

Appendix 1

Analysis of Cultural and Linguistic Capacity and Needs across the New York State Mental Hygiene Agencies

July 2010

Cultural and linguistic competence at all levels of the system of care reflects regard for the importance of culture, attention to the elimination of disparities, and the importance of adaptations to meet culturally unique needs.

To better understand the degree to which cultural and linguistic competence are being addressed across the mental hygiene systems of care and to develop a basis for examining planning strategies that could help to enhance the delivery of culturally and linguistically competent care, the Mental Hygiene Planning Committee posed five questions for consideration by local governmental units as part of the annual planning process. The following set of questions was included in the County Planning System 2010–2011 Planning Activities Form, which each county was asked to address:

- A. Does your county have a cultural competence plan in place for meeting needs of individuals and families in any of three mental hygiene areas (CD/DD/MH)? If so, please specify for which area you have a plan.
- B. Does your county currently use tools to assess the cultural and linguistic competence of county-run and other provider organizations? If so, please identify the tools and briefly describe the areas assessed.
- C. Does the county analyze data by race and ethnicity to reveal disparities in services provision? If yes, please indicate the areas you are examining (e.g., access to services, utilization patterns) and specify performance measures and benchmarks being used to reduce disparities.
- D. What data would better enable your county to identify disparities among providers and across the system of care?
- E. In which areas would it be helpful for providers to have cultural competence training? Please provide your thoughts on the content and method of delivery of such training.

At the time of analysis, 60 of 62 (96.8%) counties had responded to the set of questions. Among those yet to respond are Albany and Tompkins Counties. Based on the 60 counties reporting, the following summary highlights trends and issues, as well as some best practices, which can serve as a foundation for future activities across the disability areas to ensure culturally and linguistically competent care for people engaged in services and their families. Consistent with annual reports of statewide priorities, the results here are presented regionally.¹

¹ Regions as defined by the New York State Office of Mental Health: **Hudson River:** Albany, Columbia, Dutchess, Greene, Orange, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Sullivan, Ulster, Warren, Washington, Westchester. **Western:** Allegany,

Question A

Does your county have a cultural competence plan in place for meeting needs of individuals and families in any of three mental hygiene areas (CD/DD/MH)?

If so, please specify for which area you have a plan.

Across the State, 12 of 60 counties (20%) report having formal cultural competence plans or formal, systematic planning mechanisms in place. Broome and Delaware Counties both have plans that cover mental illness and substance abuse services. Nassau County's plan covers the three disability areas, is connected to its System of Care grant,² and is reinforced through contracting, while Orange County's plan is tied to its System of Care grant and enhanced with a $\frac{3}{4}$ full-time equivalent person dedicated to cultural and linguistic competence.

The New York City Department of Health and Mental Hygiene has a Cultural Competency Workgroup whose focus is to assure that the principles, standards, and practices of cultural competence are integrated in the work across the disability areas, including policy and planning, contracting for services, monitoring and evaluation of service delivery and outcomes, and public mental hygiene education.

Monroe County strives to incorporate cultural and linguistic competence throughout the mental hygiene and other systems of care, and through contracting it requires each mental hygiene provider agency to submit multiple cultural and linguistic competence deliverables (e.g., cultural competence self-assessment and strategic plan, race/ethnicity breakdowns of the agency board of directors, management and non-management level staff and the service population). As a System of Care county, Chautauqua County has a cultural and linguistic competency coordinator and a plan in place to serve all populations across the service system. Erie County will be expanding its cultural competence plan to take into account disproportionate minority issues. Of note, 10 of 12 counties with plans responding to the survey, including the five counties comprising New York City (83.3%), are current or alumni System of Care Counties.

Another eight counties (13.3%) have plans that are partially developed or in the process of being developed and implemented. Hamilton, Jefferson, Rensselaer and Schenectady Counties are aiming to develop plans over the next year, with Rensselaer County targeting 2011 for implementation. Westchester County has formed a Multicultural Advisory Committee and it is

Cattaraugus, Chautauqua, Chemung, Erie, Genesee, Livingston, Monroe, Niagara, Ontario, Orleans, Schuyler, Seneca, Steuben, Tioga, Tompkins, Wayne, Wyoming, Yates. **Central:** Broome, Cayuga, Chenango, Clinton, Cortland, Delaware, Essex, Franklin, Fulton, Hamilton, Herkimer, Jefferson, Lewis, Madison, Montgomery, Oneida, Onondaga, Oswego, Otsego, St. Lawrence. **Long Island:** Nassau, Suffolk. **NYC:** Bronx, Kings, New York, Queens, Richmond.

² System of Care grants offered by the Substance Abuse and Mental Health Services Administration (SAMHSA) enable localities to create coordinated networks of community-based services and supports that are organized to meet the challenges of children and youth with serious mental health needs and their families. Families and youth work in partnership with public/ private organizations to design mental health services and supports that are effective, build on the strengths of individuals, and address each person's cultural and linguistic needs. A system of care does not lead to a program; rather, it is a philosophy of how care should be delivered. A system of care approach to services recognizes the importance of family, school and community, and seeks to promote the full potential of every child by addressing their physical, emotional, intellectual, cultural and social needs.

beginning to examine cultural competency, while Onondaga County is in the process of developing a Multicultural Advisory Committee, striving to subsume cultural competence within a person-centered framework, and linking these efforts to its recently awarded System of Care grant. Cattaraugus County indicates that its Mental Health Subcommittee will be addressing the development of a plan, while Chemung County intends to develop a plan.

Has a Cultural Competence Plan in Place					
Question A					
	Yes	Partial or In Progress	No	Yet to Respond	Total
Central	2	3	15	0	20
Hudson River	1	3	11	1	16
Long Island	1	0	1	0	2
New York City	5	0	0	0	5
Western	3	2	13	1	19
<i>Total</i>	12	8	40	2	62

The remaining 40 counties (66.7%) responding to the survey report that they do not have cultural competence plans in place. Many, however, have two important components of a cultural competence plan—staff training and interpreter services. In some counties, attention to cultural competence receives much attention, as is Suffolk County, while absent a formal plan, emphasizes staff training and diverse representation on policy bodies. A couple of counties reveal an awareness of the importance of cultural and linguistic competence and culture. One county reports fiscal constraints interfering with its ability to attend to cultural and linguistic competence and a few others indicate that small county size and a good command of the community demographics make formal planning unnecessary.

Question B

Does your county currently use tools to assess the cultural and linguistic competence of county-run and other provider organizations?
If so, please identify the tools and briefly describe the areas assessed.

Fourteen of 60 counties (23.3%) are using tools to assess the cultural and linguistic competence of county-run and other provider organizations. Broome County is utilizing the Nathan Kline Institute Assessment Scale for provider and community agencies involved in delivering mental health and substance abuse services. In addition it is relying upon tools developed by Coordinated Care Services, Inc., (CCSI) of Monroe County. Orange County has surveyed providers and its Task Force has used the results for planning. Cultural competence planning seminars were also conducted with expert leaders in Broome County and followed up by management staff with attention to the importance of cultural competence and its integration into agency cultures. Broome County agencies were also provided individual technical assistance.

Uses Tools to Assess Cultural and Linguistic Competence Question B				
	Yes	No	Yet to Respond	Total
Central	1	19	0	20
Hudson River	1	14	1	16
Long Island	1	1	0	2
New York City	5	0	0	5
Western	6	12	1	19
<i>Total</i>	14	46	2	62

New York City providers are encouraged to employ the City-wide Cultural Assessment (CCA) to promote culturally competent care. The tool permits providers to better develop treatment goals and interventions that are individualized and culturally relevant. Additionally, the City Department of Health and Mental Hygiene conducts annual evaluations of provider organizations with contractd, which includes an assessment of whether programs inform persons engaged in services of their right to receive language assistance services, serve persons with limited English proficiency, have sufficient bilingual direct service staff, and offer training to increase cultural and ethnic awareness among staff of the populations served.

Nassau County has employed a professional feedback tool developed by the Nassau County Family System of Care to assess cultural and linguistic competence in multiple domains (e.g., physical environments, materials and resources, communication styles, values and attitudes and information about beliefs, values and attitudes to help shape the content of

training). The tool draws from Goode's Cultural and Linguistic Competency Self-Assessment Checklist available from the Georgetown University Center for Child and Human Development.

Monroe County has well-developed processes for assessing cultural and linguistic competence of provider agencies, using a "Cultural Competence Narrative and Self-Assessment," which sheds light on agency-level structure and functioning, enables community wide comparisons of data, and indicates proficiency in cultural and linguistic competence. In addition, it uses a "Cultural Competency Assessment Scale" during site visits to promote discussion of agency-level activities that promote cultural competence among all its staff members help to create a milieu aimed at improving access and retention in treatment of persons with diverse cultural groups.

Niagara and Wyoming Counties are using the licensing review process for assessing cultural and linguistic competence, while Cattaraugus County is using an independently developed tool to evaluate an individual's community connections, language needs, family roles, spirituality/religious affiliation and trauma history. Erie County is utilizing agency and program data as well as its CareManager database to examine areas that include the diversity of work force and boards, linguistic competence, and the diversity of individuals served and their outcomes at discharge. It is expanding its focus on cultural and linguistic competence through work with its Children's System of Care staff, contract managers and Community Connections of New York to implement quality improvement plans and identify and address disparities. The Ontario County Mental Health Clinic uses California Brief Multicultural Competence Scale and Cultural Competence Checklist–Personal Reflection tools for assessing its staff and program.

Among counties not using tools, Rensselaer indicates an interest in learning more about their use and Onondaga and Chautauqua counties report they are working to identify tools to evaluate the cultural competence of provider organizations and strategies to engage them in enhancing cultural and linguistic competence.

Question C

Does the county analyze data by race and ethnicity to reveal disparities in services provision?
 If yes, please indicate the areas you are examining (e.g., access to services, utilization patterns) and specify performance measures/benchmarks being used to reduce disparities.

Eleven of 60 counties (18.3%) appear to analyze data systematically for the purpose of understanding ethnic and racial disparities. Among these, Chenango examines race and ethnicity data, Cayuga also looks at the composition of its Community Services Board to be sure it reflects the community served, while the Broome County Mental Health Association analyzes data to detect language disparities and uses the information to plan for the provision of interpreter services.

Analyzes Data by Race and Ethnicity To Reveal Disparities Question C				
	Yes	No	Yet to Respond	Total
Central	3	17	0	20
Hudson River	2	13	1	16
Long Island	1	0	0	2
New York City	0	5	0	5
Western	5	13	1	19
<i>Total</i>	11	49	2	62

Columbia County analyzes data by race and ethnicity with respect to access to services, capacity and utilization, and Saratoga with respect to access. Rockland County reports using Office of Substance Abuse and Alcoholism Services (OASAS) data to examine demographics and disparities in services provision to persons with chemical dependency disorders. Rockland County is using the information to enhance the capacity of programs to serve individuals for whom Spanish is the primary language, particularly as a way to work more effectively with this underserved population. Nassau County captures the breakdown of services received by ethnicity to identify and monitor disparities across its system of care.

Monroe County draws upon multiple data resources to examine race and ethnicity and assist in identifying disparities. These analyses are conducted on a systems level as well as on an individual agency or program level. Efforts are underway to connect data sets in areas such as criminal/juvenile justice, child welfare involvement, homelessness and utilization of primary health care services. Importantly, the County has a Cultural and Linguistic Competence Council—a diverse group that includes peers, family members, providers, community representatives and other systems—to examine racial and ethnic disparities present in the mental hygiene system. Chautauqua County is preparing to address the overrepresentation of

minorities in high-end services across the mental hygiene and education areas through the development of performance measures and benchmarks.

Chemung County reports that in 2009 it completed an analysis of the individuals served and of staff providing services and used the data to make comparisons to the community at large. Erie County focuses its analyses on the Children's System of Care by race/ethnicity and gender using its CareManager system, looking at areas such as length of stay in program, time from intake to first visit, and degree to which goals are met by time of discharge.

While not examining data to reveal racial and ethnic disparities, a number of counties are taking steps in this direction, and some are requesting data to make this possible. In New York City, data are examined at the population level to reveal disparities in mental hygiene indicators and outcomes, but analysis of data by race and ethnicity to detect disparities in service provision is not being done. Nonetheless, the Department is moving in a direction that enables it to examine disparities effectively.

Niagara notes that it collects data on cultural makeup of county-run services as part of its mental health single point of access program, assisted outpatient treatment, and Patient Characteristic Survey (PCS) reporting requirements. In addition, the Niagara Community Services Board receives and reviews provider reports.

Some counties also focus on special populations and use the information for serving people who are deaf, blind, or living with hearing or visual impairments, and people who live in poverty. A number of counties report that Census data tell them about the racial and ethnic makeup of their communities, while a few small counties indicate that the size of their counties coupled with small minority groups makes statistical analysis meaningless or makes it possible for them to adequately address needs in culturally competent ways. Of interest is one county that uses data to look at the ethnic and racial makeup of the Community Services Board to ensure that it reflects the community it serves.

Question D

What data would better enable your county to identify disparities among providers and across the system of care?

While a few requests deal with improving the ability to interpret data through enhanced formatting and presentation, most requests cluster around the desire for comparative data and other types of data that would enhance the capacity to better engage and serve people in effective treatment and support services and eliminate disparities in care at the program, County and State levels.

Data That Would Better Enable the Identification of Disparities		
Question D		
	Data Content Request	Data Format Request
Central		
<i>Broome</i>	1. Comparative PCS data that provides a view of ethnicities served annually	
<i>Oneida</i>	1. Data that specifies the ethnicity of the individuals the County serves among all three systems	
<i>Onondaga</i>	1. # and % of client volume across a range of demographic categories and service providers, and include comparative Census data to gauge the degree to which the County system serves a representative sample of the population, and multi-year trends to be able to track the changing demographics of the local population, and corresponding subpopulation of those served. Would benefit outreach to underrepresented groups who are underrepresented and targeted approaches by providers to increase the presence of certain groups	1. Tabular form
Hudson River		
<i>Columbia</i>	1. Data to provide realistic benchmarks for demographics, staffing requirements, service access geographic location for developing performance measures	
<i>Dutchess</i>	1. Service data, referencing State averages for service provision and in comparison with Census data	
<i>Greene</i>	1. Any data from State agencies to help in meeting diverse needs	
<i>Putnam</i>	2. Customer satisfaction surveys in all languages for people engaged in mental hygiene services and their families, designed also to identify cultural competency gaps and ways to address them based on the consumer point of view	
<i>Rensselaer</i>	1. Data and tools used by provider organizations	
<i>Rockland</i>	1. Implement the same data collection method utilized by OASAS for admissions and discharges to all licensed programs 2. Universal form across systems to permit data to be aggregated	
<i>Westchester</i>	1. Race and ethnicity data by age across all developmental disability programs	

Data That Would Better Enable the Identification of Disparities
Question D

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Question D	
Long Island	
<i>Suffolk</i>	<ol style="list-style-type: none"> 1. Access to CAIRS data under PROS to conduct analyses for racial and ethnic disparities 2. Patient Characteristic Survey data in a format to analyze zip code and program level services for differing cohorts of individuals. The aggregate data currently available has very limited usefulness in this regard.
New York City	
<i>Bronx Kings New York Queens Richmond</i>	<ol style="list-style-type: none"> 1. By race, ethnicity, age, gender, socio-economic status, sexual orientation and location for children, adolescents and adults: <ol style="list-style-type: none"> a. Population-based data on the prevalence of mental health and substance use disorders and developmental disabilities b. Identification of people with unmet service needs who are/ are not receiving services, as well as the types of needs they have c. Individual treatment outcomes for those who are enrolled in services. 2. For individuals with mental health needs who are not in treatment, we are interested in the reasons they have not utilized services (e.g., not interested in services, lack of access to services, unaware of emotional health needs, stigma, etc.) and whether differences exist along demographic lines. 3. For individuals in services, outcome data would allow us to determine whether specific groups have unmet needs, and how effective different treatment modalities are for the groups we serve.
Western	
<i>Cattaraugus</i>	<ol style="list-style-type: none"> 1. # and characteristics of out-of-county individuals referred for addictions residential placement 2. Ethnicity, age, and language data of developmental disability providers for analysis
<i>Chautauqua</i>	<ol style="list-style-type: none"> 1. Access to Medicaid claims data
<i>Erie</i>	<ol style="list-style-type: none"> 2. Provision of planning reports by State broken down by race and ethnicity, with a further breakdown by provider, county, and State
<i>Monroe</i>	<ol style="list-style-type: none"> 1. Data set that is able to be manipulated for analysis across race/ethnicity factors 2. Data the State offices supply, by race and ethnicity at the State, county and provider levels 3. Data sets that include outcome indicators 4. Uniform wait list/wait time data that also includes client characteristics
<i>Niagara</i>	<ol style="list-style-type: none"> 1. Graphic presentation of mental health PCS data 2. Ability for PCS data to be exported
<i>Yates</i>	<ol style="list-style-type: none"> 1. Data describing the large Mennonite population

Among the 22 counties (36.7%) responding to the question, 21 of 22 (95.5%) provide suggestions for data that would aid their efforts to enhance cultural and linguistic competence across the mental hygiene systems. A few have requested comparisons to Census data that would permit them to assess the degree to which the group it serves is representative of the community population. Moreover, others have asked to for planning enhancements by having access to race and ethnicity data by demographic characteristics across the three mental hygiene systems.

Of interest, one county notes that much information is available regarding gaps in care and preferences, urging “less data and more resources to accommodate . . . unique and sometimes divergent needs.” Another county points to the importance of having developmental disabilities hot line operators who can respond to inquiries in the language of the speakers.

Question E

In which areas would it be helpful for providers to have cultural competence training? Please provide your thoughts on the content and method of delivery of such training.

Forty-one counties (68.3%) offered feedback on cultural competence training for providers. Broadly, comments covered three main areas: the type of training that would be helpful, desired training approaches, and openness to training by counties and providers.

Two counties suggest that training be offered for engaging people in care in culturally and linguistically ways, possibly indicating their desire to align with mental health clinic restructuring and the focus on people-first approaches to care. Other counties recommend training that helps with the development of culturally competent approaches to eliminating stigma and discrimination, addresses the unique needs of specific disability areas, offers refreshers particularly for staff who work with persons who have developmental disabilities, meets community-specific population needs (e.g., Mennonite/Amish, migrant workers), and improves knowledge across the systems of care.

Nine counties note the importance of broadening training beyond the content typically offered in basic cultural competence sessions and using training to move toward a quality improvement framework. Schenectady County, for example, advocates that knowledge be sustained through established cycles of training and knowledge sharing among stakeholders at every level, continual assessment of needs, and active engagement of the executive leadership in training, regular system-level review, and creative problem solving agency, program and County department levels. Erie County suggests that movement toward a quality improvement framework builds on training and the use by administration and staff of data to identify disparities, create performance measures to track progress toward eliminating disparities, and tracking progress toward goals. Both Niagara and Columbia Counties recommend that training focus on broader issues of diversity and a more balanced exploration of cultural and linguistic competence by examining demographic factors and their influence on treatment, attitudes, and ways to improve knowledge in real time. Related to this concept of broadening training,

Monroe County points to the need for follow up on general awareness and training that focuses on principles and values, urging that that providers be assisted in learning how to analyze and interpret data so they may identify and develop remediation processes to eliminate agency and program-level disparities. Moreover, follow up training should concentrate on incorporating and embedding cultural competence into agency and program policies, practices and service delivery. New York City notes the importance of forums for enhancing services for persons with developmental disabilities. Chautauqua County is taking time to assess training needs and work with its cultural competence coordinator to develop training plans that address strengths and weaknesses.

A number of counties welcome the opportunity for cultural competence training, one even suggesting that training be opened up to nonprofit agencies. Some, however, express concerns that reflect the very challenging environment in which service provision is taking place (e.g., less funding, more demands). In these cases, the counties appear to be trying to balance the

importance of strengthening cultural and linguistic competence in the face of limited resources. Related to this, three counties indicate that web-based training (e.g., webinars) is desired because it saves on travel costs and time. Having content delivered over the web flexibly, rather than as one-time live training sessions, would help providers with scheduling such training.