial action to address it. As of May, 2005, the initial Oregon standards for evidence based practice were revised. The revisions are intended to recognize culturally competent and other practices that produce positive outcomes and to include them as best practices.

The momentum to pursue and fund primarily evidence based practices has emanated largely from the New Freedom Commission Report. A number of states have embraced the mandate enthusiastically. Transition at the systemic level, however, takes place slowly.

It does not appear that the Oregon legislature provided targeted funding to assist OMHAS to provide technical assistance or financial support to assure that provider organizations will be able to meet the standards put forth in SB 267. Development of culturally competent services in Oregon is still in its early stages.

Informed estimates indicate that it takes as much as 10 or 15 years from the time a practice is initiated until it is demonstrated to be a best practice. Even if strict scientific methods are not used as a measure of best practice, resource and time consuming efforts will be needed at systems and provider levels to reach the goal of demonstrating that local culturally competent practices are standardized, replicated and demonstrated to achieve consistent positive outcomes by the required date.

Historically culturally competent mental health service expertise has come from community based organizations within minority specific neighborhoods. Such organizations often operate on smaller budgets. Yet they have done two things well: they have engaged and provided effective services to their

target populations better than others, and they have managed to access funding to provide those services.

Accomplishment of those two achievements has taken virtually all of the energy and resources of minority based organizations. There has been little left to engage in scientific or other rigorous exercises to demonstrate the validity and effectiveness of their efforts by mainstream standards.

The Oregon legislation significantly restricts use of state funds by mid 2009. It is reasonable to project that mainstream mental health agencies will adopt or adapt existing recognized evidence based practices as a primary way to assure continuity of funding and to minimize disruptions in service to the greatest number of their consumers as one means to meet the deadline.

It will take an unpredictable amount of time for agencies that work with culturally competent practices to demonstrate that those are effective and evidence based practices. Additional resources need to be accessed. Methodologies must be formulated formally. Protocols need to be documented. Constructs to demonstrate effectiveness have to be conceptualized, initiated and completed.

Emerging culturally focused community based community mental health programs may have to forego demonstration of their effectiveness during the process of developing and shaping their models and service approaches. Partnerships between mainstream mental health and community based minority agencies do not have access to readily available culturally competent best practice models, largely because nationally they haven't been documented, demonstrated and published. It won't be possible to "take models off the shelf" and implement them easily.

Even more well established Oregon mainstream agencies engaged in culturally competent practices are challenged in major ways to demonstrate that their alternative approaches for ethnic minorities meet even the revised standards for best practices adopted by OMHAS in May 2005. There is only one agency reported by key informants that intentionally has begun the process to achieve the standards. It provides services targeted to a single ethnic minority group. That agency has accessed funds to begin to document and demonstrate the effectiveness of their practice. Other programs are not known to have started the process to meet the standards.

The potential for minority practices to meet Oregon legislative requirements is not a question of good will. It is a matter of feasibility and whether there are sufficient resources and time available to assure an acceptable of culturally competent practice that meets institutional standards. To do so timely is at least a major challenge.

Additional work remains to be focused on promotion of emerging culturally specific and effective but undocumented practices. Mental health system leadership will need to continue to prioritize support and tangible assistance to providers of emerging practices to increase the likelihood that culturally competent practices meet systems definitions of acceptability. Failure to do so has the unfortunate potential to result in emerging or promising practices having to be discontinued or to be funded from limited alternate sources. The undesired consequence will be a reduced capacity to meet specialized needs.

KEY INFORMANT SURVEY RECOMMENDATIONS

The people who participated in the Key Informant survey identified a large number of service strengths. Among those strengths are a large number of innovative practices that appear to occur in relative isolation. The informants look to OMHAS to provide continued guidance and technical assistance to promote more cohesive efforts in building a coordinated culturally competent system of care.

- Continue to work with legislative, community and provider organization stakeholders to address the need to carry out legislative mandate to implement evidence based practices and still preserve and promote culturally and specific practices that produce positive outcomes but are not yet demonstrated to meet best practice standards.
- Take a leadership role in documenting efforts that are being made to develop capacity to serve racial/ethnic and linguistic minorities by county and by MHO.
- Promote the development of evidence based practices by identifying specialized practices being used, encouraging collaboration among MHOs and provider agencies and assisting in the engagement of resources to establish emerging, promising and best practices.
- Promote additional development of service capacity by disseminating information about successful strategies to develop linguistic and cultural competency.
- Establish additional state level capacity to provide support and assistance to MHOs and provider agencies in establishing cultural competence capacity enhancement plans through assignment of qualified staff and/or contractual arrangements.

EXAMPLES OF IMPLEMENTATION STRATEGIES

MHOs are surveyed to determine whether and what evidence based or best practices are being used currently. Survey information includes where existing evidence based practices are being adapted for use with special populations and where community specific traditional practices are being employed with positive outcomes but are not yet established as best practice.

Information received from surveys is compiled by type of service and for potential application for specific population groups. Determinations about what will need to be done to qualify a practice with positive outcomes as a best or evidence based practice are then be made in partnership with MHOs and agencies that are using the practices.

Results of the identification of existing and promising practices are circulated among MHOs and provider agencies for their potential use and collaboration among potential users of the practices.

OMHAS channels information about potentially available resources to participants in cooperative arrangements and to organizations that demonstrate interest and ability to further develop service capacity to serve racial/ethnic and linguistic minorities and other under-served populations.