Culture and Behavioral Health Service Delivery:

An Analysis of Focus Group Findings

July 2009

Executive Summary

Background. This report summarizes focus group findings conducted as part of a DMHAS Office of Multicultural Affairs Health Disparities Initiative. Findings are based on focus groups that were conducted around the state of Connecticut during an 18 month period in 2007 and 2008. Focus groups explored people's experiences with care and the ways in which their cultural beliefs and values were, and were not, incorporated through out the care process. In all, 25 focus groups were conducted across the state with African American, Latino American, White American, Asian American, Youth, LGBTQ (lesbian, gay, bi-sexual, transgender, and queer) individuals, and culturally mixed groups.

Method. To begin the data analysis process, Consumer Research and Evaluation Network (CREN) members participated in a day-long, qualitative data analysis training. Following this training, five data analysis teams, comprised of PRCH faculty and staff and CREN members, were formed with each team analyzing one or more of the focus group types. Teams met between 3-5 times to analyze their group's transcripts and then all five teams met to identify primary themes across all transcripts.

Results. Qualitative data analysis revealed eight overarching themes across the seven focus group types. Themes address both general clinical care, as well as cultural competence-related areas.

Theme #1: Positive Experiences with Care: Across many focus groups, participants reported satisfaction with services and positive feelings about care. Participants discussed feeling listened to and understood by their clinicians, and many reported that they were "getting things done." A prominent sub-theme identified was that many respondents who reported satisfaction with care reported receiving services from ethnically and or culturally similar programs or providers. There were also instances in which participants not seen by ethnically similar providers also reported positive experiences with care.

Theme #2: Bridges and Barriers to Trust. In all focus groups, participants discussed a variety of factors that either fostered or impeded the development of trust and a positive working relationship with providers. A lack of confidentiality was one such factor. Respondents raised concerns about information discussed being shared with other providers or being used against them. Also impeding the development of trust, several respondents discussed some providers being too strict with rules and this communicating that they do not really want to help them. Respondents in this and other focus groups noted that provider willingness to bend the rules -even a little-would help to establish trust and communicate a willingness to be helpful. In turn, this would contribute to respondents opening up with providers and sharing more in sessions. Respondents discussed ethnic similarity as one factor that facilitated the development of trust.

Theme #3: Things "Left at the Door" or Not Discussed in Treatment. Many respondents talked about not leaving anything at the door as a means of getting help and getting better. In a majority of focus groups, however, respondents reported leaving a variety of issues "at the door" and not discussing them with providers. For many, not discussing certain topics was directly related to the previous theme of trust and the degree to which respondents felt understood by their providers. This was particularly true for African American respondents

who consistently reported that they did not discuss race or race related issues. Respondents discussed a variety of additional issues that were not discussed in care.

Theme #4: Stereotyping and Negative Experiences with Care. Across most focus groups, respondents reported a number of negative experiences with care in which they felt stereotyped, disrespected, or dismissed by providers. Many respondents reported similar experiences in broader society and some noted that hospitals and health care systems were a microcosm of broader society, and given this, they were not surprised by their negative care experiences. In addition to reports of feeling stereotyped and disrespected, respondents discussed a range of experiences in which they felt care was not useful, providers were disrespectful, their expressions of distress were misunderstood, they were not listened to, or they felt invisible to providers

Theme #5: Language Issues/Barriers. Language barriers emerged as a prominent theme in all focus groups conducted with individuals of Latino origin. Participants discussed frustrations and difficulties they had participating in treatment when services were offered in English only. Further, many noted that not being able to communicate with providers contributed to feelings of isolation, loneliness, depression, anger, and, for many, resulted in their feeling as if they were being "choked out of the system."

Theme #6: Persistent Self-Advocacy as a Means of Getting Needs Met. Across all focus groups, respondents discussed a number of experiences in which they exercised persistence, voice, or self-advocacy as a means of facilitating their needs being met. For many, the need to engage in self-advocacy emerged from situations in which they felt that providers were not listening to them or they were pushing recommendations that were different from what they wanted or felt they needed. Many stated that they believed that if they expressed their needs consistently enough, and with intense emotion if necessary, providers would eventually listen.

Theme #7: System Challenges/Barriers to Care. System challenges and barriers to care were prominent themes that emerged in all focus groups. Respondents discussed a range of experiences that they felt impeded their being able to receive effective care and address their needs. Examples of such experiences include, 1) providers carrying heavy caseloads and appearing burned out; 2) difficulties getting into detoxification programs due to not having used enough; and 3) paperwork and administrative problems getting in the way of providers being helpful.

Theme #8: Clinician and Agency Recommendations. In all focus groups, respondents offered a range of recommendations that cluster in seven different areas including: 1) Connect with community; 2) Develop peer-based services and supports; 3) Develop additional services and supports; 4) Enhance direct care; 5) Offer more provider education and training; 6) Offer more service user education and training; and 7) Enhance agency environment/physical.

Discussion and Implications. The findings discussed in this report highlight the complex and dynamic role of race, ethnicity, and culture in the helping relationship and in the development of services and systems that are responsive to the worldviews and values of diverse groups. Eight overarching themes are discussed which summarize a range of positive, as well as negative, care experiences. Further, it is important to note that many of the negative experiences discussed exist within the context of similar themes in the broader

cultural competence and multicultural health literature nationwide. Thus, themes that suggest racism, bias, and discrimination are not unique to Connecticut; rather they mirror social patterns that have challenged health care and U.S. culture in general for generations. Nevertheless, the negative experiences discussed in this report represent an important call to action. Needed are unique and creative interventions designed to enhance attention to culture and service equity.

Echoing themes in the recovery literature, findings suggest that, when asked, service users know what works for them. This was well illustrated by the range of recommendations for improving care offered by respondents. While all may not be feasible to implement now, some likely represent low-hanging fruit that can be implemented with limited system effort or costs. To further evolve and prioritize recommendations offered by respondents, it is recommended that an Eliminating Disparities Subcommittee of the Multicultural Advisory Council (MCAC) be formed. In addition to MCAC members, individuals invited to join this subcommittee should include service users, direct care providers and relevant individuals from the DMHAS executive leadership. Goals of this group should be to discuss the feasibility of implementing these and other recommendations for improving care, in addition to identifying individuals or departments responsible for advancing goals, identifying timeframes and strategies for measuring success, etc.

Based on the findings discussed in this report additional recommendations include: 1) offering ongoing cultural competence training and technical assistance for providers that including service users in the training development and implementation process, 2) using cultural assessments to reduce the impact of stereotyping, 3) enhancing peer services and supports and 4) improving language assistance services.

Conclusion. DMHAS is to be commended on their willingness to ask difficult questions and engage in self- reflection regarding the role of culture in the service delivery process. Undertaking this evaluative work speaks to the state's longstanding commitment to creating a system of care that is responsive to the cultural values and needs of all individuals seeking care. This same commitment will likely fuel next step efforts to build on system strengths and improve the cultural responsiveness of care. Service users have offered an initial vision for enhancing direct care and outcomes. Working in full partnership with service users, it is imperative that recommendations offered are further developed and prioritized such that interventions are aligned from personnel, policy, fiscal, and administrative perspectives. Implementing new forums and formats for system planning and decision-making can help to ensure translation of strategies for change to action. Further, continued self-evaluation and the ongoing use of feedback loops can help to enhance the cultural responsiveness of care, contributing to improvements in access, retention, engagement, service quality, and outcomes for all individuals seeking care.

Background

Inequities in access, service quality, and outcomes are pervasive and long standing for individuals from diverse racial, ethnic, and cultural backgrounds. Discussing the omission of culture in mental health, the 2003 New Freedom Commission *Final Report* noted that health care systems have failed to incorporate the histories, traditions, beliefs, values, and language systems of culturally diverse groups, resulting in their having to bear a greater disability burden. As a result of these findings, the subsequent SAMHSA *Federal Action Agenda* and other federal reports identify the elimination of health care disparities as a major goal for the future.

Increasing provider and system cultural competence is frequently cited as an important strategy for eliminating disparities. DMHAS is committed to creating a transformed system of care that is both recovery-oriented and responsive to the worldview, beliefs, and values of all individuals seeking services. Through the work of the Office of Multicultural Affairs, a key goal of the state is to increase provider, program, organizational, and system cultural competence as a means of eliminating disparities. This report summarizes focus group findings conducted as part of a DMHAS Office of Multicultural Affairs Health Disparities Initiative. Findings are based on focus groups that were conducted around the state of Connecticut during an 18 month period in 2007 and 2008. Focus groups explored people's experiences with care and the ways in which their cultural beliefs and values were, and were not, incorporated through out the care process. Findings from this report will be used to inform the update of the OMA Multicultural Best Practice Guidelines.

Method

As a strategy for enhancing participation, culturally homogenous focus groups led by culturally similar facilitators, where possible, were conducted. In all, 25 focus groups were conducted across the state with African American, Latino American, White American, Asian American, Youth, LGBTQ (lesbian, gay, bi-sexual, transgender, and queer) individuals, and culturally mixed groups. Focus groups were 1-2 hours in length and were digitally recorded and transcribed verbatim. Further, the focus groups with Latino Americans were conducted in Spanish and were translated, transcribed, and analyzed in English. Five questions were used as guides for focus group discussions (Table 1).

Table 1: **Focus group questions**

1) What's it like to be an African American, Latino, Asian American, White American, or LGBTQ individual?
    a. What's it like to be an (relevant group) in recovery?
2) How has your clinician been sensitive to your struggles as an (indicate relevant group)?
3) What can you not talk about with your clinician?
    a. What do you leave at home because you think your clinician is not going to understand?
    b. What gets in the way of your clinician knowing you for who you really are?
4) If you came in and this place was more welcoming to you as a (indicate relevant group), what would it be like?
    a. If you could change things, what would you change?
    b. What might prevent someone from coming here?
5) From where do you draw your strength? What helps you get through difficult days?

To begin the data analysis process, Consumer Research and Evaluation Network (CREN) members participated in a day-long, qualitative data analysis training. Following this training, five data analysis teams, comprised of PRCH faculty and staff and CREN members, were formed with each team analyzing one or more of the focus group types. Teams met between 3-5 times to analyze their group's transcripts and then all five teams met to identify primary themes across all transcripts.

Results

Qualitative data analysis revealed eight overarching themes (Table 2) across the seven focus group types that address both general clinical care, as well as cultural competence-related areas. Within each of the major themes, a number of sub-themes were identified. Sub-themes will be discussed within the presentation of each theme.

Table 2: Overarching focus group themes
1) Positive Experiences with Care
2) Barriers and Bridges to Trust
3) Things "Left at the Door" or Not Discussed in Treatment
4) Stereotyping and Negative Experiences with Care
5) Language Issues
6) Persistent Self-Advocacy As a Means of Getting Needs Met
7) System Challenges/Barriers to Care
8) Clinician and Provider Recommendations

Positive Experiences with Care

Across many focus groups, participants reported satisfaction with services and positive feelings about care. Participants discussed feeling listened to and understood by their clinicians, and many reported that they were "getting things done." A prominent sub-theme identified within this overarching theme is that many respondents who reported satisfaction with care reported receiving services from ethnically and or culturally similar programs or providers. As noted by a respondent who participated in a group for African American women:

And this group helps too, the leaders are Black and they understand us and we understand them too. I like coming here. It's peaceful and gives me more experience talking to other people. I wish we could meet for two hours instead of once a week. They help us get things done and so does my therapist. Like the other day I was crying because I got laid off from my job and I told my therapist and she helped me find another job the next day. I am very happy. It's going to work out real good for me. I've come a long way after getting clean. If it wasn't for programs like this I'd be in the gutter somewhere. But I've got faith now and confidence. I can never go back to where I was before.

Similarly, a respondent who sought services at an organization with a number of bilingual/ bicultural Latino American clinicians noted:

> "*[I feel] appreciative of the help that they have given us here in this clinic because without it, I think that without this clinic we wouldn't survive. It is very important in our lives, well at least in mine. This clinic is very important in my life.*"

Participants who were seen in ethnically or culturally specific programs reported a number of specific factors that contributed to their positive experiences including feeling like they were working in partnership with their clinicians to achieve goals, feeling like clinicians were "opening doors" for them, feeling respected and cared about by their clinicians, believing that service providers understood their cultural background, and feeling like they could talk about anything with their providers. Addressing several of these areas, one respondent, seen by an ethnically similar African American provider, noted:

> *I like the clinician I have now, because she treats me as a human being. I can talk to her about anything, and I can see it that she is listening and that she is concerned. She gives me feedback and whatnot and I can say things you can't say to another one. I mean, you can say things that you can't say to another person, you know, not African-American. So I try with my clinician, we're real, real, real locked in. I've come here for depression. I've had a lot of help and it's been a while since I've been in that depressed state, so I'm very thankful to God for these people, because I feel that I got the help I needed.*

While a majority of respondents seen by ethnically or culturally similar providers reported a range of positive experiences with care, there were instances in which participants not seen by ethnically similar providers also reported positive experiences with care. For instance, one respondent of Latino origin reported satisfaction with services noting that his non-Hispanic provider showed professionalism and worked hard to support his recovery:

> *In my case the therapist I have, I am not going to say names, is not Hispanic, because she's not like us Hispanics, but she does find the way, and all the means to try to find an effective treatment for the persons she treats. I think that the same treatment of cordiality that she gives me and the same way she finds to help me get better, I imagine she gives to the rest. Because I cannot vote for the rest, but I think that, I am satisfied and I think that although she is not Hispanic, she tries to give the maximum so that people will recover. To me she is a tremendous professional in her profession.*

Other respondents spoke positively of a White American psychiatrist who was highly sought after and well liked by many service users of Cambodian descent. Respondents praised the psychiatrist's dedication, flexibility with time, willingness to make home visits, and his efforts to learn about and understand their culture. This psychiatrist also visited a refugee camp in Cambodia, so respondents discussed feeling comfortable talking about their experiences of trauma under Communist rule, because this psychiatrist had "been there" and had seen some of the places people described. Discussing their experiences of feeling listened to and understood, a program staff person who was also a refugee camp survivor reported:

> *Yes, he understands their experience. Yes, from their point of view, because he went to the [refugee] camp. Basically, he was at the house a long time ago where they were in the camp and he understands where they're coming from, what they have gone*

through. And he listens instead of giving them, 'Ok, here's the medication. You can take this. Here's the medication, take that.' He listens.

Bridges and Barriers to Trust

In all focus groups, participants discussed a variety of factors that either fostered or impeded the development of trust and a positive working relationship with providers. A lack of confidentiality was noted as one such factor. Respondents raised concerns about providers using information discussed against them. As stated by one respondent:

Whether the clinician is Black or White – it don't matter which color he is – first you have to trust. And then you still won't come clean because of what they put down in your record. Whatever you say, they hold against you. So now you have to think, I want to talk to this guy, but some things that I say he is going to hold it against me.

Respondents also raised concerns about personal information being shared in meetings with other providers. Discussing this one participant said:

(Respondent) Can I say something about this questions you were just saying? I used to go to another place for depression, and I had trouble with this counselor with something very, very personal. She went and told the other counselor, and I could tell because of the way they looked at me or I read their body language and how they would be like smiling and stuff. I asked her if she had spoke about this. 'Oh, we were just in a -' you know, their meeting. Still I felt that she shouldn't have even said it to them. That caused me to - yeah, I wouldn't tell any of these counselors, especially something personal, personal. I wouldn't do that.

(Moderator) You're talking about the importance of trust?

(Respondent) Yeah, but then they go into their little meetings and discuss our cases, even though it's supposed to be kept confidential. I mean I feel when you say confidential and you are on a one-on-one with somebody, it shouldn't be brought up with nobody else but you and that person….It's a big thing when you say confidentiality. Is it really going to be kept confidential?

Another respondent discussed a similar experience:

My clinician – I half-way trust her, but not trust her all the way because one time I overmedicated myself and ended up in the hospital. When I got back in three weeks, the whole staff knew about it. Everybody on the staff knew about it. 'I heard you almost died.' It wasn't even that far. It didn't even go that far. By the time it got down to the next person, it had gotten bigger and bigger and bigger, snowballed and snowballed.

Also impeding the development of trust, respondents discussed some providers being too strict with rules and this communicating that they do not really want to help them. One respondent told a poignant story of a situation in which he was sick and missed work because he had to go to the hospital to get medicine for a sinus infection. The next day he woke up early to be able to take his medicine and sign out to be able to make it to work by 7:00 am. However, when he

went to the front desk his paperwork was not there so he could not leave. As reported by the respondent:

So they called the Director and the Director called back and said, 'Wait until seven.' But at seven I have to be at work. And I said, 'well, whatever, let me call them to tell them I'll be late.' When I called work they told me 'Forget it, if you can't be here by seven forget about the job.' It didn't pay a lot. I had to take two buses and walk a half hour. I would get there out of breath. Punch in at a minute to seven, but I wanted to make a few dollars for when I get out of here. That Friday I was going to be on leave too. I had put in for a request for some money that is mine, that is here being stored…. I had planned to take my woman out to eat, to the movies, something really nice and when I went to tell the Director he says, 'No, we can't give you that amount of money because you are no longer working.' So I got a little mad and said: 'I lost my job because of you guys and now you're going to tell me you can't give me the usual amount of money today. But that's my money and I lost my job because of negligence here. I was awake at 4:30 a.m.' I don't earn a lot. It's more of a sacrifice than money… Why this situation happened I don't know…We are human and make mistakes, but they can be so strict.

Another respondent discussed a similar situation in which he was given a pass by his provider to leave the facility to fill a medication prescription. The respondent noted that he went to the place he usually did to fill his prescriptions, rather than the place that was indicated on the pass. When he returned with his filled prescription, he was reprimanded for going to the wrong place and his provider filled out paperwork for him to go 21 days without a pass as punishment for going to the wrong place. Discussing how he felt about this situation the respondent stated:

So I got mad, but it's like my friend here said, when you get mad you have to keep it all inside and when I get to the room I explode like a balloon. I was thinking about it and saying, 'wow, this guy is wrong.' How is he going to give me 21 days and tell another 'I sent him to one place and he went to another, you know?' He should have said, 'well, I didn't send you there. But you are showing me this as proof, so let's leave it there and it's between us. But next time when I send you somewhere go there'….He didn't say, 'you okay?' or anything. He only said, 'you didn't go where I'd sent you.' So I said, 'wow, this guy isn't here to help me then. He's just here to bother me.' But there are times when I've needed him and he's been there for me, you understand? But my point is that that time I said, 'oh no.'

Respondents in this and other focus groups noted that provider willingness to bend the rules - even a little-would help to establish trust and communicate a willingness to be helpful. In turn, this would contribute to respondents opening up with providers and sharing more in sessions. Discussing the experience presented above one respondent commented:

It's like my friend here says, he is professional and he is not going to stop being professional in order to twist the rules a little. Not to do us harm, but to demonstrate 'look, I'm going to do this for you' and there he'd gain the trust of the person who doesn't speak up, with that he would open up with the counselor because he would say, 'Wow, he did this for me. Well, I have this problem and I haven't spoken to you about this, but I now see you want to help me.' If I see he wants to help me, I am going to open up more to him.

Finally, for many respondents ethnic similarity facilitated the development of trust, in addition to a range of other positive care experiences as discussed in the previous theme. As noted by one respondent:

I think there's been a big change because when there's a program that doesn't have a Hispanic counselor one feels deprived of saying what's going on, but when there is a Hispanic counselor you feel more trust in talking to him. An American isn't going to treat you the way a Hispanic is going to treat you, I don't think.

Similarly, another respondent noted:

My clinician, by her being White, I can't open up and tell her how the Black experience goes, you know, how proud I am to be a Black man, how it feels to be in a Black man's shoes or a Black woman's shoes, things like that. I can't open up and tell her that, I can't….I don't care how much I think I trust her, I can't…So, I don't trust her that way.

Things "Left at the Door" or Not Discussed in Treatment

Many respondents talked about not leaving anything at the door as a means of getting help and getting better. Many talked about not being ashamed of anything that they had done and some noted that if there were things that they were ashamed of, talking about these things could help them to grow and feel better. As noted by one respondent:

I'm not leaving nothing on the bed because if there's something that bad that I need to leave on the bed, I mean, he might help me to get it off there. Do you know what I'm saying? I haven't done anything that bad enough that I needed to leave it on the bed. Do you know what I'm saying? I believe that in order for me to continue to grow, I have to let everything go and have trust in people.

In a majority of focus groups, however, many respondents reported leaving a variety of issues "at the door" and not discussing them with providers. For many, not discussing certain topics was directly related to the previous theme of trust and the degree to which respondents felt understood by their providers. This was particularly true for African American respondents who consistently reported that they did not discuss race or race related issues. As noted by one respondent: "*Well, in other words, you can talk to your therapist about a lot of things, but when it comes to a race issue, than that's taboo.*" Many other respondents agreed and reported similar experiences:

I never really discuss that with my clinician. I discuss more of how can we get things done as far as my situation, as far as my housing, my social security, bills that needs to be paid, how my depression is coming along. These are the things that we talk about. As far as being African-American and race, we never really discuss that.

Another respondent stated that she does not discuss her struggles as an African American woman, but also noted that for her there are other topics she is interested in addressing:

Well, I can actually say I don't really discuss my African-American struggles with her. I don't - I mean, I want to talk about the abuse my father gave me when I come, not necessarily that, you know, being Black, you do this or you do that. I don't go into any detail exactly about my African-American side of me.

In one exchange, several respondents, with a hint of surprise, noted that they had never been asked about racial issues or things going on in their community:

(Respondent) Excuse me. I don't remember any of them ever asking that question, how do it affect me as being an African-American or what's going on in our community or whatever. The subject never been -

(Respondent) Yeah, they never really ask you that question.

(Moderator) Is that a question that you would like to have been asked?

(Respondent) Yeah, well, I guess that -

(Respondent) Yeah.

(Respondent) Yeah, that's where you could talk about some things that's really, say, going on with us or in our neighborhood, because we are involved in it. We are African American. Yeah, it would have been a good question to ask when we have the group meetings sometimes or whatever.

Many respondents reported that they did not believe that providers understood their experiences. This contributed both to their not wanting to talk about them, and to their beliefs that providers would not be able to help. Discussing these issues one respondent stated:

Let me just say something, right. I think they wouldn't really understand, because they don't live in this community. They don't live in the hood. I'm going to say the hood, the ghetto or whatever. They don't live where we live at. So a lot of things I can't really talk to them about, because they wouldn't understand. I don't live too far from here, but I live in this neighborhood. For instance, I mean, there's things that goes on in these neighborhoods where we live at that they probably won't see on a regular basis compared to where they live at. If you live in the suburbs, you won't see certain things go on. That's what I mean. It's like we're separated.

Respondents discussed a number of neighborhood and other experiences that they do not discuss in treatment including violence and death of family members and young people, trying to get away from drug dealers, how white police officers "beat our kids and get away with it", gang networks and experiences, being stereotyped and degraded when dealing with children's schools, experiences of prejudice and racism when dealing with court systems, healthcare systems, employment, and other day-to-day experiences. Discussing how many of these areas are not addressed in care one respondent stated:

I think the services are okay, right, but do they get to the core of the matter about how things truly affect the community we live in? Not even a drop. Not even a drop in the bucket.

Across all other focus groups, respondents discussed a variety of additional issues not discussed including their sexual relationships, if one was raped or molested, if one had domestic violence in their past, buying or selling drugs, what it feels like to experience language barriers, and a range of LGBTQ issues. Many clients within both African American and Latino focus

groups noted that they were raised to believe 'what happens at home; stays at home' and therefore, family matters were not appropriate to discuss. Further, many youth talked about not wanting to open up and share personal information so as not to be left vulnerable, particularly given the high staff and case manager turn over rates. Youth respondents noted that switching providers so often was difficult for them and made them not want to open up to or rely on providers who were likely to leave soon.

Stereotyping and Negative Experiences with Care

Across most focus groups, respondents reported a number of negative experiences with care in which they felt stereotyped, disrespected, or dismissed by providers. Many respondents reported similar experiences in broader society and some noted that hospitals and health care systems were a microcosm of broader society, and given this, they were not surprised by their negative care experiences. Discussing parallels between service systems and broader society one respondent noted:

> I've been here for seven years and I will say that this is a microcosm of our larger society. You're going to deal with racism in the larger society. You're going to deal with racism here…We live in a society where people are not equal. I mean, a large society is not supposed to be racist, shouldn't be racist, but it is.

Other respondents reported feeling quite surprised, even stunned, by their negative experiences and many discussed a range of responses to the emotions stirred by these experiences, including "stuffing" their feelings, getting mad, but not showing anger for fear of retaliation, going to their room and "exploding like a balloon", or working harder to not "be" the stereotype. Respondents also speculated about possible reasons for their provider's behavior, perhaps in an effort to make sense of these unexpected experiences. Illustrating many of these sub-themes, one person discussed a situation in which he was stereotyped for being in a gang as a result of some of his grooming activities:

> Yeah - very, very ignorant as far as cultural types of behaviors are concerned. One time I had a do-rag - being Black you know what that means in grooming. Black men like to take a shower and put Noxema on and wash their face and cleanse and exfoliate their skin and then put oils in their hair and brush their hair before they go to bed or when they wake up in the morning. It's a process. One time I came for my MSE - my mental status exam - and they all jumped back and they said: 'Oh, my God, what's this all about?' They were ready to arrest me. I had to hold in any type of hostility or emotion or anger that I had. And they said, 'What is that on? Are you in some type of gang? Are you acting like those gangs out there - those Black guys in the gangs?' I said: 'No, you've got it wrong.' And I put my foot in my mouth, but what I said is true, and I'm glad you're here. I said, 'You need to take some courses on African American culture and behavior.' And I went on to say: 'When Black men groom, they always brush their hair,' and they had this blank look on their face, like 'What is he talking about? He's got an attitude.' I went and took my do-rag off and brushed my hair, because I wanted the waves in my hair. But it's so ignorant. That's why I use the word ignorant. And ignorant is not a put down. They are uneducated about African American males - the way they dress, their gait, their walk, the way they talk with their hands. They are very intimidated - any type of aggressive activity -I'm an Alpha Black male - any type of aggression or assertiveness is viewed as hostility.

Respondents discussed many similar situations in which they felt stereotyped by providers and in the larger society. Many discussed how they believed that their charts "followed them around" and this contributed to their being judged by their past and information written in their charts. Discussing this, one respondent stated:

Get to know who I am not. They look at my report and that is all they see.

Many other participants talked about feeling marginalized in society and having multiple strikes against them when applying for a job. As stated by one participant:

S*trike one, to me, is being Black. Strike two is coming out of jail. So, strike three is being Black, coming out of jail, and out of a program.*

Another participant shared an experience in which she felt stereotyped as an African American woman and betrayed by her provider. She reported that when her mother passed away she relapsed after being clean for about a year. When she discussed her drinking again, her provider, of fifteen years, asked her what she had to sell to use. While the provider did not specify what she might have sold, the respondent noted that she was hurt by the question and believed that the provider insinuated something negative – that she sold her body or her furniture or something else to pay for alcohol. In discussing how she felt about this encounter the respondent stated:

It did something to me, but I'm the type of person that I'll stuff it. I won't say nothing. But it really did something to me, to the point that what I did was I talked about it with my pastor and I prayed about it. I felt God moved her out of my life after all these - she knew all three of my kids, even my two oldest children who are adults, since they were small. My fifteen-year-old, she knew me before he was even born. She was my therapist. And she turned around and made another statement that the only time I can stay sober is if I'm on probation. She did that in front of everybody. I stuffed it. I didn't get indignant. I didn't respond. I just took it, and it hurt me… I've been told, and I know this is true because I've been praying about it and people have told me, that she lost her sensitivity towards people. It's just a job now. She has been here over twenty something years, so that's why she can make a statement like that. And not only was I humiliated, but there were men in this room when she made them comments to me. Somebody told me it's just a job to her now. It's just a paycheck. Her compassion is gone.

In addition to reports of feeling stereotyped and disrespected, respondents discussed a range of experiences in which they felt care was not useful, providers were disrespectful, their expressions of distress were misunderstood, they were not listened to, or they felt invisible to providers. For instance, many respondents of Latino origin discussed how common cultural experiences or expressions of stress are often misunderstood, and how this contributed to their feeling labeled and stigmatized. As noted by one respondent:

I think when you are referring to talking to the doctor and you tell the doctor, 'doctor, last night I saw my grandmother who died five years ago and she came to visit me'. For us Hispanics that's common, you know. A dream or something is not strange for us. But the psychiatrist is going to say, 'that person is hearing voices, is having hallucinations, he's psychotic, let's send him to the hospital.' Or they get incorrect diagnosis because since it's common in our culture it's not strange to say it, but here the psychiatrist or

social workers of other cultures are going to think, 'oh, this person is hearing voices, is having visions, is hallucinating.'

Language Issues/Barriers

Language barriers emerged as a prominent theme in all focus groups conducted with individuals of Latino origin. Participants discussed frustrations and difficulties they had participating in treatment when services were offered in English only. Further, many noted that not being able to communicate with providers contributed to feelings of isolation, loneliness, depression, anger, and, for many, resulted in their feeling as if they were being "choked out of the system." One participant shared an experience that well summarized several of these themes:

When I was placed at the hospital for seven days that was horrible because here we speak Spanish, but those seven days, I was in the hospital I spent 24 hours a day sleeping because they gave us therapy, but it was all in English. So I would take a pill in the morning and go to the room to sleep. I'd have breakfast and go to sleep at noon. Then they'd call us for lunch and then I'd take another pill, so I slept 24 hours a day for seven days. I wanted to go to therapy, but I felt I wanted to just leave because I wasn't doing anything so I slept all day. It's not like here, I like it here because here we speak Spanish all the time… Everyone spoke in English and I would try to speak with my little English and they didn't understand me. I would draw pictures so they would understand. Even to ask for a fork they didn't understand me so I had to draw a picture. I just wanted to get out of there… So, I'm depressed, I'm sick, but I get more depressed because it's a barrier and they can't help you.

Discussing a similar experience, another respondent noted feelings of embarrassment when she tried to speak English:

Yeah, it felt like I was there like two months, but I was there like two weeks really. I would get up in the morning and just thinking I would have to be in a group with everyone speaking English, I would just lie down and feel sicker, but it was because of that situation. But here it is very different, if I thought that the groups there were going to understand me, oh my god, it would have been wonderful! But it's true, it makes the stay feel much longer and it could even make you more sick because you have that anxiety that this or that is going to happen. One even feels embarrassed when you try to speak up and if you saw that the Americans were laughing, you automatically thought it was at you.

Expressing similar themes, another respondent noted that he would rather wait for services that were offered in Spanish, because participating in services in English would be a waste of his time that in the end could make him feel even worse. This participant stated:

I'm going to go in and leave worse than when I came in because they sent me to a place I wasn't helped. How am I going to get therapy in a program for the Chinese if I'm not Chinese? I can't go to a program where there's only Chinese if I can't understand what they're saying and they can't understand me. It wouldn't be good. If they told me, 'We have this program', I myself would reject it because I'm going to waste my time. I would rather wait for a program where I can get involved and tell them,' I have this problem. I have this emergency with my family or I have this situation, how can you

help me? What are my benefits here, how can you help me? What does this program give me so that I can come out doing well?' If I don't have the language, I can't do it.

An additional sub-theme that emerged across interviews with individuals of Latino origin was the preference not to use translators. Many respondents indicated that they did not like to use translators because they did not want to share confidential information with a third person who was not their provider. Others stated that while their preference was for their provider to be Spanish speaking, if they had to use a translator, they wanted this person to be in session with them, as opposed to using telephone translation services where there was no face to face contact. Finally, other respondents noted that for them it was not enough for the provider or translator to speak Spanish, but rather they wanted their provider to be both bilingual and bicultural. Many discussed the importance of providers understanding their culture in order to be able to help. Others noted that it was important for their provider to be bilingual and bicultural so that they could identify with this person and so that they could express feelings that were difficult to express in English. Discussing these sub-themes one respondent stated:

I've been 90 days without methadone now and thank God I haven't had problems with any other type of drug. And yes, groups have helped, but there are times I don't participate because the girls who run the program are American. I speak very good English and I could identify with people speaking English, but there's times I would like to express in my own language and I'm not able to do this because I don't have a Hispanic clinician. Right now, I don't have someone to identify with, with my culture and my language. There are a lot of things I would like to express in my own language that I cannot express in English.

Finally, several other less prominent sub-themes discussed by participants were their frustration at individuals who were not fluent in Spanish being asked to translate, frustration at not being able to understand providers who had strong accents, feelings that being in recovery was difficult if one did not speak English, and feelings of pride and validation when seeing or working with providers who were trying to learn Spanish.

Persistent Self Advocacy as a Means of Getting Needs Met

Across all focus groups, respondents discussed a number of experiences in which they exercised persistence, voice, or self advocacy as a means of facilitating their needs being met. For many, the need to engage in self advocacy emerged from situations in which they felt that providers were not listening to them or they were pushing recommendations that were different from what they wanted or felt they needed. For instance, one respondent discussed an experience in which she was depressed and had physical health challenges, and her provider only attended to her housing needs. This participant described feeling that her provider was pushing her away by not addressing her emotional needs; leading her to state that she had to get another provider:

I had a problem with living somewhere, and her first response was: 'I'm going to get you over there into the old WYMCA. After we get you situated with that, we'll get you some food stamps.' She actually said: 'That's about the best I can do.' She didn't even want to work with me on my problem, and she still works here. I see her. But I had to change counselors because she wasn't even trying to work with me. She didn't want to deal with the emotional problems. She figured that would solve it, I guess. I really felt that she was just pushing me away. I was just another case to her, another Black woman in

trouble… I just felt like once she found out what my situation was, she said: 'Let me solve it, get rid of her, and get somebody else.' I only saw her maybe two times after that, because I had to get another clinician. I was sitting here major depressed, and she's trying to tell me I had to go to someplace I don't even know. That was just wrong, so I got rid of her. I wasn't going to at first, but another person told me: 'Well, if you ain't happy with her, you've got to tell somebody.' I only saw her maybe five times total, but in that five times, we didn't even talk about my problems in my opinion. We didn't even talk about them. She didn't want to spend any time on them at all.

Many respondents discussed persistence in speaking up as an important component of advocating for their needs. Many stated that they believed that if they expressed their needs consistently enough, and with intense emotion if necessary, providers would eventually listen. One respondent discussed a situation in which she wanted to be assigned to a new psychiatrist because she felt insulted by the psychiatrist and because she felt that the psychiatrist was not addressing her medication concerns. She discussed the importance of voice and how she was not assigned a new psychiatrist until she "exploded and rebelled":

I had to really explode and rebel. Then it happened. I finally got what I needed. They finally got me another psychiatrist and I'm doing much better now. He's a nice guy and he's got me on the right pills. I'm not aggravating nobody. I'm cool. I know what works for me and what doesn't. I've been on this road with this bipolar thing since I was 26 years old. If anybody could tell you anything, it's me. Listen to me. All I want you to do is listen. If you don't listen because you know more than me, you got an education, that ain't going to work… It worked out and I'm doing fine now. All of us has a voice. If we don't voice our opinion and people keep doing what they're doing to you, you're not going to graduate and go nowhere. Somebody's going to hear that voice after a while, if you keep voicing it. I'm happier when I have done something I know is right for me. I'm not miserable like I used to be.

Respondents noted many similar situations in which they had to advocate for their needs to be met. Further, some noted that at times they sensed that providers did not like their asking questions or pushing for their needs, but because they were trying to advance their recovery, they remained persistent. One respondent discussed a situation in which he felt that he had to be persistent and ask questions so that he could make informed choices about his future as a means of staying clean and rebuilding his life. This respondent indicated that he was tired of "going in blind" and following recommendations without fully understanding how they would benefit him. As he said:

A lot of people in here ain't going to help me get my future out there in the world. I've got to help myself before anybody else is going to help me. But if there's anything good that can be offered to me, I'm going for it, and I'm asking questions about it, and I'm not going to stop until you answer my questions. I'm persistent. I've been persistent. I'm going to continue to be persistent. But they don't like that either…'I've already got my job. I'm sitting here doing your paperwork.' This is the attitude that I get. I don't know about the rest of them, but this is the attitude that I get. So what I do is instead of being argumentative like I used to, I say: 'All right. You're right, but I still want to know about such and such, and such and such. Is this going to advance me, or is this going to help me for the future, or is this going to help me out?' Do you know what I mean? I'm a statistic, man. Overall, we won the war, but we're still fighting the battle. It's hard. It's not easy. It's hard. It is so hard, to the point to where I used to give up. I used to give up

because I used to go numb the pain and say: 'Fuck it.' Excuse my French, but this is what I used to say. I used to say: 'Fuck it. I'm going to go numb the pain, and just go sit over here, and just go get high, and then I ain't got to worry about it.' But do you know what I found out? Every time I kept doing that, I found myself back in jail doing the same shit, going through the same motions, and I'm getting tired of that too. Do you know what I mean? It's getting old. It gets old. I be like, you know what, screw this, man. From now on, if I've got to deal with something, I'm going to deal with it head-on, just like a car crash. I've got to deal with it, and I'm going to ask questions. If I need to know, I'm going to ask. And if you don't like the fact that I'm going to ask you them questions, then guess what? That's going to be your problem, not mine. These are the things that I want to know. I'm tired of going in blind. I'm tired of dealing with people that's not going to really help you. Do you know what I mean?

System Challenges/Barriers to Care

System challenges and barriers to care were prominent themes that emerged in all focus groups. Respondents discussed a range of experiences that they felt impeded their being able to receive effective care and address their needs. Several barriers were particularly salient across focus groups and elicited numerous examples in which respondents noted how they made it more difficult for them to get help. Some of these include: 1) providers carrying heavy caseloads and appearing burned out; 2) respondents only being seen once a month and wanting more regular appointments; 3) respondents only being seen in groups despite requesting individual time; 4) feeling shuffled around; 5) difficulties getting into detoxification programs due to not having used enough; 6) paperwork and administrative problems getting in the way of helping respondents; 7) providers misunderstanding cultural expressions of distress; 8) experiencing poor follow through on the part of providers and case managers; 9) respondents feeling controlled by too many rules; and 10) difficulties getting help with non-symptom related needs. Addressing these and other systemic barriers to care, respondents described poignantly a number of experiences in which they struggled to receive appropriate care. For instance, one respondent described an experience in which she felt that she had no one to talk with and was invisible to her providers, despite being seen by both a psychologist and a psychiatrist:

You know, if I would have had someone to talk to, I would never have committed my crime. I was going out in (city name) for my outpatient psychiatric services. They would say: 'Are you okay?' I'd tell them: 'I'm fine' They'd just say: 'So you need a prescription? Your doctor will write out the prescription.' One month I would see the psychiatric doctor and she would write out the prescription, and the next month I come back and see the psychologist. I sit down and see the psychologist. He asks me how I'm doing. 'How are the children? Am I paying the rent? What have I been doing for the last month?' I tell him I've been getting ready to travel which I had been doing. I'd been paying the rent. I'm doing fine. He'll tell me: 'How is your medication?' I tell him the doctor gave me two months supply. Then he'll tell me to go to the front desk for my return appointment to come back. That's how it was going. And I didn't have anybody to talk to. There were only two African Americans going out to that clinic - me and another African American lady. The African American people were going to (clinic name). And when I say about psychiatric services, they had case management workers at (clinic name) - people that would come out into the home to check on the people. Take them to the supermarket. Take them clinic appointments. Make sure that they were taking medications. When the weather is bad - snow days - make sure they get out to get their bills paid. Make sure that they are doing well in the community. Make sure that they are eating. Make sure

they are okay. I didn't have anybody that could check on me. For ten months nobody ever came and checked on me - not one time. I isolated myself in the apartment for ten months. I was half eating. I was traveling. I was sick and confused - not taking my medication. And by me going to see the doctors in (city name), they were so busy. You would think they would've picked up on that, that I'm not making my medication.

(Moderator) You must have felt like you weren't noticed at all.

(Respondent) I wasn't noticed at all. I don't understand. If those people - they were just different. They never had time. They had a caseload that was too heavy - too many people. You sit down. They only give you a few minutes of time, and then they have to prepare for the next person to come in for their appointment. You are only allowed so many minutes. It wasn't a healthy doctor/patient relationship.

Respondents discussed many similar such examples of having limited quality time with providers. Some noted that on entering care they thought that they would be seen once a week and were disappointed that they were often seen significantly less often. Many attributed the limited time with providers to their being busy and having "heavy caseloads." Some individuals noted that they felt they were participating in self-help programs, because they did not feel like they were getting help from their providers. Discussing several of these themes, one respondent stated:

In another program, you would have a counselor, you would have a clinician, and you would have a case worker. In this program you have a counselor…. But, whenever you can catch him. If you had a problem, and you decided you wanted to get high, you know what they're going to tell you? 'I'll talk to you in a minute,' or 'I'll be right back' 'Hold on for one second, give me a half hour. I've got to' - but it's the fact that they put us all with one counselor. They put all the black men with one counselor really. And he don't have time. So, you can't pretty much blame it on him. So, like in here, this is basically a self help program. If you are in here, and you are looking for some kind of help or attention, forget it, you're in the wrong spot.

Respondents discussed a number of additional barriers to care including the limited availability of sober houses for individuals of Latino origin, limited availability of services and programs for youth and LGBTQ individuals, and limited availability of services and supports in the community. In addition, respondents, and particularly youth, reported feeling as though they were shuffled around from provider to provider and this made it difficult to get help. Many discussed how at times they had to wait several hours between appointments and this contributed to their feeling that on some days they spent more time waiting to get help than actually getting help. Discussing the experience of being shuffled around, a youth respondent stated:

I have been shuffled around a lot to different case managers. At this time I do not - one of my problems is that I do not handle change very well. I am just not prepared for it. When I am not prepared for it, it can bring my world crashing down, because I don't know what to do. I don't know how to handle it. I don't know how to express myself. Yeah, that change is hard… If someone who is close to you, who you rely on and talk to, and you can go to them with problems if you need someone to talk confidentially and need advice. Then imagine that person disappears, and you have to build a whole new - it is like trying to build a whole new family relationship with somebody else or a friendship. It is hard. It is emotionally straining. You don't have any guidance for a

certain amount of time. When you do have that guidance, you are not sure that it is something that you can completely trust in.

In addition to availability and continuity-related barriers, respondents discussed a number of barriers related to accessing care. For instance, respondents discussed difficulties being admitted to detox programs as a result of not being "high" or "strung out" enough. Addressing these barriers, a peer counselor described an instance in which he recommended a client state that he was using more than he actually was so that he could be admitted to detox:

Yeah, I ran into that predicament. There was a time that I called and said: 'This guy's using 4 bags and he wants detox.' You call and say the guy's using 7 bags and they say it's not enough to get him in there. So you know, sometimes I have to tell the clients you better say you're doing 10 bags or more or they're not going to take you.

Respondents discussed frustrations with having to use more drugs or alcohol at times or having to "hit rock bottom" in order to be admitted to detox programs. Several respondents also discussed disappointments with not being linked with more follow-up services and supports following detox, and some noted that for them staying clean was difficult because most recovery houses were located in high drug use neighborhoods.

Clinician and Agency Recommendations

In all focus groups, respondents offered a range of recommendations that cluster in seven different areas.

1) *Connect with community.* Respondents offered a number of recommendations for increased connection with community resources and supports. Recommendations highlight the need for increased connection on the part of service delivery organizations, as well as consumers:
   - Help people with transitioning to community life
   - Do more with connecting people with community services and supports
   - Give more information about events, other services, and supports in the community
   - Build more partnerships with community agencies

2) *Develop Peer Based Services and Supports.* Several recommendations for developing additional peer based services and supports were offered which suggested an interest in greater consumer involvement in service provision, training, and system-related advisement and decision making:
   - Provide more opportunities for peers to help other peers; this makes people feel good
   - Develop more peer run groups
   - Involve peers more in training providers
   - Develop more youth and consumer councils

3) *Develop Additional Services and Supports.* Respondents offered a range of recommendations for direct care, as well as civic and recreational need areas:
   - Hold more services in community centers and places other than mental health centers
   - Hire more bilingual, bicultural providers
   - Offer more language assistance services and supports
   - Develop more services for specific cultural groups – sober houses for Latinos, Women's services, LGBTQ services, Youth services
   - Offer art and music classes

- o Organize more fun activities – trips to NYC, Boston, concerts, visiting other programs with a similar focus
- o Have community picnics, barbecues in parking lot of the center to give people more information about services
- o More detox services

4) *Enhance Direct Care.* Several recommendations for improving direct care and the provider-client relationship were offered. Recommendations address a range of access, service quality, cultural competence, and recovery areas:
    - o Get to know me as a person, don't stereotype
    - o Ask about race and a person's cultural background more
    - o Let people know you are interested in their cultural background; be willing to ask questions to learn more
    - o Need to develop a plan with providers - 1 week, 1 month, 1 year, need to talk about goals
    - o Programs and providers need to teach about recovery
    - o Offer more literature about recovery, finding jobs, or other general information so if counselors are not available, you can still get the information you need
    - o Need to offer more individuals services/sessions – realize that not everyone is appropriate for group
    - o More focus on everyday life, not just symptoms
    - o Allow for gift giving
    - o Make it easier for people who need detox to get in
    - o Explain confidentiality better
    - o Be willing to bend the rules a little
    - o Provide help with transportation
    - o Have more flexible hours and weekend appointments

5) *Offer More Provider Education and Training.* Recommendations for provider training were offered in several areas:
    - o Providers need training to better understand the Black male experience
    - o Providers should take Spanish classes
    - o Providers need more training about culture and different communities
    - o Need training to help them better understand how different groups express their feelings, stress, symptoms
    - o Need training on communication, listening, and professionalism

6) *Offer Service User Education and Training.* Respondents expressed interest in participating in education and training programs in a variety of areas which they stated would help with advancing their recovery and rebuilding their lives. These included:
    - o Programming related to the economics of the community and owning one's own business
    - o Job training
    - o Preparing resumes and interviewing
    - o Recovery education
    - o Programming/services to help with rebuilding one's life after jail or treatment

7) *Enhance Agency Environment /Physical Space.* Several recommendations for improving the physical appearance of an agency so as to make it more welcoming were offered:

- o Make the center more visually appealing with more colors and artwork
- o Make the agency more appealing visually to Asians
- o Include artwork representing different cultures

Discussion and Implications

The findings discussed in this report highlight the complex and dynamic role of race, ethnicity, and culture in the helping relationship and in the development of services and systems that are responsive to the worldviews and values of diverse groups. Eight overarching themes are discussed which summarize a range of positive, as well as negative, care experiences. Further, it is important to note that many of the negative experiences discussed exist within the context of similar themes in the broader cultural competence and multicultural health literature nationwide. Thus, themes that suggest racism, bias, and discrimination are not unique to Connecticut; rather they mirror social patterns that have challenged health care and U.S. culture in general for generations. Nevertheless, the negative experiences discussed in this report represent an important call to action. Needed are unique and creative interventions designed to enhance attention to culture and service equity.

Echoing themes in the recovery literature findings suggest that, when asked, service users know what works for them. This was well illustrated by the range of recommendations for improving care offered by respondents. While all may not be feasible to implement now, some likely represent low-hanging fruit that can be implemented with limited system effort or costs. To further evolve and prioritize recommendations offered by respondents, it is recommended that a Eliminating Disparities Subcommittee of the Multicultural Advisory Council be formed. In addition to MCAC members, individuals invited to join this subcommittee should include service users, direct care providers and relevant individuals from the DMHAS executive leadership. Goals of this group should be to discuss the feasibility of implementing these and other recommendations for improving care, in addition to identifying individuals or departments responsible for advancing goals, identifying timeframes and strategies for measuring success, etc. Such concrete planning will assist in the translation of ideas for change to action and guard against recommendations remaining unaddressed. Further, inclusion of service users in the process of planning for cultural competence and disparities system change can create greater alignment between service needs and service offerings, ultimately reducing recidivism rates, behavioral health care costs, and the disability burden borne by culturally diverse communities and society as a whole.

While it is beyond the scope of this document to present a comprehensive discussion of the range of recommendations offered by service users, some findings and recommendations are discussed to provide an illustration of the ways in which recommendations and findings can inform the development of specific interventions. Such translation of recommendations for enhancing cultural competence and eliminating disparities, as noted above, should be an ongoing task of the Eliminating Disparities Subcommittee, or some other OMA/Executive Leadership action planning group charged with cultural competence and continuous quality improvement in the area of health care disparities.

Provider and System Strengths

<u>Cultural Competence Training and Technical Assistance</u>

Several provider and system strengths were reported, many of which are discussed in the broader multicultural literature as key competencies for working with diverse groups. Such strengths include respondent reports of feeling linked in; feeling that providers understand their cultural background; feeling respected, cared for, and listened to; time flexibility; being able to speak in one's primary language; providers having "been there" and being willing to open doors and help individuals get their needs met; to name a few. While many respondents seen by ethnically similar providers reported these and other positive care experiences, there were instances in which respondents not seen by ethnically similar providers also reported positive experiences. Taken together, these results highlight a well documented finding that ethnic match alone does not translate to positive outcomes, but rather, provider behaviors such as communicating cultural understanding, respect, listening, time flexibility, meeting outside of traditional treatment settings, etc, are more predictive of positive care experiences and outcomes.

From a system perspective, these findings suggests that while ethnic match and ethnically similar programs are useful, also important are providers and programs being able to implement multicultural care practices such as those discussed above and others outlined in the multicultural literature. Given this, to ensure that all providers are appropriately skilled to work effectively with diverse groups of service users, it is recommended that innovative and ongoing cultural competence training and follow-up technical assistance be provided. Further, it is recommended that the follow-up technical assistance occur on site with direct care teams focusing on specific questions and cultural challenges experienced by providers in their direct service work. Inclusion of intensive follow-up TA will assist providers in the translation of cultural competence principles to practice. Typically, standard cultural competence training does not include follow-up TA, or evaluation, contributing to questions regarding the general effectiveness of cultural competence training. As a result, to optimize the quality of the training and TA offered, ongoing evaluation is recommended.

An additional and important system strength is that service users expressed interest in being involved in system interventions to improve care. For instance, frequently cited recommendations were for the development of peer-to-peer programs and youth and consumer councils, and for peers to be involved more in training providers. Building on these system strengths, and as a strategy for creating innovative training and education approaches, it is recommended that service users be involved in developing and implementing ongoing training and TA efforts. Such trainings could include the use of recovery and culture narratives such as those reported here as a means of teaching key cultural competence principles. In addition, working with service users in developing and conducting training can help to ensure that important nuances of culture and a recovery orientation care are included in training materials and facilitated discussions.

System Challenge and Growth Areas

<u>Stereotype Reduction</u>

While important provider and system strengths were noted, also discussed were a number of negative experiences in care that represent significant system challenges and areas for needed

intervention. For instance, prominent themes were that respondents felt stereotyped by providers and felt that providers did not understand their cultural background. In turn, many respondents reported that this impeded the development of trust and their willingness to share cultural experiences that were impacting their lives; e.g., experiences of racism and discrimination in the healthcare system and broader society, trauma and violence in their neighborhoods, negative experiences with police officers, family dynamics and abuse, etc. As a means of improving cultural understanding and fostering the development of trust in the helping relationship, it is recommended that providers directly ask about important areas of culture that may influence an individual's life. As an example, use of cultural assessments with questions that directly address cultural identity, language preferences, experiences with racism and discrimination, migration history, trauma, and cultural beliefs about mental health and formal help seeking, for instance, can help to reduce the impact of stereotyping.

Stereotyping literature suggests that obtaining actual information about a person can help to minimize the automatic nature of stereotyping and "filling in the gaps," which often happens outside of conscious awareness in the absence of actual information about a person. In addition, asking about culture can help communicate cultural understanding and send the important message that race is not a taboo topic for therapy, in fact, it is appropriate to discuss as are other areas of culture influencing a person's life. Given this, it is recommended that cultural assessments such as the DMHAS OMA Ethnocultural Addendum Form or the Cultural Formulation in the current *Diagnostic and Statistical Manual of Mental Disorders* be disseminated widely throughout the CT system of care to assist providers in incorporating key cultural areas in the care process. In addition, it is recommended that these and other cultural assessments be incorporated into training and education curricula and be included on the DMHAS OMA website for easy access.

Peer Services and Supports

An additional prominent theme was that many service users reported wanting more quality and individual time with providers. Some respondents, for instance, noted that they felt that they were invisible, not noticed, or were pushed away by providers. Others stated that they felt like they were taking part in a self-help program, despite participating in a residential program and having a counselor. Further, many respondents reported that they felt as though they could not rely on providers for their recovery because they were busy with paperwork or "heavy caseloads." As a strategy for improving quality time with providers, it is recommended that more peer services and supports be developed. Such programs can serve as a cost effective strategy for providing service users with additional supports as needed or requested. This may be particularly useful for organizations, where because of limited resources, service users are seen primarily in groups, or are seen bimonthly or monthly.

In addition, working with a peer mentor or participating in a peer support program can help an individual become acclimated to the process of receiving care. This may be particularly important for individuals seeking services for the first time, or individuals for whom accessing behavioral health services is not a traditional form of help-seeking in their culture. For such individuals and others, participating in peer support programs can help to increase voice and self advocacy and facilitate navigation of behavioral health organizations and systems. In addition, working with a peer mentor can help an individual to feel socially connected, understood, and supported. In turn, such benefits can increase an individual's engagement in services, reducing recidivism rates, high system costs, and ultimately improving outcomes.

Increasing peer services and supports can also help with addressing language barriers and concerns discussed by service users. In particular, many service users discussed difficulties communicating with providers and some noted that this made them feel more depressed than when they entered care. Respondents also reported that because certain emotions did not directly translate to English, it was often difficult to fully discuss their experiences. One cost-effective strategy for enhancing language assistance services and supports would be to train bilingual/bicultural peers in translation services and hire them to provide this service. While some respondents noted that they did not like using translation services, several noted that they did not like using translation services through the telephone. Training and deploying peers as translators could help to increase face to face translation provided for interested individuals which in turn could increase engagement in services.

Conclusion

DMHAS is to be commended on their willingness to ask difficult questions and engage in self-reflection regarding the role of culture in the service delivery process. Undertaking this evaluative work speaks to the state's longstanding commitment to creating a system of care that is responsive to the cultural values and needs of all individuals seeking care. This same commitment will likely fuel next step efforts to build on system strengths and improve the cultural responsiveness of care. Service users have offered an initial vision for enhancing direct care and outcomes. Working in full partnership with service users, it is imperative that recommendations offered are further developed and prioritized such that interventions are aligned from personnel, policy, fiscal, and administrative perspectives. Implementing new forums and formats for system planning and decision-making can help to ensure translation of strategies for change to action. Further, continued self-evaluation and the ongoing use of feedback loops can help to enhance the cultural responsiveness of care, contributing to improvements in access, retention, engagement, service quality, and outcomes for all individuals seeking care.