

# Increasing Utilization

**Strategies for Engaging Culturally/  
Racially Diverse Children and their  
Families in Mental Health Services**

**Making Children's Mental Health Services Successful**



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## Introduction

This monograph was developed to increase awareness of the impact of culture on the utilization of mental health services and to provide field-based examples of strategies that can increase utilization for culturally/racially diverse children and families (Hernandez, Nesman, Isaacs, Callejas, & Mowery, 2006). Utilization is defined as the service usage rate or usability by and for the populations served based on measures such as length of time in service, retention rates, dropout rates, or rates of return (Hernandez et al., 2006; Hernandez, Nesman, Mowery, Acevedo-Polakovich, & Callejas, 2009). Utilization rates serve as indicators that appropriate services are being offered and barriers to accessing these services have been addressed. Utilization also involves engaging children and families in services, which depends upon developing trust and confidence in the services offered and compatibility with the help-seeking preferences of diverse families. The concept of compliance may also be linked to utilization in areas such as medication use and follow through on referrals. High levels of non-compliance have been found among adult consumers; however, the unique factors that lead to non-compliance are not well understood, and may be especially relevant among culturally/racially diverse parents in relation to services for their children (Cheung & Snowden, 1990; Elster, Jarosik, VanGeest, & Fleming, 2003; Herrick & Brown, 1998). The information provided in this monograph will assist providers, policymakers, and community representatives in understanding factors related to engagement and compliance as well as strategies that can improve all aspects of utilization by culturally/racially diverse children and their families.

Utilization of services is presented here in the context of the community and the organizational infrastructure through which services are delivered for a specific population of focus. Utilization by diverse children and families is linked to the level of compatibility between service delivery, population characteristics, and organizational characteristics (Hernandez, et al., 2006). An organizational focus on reducing utilization disparities involves both active facilitation of service use for diverse populations and supportive organizational policies, procedures, and infrastructure that also contribute to engaging diverse communities (Hernandez et al., 2006). The literature provides some support for this dual focus, including examples of strategies at both direct service and infrastructure levels. Strategies linked to increased utilization in the literature include providing culturally/linguistically appropriate reminder calls for appointments (Manoleas, Organista,

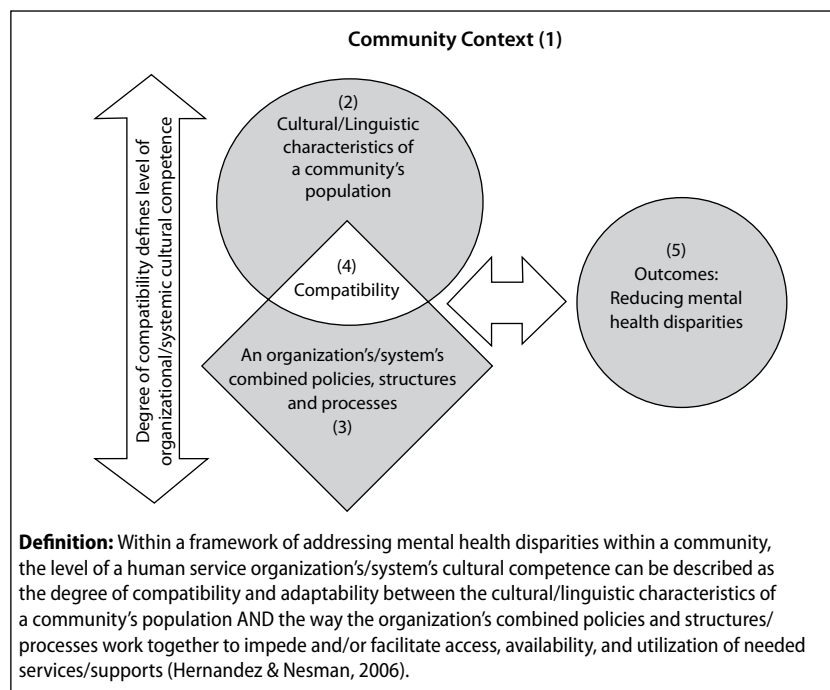
**The purpose** of this monograph is to increase awareness of the impact of culture on the utilization of mental health services and to provide field-based examples of strategies that can increase utilization for culturally/racially diverse children and families.

The strategies outlined in this monograph are derived from a series of interviews conducted as part of a larger study of the Research and Training Center for Children’s Mental Health at the University of South Florida (RTC, 2004). One of the primary goals of the larger study is to identify organizational strategies that operationalize cultural competence.

Negron-Velasquez, & McCormick, 2000; McKay, Stoewe, McCadam, & Gonzales, 1998), addressing transportation needs (Friedman, D’Aunno, Jin, & Alexander, 2000), and tracking utilization rates (e.g., length of time in service, retention rates, dropout rates, and rates of return) across cultural/racial groups (Matsuoka, Breaux, & Ryujin, 1997; McKay et al., 1998; Sue, Fujino, Hu, Takeuchi, & Zane, 1991).

The strategies outlined in this monograph are derived from a series of interviews conducted as part of a larger study of the Research and Training Center for Children’s Mental Health at the University of South Florida (RTC, 2004). One of the primary goals of the larger study is to identify organizational strategies that operationalize cultural competence. The study’s initial literature review of child and family mental health research identified strategies for increased cultural competence that could be linked to three key domains of service delivery: 1) accessibility, 2) availability, and 3) utilization, for culturally/racially diverse populations in the U.S. (e.g., African American, Asian and Pacific Islander, Latino, and Native American) (Hernandez et al., 2006). In addition, a review of cultural competence assessment measures identified strategies for infrastructure development that support cultural competence (Harper, Hernandez, Nesman, Mowery, Worthington, & Isaacs, 2006). Findings from the literature and protocol assessment reviews were incorporated into a conceptual model that includes both direct service and infrastructure domains in organizational cultural competence development (Hernandez & Nesman, 2006). An illustration of the conceptual model is shown in the following diagrams and explained in more detail in the discussion (Figures 1 and 2).

Figure 1  
Conceptual Model of Organizational Cultural Competence

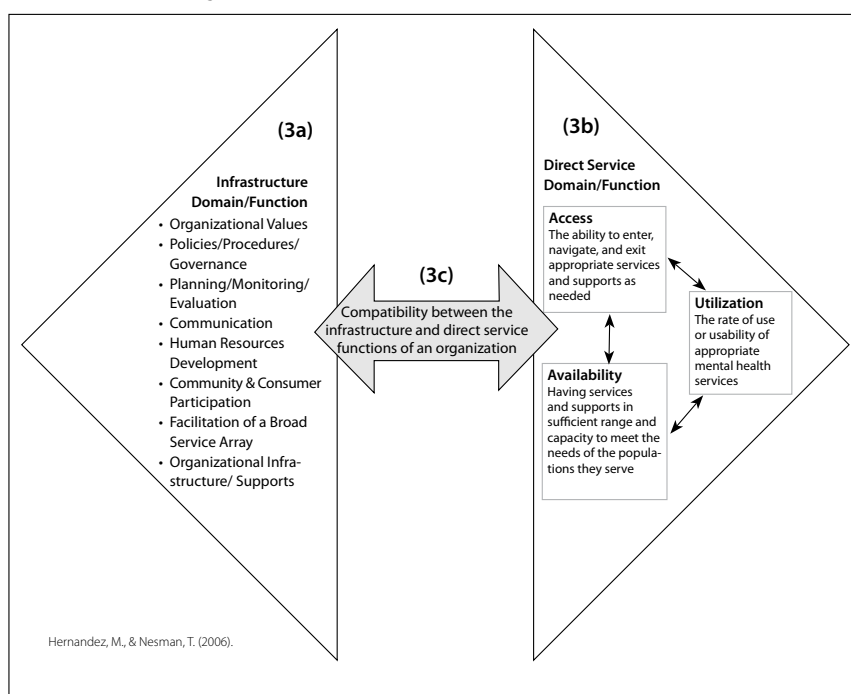


The organizational cultural competence conceptual model that frames this study, illustrates key relationships between a community's populations, organizational structures, direct services processes, and community context (Figure 1). The box labeled community context (1) illustrates that mental health organizations and systems function within larger community, state and national contexts that affect their efforts to serve local populations. The model also highlights the need for compatibility between the *population's cultural and linguistic characteristics* and the organization's characteristics (2). Characteristics of the community that are important to consider include culture, ethnicity, race, socioeconomic status, and other social factors that affect the ways in which different populations interact with the organization and specific services or programs it provides. The conceptual model also shows the importance of an *organization or system's combined policies, structures, and processes* (3). These characteristics of the organization influence the way in which it interacts with the community's populations, and are also influenced by the community context. The level of compatibility between a population's cultural and linguistic characteristics and the organizational characteristics determines the level of organizational cultural competence (4). Increasing compatibility is shown as resulting in reduced mental health disparities (5).

More detailed components of the conceptual model are illustrated in the second diagram (Figure 2). In this diagram, the *infrastructure domain* shows multiple functions that are typical of organizations, each of which must be adapted to increase cultural competence (3a). For example, the domains that include values and policies, procedures, and governance can be adapted to address the population's unique characteristics as well as community issues such as insurance cover-

**The detailed model** of organizational domains suggests that utilization of mental health services by diverse children and their families can be increased through the development of compatible, culturally competent, practices in both infrastructure and direct service domains.

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





**For the purposes of this monograph, utilization** of mental health services is defined as the rate of use of services or their usability for a population of focus shown by measures such as length of time in service, retention, and dropout rates.

age or immigration policies. The *direct service domain* includes functions related to service accessibility, availability, and utilization (3b), each of which is influenced by both organizational and population characteristics. As shown, *compatibility* is needed between infrastructure and direct service domains (3c) in order to sustain culturally competent services. According to the model, compatibility must be maintained through reciprocal knowledge development and communication between the population of focus and the organization in order to ensure an appropriate and acceptable environment and continuum of services.

The detailed model of organizational domains suggests that utilization of mental health services by diverse children and their families can be increased through the development of compatible, culturally competent, practices in both infrastructure and direct service domains. Utilization is shown as influencing and being influenced by accessibility and availability of services (shown as two-way arrows), indicating that compatibility with the population involves adaptations in all service aspects. These three aspects of service delivery cover a continuum from prevention to problem identification and help seeking, assessment, treatment, and follow up. As previously noted, **utilization** of mental health services is defined as *the rate of use of services or their usability for a population of focus shown by measures such as length of time in service, retention, and dropout rates*. The related concept of **access** is defined as the *direct service and organizational mechanisms that facilitate a person's ability to enter into, navigate, and exit the appropriate services and supports as needed*. The third aspect of service delivery, **availability**, is defined as *having acceptable services and supports in sufficient range and capacity to meet the needs of the population of focus*.

In the current study, strategies were identified that were directly linked to increased utilization of mental health services for culturally/racially diverse populations at participating sites. It is possible that the identified strategies may also be related to access and availability of services; however, this monograph focuses primarily on their relationship to increasing utilization. Separate monographs were developed to focus on strategies that contribute to increasing access and availability of services so that the unique contribution of each function to organizational cultural competence could be highlighted (Callejas, Nesman, Mowery, & Hernandez, 2008; Prince Inniss, Nesman, Mowery, Callejas, & Hernandez, 2009).

The next section provides an overview of the methods used in this study including site selection criteria, data collection techniques, and analysis procedures. The overview is followed by sections that outline the identified direct service and organizational strategies used within the study sites to increase utilization of services for each population of focus. Each section includes a description of the populations served by the participating sites as well as information about the community context and organizational characteristics. The final section provides concluding statements about overall findings and suggestions for future research.



# 2

## Method of Identifying Key Utilization Strategies

Utilization strategies were identified through interviews conducted with stakeholders from selected organizations across the U.S. that met criteria for providing culturally competent services for racially/ethnically diverse children and families. Mental health organizations or systems were selected for participation in this study through a national search. Sites were identified as exemplary by a panel of researchers, practitioners, and family advocates who have expertise in the areas of cultural competence and disparities in mental health. Sites were identified using the following criteria:

- Have strategies for increasing organizational cultural competence
- Serve one or more of the populations of focus (African American/Black, Asian and Pacific Islander, Latino, and/or Native American)
- Provide evidence that populations of focus value and use their services
- Demonstrate matching strategies to groups served
- Exhibit increased access, availability, and utilization, as well as child and family satisfaction with services
- Show evidence of sustainability

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

### Data Collection

Two versions of semi-structured interview protocols (one for organizational personnel and one for family members receiving services) were developed, piloted, and revised for use during interviews. Multidisciplinary interview teams included multilingual/multicultural researchers who were trained to administer the interview protocol. Interviews explored definitions of cultural competence, values and beliefs about serving diverse populations, and asked about specific strategies for increasing service utilization for one or more of the racial/ethnic populations that were the focus of the study.

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

### A total of 151 interviews

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

## Analysis Procedures

Responses from each site were coded using ATLAS.ti version 5.2, qualitative analysis software (Scientific Software Development, 2006). The coding process included identification of strategies related to improving utilization of mental health and support services, relevant community and organizational characteristics, and conceptualizations of cultural competence. Similarities and differences in strategies and concepts used across sites were identified through a coding and theory-building process. Initial codes were developed based on findings from the literature review related to utilization of services by culturally/racially diverse children and families (Hernandez et al., 2006). These initial categories included:

- Engaging targeted populations
- Examining disparities in patterns of service usage
- Tracking utilization by population, service type and diagnoses

More specific codes were developed for categories of information that emerged during analysis of transcripts. Once all interviews were coded, coded sections were examined for relationships to each other and organized into code families, or larger categories, that corresponded to specific components of the conceptual model of organizational cultural competence. Coded information was used to create descriptions of each study site and the populations they serve, as well as the community context and utilization strategies employed. Utilization strategies that are highlighted in this monograph are those that were intentionally implemented to increase utilization of services at the participating study sites. The utilization strategies are presented independently for each population of focus based on the unique ways in which needs, preferences, and corresponding strategies were described by respondents. Therefore, although there are similarities in strategies for each population served, the categorization of these strategies may vary. Coded sections that had relevance across multiple domains or that provided guiding principles and overarching concepts are incorporated into the conclusion section of the monograph.

## Sample

Twelve sites were selected based on the study criteria and willingness to participate in the study. Seven organizations hosted site visits and five organizations participated through telephone interviews only. A total of 151 interviews were conducted with a variety of stakeholders, including administrators, direct service personnel, funders, evaluators, and/or family representatives.

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

as a grassroots neighborhood-based effort by community residents to combat discrimination and inadequate services and later developed into a Community Development Corporation<sup>1</sup> (CDC). Agencies with similar grassroots or community-based beginnings follow, with the list moving more toward organizations that are affiliated with system of care grant communities or public behavioral/mental health departments or systems.

Table 1: Description of Study Sites

Study Site	Population Served	Geographic Region	Organizational Type	Service Type	Est.
01 Visit	Latino (95% Mexican descent); Native American	Southwest	Community Development Corporation (CDC); originated as grassroots, neighborhood based non-profit	Variety of social and human services, economic development, housing, and mental health	1969
02 Visit	Latinos (majority Mexican descent; various indigenous ethnic groups, majority P'urhépecha)	Pacific Northwest	Neighborhood-based, non-profit providing services; originated as grassroots organization	Variety of children's, family, and community development programs; information and referral to specialty services	1991
03 Visit	Native American (more than 100 different tribes/ethnic groups served)	West Coast	Community-based non-profit with culturally-specific focus on service provision; countywide services	Variety of educational, family, economic, and community development programs; mental health	1974
04 Phone	African American primarily; growing populations of Haitian and African immigrants, Latinos	Midwest	Community-based non-profit with culturally-specific focus on service provision	Chemical dependence treatment, mental health, and family preservation	1975
05 Visit	Asian and Pacific Islander	Pacific Northwest	Community-based non-profit providing services countywide; originated as grassroots organization	Variety of social services, including, aging and adult, naturalization, vocational services, mental health across lifespan	1973
06 Phone	Latinos (majority Puerto Rican)	Northeast	Community-based non-profit organization with culturally-specific focus on service provision	Variety of health and human services, including HIV/AIDS, Head Start; mental health	1960
07 Phone	Latinos; Native American	Southwest	Community-based non-profit organization	Variety of traditional, spiritually-oriented, and alternative mental health services	2001
08 Phone	Latino (about 60%; various ethnic groups); African American (about 30%); Filipino (7%); small percentages of East African immigrants and Caucasians	West Coast	Community-based non-profit organization	Variety of social services, mental health, and family preservation	1975
09 Visit	Multi-ethnic; African American; Haitian; Cape Verdean immigrants; small percentages of Latinos, Caucasians	Northeast	State-wide non-profit organization	Mental health services across lifespan, elderly services, developmental disabilities service, information & referral	1975
10 Visit	Multi-ethnic; Latino (about 35% various ethnic groups); Asian and Pacific Islander (about 15% various ethnic/cultural groups)	West Coast	Children and Youth Services Division/Cultural Competence Department; county mental health system	Variety of mental health services for children with behavioral, emotional, or mental disorders	1999
11 Phone	African American	South	System of Care grant site; public mental health system	Variety of family and mental health services focused on serving children with SED	1999
12 Visit	African American	Midwest	Managed care program operated by county behavioral health division	Variety of mental health and family preservation services (court ordered referrals)	1995

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

# 3

## Utilization Strategies for Culturally/Racially Diverse Populations

**For the purposes of this study,** a **strategy** is defined as a service delivery practice or series of related practices designed to increase service use for a specific population based upon that population's cultural and linguistic characteristics, history, and worldview.

This section presents an overview of findings related to the service delivery strategies used within participating organizations to increase utilization for culturally and racially diverse children and families. For the purposes of this study, a **strategy** is defined as *a service delivery practice or series of related practices designed to increase service use for a specific population based upon that population's cultural and linguistic characteristics, history, and worldview*. The findings are presented in a way that highlights how these strategies were tailored to meet the needs of the following service use populations: African Americans/Blacks, Asian and Pacific Islanders, Latinos, and Native Americans. Strategies were identified for both the direct service domain and the organizational infrastructure domain at each site. The terminology used to describe these strategies has been taken directly from study participants as they talked about their work at the sites.

The strategies associated with the direct service domain of the cultural competence model address barriers that impact most directly on children and families seeking services. These strategies are typically implemented by direct service personnel such as outreach workers, case managers, and therapists, and often involve direct interaction with children and families. The direct service strategies used to successfully increase mental health service utilization that were identified across sites participating in this study are listed below.

### Direct Service Strategies

- Address Childcare Needs
- Address Transportation Needs
- Community and Family Education
- Engagement Processes
- Flexible Service Provision
- Provide Incentives
- Responsiveness

This study also identified and described a number of strategies that are implemented or developed at an administrative level within organizations or systems — those that do not usually involve direct interaction with children and families needing services. These strategies, which were associated with the organizational infrastructure domain of the cultural competence model (Figure 2), are most often implemented by administrators and influenced by funders and policymakers. Such strategies are frequently reflected in mission statements, established governance poli-

cies, human resources procedures, and other components associated with the infrastructure of an agency. However, implementation of organizational infrastructure strategies can shape whether and how direct service strategies are used to address the needs of racially/ethnically diverse children and families. The organizational infrastructure strategies for increasing utilization of mental health services identified across sites participating in this study are listed below.

#### Organizational Infrastructure Strategies

- Create a Welcoming Environment
- Create Linkages
- Meet Immediate/Perceived Needs
- Promote Child and Family-driven Services
- Provide Ethnic/Linguistic Matches
- Provide for Transitional Planning
- Track Utilization Rates and Patterns

Although it is possible that other practices contribute to increased utilization, those described in this monograph were specifically linked to utilization in a majority of participating sites. Additional practices were mentioned by some sites in reference to utilization while other sites did not explicitly make that connection. For example, Site 09, which primarily serves African-American children and families, mentioned that their regular newsletter serves as a tool to continue to engage families who are no longer enrolled in services. In all likelihood, many sites produce newsletters; however, other sites did not regard the newsletter as a tool of engagement to improve the utilization of services.

It is also important to note that the utilization strategies presented as part of this study do not exist in isolation of the other domains of the organizational cultural competence model. That is, implementation of a direct service strategy designed to increase utilization of services for a particular population must be supported by other strategies in the organization. Compatibility between direct service and infrastructure domains is needed in order for strategies to work in concert so that barriers are removed for both personnel and families. For example, governance procedures that include input from community leaders, creative and flexible funding, and involvement of children and families in service development can facilitate engagement in services and increase utilization. In addition, since the direct service components within an organization are interrelated, increased utilization may be dependent upon accessibility or availability of services, and some strategies used by organizations may impact more than one of these domains. While acknowledging the potential interrelationships among organizational domains, this study classified strategies individually for each service domain of the cultural competence model and these strategies are presented in separate monographs focusing on access, availability, and utilization.

The next four sections provide specific utilization strategies used by organizations that participated in this study. Strategies are described separately for each population group in conjunction with descriptions of the organizations and the communities they serve. Although categories of strategies are similar across population groups, the manner in which the strategies are carried out at each organization reflects the unique experiences and backgrounds of the organizations and populations of focus.

**Compatibility** between direct service and infrastructure domains is needed in order for strategies to work in concert so that barriers are removed for both personnel and families.

Despite the frequent commonality of values, respondents emphasized the need to treat family members with respect and for service providers to avoid assuming they know the cultural and spiritual preferences of African American/Black families and individuals.

## Utilization Strategies for Serving African American/Black Populations

Four of the 12 sites studied served a majority of African American/Black populations, and these differed by organizational type. Site 04 is a community-based ethnic specific organization, Site 09 is a statewide non-profit organization, Site 11 is a federal System of Care grantee, and Site 12 is a managed care program (Table 1). Two of these sites hosted visits by the study research team (Sites 09 & 12), while staff members from the other two sites were interviewed by telephone. A more detailed description of each organization is available in the Appendix.

### Population and Community Characteristics

The African American/Black populations served by the organizations that participated in this study were culturally diverse with different social circumstances and mental health needs. Two of the study sites were located in the Midwest, one in the Northeast, and one in the South. Three of these sites reported that 60% to 95% of their service population can be identified as African American/Black, a category that can include one or more of the following: African Americans (native U.S. born) and immigrants from or descendants of Haiti, Nigeria, Somalia, and other African nations, as well as bi-racial or multiracial children.

Respondents at these organizations noted that there are important cultural differences between different African American/Black populations that must be respected. Respondents at sites with large or growing proportions of immigrants also noted that language barriers made it especially difficult for parents to find services for children with mental health or other needs. When discussing beliefs and views about mental illness and other needs, respondents who served Black immigrant children and families noted that parents often consider emotional or behavioral disturbances to be “disciplinary problems” and that children need to be disciplined more for “improper or inappropriate behavior” rather than a specific condition or symptoms that may need to be addressed by professionals or practitioners. Respondents also noted that there was often resistance on the part of parents who felt that mental illness was shameful or would stigmatize the family or child. Respondents who served African American/Black populations also commented on the importance many of their families place on family ties and spirituality. Despite the frequent commonality of values, respondents emphasized the need to treat family members with respect and for service providers to avoid assuming they know the cultural and spiritual preferences of African American/Black families and individuals. As one administrative respondent stated,

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

The issues addressed by the organizations in this study serving African American/Black children and youth, include serious emotional disturbance, various mental health diagnoses, and involvement in the juvenile justice and child welfare systems related to truancy, runaway, and gang involvement. Respondents



also identified poverty, domestic violence, and anger management as important issues affecting families that negatively impacted children's mental health.

The types of services delivered by participating organizations were quite diverse. They included substance abuse treatment, mental health services, family preservation, elder services, developmental disability services, information and referral, and services designed for children with serious emotional disturbance (SED) and their families.

## Direct Service Strategies

### Address Transportation Needs

Transportation was one strategy employed by sites that primarily served African American/Black children and families as a means of facilitating their continued participation in services. Site 11 reported that adequate public transportation is not available in their county and that *"families get booted out of services because they've missed appointments and that comes down to transportation."* To overcome these barriers sites turned to offering bus passes (Sites 04, 09, & 11), cab fare/taxi service (Sites 09 & 11), home based services (Sites 04, 09, 11, & 12), or transporting children and/or family members directly (Sites 09, 11 & 12). Some agencies were able to acquire vehicles specifically for the purpose of transporting families (Sites 09 & 12), but cautioned *"we are very careful with that because some families do exploit this. It becomes a taxi service. We're no longer engaging in conversation, we're just picking them up and dropping them off"* (Interview participant, Site 09). Others contracted with other organizations to provide transportation (Site 04). Site 11 mentioned that Medicaid covers the costs of providing transportation for children and families in their state.

Participating agencies recognized that missed appointments are often due to extenuating circumstances related to limited resources and lack of transportation options (Sites 04 & 11). Many noted that attendance and utilization of services increased with the provision of transportation. The link between socioeconomic status, transportation, and utilization of services was expressed in different ways by respondents, and was a major area of concern. As one respondent stated:

*Sometimes we help families with transportation and if they need transportation, and if we feel they need a bus pass we give 'em a bus pass. We talked about money. They don't have money to eat how would they have money for a bus pass? So we have to give them a bus pass (Interview participant, Site 09).*

### Community and Family Education

Education of children and families about service procedures and goals is another strategy used to enhance service utilization. One respondent remarked, *"Educating the child and family is very effective in their decision to continue using services. When they believe they need the services, they continue using them"* (Interview participant, Site 11). This strategy involved explaining the policies and practices of the agency, clarifying instructions about services, and education on issues of diagnosis and medication. Respondents at Site 09 suggested that by educating

**Many respondents** noted that attendance and utilization of services increased with the provision of transportation.



**Respondents suggested** that by reducing the stigma attached to receiving services, children and families were more willing to utilize appropriate services.

families they were empowering them to help themselves. In turn, this site reported that as parents became more educated about services they began to educate other parents as well.

Site 11 indicated that they encouraged parents to view services and resources they were learning about not solely for intervention in a crisis situation, but also as crucial to the child's continued well-being. As one respondent stated:

*Once services are in place, we continue to educate parents on the importance of...looking not just at today but to look to the future. Keeping services in place will help your child grow and move towards becoming a productive citizen (Interview participant, Site 11).*

This same site coordinated the education and training of families, service providers, and the broader community. Respondents suggested that by reducing the stigma attached to receiving services, children and families were more willing to utilize appropriate services (Site 11). Another participant added, "Parents don't look for services because of lack of knowledge" (Interview participant, Site 09). Public awareness of mental health issues and more educational outreach were linked with increased service utilization not only by increasing understanding of what services were offered, but also by changing the image of the organization within the community. A respondent at one agency stated that education and outreach gave the community a sense that their agency was something other than "where crazy people go" (Site 04).

Education was also reported to reduce the stress experienced by families because of increased understanding about the child's condition as well as resources available to help the child and family. One parent interviewed likened the experience of dealing with a child's mental illness to being caught in a war zone and not knowing which way to turn for help (Site 09). The information provided to her reduced the stress and chaos in her life and gave her the tools needed to participate in services. At another site (Site 12) a respondent related the fear and denial experienced by caregivers raising children with emotional or behavioral disorders. Education gave caregivers tools to better care for their children at home and work with service providers. It was reported that across all types of caregivers from grandparents, to younger parents, to foster parents, there is reluctance to remain in services without a good understanding of what services are intended to accomplish and how they might benefit the child and family (Site 09).

### **Engagement Processes**

Engagement of children and families includes facilitating entrance into needed services by connecting them to specific providers as well as developing skill and comfort in navigating the larger service system. A key barrier to utilization, from the perspective of families interviewed, is the lack of continuous and effective communication. In some cases this means simply staying in touch with families so they are reminded of scheduled appointments or notified in a timely manner if changes are made. One respondent mentioned that lower utilization "is due to miscommunications or lack of communication...in terms of scheduling and rescheduling of appointments" (Interview participant, Site 09). A strategy developed to over-

come this barrier was to provide appointment reminders by telephone. One family participant reported that she would not have kept appointments if staff “*had not called to confirm her attendance*” (Interview participant, Site 09). This strategy also informed providers if there were changes in family circumstances that would not allow them to keep the appointment so that they could reschedule or help the family address the barriers. Staff at this site also reported that they did not rely solely on telephone reminders because their population might not have telephones or might not receive messages left for them. Alternate practices included sending a letter in the mail or visiting the home.

Communication about other activities and events families can participate in was also mentioned as an engagement practice, which included sending newsletters and flyers to remind families of relevant activities provided by the organization or by partner organizations. According to one staff member, reminders were mailed to families about activities they might want to participate in as a way to “*keep them in the loop*” (Site 09) and maintain interest and engagement with services.

### Flexible Service Provision

A variety of types of services were developed by participating organizations in order to increase utilization by African American/Black families. Agencies at Sites 04 and 11 provided services in the family home as a way to overcome the barrier of transportation. Three of the four sites serving African American/Black populations (Sites 04, 09, & 11) identified home-based services as a strategy to improve utilization because it addressed socioeconomic and cultural barriers. One respondent commented that in-home services “*alleviate[d] transportation or privacy/fear issues*” (Interview participant, Site 04). Other respondents pointed out that providing services at times that families are at home better accommodates the schedules of the families they serve. In this way, utilization of services was enhanced by allowing flexibility so that the needs of the family could actually be met.

### Responsiveness

For African American/Black populations, a responsive approach was needed to build rapport with the family and reduce distrust. This was expressed by one respondent as: “*Listen, don’t judge. Don’t show them what to do—especially in (the) beginning. Don’t go giving orders*” (Interview participant, Site 09). A direct service respondent commented that it was important to ask families how they prefer to be identified, so that family members know that their input is respected. Another respondent explained that it is important to recognize differences within the population, stating “*sometimes it’s the difference between African American and Black*” (Interview participant, Site 12). Various respondents also stated the importance of emphasizing the strengths in African American individuals, families, and communities, and recognizing the resilience that is required to survive and overcome both current and historical hardships and discrimination.

One respondent who is a family member of a child receiving services spoke of the program addressing their concerns and providing support and encouragement (Site 11). By approaching the family in a non-judgmental, non-threatening fashion, the family was more comfortable continuing services. A direct service

### Utilization of services

was enhanced by allowing flexibility so that the needs of the family could actually be met.

**Involving community** and spiritual leaders in treatment was mentioned as a means of increasing the level of security in families who are likely to distrust formal providers.

respondent described such an approach when discussing work with adolescents at risk or with serious emotional disturbances:

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

Respondents at another site reported that they had incorporated a new intervention method that was more responsive to clients, by not “forcing structured programming down their throat or using old confrontational models” (Interview participant, Site 04). The method, called motivational interviewing, is listed on SAMHSA’s National Registry of Evidence-based Programs and Practices (2007). This approach is described as a client-centered method aimed at enhancing motivation to change by exploring and resolving problem areas with the client (Miller & Rollnick, 2008). Regarding this approach, one respondent stated:

*Really we're trying to move away from confrontation, which is also an issue in the Black therapy/counseling community that has really historical meaning about how we counsel our own people. Using traditional models that haven't been developed for or by African American people is one thing but confrontation seems to be something that a lot of counselors and therapists use too much. Motivational interviewing moves people away from confrontation (Interview participant, Site 04).*

Motivational interviewing was also mentioned as an important means of engaging children and families. At Site 04, the first two sessions with the family are designed to gather information and build a relationship prior to beginning the structured portion of the interview. This strategy builds on existing motivation to improve current circumstances and also allows for developing rapport and trust before beginning the formal treatment process.

## **Organizational Infrastructure Strategies**

### **Create Linkages**

Linkage to informal supports was considered to be of particular importance in serving African American/Black families. Involving community and spiritual leaders in treatment was mentioned as a means of increasing the level of security in families who are likely to distrust formal providers. This distrust was thought to be greatest when services are mandated by the legal system. One respondent reported that, “If someone has a spiritual belief and they feel that that [spiritual leader’s] really important to their family, that person gets invited to the team. If there’s a neighbor that has been particularly supportive to them, that person gets invited to the team meeting” (Interview participant, Site 12).

Site 12 reported that informal and natural supports not only served to encourage utilization of services but also supported the maintenance of positive outcomes for the child and family once formal services were no longer in place. As one respondent stated:

*We always try to connect the families with community resources. If they had a mentor, put them on the waiting list for Big Brothers/Big Sisters. Depending on whatever age, we have mentors in the community or making sure if they had a therapist to find a therapist through their insurance and then they can continue with that. So making sure they...have services once wraparound has done its job (Interview participant, Site 12).*

Respondents suggested that some families can isolate themselves from natural supports while they are addressing critical needs. Therefore, these sites found it important to focus on reconnecting families to informal supports. One respondent stated:

*Sometimes it's just like they forgot what they used to do before this. They got caught up in so many other crises that brought them to us that they forgot what they used to do before that, so it's just kind of reminding them" (Interview participant, Site 12).*

### **Meet Immediate/Perceived Needs**

By providing services that addressed the immediate perceived needs of the child and family, participating agencies ensured their continued engagement. One respondent remarked that: *"Families rely on programs that address truancy, peer interactions, and social skills for their kids"* (Interview participant, Site 09). Also important to address were transportation barriers and lack of basic resources such as food and adequate housing. In general, listening to the family's story and identifying immediate perceived needs were described as ways to be responsive and demonstrate the organization's capacity to help. Whether services could be provided within the organization or through referrals to other providers, the ability to identify the need and willingness to do something about it were considered to be key to engaging families in utilization of mental health services.

In addition to meeting basic needs, participating organizations also addressed unarticulated needs related to historical and contemporary discrimination of African Americans/Blacks. For example, some organizations promoted positive interpretations of *"Black identity and the Black experience"* (Interview participant, Site 04). According to respondents at one site, programs assist individuals and families to place mental health and other issues in a historical context — for instance, understanding that anger can be an expression of the frustration that has been experienced from generation to generation due to discrimination, racism, and poverty.

### **Promote Child and Family-driven Services**

Allowing African American/Black children and families a choice in the level of involvement or type of services received has been a useful utilization strategy at participating sites. Child and family choice was evident in the way the service array was adapted to the needs and preferences of diverse children and their families. For example, some programs adapted policies so that there might be flexible time limits for services, using a variety of funding sources to support this. At one organization, flexible length of service requirements allow for a child and/or family to take a

**In general**, listening to the family's story and identifying immediate perceived needs were described as ways to be responsive and demonstrate the organization's capacity to help.

**Across participating organizations, flexibility, rather than dictating service types or lengths of service, was a way to promote utilization of services.**

break from services and then return for services if needed. Direct service providers such as case managers are often involved in these decisions and/or maintain contact with families to ensure adequate supports are available when formal services are not being utilized. Other sites have staff that accompanies the families to the first session at other agencies, including riding the bus with them, so that the families feel comfortable. Staff also explains services to families when they are referred to other programs to ensure a smooth transition (Site 04).

A participant at Site 12 similarly spoke of the services being “*sustainable; not service-driven.*” In this case, some services may be provided after the child and family no longer meet eligibility criteria, if there is a need. Across participating organizations, flexibility, rather than dictating service types or lengths of service, was a way to promote utilization of services by families already involved with the organization and also a means of outreach to others that hear about the organization through word of mouth testimony.

### **Provide Transition Planning**

To compensate for potential interruptions to service utilization, some participating sites employed the strategy of transitional planning. Transitional planning included linking families with other resources in the same community or with service providers in communities they were moving to. Transitional services may include those that support a child and family as they are discharged from formal services, for example, a respondent at Site 11 explained that “graduation” from services does not necessarily mean “termination” of services. That is, after children graduate from the program, the organization may continue to work with the youth in helping them find work or engaging them in outreach to youth who are new to the program. In the case of changing location, a respondent explained that when families relocate to another city, their agency “*will make sure that their services are in place so that they will not feel abandoned*” (Interview participant, Site 09). A respondent at Site 12 underscored the importance of transitional planning in providing a safety net, stating, “*We never want to close a case and just end services completely and not leave them with anything*” (Interview participant, Site 12). Included in the transitional planning process is an assessment of potential future needs and identification of available resources, as well as assurance that the child and family can contact the organization at any time for assistance in linking to services (Interview participant, Site 12). Another respondent explained that transitional planning is based on the goal of self-sufficiency.

*We always have a transitional plan and the ideal care coordination here would be 6 months of stabilization and 6 months of transitioning out. We start transitioning out from the day we are there and we tell them the idea is to work ourselves out of a job because we do not want to become a crutch to them. But we want to give them the tools so that they can stand on their own feet and that is where they want to be anyways (Interview participant, Site 12).*

### Track Utilization Rates and Patterns

Participating organizations have some means of tracking their services with African American/Black families in order to assess their level of utilization of available services. One participant explained that the organization (Site 11) and program partners track utilization disparities and discuss the barriers that might be limiting use. They also continuously enhance their evaluation processes, as well as policies and services, based on data collected and direct feedback from families served.

Some sites use information related to the service process that is documented in team meetings as well as data that are tracked through other methods. Some examples of data that are tracked include child outcomes such as school suspensions, expulsions, and behavior incident reports. This information is used to identify any trends for the populations served and to adjust services as needed. One participant explained this approach as follows:

*We track them through the process. [The] child and family team meets every 90 days to update the service plan on the needs and progress made. This ensures that families get services as long as they need [them] (Interview participant, Site 11).*

Site 11 uses process data internally to inform decisions about program and service adjustments, especially in terms of length and intensity of services needed. As stated by one respondent, “Some families only need a month or two of services offered through [the site] and [the site] still continues to follow and track them. Some families have been in the program for 5 years” (Interview participant, Site 11). The site also uses the data to advocate for increased and/or continued funding based on identified priorities. Several sites also emphasized the importance of Customer Satisfaction Surveys. Satisfaction surveys assisted providers in identifying and addressing any barriers to utilization of services.

**Satisfaction surveys** assisted providers in identifying and addressing any barriers to utilization of services.



**Organizations in this study** serve API populations from a variety of backgrounds, experiences, and age groups including immigrants, refugees, and American born.

## **Utilization Strategies for Serving Asian and Pacific Islander Population**

Two of the 12 organizations in this study served a substantial number of Asians and Pacific Islanders (API). Site 05 is a community-based ethnic specific organization, and Site 10 is a public county behavioral health provider (See Table 1). Both of these sites hosted visits by the study research team. A detailed description of each organization is available in the Appendix.

### **Population and Community Characteristics**

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

Site 05 serves over 1,300 children, youth, and their families annually. Among those served, 85% are from low-income households and 88% are youth of color, of which 75% are API. The population of children and youth served by Site 05 is also described as at-risk and low income, with many single parent families or two parent families in which both parents work for low wages. Many families depend on Medicaid, but some do not have any insurance. Children who are referred to Site 05 are most often children of immigrants or refugees, and some youth are refugees. Children who are born in the United States are highly acculturated and bilingual, but most parents primarily speak a language other than English, which results in generational and cultural clashes within these families. Other populations with immigrant and refugee backgrounds are also served, including East Africans and Eastern Europeans.

At Site 10 the API population makes up a smaller percentage of the children and families served (14%), but include one of the largest communities of Vietnamese in the country. The API population has been found to access services at substantially lower rates compared to White populations based on studies of local penetration rates. The agency identifies language and stigma as major barriers to access. Emerging populations such as Iranians, Koreans, and Cambodians are also beginning to seek services, as identified through the agency's ongoing monitoring and data collection. In response to emerging needs, agency forms have been translated into Spanish, Vietnamese, Farsi, Korean, and Cambodian languages.

Children and youth are referred to Site 05 for a range of issues including low school attendance, depression, selective mutism, eating disorders, destructive behaviors, low school achievement, and fighting at school. Referrals may



also be made for family issues such as divorce, poverty, dysfunction related to cultural factors, serious domestic violence (including homicide), sexual assault, and gambling. The most common mental health problems identified by Site 05 include schizophrenia, depression/anxiety, and chronic pain associated with Post Traumatic Stress Disorder (PTSD). Services delivered cover a wide range of social, medical, educational, legal, and mental health needs for over 30 different API ethnic populations of all ages. A health clinic and day care center are co-located with other services in a complex located in the center of the Asian community.

## Direct Service Strategies

### Community and Family Education

Education of families within API populations is a common strategy for increasing utilization. One participant at Site 05 explained the need to make the family aware of treatments and interventions so that the provider is not seen as circumventing the parents. Keeping the families involved does present some challenges, however, as explained by one staff member:

*It's a particular challenge if you have...a bilingual Vietnamese child or teenager whose parents speak no English. That's where a bilingual clinician becomes really important for us. The child may do fine receiving services in English, but in order to discuss issues with the family, we really need the ability to talk to them as well...Families are routinely involved in the treatment process" (Interview participant, Site 10).*

In addition to acclimating children and families to mental health services, it is also helpful to educate other professionals and the community at large. This education includes information regarding mental health and mental illness, but may also incorporate information about cultural or social factors. One participant at Site 10 gave the example of hoarding behavior that had previously been addressed in their community as a police issue. Their agency is helping to reframe public perception and identify this as a mental health issue.

The strategy of involving both children and their family members in activities was also found to impact utilization of services. At Site 05 children and their families were invited to participate in cultural celebrations at the organization. Respondents also related that parent participation and involvement was promoted in a teen dating violence prevention program through inclusion in meetings and an end-of-the-year celebration. These strategies increased trust in the organization as family members came to understand the program goals and approach and became acquainted with the staff and facilities.

### Engagement Processes

Rapport and relationship building were identified as very important components of mental health services for API populations. Participants at Site 05 spoke of taking time to listen to the child and family members' stories about what has led to their current situation. They reported that this often requires longer sessions than the typical one-hour block, especially if language interpretation is needed. This strategy is based on viewing sessions with children and families as

**The strategy** of involving both children and their family members in activities was also found to impact utilization of services.

**Persistence and sensitivity** are important aspects of engaging the API populations.

encompassing much more than treatment alone. For example, additional goals might include communicating interest in the child and family's experience and cultural perspective, and finding out how to make services more understandable to the child and/or the family. In some cases, providers describe themselves as partners and advocates with the family in the process of service delivery.

*It's not just sensitivity, but also what you do for access, including materials, information, and making it comfortable for everyone. Getting to know the culture and what it means. Taking an active interest in the client, knowing their norms, how they relate and interpret the world (Interview participant, Site 10).*

Utilization of mental health services is a challenge when working with a population that is reticent to identify mental health issues or seek mental health treatment. As one staff member reported: *"There's still a great deal of stigma about mental illness, in spite of the efforts that we've put forward towards education. So mental illness is under-identified and under-treated in all populations"* (Interview participant, Site 10). Persistence and sensitivity are important aspects of engaging the API populations. One staff member at Site 10 mentioned that the first contact is often brief, with families remaining reserved because of the potential shame it can bring to the family if a mental health problem is identified. This was especially true for adults, as noted: *"With older adults, we rarely get our foot in the door on the first contact. So what we've learned in the older adult program is persistence and sensitivity"* (Interview participant, Site 10). Another respondent at this site reported that persistence in helping families understand what a mental health problem is and helping them address it is understood to be an expression of genuine concern and can eventually lead to more positive outcomes.

Another strategy for engagement of API families is sending appointment reminders, although a respondent at Site 05 also noted that families tend to be very dependable and punctual. Families reportedly return calls and emails and follow through with commitments in an efficient way. In addition, when a family has not communicated with staff for awhile, the head of the family is contacted.

Utilization is also increased through engaging children and families in settings that are comfortable and familiar to them, such as public schools. Locating staff at these community-based sites gives providers the opportunity to bond with the youth and families outside of the mental health service environment. Locating staff at schools in particular increases opportunities to work with administration and faculty on identifying youth who need assistance, and getting to know parents when they visit the school, whether it is to transport their children or attend a meeting.

For API youth in particular, having staff that is similar in age and background can enhance engagement in youth activities. For example, Site 05 employs a young Asian woman to coordinate the dating violence prevention program that works with adolescent girls at targeted schools. One respondent explained, *"They see her as a role model, as a young Asian woman, and she can speak to them. She's been able to forge bonds not only with the young women, but also with the school officials"* (Interview participant, Site 05).

## Flexible Service Provision

Flexibility in the location and times of service provision enhances utilization by API families by accommodating their schedules and preferences. Services at Site 05 were reportedly very individualized, which was linked to cultural values. Staff members reported making home visits at five or six o'clock in the evening after the parents concluded their workday. One participant said, *“That’s when parents come home and they’re all home and that’s when you can do family therapy”* (Interview participant, Site 05). By making service locations and times convenient, families were more likely to utilize services.

Within the framework of flexibility, one site reported having guidelines informed by the severity of the child and family’s situation. They reported a three-level tier system that provides options in the manner and frequency of service provision. For example, a child at one tier would receive one and a half to two hours of face-to-face services in addition to case management, whereas a child at another level might receive a different mix of services and face-to-face contact with the family less frequently.

The type of health insurance coverage was also a factor in the flexibility of the timeframe of service provision. Families with private health insurance were typically limited to 6 or 8 sessions, while those with Medicaid (referred to by the agency as a medical coupon) were approved for a whole year of services. In this latter instance, a case file is kept open for as long as it is needed. In fact in chronic cases families may continue using adult services for 20 years or more. As one respondent commented, *“there’s no other place to go”* (Interview participant, Site 05).

## Organizational Infrastructure Strategies

### Create Linkages

Site 05 reported working closely with schools and/or other agencies as another strategy to enhance utilization. Staff intentionally forged bonds and served as advocates and translators between families and formal systems such as schools. One respondent characterized the API population as *“more likely to deny or give up on school before they give up on someone who’s trying to help them personally”* (Interview participant, Site 05). Another respondent explained the importance of linkages as follows:

*If you enlist the community you’re trying to serve in the process of designing services and programs that you’re going to get more of a buy in, and you’re not going to be viewed as a county or a government office trying to force services to people who may not be able to relate to them. But when you involve them and incorporate them as part of the process, there’s more of an ownership, more of an investment, more of a willingness and comfort in getting involved. It bridges the gap. The stakeholder process can reduce mistrust and stigma that makes people shy away. It makes them more willing to use the services (Interview participant, Site 10).*

Site 10, which is a county public behavioral health provider, has integrated cultural competence into many services across their provider network through the work of a cultural competence department. The organization contracts with region-

**Site 10** has integrated cultural competence into many services across their provider network through the work of a cultural competence department.

**The decision** to drop or modify services was informed by family participation or other information gathered about the needs and preferences of their population of focus.

al clinics and community-based providers that serve specific culturally/racially diverse populations and monitors the implementation of culturally/linguistically competent strategies as well as child and family outcomes.

### **Promote Child and Family-driven Services**

A child and family-driven approach to services for API populations was described in terms of gathering feedback about services received using satisfaction surveys or other evaluation tools. For example, Site 05 gathers youth and parental feedback for their teen dating violence prevention program through a short evaluation form at the end of the program. Sites also tracked utilization rates to determine the types of programs and services that were received well by families. The decision to drop or modify services was informed by family participation or other information gathered about the needs and preferences of their population of focus. As explained by a respondent,

*Just to be capable of meeting the needs of our consumers in a manner that is acceptable to them and their culture and having an understanding of what their needs are... Too frequently I think we get stuck in delivering things just one way. It's the way we're most comfortable with as opposed to the way that the consumer or the client is most comfortable with (Interview participant, Site 10).*

Another site also mentioned tailoring the frequency of appointments to the desires of the children and families. Staff from Site 05 explained that the severity of the situation may dictate more frequent appointments initially, but when the crisis is over, the child and family are offered the option of decreasing the frequency. One participant stated:

*We can cater to them and say, 'You know what, we don't have to meet once a week like we were six months ago because you were having all these problems.' And the kids like that, because then it's like, they're in control, and they like that. So it's again, it's giving that empowerment, saying 'What would you like?' versus us telling them what they need and what they want (Interview participant, Site 05).*

One community, in developing a proposal for programs sought input from community stakeholders during the planning process. A respondent described this as “a very good learning experience for us because it wasn't us telling the community what was best for them, it was the community telling us what they wanted” (Interview participant, Site 10).

## Utilization Strategies for Serving Latino Populations

Five of the 12 sites studied served a majority of Latino populations and all of these were classified for this study as community-based organizations, although two of these organizations did not provide mental health services as a primary part of their service array (See Table 1). One of these sites (Site 01) was identified as a Community Development Corporation and a non-profit organization that provides a wide range of housing and social services at the neighborhood level. Three organizations (Sites 02, 06, and 08) are community-based non-profits that provide a variety of mental health and family support programs geographically oriented in the Northeast and West Coast. Site 10, is a department within a county behavioral health division on the West Coast that serves a number of diverse populations, of which 35% are Latino. Two of the sites (Sites 01 & 02) highlighted in this section hosted visits by the research study team, while staff from the other three sites were interviewed by telephone. A more detailed description of each organization is available in the Appendix.

### Population and Community Characteristics

The Latino populations served by the organizations that participated in this study were culturally diverse with different social circumstances and mental health needs. All of these sites reported that between 35% and 95% of their service population can be identified as Latino. This category can include descendants or immigrants of one or more of the following nations of origin: Mexico, Puerto Rico, Dominican Republic, Ecuador, Nicaragua, and other nationalities from the Caribbean, Central and South America, as well as indigenous groups from Mexico for whom Spanish is a second language.

In many cases, English was not the primary language for the populations served by these organizations, making language an important barrier to services for children and families. The lack of fluency in English was characterized by respondents at each of the Latino sites as a primary contributor to lack of knowledge about available services. A number of sites also noted serving a significant number of undocumented families or individuals with funding/legal restrictions, often making it difficult to provide all needed services.

Respondents at each of these sites noted differences between particular populations based on different national and cultural traditions. For instance, respondents at Site 06 described differences in the way Spanish is spoken in different countries of Latin America and the Caribbean—especially with regard to particular words that may be acceptable in one country or region and vulgar in another. Respondents at various sites also noted cultural differences with regard to communication styles—some groups were characterized as being introverted, deferential to doctors and professionals, and less likely to vocalize concerns in public or professional settings. At Site 02, differences in cultural norms and communication styles were reportedly more pronounced within populations of indigenous Mexicans, who were identified as unwilling to share concerns or problems with neighbors and/or multiple staff members. Rather, indigenous family members preferred to work with one staff member, and often worked with that person exclusively.

**In many cases**, English was not the primary language for the populations served by these organizations, making language an important barrier to services for children and families.

**Parents were reportedly resistant** to seeking mental health services because they felt that mental illness was shameful or would identify the child or family as “crazy.”

Respondents also pointed out that it is important to recognize the cultural differences within the Latino population in general. As an example, a respondent at Site 01 noted that the term “family” itself is a cultural concept that is defined differently, even among members of the same cultural group or population. This respondent noted that Hispanic families include nuclear families in which men assume a dominant and central role, families that include grandparents living within the home, single-parent households, and nuclear families in which women have a great degree of independence and decision-making power. Therefore, he cautioned, against placing individuals in conceptual “boxes” defined solely by their cultural heritage.

A number of respondents identified barriers to receiving services related to social and cultural factors. For example, respondents mentioned stigma as a barrier among the Latino populations they served with regard to mental health and behavioral issues. Parents were reportedly resistant to seeking mental health services because they felt that mental illness was shameful or would identify the child or family as “crazy.” Families were also described as hesitant to have providers visit in their homes, as explained by one participant:

*Many families are initially hesitant about receiving home visits because they are unfamiliar with the process and have not developed trust with the agency personnel. ‘No tienen confianza’ [They don’t have trust] (Interview participant, Site 08).*

A number of respondents noted that the majority of the families they served lived below the federal poverty level, with limited access to transportation, which often hindered their ability to access the services to which they were referred. Respondents also emphasized the barriers that exist for undocumented families or individuals, including hesitation to seek help for problems or issues even when they acknowledge needing them, because of fear of arrest or deportation.

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

Services provided by these organizations included therapy and counseling for individuals and families, intensive day treatment for adolescents, family support and intensive case management, partial hospitalization, residential programs, child care and Head Start programs, after school programs, family preservation services, system navigation, and family education services. One organization (Site 02), did not provide mental health services, but did offer support groups for women who were victims of domestic violence, child/youth prevention programs, as well as information and referrals to partner mental health clinics.



## Direct Service Strategies

### Address Childcare Needs

Providing childcare is a utilization strategy that demonstrates an awareness of the needs of the family and a willingness to address those needs (Site 08). Participants noted that families often lack a social support network to assist them with issues like the care of young children or the challenges of caring for a child with special needs. As one parent explained:

*Parents of special needs children a lot of times are very isolated and they can't go to their friend's house because their kid's behavior is too bad. My son, I couldn't go to anyone's house because his behavior was horrendous. And he had alienated every babysitter he could have possibly had, nobody would watch him. And my parents, they loved him, that was their grandson, but they couldn't have him around because he was hell on wheels. And I didn't know how to control him because I didn't have these parenting strategies. We didn't have a lot of people to turn to. And of course, my parents are looking at me going 'why aren't you parenting your child better' (Interview participant, Site 08).*

At one site serving the Latino population, childcare is a service provided by natural helpers (Site 02). Staff recognized that mothers needed time to be able to receive services and attend programs and workshops away from their children. They provided a daycare with Latino workers who spoke Spanish to accommodate this need (Site 02). Childcare was also utilized as a support to encourage parents to attend English classes through programs at the local community college in order to complete their education and “move forward – salir adelante” (Interview participant, Site 02).

A respondent at Site 08 indicated that childcare was now one of the most utilized services offered by their site, although it was a need that was addressed because the community brought it to their attention.

*A long time ago, the families here basically came forward and said, 'we don't have childcare in this area. We have to commute to work. We can't take our kids with us. We need childcare.' So we said OK, we will start childcare. And that's what we did. And now we have tons of sites throughout [the site's] county. So we really just get a feel for what the community needs. We're involved in collaboratives, and just really hear what people are saying and then we do it (Interview participant, Site 08).*

### Address Transportation Needs

Transportation was employed as a strategy for utilization in sites that primarily served Latino populations. Since many of the families do not have transportation or do not know how to use public transportation, participants at Sites 01, 02, & 08 reported that transportation was provided. Other sites provided families with “Metro” transportation cards, bus tokens, or transportation vouchers to facilitate access to mental health services. Site 08 also located its programs and offices close to public transportation and within the community for easy access.

**A respondent** at Site 08 indicated that childcare was now one of the most utilized services offered by their site, although it was a need that was addressed because the community brought it to their attention.



**At Site 10** bilingual promotoras call families as often as needed to keep them engaged in services and find that even this simple activity can make a difference.

Differences in insurance coverage also played a role in the type and amount of transportation assistance available for participants to support utilization of services. One staff member remarked that some HMOs cover one-way rides, some cover roundtrips, and others do not cover any transportation support (Site 06).

Sites 08 and 10 reported a lack of good public transportation in their communities. One solution to overcome this barrier was to “go where they are” (Site 08) and provide services to the youths and families near their homes. This included in-home services (Sites 01, 02, 06, 08, & 10) and services at the child’s school (Sites 01, 08, & 10).

### Community and Family Education

For Site 06, education of Latino families involved talking to them after appointments to clarify provider instructions and/or to “*explain the benefits of mental health treatment*” (Interview participant, Site 06).

Respondents at multiple sites reported that parents often consider emotional or behavioral disturbances reported by the schools to be “disciplinary problems” rather than mental health issues. Reportedly, parents feel that the solution to these problems is more or harsher discipline at the school rather than counseling or other mental health interventions. Respondents at Site 02 discuss such behavioral issues with parents in terms of their impact on the child’s educational success and point out the need to work with service providers to help their children succeed in school.

### Engagement Processes

Another utilization strategy employed by sites primarily serving the Latino population was appointment reminders. Sites reported that these reminders took the form of telephone calls, emails, and postcards (Sites 01, 02, 06, & 08). Calls were also made to contact families when they did not keep appointments. At Site 08 if a consumer misses an appointment they must take the next available one, which may not be the most convenient for the consumer, but staff still work with families to make the scheduling work for everyone. One staff member at Site 06 remarked that there is constant outreach to the families in the form of telephone calls and emails, occurring at months 1, 3, 9, and 12 after families began services. Families were even provided the option of calling anytime they needed to speak with staff (Site 06). At Site 10 bilingual promotoras call families as often as needed to keep them engaged in services and find that even this simple activity can make a difference. One participant explained “*sometimes that’s all it takes because [I] speak their language*” (Interview participant, site 10).

With this population in particular, a relaxed approach to communication and service delivery helps to engage families by establishing rapport and building trust. One respondent stated the issue this way: “*If we attend to them in a good, helpful, kind manner, they will return*” (Interview participant, Site 02). Since the Latino population is often resistant to formal mental health services, providers encourage treatment and compliance, but do so gently in order to avoid offending the consumer. Participants also explained that providing support to families

builds rapport, especially as families realize that staff will listen to their “stories” and know first-hand what they are going through because they have been through it themselves (Site 08).

Sites 02, 08, & 10 built relationships and overcame utilization reluctance by means of paraprofessionals. These natural helpers had the trust of the community and were able to relate by virtue of being or having been members of the same community. Their names and functions were varied from site to site, but the common underlying aspect was that they represented a first contact with a formal system in a relaxed and welcoming way. The titles identified were parent partners and capacitadora. As current or former consumers of the services, these natural helpers were passionate about their work, and they were not perceived to be a threat by the people with whom they worked. As one respondent stated:

*It goes a long way towards building rapport when you're working with a family that's having problems; it really does help build a rapport when it becomes evident that you've already been through what they're going through and that you know firsthand. It does. The trust factor goes up and you're able to be much more accepted (Interview participant, Site 08).*

A number of respondents also highlighted generalized cultural characteristics that they felt were important for service providers to incorporate when working with Latino populations. These included relationships that were variously described as “informal,” “personable,” “comfortable,” or “familiar”. To illustrate, a respondent at Site 06 described the relationship that his organization’s receptionist has with the individuals and families that use their services as follows:

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

### Flexible Service Provision

Respondents at all organizations provided similar responses with regard to flexibility in their service delivery practices with Latino families. Common examples include flexible hours, acceptance of walk-ins, and in one case, allowing clients to “hang out” in the offices socializing with other clients and/or direct service staff. Many services are offered in the home and outside of normal operating hours to accommodate the families’ schedules. For most sites, providing services in the family home and at school removes the barriers of transportation and childcare. Providing extended office hours helps to meet the scheduling limitations of families who work long hours.

Respondents also noted the importance that service users placed on family support and encouraged the participation of family members in treatment when possible. This was associated not only with improved outcomes for the child, but

**Respondents also noted** the importance that service users placed on family support and encouraged the participation of family members in treatment when possible.

**Several sites** also employed Latino paraprofessionals or natural helpers to facilitate service navigation, assist with translation needs, and serve as flexible resources for families within their own community.

also greater likelihood of identifying other issues in the family that were impacting the child. One participant stated it this way: *“Working with them, and family, will help the individual and the whole family with other aspects of their life stressors”* (Interview participant, Site 06).

Several sites also employed Latino paraprofessionals or natural helpers to facilitate service navigation, assist with translation needs, and serve as flexible resources for families within their own community (Site 02, 08, & 10). One paraprofessional explained her role this way:

*I’m also in charge of helping individuals in the community. We help with appointments at the hospital; we help them translate any papers, make phone calls. And many times if they have problems, we’re like their confidants, because they trust us and we’ll work together to solve that problem or find resources that would help* (Interview participant, Site 02).

Respondents at Latino serving organizations also spoke of the need to advocate for funding for more flexible approaches to engaging families, by helping to redefine services, and *“convince funders of a different way of defining need”* (Interview participant, Site 01).

#### **Provide Incentives**

Sites serving Latino populations also provided incentives as a utilization strategy. This was especially true when serving youth. One respondent at Site 02 explained that service termination was more likely when youth view treatment as drudgery without reward. In order to motivate youth to continue treatment, incentives were offered including outings, movies, and swimming. Other incentives to encourage and reinforce participation included gift cards or vouchers (Sites 02 & 10). As one staff member commented, *“If we have something to offer them, not something to do to them, you know, they’re going to be more likely to continue with us”* (Interview participant, Site 10).

#### **Organizational Infrastructure Strategies**

##### **Create a Welcoming Environment**

Sites view a welcoming environment as a strategy for utilization. This applies not only to the décor incorporating aspects of culture, but also to the staff exhibiting a sense of community and camaraderie. Again, since many families lack a social support network in the community, providing social support through the agency encourages their continued utilization of services and increases the return rate. Examples of this strategy included welcoming clientele and offering them a cup of coffee (Site 06). A participant from a different site said, *“We try to provide an environment that’s inviting and that’s trusting. That this is a safe place for you to come”* (Interview participant, Site 10). This participant went on to explain that serving food and beverages also puts people at ease.

One respondent explained the atmosphere of their agency as being *“like a family: the way they feel embraced here. Clients congregate”* (Interview participant, Site 06). This seems to agree with another respondent from a different site who explained that having a common Latin blood *“sangre Latina”* or a common way of being made their environment more appealing to Latino people (Site 02).

## Develop Linkages

Organizations serving Latino families emphasized the importance of following through on linking families to services they need, even if services are not provided by the same agency. A respondent at site 06 explained that cases were not closed until the child was accepted into another program. The respondent explained:

*Most places would make the referral and then they close the case, but we actually wait until we get the green light that they're accepted in the next program. We make sure that they're connected, that way there's no lapse in medication, for example (Interview participant, Site 06).*

Helping families by linking informal supports to service intervention processes was also thought to increase utilization. Involving family members, in particular, helped to reduce their mistrust of and fear of the stigma associated with mental health services. Participants revealed that families were more willing to use the services when trusted family or community members were involved in services with them and were able to learn about the process along with them.

Another strategy to increase utilization was the activity of paraprofessionals in linking parents and providers, especially when there is a language barrier. One respondent explained that the capacitadora, who serves in a role similar to a natural helper, is “in charge of connecting the families with the school and with their children, creating the bridge” (Interview participant, Site 02).

Transitional planning to ensure families' continued utilization of services as needed was also considered to be an important linking strategy. At Site 06 exit interviews are conducted to develop a plan for continuing services or connecting to other services that might be needed in the future.

## Match by Ethnicity/Language

Respondents considered ethnic match between providers and families as a tool to enhance utilization among the Latino population. Sites overcame barriers of language and culture by assigning families to providers of similar background. According to one staff member interviewed, “If a family does have a language request or a specific ethnicity in who they see and that's who they're most comfortable with, or a male or female, then we should be able to be flexible enough to provide that” (Interview participant, Site 10).

## Promote Child and Family-driven Services

The child and family-driven services approach used at sites primarily serving the Latino population allowed children/youth and families to choose aspects of the services and programs that would benefit them most. One participant stated, “We flexibly adapt to the identified needs of the family” (Interview participant, Site 01). Sites also involved children and families in decisions about the nature and length of their treatment. This strategy was thought to reduce the child and family's mistrust of authority and increase their sense of being respected and valued. Involving clients in choosing services, as well as overall design of services was explicitly linked to increased utilization. As one respondent explained, “The stakeholder process can reduce mistrust and stigma that makes people shy away. It makes them more willing to use the services” (Interview participant, Site 06).

**Participants revealed** that families were more willing to use the services when trusted family or community members were involved in services with them and were able to learn about the process along with them.

**A respondent** from Site 02 reported that they provide services and programs in response to community input.

Sites serving the Latino population were also concerned with maintaining treatment without a pre-determined termination point. Service lengths were reported to be flexible and focused on need and the achievement of goals. Having a variety of funding sources was important to being able to maintain this flexibility. One participant at Site 01 explained that when the child and family have a say about the proper length of service the measurement of attrition rates is more reliable because there is greater congruence between the goals and timelines of both provider and family.

An example of the child and family-driven approach for one agency was a prenatal program that was designed to serve mothers and their children through the child's sixth year. Based on experience with participants, the program was adjusted to include only the first six months after birth of the child. This change was needed because many of the program participants migrated for work and were only in the community for one growing season during the year (Site 01). At Site 10 input from the community is also used to identify the needs for child, youth, and family therapy or other interventions.

#### **Track Utilization Rates and Patterns**

Another utilization strategy used by many of the Latino population sites was tracking service use. Tracking was used to record consumer participation in services as well as therapist and agency utilization rates. A respondent from Site 02 reported that they provide services and programs in response to community input. For example, when it was observed that computer classes were not well attended and community members reported that it was not relevant to their needs, the program was discontinued.

Site 01 tracks non-attendance at sessions to assess utilization rates for families and determine effectiveness of providers in engaging families. A respondent at Site 01 explained, "*We track service use by individual providers and just started tracking no-shows. We also track credentials of providers to see which are serving families best (e.g., which have fewer no shows)*" (Interview participant, Site 01).

## Utilization Strategies for Serving Native American Populations

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

### Population and Community Characteristics

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

Children and families served by Site 03 were described as varying in their acculturation levels and length of residence in the county. For example, some had lived in the area all of their lives, while others had moved from reservations or traveled back and forth between their reservations and the area. Families were described as ranging from those who are very traditional and speak primarily tribal languages, to those who *“know that they are Indian, but they may not be as traditional . . . [for which] the identification isn’t as strong”* (Interview participant, Site 03). Most families served by Site 03 reportedly speak English or are bilingual. For the few older adults who speak their tribal language translation might be required, but staff reported that *“We talk it out. Generally it’s not a barrier”*

**Site 03** includes representatives from approximately 105 different tribes. According to the 2000 Census, the American Indian and Alaska Native population was over 76,000 or 0.8% of the population in the county.



**Respondents reported** that children and family members often describe themselves as being the only Native person at their job site or school and feeling that they have little support or connection with other Native Americans.

(Interview participant, Site 03). Although some Native American families moved to the area by choice, there were also many whose ancestors had been forcibly removed from traditional lands or relocated from other parts of the United States by the U.S. government. Families were considered to be affected by the historical trauma of placement of Native American children in government boarding schools as well as negative experiences with programs that promised improvements in services but did not deliver on these promises. These experiences were linked to high levels of distrust in this community.

The majority of children currently served by the system of care (about 80%) at Site 03 is in out-of-home placement foster care and is referred through the Department of Children and Family Services, schools, and juvenile probation. Common reasons for referrals involve child abuse and neglect. The majority of child diagnoses include attachment disorders, depression, behavioral problems, anxiety, PTSD, and substance abuse (methamphetamines for children and women, alcohol for men). For women and girls, sexual abuse and domestic violence are issues in addition to other social and economic issues. Some of the children also have family members or communities members dealing with substance abuse issues. Children and youth who enter through probation are primarily referred for truancy and theft. Many who are truant have run away from home and are living on the streets.

Children and families served at Site 03 were described as experiencing complex issues that involve more than a single diagnosis or individual within a family. Common issues for children included: domestic violence, child abuse, low graduation rates, and behavior problems. Children were also described as lacking “balance” and having little knowledge about “who they are as American Indians.” In some cases families were experiencing “multigenerational trauma” and substance abuse and mental health issues. Substance abuse was reportedly related to cycles of abuse that are perpetuated from one generation to the next. Low socioeconomic status (SES) also impacts families’ ability to provide basic necessities such as food, shelter, and transportation. Low educational levels and involvement with the law also limit job opportunities and the ability of families to “get ahead.” Geographic separation from extended family or native tribes, often due to historical relocation efforts of the U.S. government, has also taken its toll on Native American families’ ability to rely on traditional sources of support.

Utilization of services at Site 03 is reportedly limited by lack of knowledge about mental health services and lack of services that have been adapted for Native Americans. Many providers were considered to be unaware of the existence of Native Americans in the community, lacking knowledge of cultural issues that should be considered, and lacking awareness of the culturally appropriate services that are available. Respondents reported that children and family members often describe themselves as being the only Native person at their job site or school and feeling that they have little support or connection with other Native Americans. For these reasons Native Americans in the community were considered to be an “invisible population.”



Although the primary populations served by Sites 01 and 07 are Hispanic (90% and 50% respectively), the organizations also serve substantial numbers of Southwestern Native Americans. At Site 01 a recent expansion to providing state-wide services has increased the number of Native Americans served in the northern regions, which include primarily Navajo and Hopi communities near reservations. The total Native American population reported by the ACS for the state served by Site 01 is 328,340, which includes those of mixed race as well as major tribal groups such as Cherokee, Chippewa, Navajo, and Sioux. A few Native Americans are also served in the urban areas through the continuum of services provided in low to moderate income communities. Services are provided in English, Spanish, Navajo, and Hopi, based on the needs of the community. Issues faced by Native American populations served by Site 01 tend to be complex combinations of depression, substance abuse, limited jobs, and low levels of education, and poverty, which contribute to child neglect or abuse.

Site 07 is located in an urban setting that has a Native American population of 31,160, according to the ACS. Native American families from urban and surrounding rural areas are referred to Site 07 for mental health and substance abuse problems through a county referral process. Site 07 provides access to a variety of contracted clinicians from diverse ethnicities and professional backgrounds.

## Direct Service Strategies

### Address Transportation Needs

Transportation was one strategy employed by sites that primarily serve Native American children and families as a means of encouraging them to continue participating in services. One staff member said, *“We have a lot of people here that are using public transportation in order to get here. Anything to help them out, to get them back, is huge for us”* (Interview participant, Site 07). Sites 01, 03, and 07 provided families with bus tokens, taxi vouchers, gas vouchers, or in-house transportation. One staff member explained:

*We also saw the need for vehicles. There are times that they [families] have to be here, like for assessments. We would provide bus tokens to get them here, but it may take 2 hours on a bus. So, now we have 2 vehicles to pick them up and get them here. In [site’s county] that’s a lot of driving. We are always trying to find more funding for transportation. (Interview participant, Site 03)*

### Community and Family Education

Sites identified the education of children and families as a strategy to enhance utilization of Native American families. Participants spoke of compassionately educating children and families about the ramifications of their choices. One respondent said, *“You have to constantly help them in giving them good tools to make good decisions or somebody else is going to make the decisions for them...and then you will have problems”* (Interview participant, Site 03).

Site 01 provides information and educates its community on other topics including diagnoses, issues surrounding mental health, and how to advocate for,

**Participants spoke of** compassionately educating children and families about the ramifications of their choices.

**The best locations** for satellite services were identified through a community needs assessment process that considered the geographic distribution of Native Americans in the county, as well as recommendations from focus groups with community members.

access, and use services. As one respondent stated, “Once services are in place, we continue to educate parents on the importance of it in looking not just at today but to look to the future” (Interview participant, Site 01). One of the participating sites also sought to increase the number of community members qualified to provide services, as one respondent stated,

*There’s no substitute for having people who are Native to the community and trained in the treatment. We need more people who are trained; we need community organizers to team up with universities to train them (Interview participant, Site 01).*

### **Flexible Service Provision**

Providing services in a flexible manner is an important strategy that encourages service utilization in the Native American population. One respondent from Site 07 discussed the commitment of their agency by saying they “bend over backwards to keep their clients here” (Interview participant, Site 07). For example, they would find a therapist who would see the family on Sunday, if that was what was needed. Staff also takes socioeconomic status into consideration when arranging service appointments or inviting children to events and makes arrangements for transportation if needed.

Sites 01 and 03 provided services in the family home in order to accommodate the schedules of families. Since service times typically conflict with working hours and families face the additional hardship of transportation, services provided in the home supports ongoing utilization of services and contributes to a stable routine. Due to the sprawling urban setting, Site 03 has established satellite locations in areas more densely populated by Native Americans. Site 01 reported providing services in the schools in addition to providing services within the homes.

Site 03 also continually assesses the mix of services that are provided at their centrally located downtown facility and makes adjustments to meet identified needs. For example, they have found that families have difficulty making appointments because of the long distances they must travel to get to the facility and the absence of child care facilities nearby. Strategies that have been developed include conducting home visits and meeting at the child’s school or a neighborhood clinic. The best locations for satellite services were identified through a community needs assessment process that considered the geographic distribution of Native Americans in the county, as well as recommendations from focus groups with community members.

### **Engagement Processes**

With the Native American population in particular, the process of engagement includes establishing rapport and building trust through a personalized and in some cases, informal approach. One participant described their agency as “laid back [as opposed to] real rigid. There’s just a lot of flexibility” (Interview participant, Site 07). Engagement also included keeping the child and family’s “interest in personal growth and sobriety interesting” (Interview participant, Site 07). Also mentioned were the importance of showing respect, “honoring the dignity of their clients,” and demonstrating a sense of caring for the individual (Interview participant, Site 07). One respondent explained this approach as:

*Knowing they can do it. Empowerment. Providing them tools and supporting them in seeking help is a good thing. People stick with therapy longer if they are clear that this person really cares (Interview participant, Site 07).*

### Responsiveness

Responsiveness in serving Native American children and families involves sensitivity to preferences and accommodation to unique circumstances. In addition to providing services using Western methods of treatment, sites serving Native Americans may also include treatment modalities that are traditional to Native American populations if these are preferred by children and their families. One participating site (Site 03) has a Spiritual/Cultural Adviser on staff that is available to assist in integrating traditional Native American treatments with mainstream treatments. Also available at several sites are linkages to indigenous curandera services and opportunities to participate in activities such as beading workshops. Site 03 also invites traditional practitioners and tribal leaders to assist in meeting the needs of families who are members of their tribes, which at times includes flying them in from other states to meet with families. Tribal representatives have also been brought in to assist with special events such as a Coming of Age ceremony for girls and traditional dance workshops for the community.

Staff as well as tribal representatives may also facilitate talking circles and sweat lodges at some sites (Sites 01 & 03). At Site 01 staff are supported in receiving training to use traditional practices, for example, “...program staff are trained in Native American substance abuse strategies like sweat lodges” (Interview participant, Site 01).

Considering the various levels of acculturation among Native American people, one participant explained that it is important to take each individual family’s beliefs and values into account when designing a service strategy (Site 03). Whether or not traditional practices are included depends on what the family is comfortable with, an approach which in itself is consistent with Native American ways. As explained by one participant: “*In that way, being culturally competent is setting up our system in a way that also is in line or consistent with American Indian values and beliefs*” (Interview participant, Site 03).

### Organizational Infrastructure Strategies

#### Create a Welcoming Environment

With the Native American population, sites also viewed a welcoming environment as an important utilization strategy. This might include décor such as a flag or a staff with eagle feathers and culturally-affirming art. As previously mentioned a welcoming environment goes beyond the furnishings and art to include a sense of community among staff. Respondents spoke of the benefit to Native American children and families of finding a program that was designed to serve them and had visible evidence that it was a place where they belonged.

One participant reported that children and families continued to return because it was a place where they could be with other Native Americans, even for informal activities such as watching television (Site 03). At this site, having all the

#### One participating site

(Site 03) has a Spiritual/Cultural Adviser on staff that is available to assist in integrating traditional Native American treatments with mainstream treatments.

**Having youth** promote the program convincingly demonstrates to communities that the program works and encourages current consumers to remain engaged in services.

services in one place also encouraged families to continue with formal services because they felt comfortable going to the site for whatever need they might have (Site 03). A participant at Site 07 explained that a friendly environment also contributes to their ability to retain families for as long as they need services and increases their compliance with service requirements. Being able to retain families in services also improves the organization's reputation with funders and agencies that refer families to them.

### **Promote Child and Family-driven Services**

Sites serving the Native American population spoke of allowing children and families to choose their services and treatments to the greatest degree possible. One respondent expressed that their agency allows the child and family *“to have a dominant role in deciding what their treatment will include”* (Interview participant, Site 07). Some sites also consider child and family preferences when deciding how long to keep cases open in order to *“allow the longest amount of time for that client to become engaged in treatment”* (Interview participant, Site 07).

Connected to this strategy is the involvement of former clients in promoting utilization of services. For example, Site 03 began a summer camp program that employs youth who were previously recipients of services. This program encourages continued contact and also allows youth to feel ownership of the program and serve as spokespersons. They have found that having youth promote the program convincingly demonstrates to communities that the program works and encourages current consumers to remain engaged in services.

Participating sites were also willing to share control over how services are delivered in the community in order to foster trust and increase utilization of services among Native American families. A strategy for sharing control is practicing the culturally appropriate skill of listening and learning from community members who come to the organization for services or conducting interviews with community members in the community. As one participant explained, *“We have to learn—you can't make assumptions, so we do focus groups and ask key informants. We don't try to sell ideas, but instead listen”* (Interview participant, Site 01).

### **Develop Linkages**

Participating sites emphasized the importance of maintaining linkages with family, community, and a variety of services in order to meet the needs of Native American populations. These sites seek ways to involve the family and community whenever possible and appropriate as a way to increase buy in and utilization of services. For example, one participant mentioned a strategy of *“connecting youth/families with other Native groups or organizations”* (Interview participant, Site 03). At this site, the interconnectedness of family, community and spirituality of the Native American people is supported by creating linkages within Native American providers and community activities, especially for children and families that are isolated from other Native Americans. One participant explained this role of the organization as creating *“not just a place where people come for services but a place where they socialize and connect with other Native people”* (Interview participant, Site 03).

Sites serving Native Americans also link children and families to other providers as needs are identified. At Site 01 families participate in personalized assessment of multiple life domains, which helps to identify the need for other services such as substance abuse or parenting programs. At Site 07 families are linked to a network of services and informal supports according to identified needs and preferences. Services to which they can be linked include acupuncture, martial arts, childcare, massage therapy, tutoring, spiritual support, and alternative healing methods.

Participating sites have also developed linkages with schools in order to increase utilization by Native American children. Therapists from Site 03 provide services in the schools and also increase the utilization of other school services by Native American students who need them. At Site 07, therapists work with children in the local schools as well as at the juvenile detention center.

Several sites have also developed contracts with clinics in strategic locations around the county to co-locate staff and provide training in culturally competent strategies to increase utilization of services by Native American families. At Site 03, Native American staff is placed at community-based clinics specifically to increase the comfort level of families receiving services there.

Site 03 has also brought multiple services to one centrally located facility that allows for a common intake process and connection to a variety of services and activities. This has also facilitated referrals from other providers, who can refer families to one location rather than sending them to multiple providers. One respondent at Site 03 described the advantages of linking to services in a single location as follows:

*We wanted to create a one-stop place for our children and parents. For example, parents would say that the [child welfare] system had so many requirements for them to get their children back. . . . It's almost set up for failure. They don't know where to go or what to do, and once they start failing they just go back to alcohol or drugs and just give up (Interview participant, Site 03).*

**At Site 03** Native American staff is placed at community-based clinics specifically to increase the comfort level of families receiving services there.

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**A common theme** across sites was the importance of creating a sense of community for consumers and staff in order to increase trust and comfort with participating in formal mental health services.

## Conclusion

Across sites that participated in this study children and families were reported to use services more readily when organizations sought compatibility between their practices and the cultures of the populations they served. The way in which compatibility was sought was uniquely tailored to the populations served and the mission, structure, and resources of the organizations. There were also many similarities in strategies across populations served that can provide useful examples for organizations serving a variety of populations of focus. As suggested by the conceptual model that guides this study, organizations that participated in this study developed compatibility through knowledge of the population of focus as well as knowledge about how the organization functions and how it is perceived by diverse children and families. Participating organizations were able to use this understanding to develop strategies for engaging families in services and ensuring that services were meeting their needs.

Across participating sites it was clear that it was necessary to develop strategies at both organizational and direct service levels to foster and support the utilization of mental health services by the families they served. Broad, cross-cutting themes that emerged in this study included the concept of creating or supporting a sense of community, addressing the complexity of families' experiences, knowing the current local context, using data for strategic decision-making, and creatively meeting funding challenges. Each of these themes is described in the following sections.

### **Creating a Sense of Community**

Many of the strategies that were described were aimed at increasing trust and comfort with the organization and its services among families that had been hesitant about seeking help outside the family or community. These strategies also addressed family perceptions such as fear and stigma associated with mental illness and misunderstanding or lack of information about mental health services. A common theme across sites was the importance of creating a sense of community for consumers and staff in order to increase trust and comfort with participating in formal mental health services.

Creating a sense of community included attention to organizational environments, service delivery approaches, and personnel characteristics and skills. Examples were given of strategies that required varying levels of adaptation to



services and infrastructures, from simple changes in the physical environment to comprehensive adaptations to treatment approaches, such as incorporating informal supports and paraprofessionals. These and other adaptations were linked with increased comfort of families as they approached agencies for assistance as well as increased compliance with treatments.

Responses across sites also suggest that creating a sense of community includes developing strategies to sustain engagement of families, such as maintaining contact throughout their involvement with services and after services are completed. Also important to creating a sense of community was the presence of staff that looks like the families and speaks their language, and/or effectively communicates acceptance and support for differences. Strategies that contributed to building community were those that facilitated the communication of a message that diverse children and families belong and will be supported in the process of seeking and finding the assistance they need, as well as building capacity for self-sufficiency and giving back to the community.

### **Acknowledging and Addressing Complexity and Uniqueness**

Another overarching theme across study sites was acknowledging and addressing the complex and often overwhelming problems and barriers faced by diverse families. These strategies addressed barriers such as beliefs about mental health and child rearing, economic difficulties, social or linguistic isolation, parental issues such as substance abuse, and limited knowledge about community resources. For diverse families, such complex combinations of barriers decreased the likelihood that a child would receive formal mental health services until serious problems had been manifested.

Participating sites were able to engage families in various ways through connecting to a variety of services that could meet the needs of all family members. Sites also developed engagement strategies that encouraged families to continue to be involved with the organization beyond the point of crisis. For example, sites provided personalized information in languages that families understood, service locations and procedures that were comfortable and responsive to immediate needs and interests, interactions that did not stigmatize or demean the child's condition, and events that involved children and families in positive, culture-based and/or family-focused activities. Such interactions with families acknowledged their strengths and capacities and communicated respect for their beliefs and values.

The study findings suggest that creating such a welcoming environment requires strategic adaptations across organizational domains, as well as support for personnel to make changes in their approaches to services. Participating sites demonstrated that by shifting the organization's values and service philosophy toward a culturally compatible paradigm, staff were both influenced and supported in adapting service delivery to that which engaged diverse populations. Study sites also emphasized the need to be proactive in identifying community needs and preferences in developing compatible services and activities, and suggested that this can be a wise investment for organizations that are serving communities with increasing diversity.

### **Participating sites**

demonstrated that by shifting the organization's values and service philosophy toward a culturally compatible paradigm, staff were both influenced and supported in adapting service delivery to that which engaged diverse populations.



**The uniqueness** of the specific strategies implemented reflected differences in community characteristics related to geography, population density, economy, politics, and available resources.

## Considering the Current Context and Population Characteristics

Utilization strategies were implemented in a variety of ways across study sites based on the contexts and populations served. For example, strategies to address transportation needs were addressed by transporting clients directly, facilitating the use of public transportation, or bringing services to communities where families live. The uniqueness of the specific strategies implemented reflected differences in community characteristics related to geography, population density, economy, politics, and available resources. There were also differences in the cultural/racial groups served, which influenced the choice of strategies as well as how those strategies were expected to enhance utilization. For example, some sites mentioned the use of newsletters and consumer satisfaction surveys as a tool to increase utilization, while other sites, although they might use them, did not mention these in connection with promoting utilization. The relative importance given to a strategy in relation to engaging a population may reflect specific cultural aspects of that population, organizational priorities, lack of experience, or limited knowledge about how to implement a particular strategy. In spite of these differences, a common characteristic across sites was recognition of the need to overcome barriers for specific racially/ethnically diverse families as well as the need to develop strategies with input from families and communities served. Most sites also placed an emphasis on collecting service use data, identifying existing strengths and resources, and applying research findings to their decisions.

The variety of the mix of strategies across study sites suggests that it is not necessary to implement a predetermined list of strategies in order to reduce disparities in utilization of services by a given population. However, getting to know the community and becoming involved as a partner in meeting needs seems to be critical to making appropriate organizational changes that lead to increased utilization. It may not be necessary to implement all of the strategies described in this monograph to ensure cultural competence in serving a specific population of focus. In fact, implementing even one of these strategies may be sufficient to initiate the required momentum for developing cultural compatibility. A lesson learned from sites that participated in this study is that organizations that know the communities they serve are better able to develop compatible strategies, whatever those strategies might be, and are better known and accepted in the community.

The utilization strategies designed by organizations in this study were based on experience with the population and involvement with the community, as well as professional expertise and knowledge of the research literature. Many of these organizations also supported sustained utilization of their services by continuously monitoring usage patterns and making adjustments in their practices as needed. With this approach, it is possible that other strategies might be developed as communities or populations change over time, an important part of maintaining cultural compatibility.

## Using Data for Program Development and Advocacy

Although all sites participating in this study were able to identify strategies that increased utilization, not all were systematically tracking utilization levels in a way that could document the effectiveness of these strategies. Some organizations monitored utilization by race/ethnicity and/or language but were not linking this information to utilization strategies. Other organizations did not track utilization rates systematically, but used combinations of staff, community, and client input to inform decisions about the effectiveness of services. Decisions about funding priorities and service strategies were made based on data and information from these sources, as well as from professional expertise and knowledge.

Findings from this study suggest that once adaptations are made it is important to document changes in utilization for the population of focus, especially if changes are tied to funding. Having evidence that services are being utilized by a population that is difficult for most providers to engage in services can provide a platform for advocating for increased funding and other support for the organization. Demonstrating increased utilization can also provide an opportunity to advocate for more widespread use of culturally competent practices that might not have received support in the past. Ultimately, the data might also be used to show that investment in services that families will use can reduce costs due to missed appointments and ineffective and unwanted services.

## Funding and Sustaining Efforts

Although not specifically addressed in this study, financing for utilization strategies was mentioned by many participating sites. Organizations studied used a variety of funding sources to support the strategies they developed, including federal funding for system development, county funding that supported referrals within a network of diverse providers, Medicaid funding, private funding based on interest in serving the population of focus, partnerships or contracts with schools and health clinics, foundation funding, and training grants for professional development. Sites that were community-based organizations often developed collaborative relationships with public and/or private mental health providers that allowed them to refer families for services. Some sites developed the capacity to provide mental health services to their population of focus by hiring part-time psychologists or psychiatrists who worked alongside a bilingual/bicultural case manager or counselor. Those who were county mental health providers contracted with community-based organizations to serve as contact points to engage families, assess needs, make referrals, and assist with navigating service systems. In each case resources were made available through a variety of funding streams and creative staffing patterns that included volunteers, paraprofessionals, interns, and different levels of credentialed professionals. All participating sites have struggled with the challenges of funding, but demonstrate a strong commitment to implementing services in the ways they had learned would be most beneficial and acceptable to the community.

**Ultimately**, the data might also be used to show that investment in services that families will use can reduce costs due to missed appointments and ineffective and unwanted services.

**It is possible** that one change can make a difference across the continuum of service utilization, from outreach to engagement and maintenance.

As most agencies and organizations are operating with tight budgets and heavy workloads, the idea of completely restructuring agencies may seem daunting, especially since trends emerge and fade in favor of newer trends. Findings from this study suggest that a complete restructuring may not only be impractical but unnecessary. However, it is suggested that it is important for strategies that are chosen to be based on knowledge about the community and developed in partnership with community members. For some providers this may mean increased investment in outreach and identification of community partners that can help them learn about the population of focus, while for others it may mean hiring staff that better reflects the population. Identifying the utilization strategies that are first priority may be linked to not only identified gaps in services but also community strengths and resources, as well as funding that can be used in new and creative ways. It is also important to consider how to sustain utilization levels through continued monitoring of how services are utilized, gathering information on needs and preferences of the community, and tracking changes in population composition and other community characteristics.

### **Future Research**

A final consideration based on the findings of this study is that strategies developed for increasing utilization may not be easily isolated from other strategies used by an organization, and may also not be unique to serving a specific population. It is possible that strategies aimed at increasing utilization may also have an impact on increasing access and availability of services, as indicated in the conceptual model presented in the introduction to this monograph. It is because of the interconnectedness of these components of service delivery that organizational cultural competence may be improved through a relatively small number of changes. For example, it is possible that one change can make a difference across the continuum of service utilization, from outreach to engagement and maintenance. Because of this connectivity and complexity, it is important to continue to examine the development of organizational cultural competence as a holistic process that occurs within specific contexts.

It is also important to be able to identify specific cultural competence strategies that are impacting certain aspects of service disparities. Identifying the specific strategies that uniquely affect access, availability, and utilization can ensure that families are entering services when they need them and are continuing to use them as long as they need them. This monograph series provides some examples of strategies that have been developed in each of these key service delivery domains, but further research is needed to establish clear links between adaptations and the reduction of disparities in each domain.

Future research should provide evidence for why strategies developed for specific populations of focus work well for that population, and in what ways they might also be applied with other populations. Research might also examine costs of adaptations in contrast with costs of non-compliance and missed appointments. As the evidence base is built for the use of culturally compatible strategies, it may become clearer to mental health providers, as well as policymakers and funders that strategies aimed at outreach and engagement for diverse communities in combination with culturally compatible treatment approaches are well worth the investment.

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## Appendix: Descriptions of Study Sites

### Site 01

Site 01 is a statewide organization founded in 1969 in the Southwest to address a variety of social problems affecting the Mexican American population. The organization traces its origins to the grassroots efforts of family members and community leaders protesting discrimination and unfair treatment of Chicano students in public schools. Following a three month boycott of public schools to address these conditions, the leaders of this grassroots movement incorporated to address other important social issues identified in the community. Since that time Site 01 has become a Community Development Corporation which provides a variety of for-profit and non-profit services to address issues faced by low to moderate income communities. Site 01 has over 100 contracts to provide services such as dropout prevention and education, after school, Head Start, cultural development, mental health, domestic violence, substance abuse, parenting, leadership development, elder services, housing, economic development, and subsidiaries (including credit unions, and a mortgage company). Site 01 includes a staff of over 600 that provides services to a primarily Mexican/Mexican American population (90%), but is currently expanding to areas that are primarily Native American. The history and longevity of the organization have contributed to the organization's reputation and stature within the Mexican American community and throughout the state. In order to maintain a direct connection with community needs and issues, 51% of Board members are community residents. Many staff

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

### Site 02

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



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

### Site 03

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

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

### Site 04

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

Some of the services that Site 04 provides to community residents are court mandated. The majority (90%) of the population served by Site 04 is African American (both child and adult), but there is an increase in the number of other populations served. Site 04 staff estimates that 99% of the families receiving services are at or below Federal Poverty Guidelines levels. The largest growing population in the area is Haitian and various African immigrant populations, although Site 04 does serve small populations of Hispanics, Asians, and Middle Easterners. Some of the main issues identified for the population served by Site 04 personnel, include homelessness, truancy, domestic violence, and child protection. Site 04 staff also identified the following barriers that affected access to mental health services for the African American population they serve: lack of affordable, public transportation and lack of information regarding navigation of available services. The underlying principle of Site 04, as identified by the staff interviewed, is that the Black experience in this country must be understood fully in order to appreciate the challenges faced by many members of the African American population, especially with regard to mental health and related issues. Further, the strengths of African American communities must be identified and nurtured in order to successfully address ongoing mental health and chemical dependency issues. According to Site 04 staff, their culturally-specific programs that incorporate history and traditions, exhibit outcomes that are 50% more successful than those for programs that do not take culture into consideration.

### Site 05

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

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

ample, the organization addresses racial disparities and works toward equity through involvement in issues such as deportations and anti-immigrant policies, which are important to the community it serves.

### Site 06

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

are one of the only organizations in the city that provides mental health services and printed information in Spanish. Site 06 also employs staff that speaks French and Haitian Creole. The organization emphasizes the communication of respect for cultural identity in all interactions with individuals and families served by the organization, regardless of ethnic background.

### Site 07

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

uniquely match our services with the client and then try to allow them to have a dominant role in deciding what their treatment will include.”

### Site 08

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

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

### Site 09

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

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

#### **Site 10**

Site 10 is located in a large county on the West Coast. About 35% of the population is of Hispanic or Latino origin and 15% is Asian (of which 33% is Vietnamese). Nearly 30% of the population is foreign born. Large populations of Spanish-speaking and Vietnamese speaking families are located in distinct communities. The Vietnamese population is reportedly the largest outside of Vietnam. Mental

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

#### **Site 11**

Site 11 is a non-profit statewide parent support and advocacy organization for families with children who have emotional, behavioral, and/or mental health issues. It is the state chapter of Federation of Families and was founded in 1990. Site 11 provides information, referrals, advocacy, and support groups, along with the opportunity for families, professionals and other interested state and community representatives to speak with each other about the needs of children with emotional problems. According to staff interviewed, up to 60% of the children served by Site 11 are African American. The remaining proportion of families served were identified as White, biracial, and Hispanic. Site 11 programs are funded through a variety of federal and state funding streams and assist parents and caregivers in addressing their children's mental health issues. These services include a statewide information and referral service network, child care training and consultation in three areas of the state, an early identification and treatment program for teens, family support services for families with children at-risk of being placed in child welfare, and a program that provides services to uninsured and underinsured children.

## **Site 12**

Site 12 was founded in 1995 and is operated by the Behavioral Health Division of the County Department of Health & Human Services in a Midwestern state. Site 12 serves families living in the county who have a child with serious emotional or mental health needs, is referred through the child welfare or juvenile justice systems, and is at immediate risk of placement in a residential treatment center, juvenile correctional facility, or psychiatric hospital. Their services were designed to reduce the use of institutional-based care such as residential treatment centers and inpatient psychiatric hospitals while providing more services in the community and in the child's home. Site 12 utilizes a wraparound approach to service delivery, which focuses on strength-based, individualized care. Site 12 was named an exemplary program by the President's New Freedom Commission on Mental Health in 2004. Seventy-one percent of children and youth served by Site 12 are African American, followed by 20% White, 6% Hispanic, and 3% of youth with ethnicity identified as "Other." Site 12 offers a variety of services including group homes, care coordination, residential treatment, foster care, psychological assessments, intensive in-home therapy, crisis 1:1 stabilization, medication management, day treatment, discretionary/flex funds, life skills, support services, transportation, alcohol and drug abuse services, inpatient, mentor/support, outpatient mental health, parent support, and respite.





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