



## **Implementing the Ohio Consumer Outcomes System in a Culturally Competent Context**

**A Summary of Four Projects to Identify Perceptions of the Ohio  
Mental Health Consumer Outcomes System Among Representatives  
of Diverse Communities**

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## FORWARD

Ohio's mental health system has a substantial and respectable history of leadership in the area of cultural diversity and, most recently, cultural competence. Many resources are available to assist local systems in establishing a culturally competent system, and there are several agencies and local systems that are models in this regard. Unfortunately, however, these are the exception rather than the rule, and cultural competence is too often viewed as a valuable enhancement, rather than a basic necessity for local systems. (A similar charge might be leveled at state systems, as well.) This report underscores the fact that cultural competence guidance aimed at effective administration of the Outcomes System is only a subset of the larger issue of system cultural competence. One reviewer noted that,

“...system barriers include MACSIS, claims billings, systems that are unwilling to pay for co-therapy/co-interventions, and the lack of flexible service categories that could support non-traditional interventions. Our institutionalized ways of doing business are loaded with racism; yet we continue to give lip service to cultural competency.”

**It will be of little benefit to develop a culturally competent Outcome implementation plan if consumers and families are not also offered culturally competent services, supports and opportunities to participate meaningfully in local system management. Similarly, it will be of little benefit to develop a culturally competent outcomes implementation plan unless ODMH and boards are willing to make significant administrative, operation and procedural changes to support provider efforts to be culturally competent.**



## INTRODUCTION

It is a truism that we are all more similar than we are different. People everywhere seek much the same kinds of sustenance, support and success regardless of age, race, creed, gender, ethnicity, geography, or other defining characteristic. In Ohio, a preliminary survey found no significant differences among the *kinds of outcomes* that Ohio consumers sought to achieve when compared by race and ethnicity. <sup>1</sup>This conclusion helped form the basis of the ODMH decision to seek a standard, statewide approach to measuring consumer outcomes, a decision that was later validated by the Outcomes Task Force (*Vital Signs*, 1998). Of course, it is also true that there are generally more differences *within* a group than between groups. One reviewer emphasized, for example, that "Hispanics are an incredibly heterogeneous group," and that there are also significant generation differences within these sub-groups, all of which produce variations in cultural focus. This suggests that even the general recommendations included in this report must be tempered by local knowledge of specific cultural groups and the particular individuals involved.

While cultural characteristics may affect consumers' desired outcomes only marginally, these characteristics can influence how receptive and responsive consumers are to the services they are offered, based on the sensitivity and competence with which they are offered. Many local systems have figured out how to tailor their programs and train their people to be sensitive and responsive to the unique individual and community characteristics of the people they serve. Advocates report that consumers served by these systems are better able to advocate for themselves, have more satisfaction with the services they receive and participate more actively both in their own services and in the local system's decision process. It has yet to be seen whether their outcomes are better, as well. In the best settings, consumers and families find "seamless" processes and staff who are comfortable and competent with a wide range of consumer and community characteristics. In these settings, we should be able to predict that consumers and families will willingly complete Outcomes Surveys and act as partners with providers in using the information to shape a course of treatment.

On the other hand, it should come as no surprise that consumers and families who are treated with disrespect, rudeness, insensitivity and disregard for or hostility toward their race, gender or other characteristics will be less likely to view the agency as helpful. They may not participate actively in the services offered, might drop out of services prematurely, or might engage in disruptive behaviors to express their unhappiness. In all likelihood, they will not directly state that they are dissatisfied. In this, they will act not so much differently from

<sup>1</sup>Unpublished study, Ohio Department of Mental Health, 1996.

## INTRODUCTION continued...

people with no psychiatric disability, who recognize that they are in a relatively powerless position and will have to act compliant to get even a modest amount of service. In these settings, it will be a challenge to gain active participation in the Outcomes System and to overcome the common suspicion that the data meets only the needs of administrators.

Third, any Outcomes Measurement System will only be as effective as its use of data. Throughout the development of the Outcomes System, consumers and families have seemed to understand implicitly that the effort to measure their outcomes has merit. This comment has been typical:

"Now we have a voice. They are asking us what we think is important, or what we think works, rather than just asking if what you say we need is working."

Even the most valid, reliable and culturally sensitive survey will be useless if the data is not put to use for the improvement of quality at all levels: fostering Recovery, improving treatment planning, supporting program development, and informing funding, marketing and communications about mental health and mental illness. In doing so, we must also be very cautious to not develop incentives and disincentives at any level of the system based on outcomes data before we understand and appreciate the subtleties and complexities inherent in the data. We must all have confidence that any use of data has been preceded by the appropriate, thoughtful analysis and reflection that will build, rather than undermine its credibility. In any case, the successful use of data will be influenced by the attitudes expressed and the actions taken by system representative. One staff member put it this way:

"It's hard for us to convince our clients to (participate in Outcomes Surveys), if we don't think it's worthy. If I go in with a negative attitude, I have to watch that, you know, because you relay that to them and they think the same thing."

In the process of deciding to recommend a single, statewide package of outcomes instruments, the Outcomes Task Force struggled mightily with issues around the differences between culturally defined groups. These concerns can be grouped into two categories. First, members of the Outcomes Task Force noted forcefully that consumers from varied demographic categories would not



all respond similarly when approached to complete surveys. Members noted, for example, that African-American consumers might react with suspicion to questions of such a personal nature, especially if queried in an impersonal manner or in an environment perceived to be unfriendly.

Second, members noted that some of the content of the survey questions might be alien, at best, or insulting, at worst, to consumers from some cultures. Members noted, for example, that Amish consumers might find the "individual empowerment" questions at odds with their cultural values of community and deference to male and church authority. Others noted that traditional African-American community values rely heavily on family and church for support and even for what might otherwise be considered "mental health services" such as conunseling. For these communities, the quality of life measures might make less sense than for others who have no extended support system. Similarly, members observed that survey content might eventually need to be modified to accommodate the clinical status and needs of older adults, people with co-morbid conditions and by gender.

As a result of these observations, the final recommendations of the OTF ([Vital Signs](#), 1998) included the following:

- Develop an outcomes strategy for culturally diverse populations and older adults, and for persons with co-morbid conditions, especially mental illness and substance abuse.
- Conduct data analysis by consumer clusters, including but not limited to cultural/racial, gender and age distinctions.
- Include cultural sensitivity concerns in the process and product evaluation of the Outcomes System.

Subsequently, ODMH funded four grants to local systems to study the implementation of the Outcomes System in the three largest culturally diverse<sup>2</sup> communities in Ohio (Hispanic/Latino, African-American, rural/Appalachian) and in one community where there was a high likelihood of some survey content being considered irrelevant or inappropriate (Amish). The first three of these grantees were asked to study consumer perceptions of the Outcomes System and to identify strategies for ensuring that the System be implemented in a culturally

## INTRODUCTION continued...

competent manner, especially with regard to communications, training and use of data to support Consumer Recovery. In addition, the recipients of the Amish grant were asked to explore issues with the actual survey items.

This report is a consolidation of the four reports (including a very preliminary report on the Amish grant). In general, the reports simply verify the direction in which Ohio's Mental Health system has been trying to move for two decades. They suggest specific strategies that might be helpful in developing a culturally competent Outcomes implementation plan, **but these really tread little new ground. They underscore the work already underway to develop training programs and build incentives to increasing the cultural competence of local systems.**

The grantees were asked to study the acceptability of the Outcomes System, and to generate recommendations for making the System as acceptable as possible to all cultural groups. ODMH anticipated recommendations related to best practices in administering and communicating about the System, as well as using the data to support consumer recovery. Ultimately, grantees found that it was impossible to separate this question from the nature of the survey items. Therefore, the studies generated a substantial body of recommendations about the survey items. For the moment these must be considered separately from the implementation recommendations, because ODMH has committed to retaining the instruments without revising the items for three years (until no later than September, 2004). This decision flowed from strong local feedback during both the OTF and the Pilot that frequent revisions to the instruments would cause significant disruptions and would jeopardize their ongoing participation. A commitment to holding the instruments stable for three years would reassure local systems, at the cost of sacrificing (*temporarily*) the system's responsiveness to particular issues such as those raised in this report.

In the interim, the Department and local partners are keeping track of issues related to survey items which will be included in an Outcomes System evaluation process that will be launched as soon as feasible. Many recommendations that were generated in the current process have been recorded in the Appendix as "General Implications for the Outcomes System." As a group, they are highly suggestive of the kinds of cultural issues that have been and continue to be raised in implementing the Outcomes System, and readers are encouraged to use them as a reference in building in the specific elements of cultural competence locally.



## LIMITATIONS

The consolidated findings from these four reports should be read with several qualifications in mind.

- Each study interviewed a small number of consumers, families and system representatives. While their comments can be considered a helpful baseline, they cannot be considered to reflect the full range of concerns that might exist in local systems.
- The small budget for each study constrained the scope, depth and duration of the studies.
- Being qualitative in nature, these studies were not designed to compare one group against another, and so cannot be considered conclusive. Rather, they were designed to identify the kinds of concerns that people might be likely to express and so must be considered suggestive of concerns deserving further exploration locally and statewide.
- Local data has not yet started flowing to ODMH, so there is no way to as certain at the state level whether the identified concerns are reflected in differences in the data profiles between groups. This kind of data analysis will be conducted as soon as enough data has accumulated to build a database that represents the population as a whole.
- Any guidance about cultural competence must be filtered through and tempered by the specific characteristics and needs of individuals, rather than imposed based on abstract conceptions of culture. Ultimately, applying this information must be practiced as an art, rather than as a science. At its best it can uplift and inspire both consumer and provider toward the common objectives of healing and recovery.

## **LIMITATIONS** continued...

As noted earlier, the individual studies were based on relatively small samples of consumers, families and individual providers, ranging from a substantial number in the rural/Appalachian focus area to a modest number in the Hispanic area. Therefore, the conclusions must be considered preliminary, and the recommendations must be understood as contingent on further exploration. We must continue to study the dynamics of cultural competence (and the lack thereof) and the implications it has for the evolving Outcomes System. On the other hand, qualitative methods such as these are commonly used to begin to understand a phenomenon and to begin shaping a strategy for further study. This is entirely consistent with the established practices of system partners who have participated in the development, piloting and implementation of the Outcomes System. We expect changes and enhancements to be needed over time, and we will proceed as the data suggests, in partnership with local systems.



## METHODOLOGY (IES)

All four grantees used some combination of key informant interviews and focus groups as the source of data. The participants included consumers, families and individual providers. Focus group and key informant interview outlines are available on the Outcomes website as appendices to each of the individual reports. Following is a brief summary of each grantee's approach.

### **Rural/Appalachian**

- The report notes that no strong evidence was found for distinguishing how rural and Appalachian consumers might respond to being asked to participate in the Outcomes System that would be different from their non-rural counterparts. Because of the limited exposure consumers have yet had with the System, this remains an open question that would be useful to explore further. The report recommends that, to fully study this issue, demographic items should include questions on the birthplace of consumers and their parents because geographic location is not necessarily the same thing as cultural background. Many persons who live in Appalachia do not have a history and cultural ties to the region, and many persons raised in Appalachia have moved to urban centers and would be missed in a purely geographic demographic database. Similarly, rural and Appalachia are not equivalent; flat land rural and rural hill country are different.
- Eight focus groups were convened with board staff, agency case managers and consumers. Open-ended telephone and/or face-to-face interviews were conducted with fifteen individuals (administrators, providers and consumers).
- Contact with consumers and families and case managers was limited because systems were in the early stages of implementation.
- The initial focus of the study was on administrative processes. Participating boards and agencies were recruited through the Southern Consortium for Rural Care and Richland County to present the rural perspective. Later, once implementation began, additional boards and agencies were recruited to gather the case manager and consumer experiences.
- Original participants were from Athens-Hocking-Vinton, Gallia-Jackson-Meigs, Richland and Columbiana boards; later participants were from Ross, Pickaway, Fayette, Pike, Highland, Licking, Knox, Stark and Richland counties as well as the Public-Private Solutions (PPS) group of boards (Delaware-Morrow, Fairfield, Crawford-Marion, Licking-Knox and Paint Valley).

## METHODOLOGY (IES) continued...

- Focus group and interview questions were formulated based content in the Outcomes Implementation Planning Checklist.
- Both focus groups and interviews focused on knowledge of the Outcomes System, planning for implementation, local collaboration, technology issues, barriers and opportunities for using the outcomes data for service improvement, and additional support needed for successful implementation.
- The report identifies “best practices” demonstrated by local systems in the areas of planning, technology, and information utilization.

### **Hispanic/Latino**

- Three consumer focus groups were convened, including two male and 16 female consumers.
- Consumers represented diverse ethnic backgrounds: Puerto Rican, Mexican, El Salvadoran, and Guatemalan.
- Ten providers participated in two provider focus groups.
- Interviews were conducted with four key informants.
- Key informants were identified by providers and/or consumers.
- Eligibility criteria included high visibility in and familiarity with the Hispanic communities and the mental health systems of Cuyahoga and Lorain Counties, and identification by consumers and/or providers.
- Consumers and providers were located in both Cuyahoga and Lorain Counties.
- Consumers were recruited through providers by placing flyers in prominent locations.
- Eligibility criteria included self-reported Hispanic ethnicity and current receipt of services from a mental health provider.
- Consumers were paid \$20.00 for their participation and refreshments were provided; providers were offered refreshments only.
- The focus group questions covered basic knowledge of the Outcomes System, questions about how best to gather their opinions, how understandable the surveys were, ideas about cultural issues in interpreting the data, gaps in the survey, cultural problems with information asked and information not asked, and opinions about the expected and ideal use of data.



## **African-American**

- Consumers, families and service providers were identified through contract agencies in Trumbull County.
- Modified focus-group interviews were conducted, including consumers, families, providers, and African-American community leaders.
- Sessions included completion of the Adult A instrument by paper and pencil.
- Twenty providers participated, including administrators, supervisors and direct care workers; eight of these were African-American.
- Interviews were conducted with 18 African-American community leaders: 14 were from Trumbull and Mahoning counties and the remainder were from Lucas and Franklin counties.

## **Amish**

- Participants were from Amish settlements in Wayne and Holmes counties and in Geauga Settlement that is located in parts of Ashtabula, Portage and Trumbull counties; these are reported to be the world's largest and North America's fourth largest Amish settlements, respectively.
- Participants were recruited through existing service networks in these areas.
- Study activities with providers and service recipients included structured conversations and completion of a questionnaire regarding the Adult A instrument; conversations were also held with community leaders.
- Conversations focused on the purpose of measuring consumer outcomes, concerns about who has access to the data and how it will be used, the potential role of support groups in Amish settlements.

The Amish grant is structured around the Amish church hierarchy and leadership. These key community members are being educated about the Outcomes System and are being asked to allow the researchers access to consumers and families. These men control access to the settlements both formally and informally; without their participation it would be virtually impossible to gain the participation of community members.

The Amish grant bears particular mention in light of the delayed timeframe. The grant program did not gain momentum until early fall, 2000, by which time it became apparent that the change in seasons and the resulting loss of daylight would become a major obstacle to data gathering. Over the late fall

## **METHODOLOGY (IES)** continued...

and winter, the grantees began to make contact with designated bishops in individual Amish communities, but it was extremely difficult to find mutually agreeable times to meet. Many Amish in Northeast Ohio work in furniture factories and other employment locations during the day and return at night to farms lit only by kerosene and candles; visitation after dark was not an option. It became clear that the bulk of the data gathering would have to occur in the warmer, lighter months of the spring and summer. Thus, this document has only a very preliminary report to draw from and must be considered somewhat speculative. However, the speculation itself is based on sound commentary from the bishops and from providers who work with Amish communities, so it is considered quite reliable, and probably predictive of the responses of community members.



## SUBSTANTIVE FINDINGS

### **Major Findings: Issues and Recommendations for Implementation in Local Systems**

This section reflects both areas of commonality and the areas of difference between the four studies. It is grouped into subject areas according to issues raised by participants and/or suggested by interviewers. Three points should be remembered while reviewing these findings. First, there is anecdotal evidence and information from unrelated works that other cultural groups, such as Asian-American and Native American Indian, will respond similarly to many of the findings listed below. There will also be differences, and it will require additional exploration to discover the commonalities and differences among all the cultures represented in Ohio.

Second, since these studies were not conducted with comparisons to European-American populations, it is too early to say whether these same findings apply across the board to consumers and families regardless of culture. It should be obvious that all people wish to be treated with dignity and respect, to be provided services that are acceptable and available, and to achieve a place in their community that affords economic, social and psychological security. Direct care staff who operate from these assumptions have the basic attitudes necessary to begin to *develop* cultural competence. For them to succeed in achieving cultural competence will require taking what a reviewer called the “long road” which includes at least effective training, supervision and self-reflection.

Finally, the reports contained many findings that do not relate specifically to the question of culture. These include issues such as resource limitations, policies and priorities, communication and training within the mental health system, and intergovernmental relations. A summary of these is located in Appendix A, and these will be taken into consideration as implementation continues statewide.

## **SUBSTANTIVE FINDINGS** continued...

### **General Findings**

- Participants are generally supportive of the effort to measure consumer outcomes, as long as other implementation issues are resolved — see below (All).
- Many participants are unclear about meaning of "outcomes," the need for consumer outcomes information, and how the data would be useful to consumers and families (Amish, African-American, Rural).
- Participants have concerns about who has access to the information and how it will be used (Amish, Hispanic, Rural).
- Outcomes implementation provides an opportunity to develop consumer and family support groups where they do not already exist (Amish).
- The Adult A survey is "too long," especially when administered by paper and pencil; consumers with significant disabilities may have difficulty remaining focused (African-American, Rural).

### **Cultural and Language Issues**

- A trusting relationship is the foundation for a successful therapeutic alliance; the absence of such a relationship will make it difficult to gain willing participation of consumers and families, no matter what other accommodations are made (All).
- There is reluctance to rate survey items on the negative extreme due to the cultural value of politeness (Amish).
- There are "reservations" as well as objections about the appropriateness of many Adult A items, especially related to the Empowerment scale items; English; some terms do not translate readily into Spanish. Some idiomatic English expressions have no parallel in some other cultures (Hispanic, Amish), and some terms are simply irrelevant. For example, it was observed that "city hall" is a generational term that has been supplanted, especially by males, by the term "The Man". (African-American)
- Some terms are difficult to understand, even for those proficient in English; consumers with limited literacy will need more assistance to complete the surveys (All).
- Part I of the Adult surveys is perceived as too personal and sensitive for the beginning of the survey and many consumers will simply refuse to respond or not answer honestly; these items will impair the desired tone of trust and cooperation (African-American, Hispanic, Rural).



- Personal contact and communication is essential in establishing and maintaining trust between consumers and families and service system personnel (Rural); a higher value is placed on relationships than "things" (Amish, Hispanic, African-American).
- Limited literacy in English or Spanish, or both, is perceived to be intimidating and shameful and must be accommodated tactfully; literacy should be considered when choosing how the survey will be administered. (Rural, Hispanic, African-American).
- The absence of "street language" may alienate some consumers, especially young people (African-American).
- Very significant differences exist between the cultural interpretations of Hispanic, African and mainstream American society. For example:
  - the Empowerment scale's emphasis on individual liberty and self-expression is directly contradicted by cultural values that emphasize obligation to and reliance on family and community (Amish, Hispanic, African-American);
  - questions about the number of friends in one's life is viewed as under-emphasizing the qualitative value and importance of family and friends;
  - questions about "free time" fails to recognize the importance of meeting obligations to family and community and the implication that free time equates with failing to meet these obligations;
  - questions about feeling comfortable asserting oneself raises concerns about being perceived as defying the dominant authority of the church and/or male family and community members;
  - questions in the Empowerment scales about standing up to authority raise issues about cultural patterns of response by marginalized peoples to authority figures, including officials, police, elected officials, as well as provider staff.

## **SUBSTANTIVE FINDINGS** continued...

### **Service System Implications**

- Providers should base their actions on an actual assessment of the individual's cultural identity, characteristics and needs (African-American).
- The Outcomes System represents a "paradigm shift" for local systems in how to view the nature of their work; to increase acceptability of the system by case managers and consumers will necessitate immediate feedback on the survey measures to use in treatment planning (Rural).
- Assessment of and training for cultural competence should be a regular feature of all local service delivery systems; providers should be aware of potential cultural differences (All).
- Provider agencies will need to assess when consumers cannot adequately complete surveys on their own, and provide personal assistance tactfully; this may mean literally reading every item aloud; care will need to be taken to accurately reflect the meaning of the item (Hispanic, African-American, Rural).
- People from diverse communities will tend to fear expressing dissatisfaction, or even showing unsatisfactory outcomes, in order to avoid confrontation with authorities; providers must work within a trust-building context; they must reassure consumers and families that the data will be kept confidential and will not be used to deny services; providers must continually demonstrate how the data can be used to improve services and Consumer outcomes in as much as consumer satisfaction is intended to be a bellwether for problems at a provider or in a system, consumer satisfaction and outcomes surveys should be separated administratively with former completely anonymously. (Rural, African-American, Hispanic).
- These same measures must be taken to overcome the sense of shame and stigma about mental illness (Hispanic).
- Surveys should not be completed in waiting rooms, because these are perceived as impersonal and as invading one's privacy (Hispanic).
- It will generally be helpful to have services provided by individuals of the same cultural background as consumers; occasionally this will be essential to achieve a trusting relationship; when it is not possible to do so, providers must be trained and receptive to adjustments and accommodations (African-American).

**The Role and Application of Technology**

- Paper and pencil may be the main data entry technology, but other electronic options may also be acceptable, especially for youth (Amish).
- It would be ideal for consumers and families to have a choice among data entry options; any approach will need to be evaluated and alternatives offered for individuals with particular strong preferences or specific limitations (African-American, Rural).
- A face-to-face interview is the preferred mode of administration; paper and pencil may be acceptable and would be preferable to a computer-based or mechanical/electronic option (Hispanic).
- Interactive Voice Response (IVR) technology is the overwhelming choice of rural systems, primarily because of cost-efficiency, synergy with the existing satisfaction survey approach and accessibility to remote residences (Rural).
- Some consumers and families will refuse to cooperate with data entry technologies due to "intimidation" with the technology, "suspicion" about where the data will flow, and alienation with an impersonal versus a face-to-face interaction (Hispanic).
- Phone data-entry technologies are perceived to be the height of impersonality and to increase suspicions about who is on the other end of the line and what will happen to the data (Hispanic).

## SUBSTANTIVE FINDINGS continued...

### **The Interpretation and Use of Data**

- Differences in culturally defined meaning of terms (see above) creates a significant challenge in interpreting the meaning of responses. It will be important to establish norms for different cultural groups so that cultural groups so that culturally determined behaviors are recognized as such and not misinterpreted.

For example:

- Men will tend to underreport symptomatology as a reflection of the cultural value on appearing strong and reliable (Hispanic, African-American, Rural).
- Women will score low on measures of empowerment as a reflection of the cultural value of deference to male authority (Hispanic, Amish).
- The absence of survey questions related to spirituality and religion in general, and the role of fate, in particular, is perceived as a major omission that makes it confusing for consumers to respond and impairs the validity of the survey overall (Hispanic, African-American).
- More information than age is needed to identify the cultural orientation of consumers; it is essential to know whether they were raised within the specific culture (i.e. born and/or raised in another country) or raised within and acculturated to the dominant U.S. culture (Hispanic, African-American).
- Participants were highly sensitive to the absence of "context" in the surveys, and concerned that information could be easily misinterpreted without a deeper appreciation for the particular situation (Hispanic).
- There are concerns that data will be interpreted with a cultural bias. For example, non-African-Americans tend to see drugs and alcohol as a primary diagnosis and mental health as a secondary diagnosis while African-Americans tend to reverse the emphasis.
- Funders and regulators must be very cautious about developing administrative measures (incentives, disincentives) based on early interpretation of the data; as the OTF and Pilot groups both stated, the data should be used only for purposes of quality improvement for the foreseeable future.



## SUMMARY

These reports suggest several important conclusions that have implications at all levels of the Mental Health System. First, the critical role of direct care staff cannot be overemphasized. While boards and ODMH have supporting roles — leadership, funding, training — it is only in the face-to-face interaction between a consumer or family member and the case manager or clinician that cultural competency comes to life. If there is one consistent message in these reports to "take home," it is that a trusting relationship with strong rapport must exist before consumers will share personal information with candor and participate actively in the process of managing their care. The options for direct care settings are limited only by the sensitivity, creativity and caring of agency staff. Even on the first visit there are concrete actions that a staff member may take that will set the desired tone of the interaction, even if deep rapport must await further interaction. After all, grandma was right that first impressions are lasting.

Second, these reports suggest that significant cultural differences exist between groups of consumers, perhaps to the point that the validity of the adult instrument, in particular, is called into question. At the very least, the reports suggest that more effort needs to be focused on two specific areas as implementation of the Outcomes System proceeds: careful data analysis to sort out and understand the meaning of the data for these populations, and either revision of or development of alternate versions of the instruments. This latter suggestion raises the prospect that we will eventually have to judge whether we have a basis for statewide comparison of Outcomes data. If the answer is "no," we will have to decide on whether we care more about validity or statewideness.

Finally, as noted earlier in this document, it will not be sufficient for local systems to implement Outcomes measurement in a culturally competent manner. It is, of course, the specific goal of this document to foster culturally competent implementation of the Outcomes System. However, to have the desired impact of engaging and retaining consumers through an effective course of recovery, it is necessary for local systems to fulfill the promise of an entire culturally competent system. One reviewer prodded us on this point:

"Do we just want 'cultural awareness' classes offered to direct service workers, or do we want an overhaul on how our system responds to persons who don't fit the mold of an obedient, passive client? We are finding out through the recovery movement that awareness training once or twice a year for half a day does not impact the changes we want to see in a local system."

## **SUMMARY** continued...

We hope that some local systems will take up the challenge posed by implementation of the Outcomes System to institute comprehensive systems change around cultural competence. Asking providers to be culturally competent in one or another context is what a reviewer called a "band-aid" approach that ultimately fails. We consistently hear from consumers and families and from research studies that such an approach fundamentally misses the point — it is like wearing sunscreen only when the temperature is above 90 degrees, or only being kind when the mood strikes. It would be equally short sighted to ask a provider to think about Recovery only when offering diagnostic services, but not when considering employment options.

One reviewer recommended the development of a template or manual for system changes around cultural competence that would make it possible for local systems to follow an established program. At the same time, and even with such a "template," the challenge of cultural competence is to transcend manualized approaches and to infuse all aspects of the service system with the values and practices that make it a reality. Ultimately, it will take successful, guided experiences to convince system personnel of the value of this approach.



## APPENDIX A

### **General Implications for the Outcomes System**

The reports included many findings that relate more to the Outcomes System and implementation as a whole than to cultural issues in particular. This list summarizes the major findings. These will be used, as appropriate, to develop guidance and technical assistance resources for local systems, to evaluate the Outcomes System after implementation and to inform the work of data analysis and data use.

- Consumers are generally positive about the endeavor to measure and use outcomes, but want to be sure the information is used to improve services and help them achieve desired goals.
- The evaluation stage must take into consideration issues related to literacy, language and culture that have implications for survey items and design.
- In many cases, but not all, consumers and families have not been informed nor involved in local implementation planning; in some cases this may be an artifact of the sampling methodology, but in some it is a clear decision to involve only administrators at this point.
- Board and agency administrators are similarly positive, but are concerned about overall cost, integration with other ODMH-initiated activities, effective use of aggregate data, and relationship to local priorities.
- Staff are concerned about administrative burden and are looking for relief, especially through revision of Certification Standards.
- Rural systems are especially challenged by lack of resources, including MIS personnel, hardware and software; one report suggests a "best practice" that achieves economies of scale and synergies between activities.
- Many of those interviewed were at the beginning stages of planning for implementation and they presented numerous concerns questions; one report suggested that it will take time to determine which of these concerns are well-founded, and which will resolve successfully as implementation proceeds.