2015 Behavioral Health Equity Report

Colorado Office of Behavioral Health

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OMNI

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Department of Human Services

2015 Behavioral Health Equity Report

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Acknowledgements

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Agencies

Touchstone Health Partners, Northrange Behavioral Health, Aurora Center for Mental Health, Southern Ute Peaceful Spirit

Committees/Councils/Networks

OBH Cultural Competence Advisory Council

The committee serves to assist OBH in eliminating disparate outcomes in behavioral health through advisement of changes in policy, procedure and accountability that are informed by culturally and linguistically responsive and inclusive practices in behavioral health services.

Providers for the Advancement of Cultural Competence (PACC) Network

This committee meets in different regions of the state on a quarterly basis and serves as an open forum in which providers and the OBH can communicate about OBH activities related to cultural competency, as well as provider efforts, challenges, solutions and ideas about the current needs of their community, specific to culturally competent behavioral healthcare.

Background

Equity has been defined by the World Health Organization as ***"the absence of avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically"*** (WHO, 2015). Health or behavioral health equity, therefore, can be described as achieving a state in which all people have ***"the opportunity to attain their full health potential, and no individual or group of people is limited in reaching this potential because of socially defined positions, roles or circumstances"*** (Braveman, 2003). Although governmental and health care systems may recognize and promote physical and mental health equity as an ultimate standard, disparities between diverse populations exist and are widely documented. Individuals of specific racial/ethnic backgrounds, for example, have been shown to have reduced access to treatment, as well as poorer retention and treatment outcomes (U.S. DHHS, 2014). Health disparities have been defined as:

"…a type of difference in health that is closely linked with social or economic disadvantage. Health disparities negatively affect groups of people who have systematically experienced greater social or economic obstacles to health. These obstacles stem from characteristics historically linked to discrimination or exclusion such as race or ethnicity, religion, socioeconomic status, gender, mental health, sexual orientation, or geographic location. Other characteristics include cognitive, sensory, or physical disability *(DHHS, 2009)."*

As with health in general, behavioral health disparities related to treatment access, retention, and outcomes, are shaped by factors at the individual, social, structural, and policy levels. Social influencers of health such as race and ethnicity, income level, geographic location, and health insurance status have been shown to affect behavioral health outcomes through a number of pathways (SAMHSA, 2015a). Like physical health disparities, behavioral health disparities reflect a number of social factors including differences in how groups experience behavioral health conditions and supports; differential access to services; disparate rates of service retention; and inequalities in behavioral health outcomes.

Disparities in both mental health and substance use are a significant and well documented problem at the national level (SAMHSA, 2015b). There is also broad recognition that the underlying causes and correlates of behavioral health disparities are complex to understand and study. One factor is the historically limited data at federal, state, and local levels for measuring and documenting behavioral health disparities. For example, differences in how culture and demographic variables are measured as well as insufficient samples to support subgroup analyses have created challenges in understanding the scope and nature of behavioral health disparities. Additional factors such as health condition or geographic region also intersect with culture and demography to shape disparities.

Another related challenge is the limited information available regarding effective, culturally responsive behavioral health practices, including engagement, service provision and retention of clients across cultural backgrounds. Colorado's Office of Behavioral Health (OBH) defines culture as the ***"shared patterns of behaviors and interactions, cognitive constructs, and affective understanding learned through a process of socialization. Culture includes, but is not limited to: race, ethnicity, religion, spirituality, gender, sexual orientation, language and disabilities."*** Because culture influences attitudes, expressions of need, and help seeking practices, understanding culturally competent best practices to serve clients across diverse backgrounds is crucial for reducing behavioral health disparities.

THE COLORADO BEHAVIORAL HEALTH EQUITY REPORT

Understanding that health and behavioral health disparities exist and require monitoring and intervention, the Substance Abuse and Mental Health Services Administration (SAMHSA) established the Office of Behavioral Health Equity (OBHE) to promote behavioral health equity at a national level. The Colorado OBH has also demonstrated an ongoing commitment to understanding and addressing behavioral health disparities, as evidenced by provider cultural competence training efforts; the creation of a management position dedicated to culturally informed and inclusive programming; and the initiation of dedicated groups of providers and community advisors to inform the ongoing direction of cultural responsiveness efforts (i.e., Providers for the Advancement of Cultural Competence Network and the OBH Cultural Competency Advisory Council).

In early 2014, OBH initiated a 15-month project to produce an exploratory behavioral health equity report for the state of Colorado. The project was funded by OBH in recognition of:

- Existing disparities in access to behavioral health treatment, as well as treatment retention and outcomes, across populations
- A need for information regarding culturally responsive best practices for engaging, retaining and serving clients across cultural backgrounds

Committed to improving and promoting behavioral health equity in the state, OBH partnered with OMNI Institute, a Denver-based non-profit social science research firm, to lead this effort. *The 2015 Colorado Behavioral Healthy Equity Report* can be seen as an initial exploration of the many factors impacting behavioral health disparities in Colorado, and a means to identify priority action steps at both the state and provider levels. Key goals for this report are to:

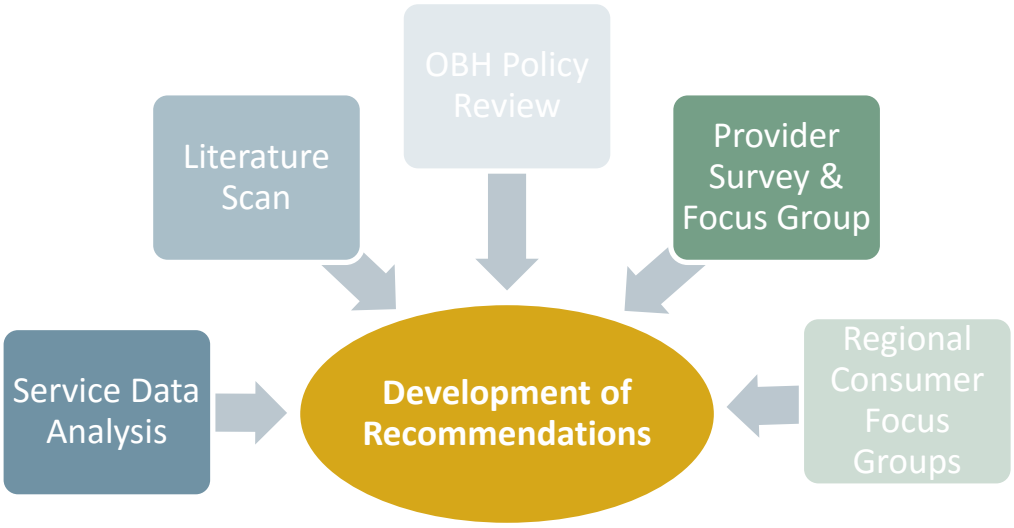
- Broaden understanding of behavioral health equity at the national level and within Colorado, through review of national data related to equity and a preliminary exploration of Colorado mental health and substance abuse service data
- Identify potential responses to behavioral health disparities based on examination of literature in the field, and local information sources including provider and consumer input and OBH policy assessments

Primary intended uses of the report and next steps are as follows:

- Generate dialogue among key behavioral health systems and service providers to: 1) promote transparency and open discourse about equity issues; and 2) identify appropriate action steps
- Identify priorities for OBH action at the organizational policy level, and in support of providers statewide
- Enhance the quality of ongoing data collection efforts to monitor disparities over time
- Inform related policy change efforts

Project Methods

Five core project components served as primary information sources for the development of *The 2015 Colorado Behavioral Health Equity Report* and are further detailed below: an analysis of client-level mental health and substance abuse service data from the state mental health and substance abuse data systems; a literature scan of best practices and field research; a review of OBH policies in relation to national standards and cultural responsiveness assessments; a focus group and brief survey of behavioral health service providers; and four regional focus groups with participants receiving behavioral health services. Additionally, project findings were shared at the July, 2015 OBH Research Forum at which a final round of stakeholder feedback from forum participants was gathered and incorporated into the relevant recommendation sections of this report.



PROJECT TEAM

Project team members at OMNI were assembled based on both content knowledge and expertise in quantitative and qualitative research methods. Several of OMNI's Regional Prevention Consultants, who provide training and prevention consultation to Colorado communities, assisted with gathering information from local community stakeholders. OMNI also sought consultation from OBH and its Cultural Competence Advisory Council (CCAC), comprised of local systems professionals and community members. This group was integral to the initial project design and research approach throughout the course of the project. CCAC members are listed in the *Acknowledgements* section of this report.

KEY PROJECT COMPONENTS AND METHODS

Service Data Analysis: Learning from Mental Health & Substance Abuse Data

While many of the project components were carried out concurrently, a critical step was obtaining and analyzing client-level data collected through Colorado's community mental health centers and substance abuse service providers. Colorado's behavioral health data systems include the Colorado Client Assessment Record (CCAR) and the Drug Alcohol Coordinated Data Systems (DACODS). The Colorado Client Assessment Record (CCAR) data are required on all admissions and discharges to the Colorado Public Mental Health System. The Drug/Alcohol Coordinated Data System (DACODS) data are a SAMHSA-required source of data in order for states to receive funding to support substance use treatment services. Both systems record client demographics, behavioral health diagnoses, treatment episodes, and treatment outcomes indicators. Aggregated data sets representing five years of treatment admissions (2009-2013) were prepared which included similar indicators from both behavioral health service data systems. Percentages or mean scores on these indicators were calculated across culturally diverse groups, including age group, gender, ethnicity (Hispanic/Latino or non-Hispanic/Latino), race, need for language considerations (CCAR data only), and veteran status (DACODs data only). Emerging patterns of access, service participation (e.g., length of stay, number of treatment episodes), and treatment outcomes within culturally diverse groups were explored to begin to identify possible inequities and areas for further examination. A full description of the analytic process can be found in *Appendix A* and complete data findings in *Appendix B*.

Limitations: Data explored in these analyses reflect only clients receiving services from OBH designated mental health and licensed substance abuse treatment providers, and may not be fully representative of Colorado's populations involved in behavioral health services. Data quality issues, including missing and duplicate data, and limited data to assess important contextual factors known to influence behavioral health inequities (e.g., poverty) reduce confidence in drawing definitive conclusions. For these reasons, the findings from this review should be considered exploratory. Other limitations are detailed in the *Project Findings* section of this report.

Literature Scan of Best Practices: Learning from Field Research

A scan of the literature was also conducted to identify strategies for advancing behavioral health equity. The review encompassed scholarly publications, research studies, and non-peer-reviewed published reports. Key themes were identified regarding practices for improving cultural responsiveness at the organization-level and included workforce development and training; community engagement and partnerships; education and outreach; service delivery modifications; and data collection and monitoring.

Limitations: The literature scan included research on advancing behavioral health equity and approaches related to overall health equity as well. Most available studies focused on cultural responsiveness, drawing inferences about its role in advancing overall behavioral health equity. Further, while adequate studies with strong designs were sought, those with methodological weaknesses were also considered as they served to highlight exploratory efforts and emerging research trends. For these reasons, the findings from the literature review should be considered provisional.

OBH Policy Review: Learning from the National CLAS Standards & OBH Policy Assessment Data

Project methods also included an exploration of OBH policy and the Volume 21 Behavioral Health Treatment Rules (herein referred to as "rules") related to culturally responsive practices. Rules were reviewed specifically within the context of National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (the CLAS standards). The CLAS standards, promoted by the US Department of Health and Human Services, Office of Minority Health, are "*intended to advance health equity, improve quality, and help eliminate health care disparities by providing a blueprint for individuals and health and health care organizations to implement culturally and linguistically appropriate services*" (DHHS, 2013). The Office of Minority Health promotes adoption of the CLAS standards as a means to advance health and health care in the United States. It is important to acknowledge the University of Denver Graduate Psychology Department, which had previously completed a similar review that provided additional support for the findings in this area. A full list of the CLAS standards can be found in *Appendix C*.

A second element of the policy review included the analysis of data gathered by OBH using the Cultural and Linguistic Competence Policy Assessment (CLCPA). The CLCPA was developed by the National Center for Cultural Competence at the Georgetown University Center for Child and Human Development. The assessment is intended to guide organizations in improvements to health care access, service quality (particularly with diverse populations) and promotion of cultural and linguistic competence as strategies to eliminate disparities in health (NCCC, n. d.). In 2013, OBH leadership approved use of this instrument to facilitate internal assessment of its cultural responsiveness processes. All OBH staff were invited to complete the assessment, with a response rate of 56%. OBH supported the analysis and sharing of the assessment data within this report to promote transparency and encourage dialogue among providers. See *Appendix D* for full results of the OBH CLCPA assessment.

Limitations:
Although the policy analysis component of this project included a thorough review of OBH rules and the CLAS standards, it is important to highlight the complexity of the CLAS standards and the array of resources available to support organizations in their internal examination of policy alignment with CLAS. Currently, numerous state-level efforts are underway for OBH to further examine its rules and their relation to CLAS. One such effort is OBH's involvement in the National CLAS Learning Collaborative, which brings together agencies to deepen understanding of CLAS standards, and to share strategies for implementation within behavioral health settings.

For the CLCPA assessment, a significant constraint was the limited number of staff who participated in the assessment. While over half of OBH staff completed the assessment, it is important to ensure the representation of all staff perspectives in an assessment of this nature. Further, because internal assessment activities were new at the time of administration, many staff may have been unclear of the goal of the measure and its relevance to their everyday work. Additionally, the assessment was

completed in 2013 and results may differ significantly with a more recent administration of the tool. Finally, it is important to note that the CLCPA assessment is geared toward agencies in direct service provision and therefore includes some items that may be less relevant for a state-level agency such as OBH.

Regional Focus Groups: Learning from Participants Receiving Behavioral Health Services

Another critical information source for the project were the insights shared by participants receiving services. OMNI partnered with local service providers in four regions of the state (Metro Denver, Northeast, Southern and Southwest regions), to convene individuals from a range of cultural backgrounds. Focus groups explored participant perceptions about barriers to treatment access and retention as well as ideas for advancing cultural responsiveness and behavioral health equity (see *Appendix E* for the full focus group guide). OBH's Cultural Competence Advisory Council provided consultation on key areas of inquiry and the focus group questions were shared with all partner organizations in advance. In total, 32 individuals took part in the focus groups. The majority of participants were female (78%) and ranged in age from 23-68 with an average age of 39. Half of participants identified as Hispanic/Latino, 16% of participants as American Indian/Alaska Natives, and 13% as multiracial. See *Appendix F* for a full summary of focus group participant demographics. Qualitative data were aggregated and analyzed for common themes as well as critical unique perspectives, and participant feedback is incorporated throughout the findings and recommendations presented in this report.

Limitations: Considerable efforts were made to ensure diverse perspectives were represented across focus groups, and the individuals who participated shared valuable information and insights. However, resources did not permit a larger, more strategic sample of participants and only four groups were convened throughout the state. Thus, findings cannot be generalized to the larger state population, and in particular, cannot be assumed to fully represent the perspectives of particular demographic or regional groups.

Provider Survey and Focus Group: Learning from Behavioral Health Service Providers

Providers offered knowledge and insight to the project through a provider survey and focus group with the state PACC network (Providers for the Advancement of Cultural Competence). The survey was administered at the July 2014 research forum and yielded 28 survey responses from provider attendees (See *Appendix G* for complete results of the Provider Survey). Twelve providers took part in the PACC network focus group conducted in October of 2014; SummitStone Health Partners in Fort Collins provided the meeting space and providers attended in person or via conference line from multiple regions throughout the state.

Limitations:
A convenience sampling approach was used for both the survey and focus group due to limited project resources. Providers at both of these events likely represented a subgroup of providers statewide with particular interest and investment in issues related to cultural responsiveness. Further, the survey sample size was small, and there was limited representation from diverse groups across both methods.

Project Findings

Project findings are organized by two key areas: (1) *Exploring Behavioral Health Equity in Colorado*, and (2) *Exploring Options for Colorado's Response to Behavioral Health Equity Issues*. The first section contains a preliminary exploration of Colorado mental health and substance abuse service data, with the critical goal of identifying areas in need of further inquiry as OBH works to enhance statewide data systems and promotes behavioral health equity efforts statewide. The second section of project findings focuses on exploring potential responses to behavioral health disparities through examination of the national literature, as well as local information sources including provider and consumer input and OBH policy assessments.

PROJECT FINDINGS PART I: EXPLORING BEHAVIORAL HEALTH EQUITY IN COLORADO

Achieving a more equitable behavioral health system requires a multi-faceted approach to improving treatment access, utilization and outcomes for diverse populations. A critical concern is ensuring equal ***access*** to services for diverse populations. For example, appropriate treatment of mental and physical health disorders requires screening and diagnosis of treatment needs, which can only be determined through effective communication between clients and providers, and the use of linguistically accurate assessments (Sanchez et al., 2012). Geographic region affects access to behavioral services as well, with rural residents encountering more obstacles than residents located in more populated areas (Safran et al., 2009), such as greater distance from, and difficulty securing transportation to care providers. Health insurance is also essential to ensuring equal access to behavioral health services and various factors shape differential health insurance coverage, including race and ethnicity. As of 2013, 42 million Americans were reported to be without health insurance, affecting 15.9% of African-Americans, and 24.3% of Hispanic/Latinos (Smith & Medalia, 2014).

A number of social and economic factors also shape the ***utilization*** of behavioral health services. Research has shown that a higher number of white adults than African-American or Hispanic/Latino adults use mental health services, and a higher number of White adults use prescription psychiatric medication and outpatient mental health services, regardless of the severity of mental illness (SAMHSA, 2015b; DHHS, 2001). Treatment barriers for culturally diverse groups, such as inability of providers to recognize influential cultural beliefs and traditions, can lead to patient frustration, misdiagnosis, and a lack of patient follow-through with treatment plans (Sanchez et al., 2012).

Not only are there barriers to accessing and utilizing behavioral health services, but groups with historical social and economic disadvantages often experience poorer health and behavioral health ***outcomes*** in general. Research has found a link between mental health disorders and experiences of racism, bias, and discrimination, as these stressful events negatively affect physical and mental health (DHHS, 2001). Other factors such as poverty, low socioeconomic status, and lack of health insurance can also contribute to poor health outcomes and exist along racial and ethnic lines disproportionately (CDC, 2011; Kaiser Family Foundation, 2012).

In Colorado, more than 1.5 million people or 3 in 10, need treatment for mental health or substance use disorders each year (TriWest, 2011). Colorado ranked 39th for its access to mental health care when compared to other states, and ranked 28th when access to and need for mental health care were

assessed together (MHA, 2015). However, there is limited data available on behavioral health disparities across specific populations in Colorado.

Summary of DACODS and CCAR Service Data Analysis

In an effort to better understand behavioral health disparities in Colorado, OBH provided OMNI with statewide data for analysis, including client-level data from the Colorado Client Assessment Record (CCAR) and the Drug/Alcohol Coordinated Data System (DACODS). The overall objective of the analyses was to examine the extent to which the data indicated behavioral health inequities in Colorado among subpopulations of interest, taking into account limitations of statewide mental health and substance use assessment and service records (further described below). The subpopulations of interest included those defined by age group, gender, ethnicity, race, and where data were available, sexual orientation, veteran status, and language considerations. A critical goal was to identify areas in need of further inquiry as OBH continues its efforts to promote behavioral health equity statewide.

Exploratory analyses focused on the following overarching question: **Among which culturally diverse groups is there <u>emerging evidence</u> of behavioral health inequities in Colorado?** More specifically:

- What are the estimated rates of **access to treatment** among subpopulations (as defined by percentage estimates of those receiving services relative to Colorado population rates)?
- What are patterns of **service characteristics** among subpopulations, in terms of:
    - **service engagement/retention**, as assessed by length of treatment, number of treatment episodes, and rates of completion?
    - **modality** (type) of treatment?
- What differences, if any, are observed in **behavioral health diagnoses** and **outcomes** among subpopulations (as assessed by presence of disability or co-occurring disorder; and improvement in physical health, family, interpersonal, role performance, mental health, recovery, and functioning) from initial assessment to discharge from services?

<u>Limitations:</u>

While CCAR and DACODS data provided a critical opportunity to examine and understand behavioral health inequities in Colorado, it is important to note key limitations of these data:

- Data sets for analysis were limited to similar items tracked across the two state systems (CCAR and DACODs), representing only some aspects of mental health and substance use treatment.
- CCAR data tracks publicly funded mental/behavioral health services among OBH designated providers only, thus the CCAR data set may not be representative of all populations receiving mental health services (e.g., clients served by private pay providers or non-OBH licensed providers).
- There were considerable rates of missing data for some client variables (e.g., sexual orientation, veteran status), preventing examination of some subpopulations.
- There were considerable rates of missing and duplicate cases in the datasets. This reduces confidence in the generalizability of findings (i.e., ability to draw firm conclusions that estimated rates represent the actual rates in Colorado).
- There is limited information contained in these data sets for elucidating contextual factors that could account for any observed differences.

- These analyses represent an aggregated five-year snapshot; it is important to examine changes over time in relation to context, policy shifts, population changes, etc.

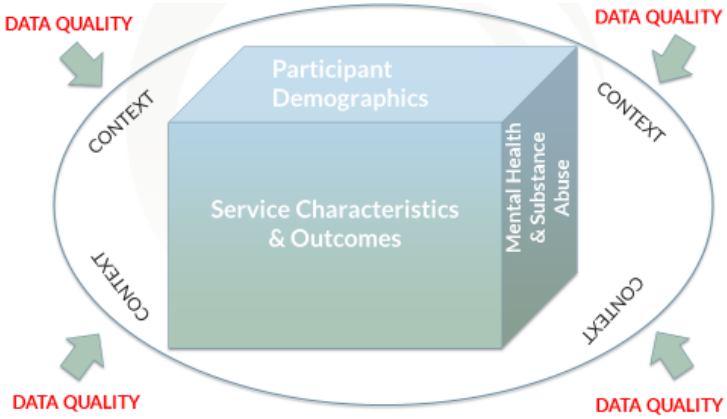
Despite these limitations, the two datasets provided key information on individuals served through OBH designated mental health providers and OBH-licensed substance use disorder programs throughout the state.

General Analytic Approach

As mentioned in the Methods section of this report and detailed in *Appendix A*, a similar analytic strategy was applied to each dataset, to facilitate cross-area and cross-dataset synthesis where appropriate. Both datasets were analyzed at the client level from 2009 to 2013; and all client activities within a five-year period were aggregated (e.g., clients could be represented multiple times if they experienced both inpatient and outpatient treatment episodes). Detailed data tables (included in *Appendix B*) provide the following information from each dataset:

- **Sociodemographic characteristics**, including the total number and percentages of clients according to socio-demographic categories (age group, gender, ethnicity, race, sexual orientation, marital status, veteran status, language considerations);
- Key indicators, including **service characteristics** (average number of treatment episodes, length of stay, treatment completion, etc.) and treatment **outcomes** (percent with improvements in health, behavioral health, and functioning); and
- **Treatment modality**, including types of inpatient and outpatient programs, and programs targeting specific presenting needs (available from DACODs for substance use treatment population only).

Figure 1. Multidimensional Framework for Behavioral Health Data Analysis



The overarching framework for the analyses considered the multi-dimensional associations among types of behavioral health services (mental health and substance use), cultural diversity (as assessed in sociodemographic variables such as age group, gender, ethnicity, etc.), and service characteristics and outcomes. This framework is visually depicted by the cube in Figure 1. Each side of the cube represents a dimension that is taken into account when examining intersections between culturally diverse groups (e.g., Hispanic versus non-Hispanic participants), specific service characteristics (e.g., length of stay), and particular behavioral health service areas (e.g., mental health). Percentages (rates) or means (averages) can be calculated for each of the many subgroups representing the intersection of these three dimensions (e.g., the average length of stay for older adults receiving inpatient mental health services). The findings in the sections that follow are organized within this framework. Despite the utility of these data in surfacing potential disparities in health access,

utilization, and outcomes, they cannot be used to understand the contextual factors that may account for them. For example, the datasets do not include information on key social determinants of health such as poverty, environmental stressors, and cultural factors that may impact standard screening and assessment processes. Moreover, confidence in the rates generated by the data must be tempered by the limitations of the dataset itself, as noted above.

Coding and Analyses

Select results from both CCAR and DACODS data sets are displayed in this section with the full data results included in *Appendix B*. Results are presented for the same variables across both data sets (as facilitated by recoding) where possible. There are some critical differences across data systems, however, and unique information is presented below as well. *Appendix A* provides additional details regarding the data and analytic decisions, with key examples including the following:

- CCAR and DACODS disability response options varied, so responses were collapsed into "non-disabled" or "disabled" categories
- CCAR includes diagnostic codes which enabled estimation of co-occurring disorders
- While treatment progress in physical, social, family, role performance, and mental health domains are collected in both systems, data items are defined and rated differently
- DACODS data contained a service modality variable that allowed for exploration of key participant demographics by service type. Because OBH does not consider Detox and DUI services to be forms of treatment, they are excluded from overall analyses and reported only when data findings are separated by modality.

Given the number of considerations regarding data quality and completeness, findings of potential behavioral health inequities are reported only when group differences in percentages met certain criteria. For both dichotomous (two category) variables related to culturally diverse groups (e.g., gender, ethnicity, veteran status, language considerations) and variables with more than two categories (e.g., race)[1], a magnitude of difference of at least 2% was required to be observed. This criterion was applied to ensure that patterns could be identified while minimizing reporting of spurious differences. Statistical significance tests of differences across groups are not reported, as the large sample sizes would result in the overwhelming majority of observed differences meeting significance levels (even those that are objectively small and not clinically meaningful).

In the section that follows, the first question regarding behavioral health access is examined, through the provision of descriptive information about the clients served in each system, and exploration of who

[1] The abbreviations for the following demographic characteristics are used as appropriate throughout the report: Participants ages 12-17 ("Adolescents"); Participants ages 18-24 ("Young Adults"); Participants ages 65+ ("Older Adults"); Participants who identify as American Indian Alaska Native (AIAN); and participants who identify as Native Hawaiian Pacific Islander (NHPI).

is accessing treatment across culturally diverse groups. Subsequent sections address the second question regarding behavioral health service characteristics, and the third question regarding conditions and outcomes. Throughout these sections, we summarize and draw interpretations across data sets where possible, highlighting key findings in tables.

Access to Behavioral Health Services

The data were first used to explore which groups are accessing mental health and substance use services, and potential differences in access across culturally diverse groups. To examine this, demographic information was first analyzed in each of the two datasets. For the following demographic information, detox and DUI clients were excluded from analyses as OBH does not define these modalities as forms of treatment. *Appendix B* contains detailed data tables with select key findings including the following:

- Among those receiving services tracked in CCAR and DACODs systems, the largest age group in both datasets was adults between 25 to 44 years old (32% and 49%, respectively)
- Those receiving mental health services were somewhat more likely to be women (55%), while far more males than females (67% versus 33%) were represented in substance use services.
- The majority of clients in CCAR and DACODS systems identified as White (84% and 87%), and heterosexual (95% and 97%).
- A greater proportion of Veterans received substance abuse services (5%) as compared to mental health services (1%).

A second area of exploration looked at rates of subpopulations accessing services, as compared to state population rates for each group. Discrepancies may signify differences in service access but additional context regarding mental health and substance use patterns within sub-populations is needed for further interpretation of findings. Full results are provided in *Appendix B* with key findings suggesting the following (see Table 1 below):

- **Relative to the Colorado state population**, the following groups may be *underrepresented* in services:
    - In both mental health and substance use services: adults 45+, older adults, Asian and Multi-racial individuals
- **Relative to the Colorado state population**, the following groups may be *overrepresented* in services:
    - In mental health services: adolescents and young adults through age 24; females; Hispanic/Latino and African-American individuals
    - In substance use treatment: adolescents and young adults through age 24; adults (all age groups); males; Hispanic/Latino and African-American individuals

It is important to note again that these findings should be considered provisional, given the concerns regarding data quality and completeness raised earlier in this report.

Table 1. Behavioral Health Services Utilization (Access) In Culturally Diverse Groups, Relative to CO State Population*		
	Emerging Patterns	
Relative to:	*Mental Health Services*	*Substance Use Treatment*
Age group	▪More children and adolescents were represented (38% vs. 24% CO) ▪Fewer older adults were represented (2% vs. 11% CO)	▪Fewer children and adolescents (11% vs. 24% CO) and older adults (1% vs. 11% CO) were represented ▪Adults ages 18-64 were represented at higher percentage (89% vs. 65% CO)
Gender	▪More females represented (55% vs. 50% CO); opposite for males	▪More males were served (67% vs. 50% CO); opposite for females
Ethnicity	▪Slightly more Hispanic/Latino individuals were represented (26% vs. 20% CO)	▪Slightly more Hispanic/Latino individuals were represented (26% vs. 20% CO)
Race	▪A lower proportion of Asian (1% vs. 4% CO) and Multi-racial (0.6% vs. 3% CO) individuals were represented ▪Approximately twice the CO percentage of AIAN (4% vs. 2% CO) and African-American individuals (10% vs 5% in CO) were represented	▪A lower proportion of Asian (1% vs. 4% CO) and Multi-racial (2% vs. 3% CO) individuals were represented ▪Larger proportion of African-Americans (8% vs 5% in CO) were represented

**as represented by total number/percentages of individuals with CCAR record (mental health services) or DACODs record (substance use treatment) in 2009-2013. Sexual orientation, Veteran status, and Language considerations are not reported here due to missing data issues in either or both data systems, or lack of comparable state level population data.*

Service Characteristics

Data analyses also explored the patterns of service characteristics among subpopulations. OBH stakeholders worked together to identify a set of indicators with the following characteristics: 1) known associations in the research literature with culturally-related behavioral health inequities; and 2) representation in both mental health and substance use state-level data sets, where possible. Two service-related indicator areas were examined: service participation (i.e., indicators of engagement, retention, and completion); and types of treatment (substance use only). For the following section, detox and DUI clients were excluded from analyses as OBH does not define these modalities as forms of treatment.

Service Participation

Indicators assessing service participation by subpopulations were also investigated, to understand utilization patterns and potential areas of inequity. Three indicators were examined, each reflective of key aspects of engagement, retention, and completion of services: length of stay (average number of days); average number of treatment episodes and percent individuals with multiple treatment episodes; and treatment status at discharge (completed, transferred or referred to other services, or not completed). Tables 2 and 3 following, present percentages and averages of these treatment components for individuals served.

It is important to note that these findings only allow for surface-level identification of potential utilization differences across culturally diverse groups. For example, one critical factor not represented in these analyses is the reason or focus for treatment (e.g., diagnosis or mental health condition, type of substance abuse); yet, the reason for treatment is directly associated with type and length of treatment (e.g., some types of substance use disorders require lengthier treatment than others). Further, there are documented differences in mental health and substance use issues, and treatment seeking behavior, across culturally diverse groups (SAMHSA, 2015b). Thus, it is important to further investigate these patterns by conducting more fine-grained analyses, and in relation to other contextual factors. For this reason, the findings are included in the table, but not interpreted.

Table 2. Emerging Patterns of Behavioral Health Service Participation by Culturally Diverse Groups: Engagement and Retention*				
	Average Length of Stay (LOS)		***Average # of service episodes & % of participants with multiple episodes***	
Relative to:	*Mental Health*	*Substance Use*	*Mental Health*	*Substance Use*
Overall rate/average	*210 days*	*119 days*	*1.4 episodes (25% w/multiple episodes)*	*1.4 episodes (22% w/multiple episodes)*
Age group	▪Children under 12 (238 days) and adults 25-64 (207-230 days) had relatively longer LOS	▪Adolescents and young adults (under 25) had shortest LOS (87 and 105 days)	▪Average number of treatment episodes decreased with age (from ~1.7 to 1.3) ▪Adolescents were slightly more likely to have multiple episodes (30%) and adults over 65 were less likely to have multiple episodes (13%)	▪Adolescents least likely to have multiple treatment episodes (18%)
Gender	▪Females had longer LOS (213 days)	*-No differences observed-*	*-No differences observed-*	Females slightly more likely to have multiple treatment episodes (25%)
Ethnicity	▪Non-Hispanic/Latinos had longer LOS (213 days)	*-No differences observed-*	▪Hispanic/Latinos less likely to have multiple treatment episodes (22%)	*-No differences observed-*
Race	▪Shorter LOS among AIAN (204 days), Asian (202 days) and NHPI (201 days) individuals	▪Shorter LOS for NHPI (97 days), Multi-racial (115 days) and African American (117 days) individuals ▪Asian and AIAN individuals had longest LOS (124 and 125 days)	▪African-American, AIAN and NHPI individuals were more likely to have multiple treatment episodes (32% for African-Americans; 29% for AIAN and NHPI)	▪NHPI had highest percentage of multiple episodes (28%); Asian individuals had lowest percentage (16%)
Language Considerations	▪Longer LOS among individuals with language considerations (225 days)	*--not available--*	▪Participants with language considerations were less likely to have multiple treatment episodes (16%)	*--not available--*
Veteran status	*--not available--*	▪Veterans had longer LOS (125 days)	*--not available--*	*-No differences observed-*

**as represented by total number/percentages of individuals with CCAR records (mental health services) or DACODs records (substance use treatment) in 2009-2013. Cells designated as 'no differences observed' indicate that no differences meeting the reporting criteria were observed for that subpopulation (see Approach above).*

To examine treatment completion rates, a variable indicating treatment status at discharge as noted by providers was examined. There are three possible ratings at discharge: completed (i.e., successful/planned end of service episode), transferred or referred to other services, or not complete (i.e., unsuccessful end to services). Table 3 presents emerging patterns including the following:

- In mental health services, children and adolescents had lower completion rates and higher percentages of transfers or referrals to other services, relative to other age groups. In substance use services, percentages of treatment completions were slightly higher for adolescents and for adults over 65.
- Treatment completion patterns across racially diverse groups differed by service area. For example, Asian participants had relatively higher rates of completion for substance use treatment but lower completion rates for mental health services, relative to other race groups. African-American individuals had relatively lower completion rates in substance abuse services but similar completion rates to other race groups in mental health services.

Table 3. Emerging Patterns of Behavioral Health Service Participation by Culturally Diverse Groups: Treatment Completion

Percent treatment completion, transfer/referrals, and non-completion assessed at discharge

Relative to:	*Mental Health*	*Substance Use*
Overall rate/avg	*73% completion, 25% transfer/referrals, 2.3% non-completion*	*55% completion, 8% transfer/referrals, 36% non-completions*
Age group	Lower completions (71%) and higher referrals to other treatment for children (27%), adolescents (70%, 28%), and older adults (66%, 32%) Higher completions (~77%), and lower referrals (21%) for adults ages 18-44	Percentages of completion were slightly higher for adolescents (61%) and for adults over 65 (66%)
Gender	*-No differences observed-*	*-No differences observed-*
Ethnicity	*-No differences observed-*	Lower completion and higher non-completion percentages for Hispanic participants (53%, 39%)
Race	Higher completion and lower referrals among AIAN (75%, 22%) and Multi-racial individuals (76%, 20%) Lower completion and higher referrals among Asian participants (68%, 30%)	Higher completion percentages for Asian individuals (61%) Lower completion and higher non-completion rates for African-American participants (49%, 43%)
Language Considerations	Participants with language issues had lower percentage of completion and higher referrals (68%, 30%)	*--not available--*
Veteran status	*--not available--*	Higher completion and lower non-completion percentages for veterans (58%, 34%)

**as represented by total number/percentages of individuals with CCAR records (mental health services) or DACODs records (substance use treatment) in 2009-2013. Cells designated as 'no differences observed' indicate that no differences meeting the reporting criteria were observed for that subpopulation (see Approach above).*

Treatment Modality

Indicators of types of substance use treatment (treatment modality) by culturally diverse groups were investigated, to explore broad patterns and possible inequities in these areas. (Note: Treatment modality information was limited to substance use services data from DACODS). Table 3 in *Appendix B* provides percentages and/or means of participation indicators in nine coded service modalities (Detox; Residential; Opioid Replacement Therapy or ORT; Outpatient; Short Term Intensive Remedial Residential Treatment or STIRRT; Day Treatment; DUI; Differential Assessment; and Minors in Possession). It should be noted again that OBH does not consider Detox and DUI to be forms of treatment, per se. Thus, these two types of behavioral health services are only included in data findings within this section because they are separated by service modality. The following calculations were completed across each cultural diversity category (e.g., age group, gender, ethnicity, etc.): 1) engagement (% in each treatment modality); 2) average number of treatment episodes per client, and 3) average length of stay (in days).

Key patterns emerging from these analyses included the following.

- **Engagement in Treatment Modality**
    - Detox and DUI services are by far the most common types of services across all participants (66% combined) with outpatient (22% combined) the next most common type of service.
    - Age Groups: Adolescents received the majority of service episodes as Outpatient and Minor in Possession status (a service modality specific to youth up to age 21), whereas Adults were more frequently admitted to Detox, Outpatient and DUI treatment.
    - Gender, Race and Ethnicity: Service type rates were similar by gender, ethnicity and race with the exception of Asian and White individuals who were more likely to receive DUI services than individuals of other races.
    - Veteran Status: Veterans were less likely than non-veterans to attend Outpatient treatment and more likely to receive Detox services.
- **Service Episodes**
    - The number of service episodes was generally highest for Detox compared to all other coded treatment modalities (e.g., Residential, Outpatient, etc.).
    - Average number of Detox treatment episodes was especially high for adults and older adults, males, and the AIAN and African American populations.
- **Length of Stay**
    - The average length of stay was highest for ORT (260 days) and DUI (195 days) followed closely by outpatient services (137 days).
    - Age Groups: The average length of stay generally decreased with age for Residential, STIRRT, and Day Treatment whereas the length of stay generally increased with age for Detox, ORT, Outpatient, DUI, and Differential Assessment.
    - Gender: There were few gender differences, but females attended ORT longer than males.
    - Race and Ethnicity: Regarding ethnic differences, Hispanic/Latinos' average length of stay for Minor in Possession treatment was longer than for non-Hispanics. NHPI

individuals appear to stay in treatment for fewer days across all treatment types whereas the White individuals stay in treatment for the longest number of days.

- Veteran Status: Finally, Veterans stay in Day Treatment fewer days than non-Veterans.

Outcomes

Analyses were also conducted to explore patterns of behavioral health diagnoses and improvements in outcomes, across both behavioral health service datasets. The goal of these analyses was to explore differences in behavioral health diagnoses and outcomes across culturally diverse groups (as assessed by determination of disability or co-occurring disorder, and improvement in physical health, family, interpersonal, role performance, mental health, recovery, and functioning) from initial assessment to discharge from services. The analytic approach and details regarding the data coding and exclusion decisions for these analyses are included in *Appendix A*. For the following analyses, detox and DUI clients were excluded from analyses as OBH does not define these modalities as forms of treatment.

Behavioral Health Diagnoses

In the Indicator Tables seen in Appendix A, descriptive statistics are presented regarding the percentage of clients who were determined through assessment or self-report to have a disability and the percentage of clients with a co-occurring disorder (defined as client has DSM-IV codes reflective of a mental health and a substance use diagnosis at admission). Data regarding co-occurring disorders were only available for mental health services (from CCAR). Table 4 displays data patterns that emerged for these diagnoses, by culturally diverse groups (see *Appendix B* for comparisons within groups).

- In the mental health services dataset, 15% of clients had a disability, with greater proportions of males (18%), non-Hispanics (16%), American Indian /Alaskan Natives (19%) or Black/African Americans (19%) reporting a disability. Some groups were more likely to have reported co-occurring disorders including males (18%), Non-Hispanics (17%), American Indian /Alaskan Native (22%) and African-American (18%) participants.
- Among those in substance use treatment, approximately 15% of clients served reported a disability, with more female (21%), non-Hispanic (16%), African American (19%), adults 65+ (23%), and Veteran (22%) clients having a reported disability.

Table 4. Emerging Patterns in Behavioral Health Conditions* among Culturally Diverse Groups: Participants With Relatively Higher Rates

	Disability		*Co-Occurring Disorder (CCAR only)*
	Mental Health Services	*Substance Use Treatment*	*Mental Health Services*
Overall Rate	*15%*	*15%*	*16%*
Age group	*-No differences observed-*	Adolescents *(14%)* Adults, 45-64 *(22%)* Adults, 65+ *(23%)*	Adults, ages 18-64 *(ranged from 21.4-24.7%)*
Gender	Males *(19%)*	Females *(21%)*	Males *(18%)*
Ethnicity	Non-Hispanics *(16%)*	Non-Hispanics *(16%)*	Non-Hispanics *(17%)*
Race	AIAN *(19%)* African-American *(19%)*	African-American *(19%)* NHPI *(17%)*	AIAN *(22%)* African-American *(18%)*
Language Considerations	*-No differences observed-*	*-No differences observed-*	No Language Issue *(17%)*
Veteran Status	*--not available--*	Veterans *(22%)*	*--not available--*

**As represented by total number/percentages of individuals with CCAR records (mental health services) or DACODs records (substance use treatment) in 2009-2013. Cells designated as 'no differences observed' indicate that no differences meeting the reporting criteria were observed for that subpopulation (see Approach above). Results in table reflect where percent difference across groups within dichotomous categories (gender, ethnicity, language consideration, veteran status) was >2%; or for multiple response groups (age group, race), where percent difference for group was >2% from overall average.*

Behavioral Health Outcomes

The relative rates of improvement in key behavioral health outcomes across culturally diverse groups were next explored. In partnership with OBH and its CCAC Committee, five outcomes were selected that measured similar areas of functioning, in order to facilitate pattern analysis across mental health and substance use service systems. It is important to note that the outcome areas were defined and assessed differently across systems. Table 5 summarizes the definition of each outcome area and alignment across systems.

To calculate improvement scores, the samples were first restricted to include only those individuals with CCAR scores of 3 or more at the time of admission (ratings are from 1-9, with greater scores indicating more challenge) or DACOD scores of 2 or more at admission (ratings are from 1-4, with greater scores indicating more challenge). This threshold for inclusion was applied to remove those individuals who were not experiencing enough challenge in the outcome at admission to show improvement at discharge. Individuals remaining in the sample were then coded as having improved when their score at discharge was at least 3 points lower (CCAR) or 1 point lower (DACODS) than at admission. The percentage of individuals demonstrating this level of improvement was then calculated (shown in Table 5). The one exception is the rating of mental health improvements in the DACODS system; the item assessed by the clinician is a dichotomous (yes/no) rating of whether the client currently is experiencing a mental health problem. Thus, the percentage improved reflects the proportion of clients whose response changed from a "yes" at admission to a "no" at discharge.

TABLE 5. OUTCOME AREAS INCLUDED IN ANALYSES AND PERCENTAGE OF INDIVIDUALS SHOWING IMPROVEMENTS*

	CCAR		DACODS	
	Definition	*% Improved***	*Definition*	*% Improved***
Physical Health	Extent to which a person's physical health or condition is a source of concern	33.2%	Clinician assessment of the client's medical or physical level of functioning	34.9%
Mental Health	Severity of the person's mental health symptoms	51.0%	Clinician assessment of the client's current mental health status	30.2%
Role Performance	Extent to which a person adequately performs his/her occupational role.	43.6%	Clinician assessment of the client's functioning in the educational or employment setting (role performance)	31.8%
Family	Extent to which issues within the individual's identified family and family relationships are problematic	38.4%	Clinician assessment of the client's skills and functioning level in the family setting	29.5%
Interpersonal	Extent to which a person establishes and maintains relationships with others	37.9%	Clinician assessment of the client's social skills and ability to function in positive relationships	30.6%

**As represented by total number/percentages of individuals with CCAR record (mental health services) or DACODs record (substance use treatment) in 2009-2013. Cells designated as 'no differences observed' indicate that no differences meeting the reporting criteria were observed for that subpopulation (see Approach above).*
***Percent of individuals who demonstrated at least 3 points (CCAR) and 1 point (DACODS) reduction in scores from admission to discharge (after removing individuals reporting low level of challenge in outcome at admission).*

Overall, improvements were seen in each of the five selected outcomes. The percentage of individuals demonstrating improvements were then explored by culturally diverse groups (see *Appendix* B for detailed results). In general, patterns across outcome areas for culturally diverse groups were similar; these patterns are described below in Table 6. Where differences in outcome areas were observed across groups, these are noted. Emerging patterns suggest the following:

- Adults (including young adults ages 18-24) have lower rates of improvement following mental health services, and adolescents show less improvement following substance use treatment, ranging from a 5-10% difference.
- There were few differences by gender.
- In both types of behavioral health services, most racial minority groups showed lower percent improvements in treatment outcomes for the majority of outcome areas (e.g., family, interpersonal, physical health) when compared to white participants.
- In substance use treatment, veterans demonstrated higher percentages of improvements than non-Veterans (approximately ~2-8% difference).

Some findings were unexpected, given the research literature, and warrant further examination. For example, within mental health services, outcomes were more positive across the five improvement areas for clients with language challenges. It is unknown why improvement was greater, though there is research that indicates better mental health in Mexican-born Hispanics than U.S.-born Mexican Americans (Sanchez et al., 2012).

TABLE 6. EMERGING PATTERNS IN BEHAVIORAL HEALTH OUTCOMES IN CULTURALLY DIVERSE GROUPS*

Relative to:	*Mental Health Services*	*Substance Use Services*
Age group	Greater improvement among children, adolescents, and adults over 65, across all areas (~3-4%) except for mental health severity, which was higher only for adults over 45	Lower improvements among adolescents (~6%), and greater improvements for adults over 65 (~5%) on *family, interpersonal*, and *role performance* outcomes Greater improvements for *mental health* for older adults (~4%) and lower improvements for adolescents (~3%)
Gender	Slightly lower *physical health* improvement for females	Slightly greater improvements for females across all areas (~1-3%)
Ethnicity	Lower improvements for Hispanic participants across all areas (~2-3%)	Lower improvements for Hispanic participants across all areas (~2-4%)
Race	Lower improvements for Multi-Racial participants across all areas (~4-10%), and AIAN, African-American participants in most areas (~3-4%) Lower improvements for NHPI participants for *family* and *interpersonal* outcomes (~5-6%) Greater improvements for Asian and White participants in *physical health* and *mental health severity* (~3%)	Lower improvements for AIAN (~4-5%) and African American participants (~6-8%) across *family, interpersonal, role performance,* and *physical health* Greater improvements for Asian participants across *family, interpersonal, role performance*, and *physical health* (~5-8%), and White and Multi-Racial participants in most areas (~3-5%)
Language Considerations	Greater improvements for participants with language issues across all areas (~3-5%)	*--No data available--*
Veterans	*--Insufficient data available--*	Higher improvement for veterans across all areas (~2-5%)

**comparisons reflect relative differences (noted by % in parentheses) from the overall average for age group and race categories, or across dichotomous groups for gender, ethnicity, language considerations, and veteran status.*
**as represented by total number/percentages of individuals with CCAR record (mental health services) or DACODs record (substance use treatment) in 2009-2013. Cells designated as 'no differences observed' indicate that no differences meeting the reporting criteria were observed for that subpopulation (see Approach above).*

Multi-Dimensional Understanding of Behavioral Health Equity Patterns

As described earlier in this section, the assessment of behavioral health equity patterns is a complex endeavor. The exploration of state-level mental health and substance use data to address key questions about access, service experiences, and outcomes revealed potential inequities for culturally diverse groups in each of these areas. The following selected findings illuminate how the data can be brought together to provide a more comprehensive illustration of patterns across cultural groups:

- Colorado's mental health providers represented in the CCAR database are serving a higher proportion of children and adolescents than are represented in the state population. While this younger population is more dependent on public sources for paying, they tend to stay longer in treatment and report higher improvements in many areas including family, interpersonal, role performance, physical health, and general functioning.
- In general, gender groups showed roughly the same pattern across all behavioral health service and outcome indicators, with a few exceptions:
    - Within mental health services, females attend treatment slightly longer.
    - Opposite patterns emerge for gender when considering disability status, with a greater proportion of males with disabilities in mental health services and females with disabilities in substance use services.
- Within mental health services, the Hispanic population is less likely to have a disability or co-occurring disorder, stay in treatment as long, or have improvements as high as the non-Hispanic population. Mental health services are also serving a lower proportion of Asian participants than are represented in the state population. These groups were also the most likely to have multiple treatment episodes.
- Within substance use treatment, Asian participants are least likely to have multiple treatment episodes while NHPI and African-American individuals are more likely to have shorter lengths of stay in treatment.
- Among those served in the mental health system, individuals with language considerations were more likely to have only one treatment episode, stay in treatment longer, and show greater improvements.
- Veterans seeking treatment for substance use issues showed higher rates of improvement than non-veterans.

These findings provide an initial snapshot that can be used to identify potential areas for attention, further inquiry and improvement efforts. They also demonstrate the complexity of the relationships among behavioral health service delivery, cultural diversity, and outcomes. The findings are not exhaustive and caution is warranted in drawing definitive conclusions from these analyses, given the limitations of the data as well as considerations around the data monitoring and quality. Similar to national efforts, it will be critical for Colorado to move towards more comprehensive, well-specified data collection and monitoring systems, in order to increase confidence in the use of behavioral health service data to drive policy and practice decisions moving forward.

Potential Action Areas: Behavioral Health Service Data

- Conduct further inquiry to confirm emerging findings, elucidate needs, and guide strategies for addressing potential behavioral health inequities.

    - **Access**: Possible overrepresentation of children and adolescents, females, Hispanic individuals, and AIAN, NHPI and African-Americans within mental health services; and underrepresentation of Asian participants
    - **Service Characteristics**: Differences in number of treatment episodes and length for diverse groups
    - **Behavioral Health Outcomes:** Differing outcomes for adolescents, Hispanic individuals, and AIAN, African-American, and NHPI individuals

- Work with appropriate stakeholders to develop additional measurement, and ensure that data tracking systems and new data integration efforts include data items to assess contextual factors (e.g., social determinants of behavioral health including socioeconomic factors, unique issues associated with geographic variability, etc.) that will facilitate understanding of trends and differences
- Continue focused efforts to improve the completeness and accuracy of mental health and substance use treatment data; ensure that the new data integration efforts and systems include processes to ensure high data quality and facilitate on-going monitoring of needs and emerging concerns
- Set up processes (data reports) to continually analyze behavioral health patterns in relation to population shifts, policy changes, and other contextual factors to monitor trends and pinpoint contributors to change over time

PROJECT FINDINGS PART II: EXPLORING OPTIONS FOR COLORADO'S RESPONSE TO BEHAVIORAL HEALTH EQUITY ISSUES

As outlined above in *Exploring Behavioral Health Equity in Colorado*, a number of areas for further exploration were identified to deepen understanding about the extent and nature of existing behavioral health disparities in Colorado. Even with many remaining questions about the scope of potential inequities throughout the state, both national trends and emerging local patterns warrant a strategic response for improving treatment access, retention and outcomes for diverse populations. OBH invested in this report not only to examine information contained within state mental health and substance abuse data systems, but to draw from field literature, stakeholder perspectives and OBH policy to inform next steps for statewide behavioral health equity efforts.

To guide and frame this work, a scan of the literature was first completed to explore organization-level practices related to cultural responsiveness as a means to address behavioral health disparities. The principal CLAS Standard (*National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care*) states the following:

"Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs."

Colorado providers also supported this standard as nearly all providers (94%) surveyed at the July 2014 OBH Research Forum indicated the belief that access to culturally responsive behavioral health services is a critical challenge in Colorado. The literature scan revealed numerous models and frameworks for advancing cultural responsiveness (Betancourt, Green and Carillo, 2002; Semansky & Goodkind, Sommerfeld and Willging, 2013). While differing language is used across the research in this area, the overarching themes typically aligned across sources. Six primary themes were identified which also closely reflected insights shared by providers and participants receiving services. These overarching themes or strategy areas are listed on the following page and provide the organizing framework for reporting of findings across project methods.

Common Strategy Areas for Advancing Behavioral Health Equity

(1) Organizational Leadership & Policy
Practices and processes that support high-level organizational cultural responsiveness and related infrastructure: leadership investment and communicating the value of the work through the organizational mission; developing a strategic plan; budgeting for cultural competence efforts; developing a committee or advisory group dedicated to the issues; and conducting ongoing organizational policy assessments

(2) Workforce Development & Training
Recruitment and retention of a workforce that reflects the population(s) served; training and professional development related to increasing the cultural responsiveness of providers and staff at all levels

(3) Community Engagement & Partnerships
Practices related to improving relationships and communication with diverse communities; increasing collaborative partnerships to facilitate community consultation and involvement in service design and implementation

(4) Education & Outreach
Efforts to promote community awareness and understanding regarding both behavioral health in general and local services and support

(5) Service Delivery Modifications
Considerations about the way services are provided including: barriers to access; provision of communication and language assistance; service environment; and rapport building, family engagement and peer support

(6) Data Collection & Monitoring
Activities to evaluate the effectiveness of cultural responsiveness efforts including internal organizational self-assessments as well as quality improvement and client satisfaction measures

Key findings from each of the five project methods are incorporated (where appropriate) within each theme in this section of the report: 1) the scan of field literature; 2) the review of OBH policy in relation to national CLAS standards; 3) internal OBH *Cultural and Linguistic Competence Policy Assessment* (CLCPA) data findings; 4) provider insights from the provider survey and focus group; and 5) insights from regional focus groups with participants receiving services. It is critical to note that project findings were shared with Colorado providers and stakeholders who attended the *July 2015 Research Forum*; attendees then engaged in dialogue to contribute to the development of potential action steps and recommendations for OBH. Following a description of key findings below is a brief summary of recommendations in each area, designed to include both short-term actionable items and longer term goals. Some recommendation areas may reflect work that OBH has already initiated; a broad summary of recommendations and current OBH efforts is therefore included in the *Conclusions* section of this report.

Table 7 below provides a snapshot of research methods and key themes included in this section of the report. More detailed summaries of several information sources are included as appendices. For further detail, refer to the full *Methods* section of this report.

Table 7. Key Strategy Areas and Research Methods/Information Sources

Key Themes	*Methods/Information Sources*					
	Literature Scan	*Policy Review: OBH Rules & CLAS Standards*	*Policy Review: OBH Internal Policy Assessment*	*Regional Consumer Focus Groups*	*Provider Survey*	*Provider Focus Group*
Organizational Leadership & Policy	✓	✓	✓		✓	✓
Workforce Development & Training	✓	✓	✓	✓	✓	✓
Community Education & Partnerships	✓	✓	✓	✓		✓
Education & Outreach	✓			✓		✓
Service Delivery Modifications	✓	✓	✓	✓	✓	✓
Data Collection & Monitoring	✓	✓	✓		✓	✓

Key Theme 1: Organizational Leadership & Policy

Leadership direction and formalized policy are required to transform organizational practices, and both of these intersect meaningfully with the other themes presented in this report. For example, policy can be used to influence practices for modifying service interventions, recruiting and retaining staff, and even data collection. Here, we focus primarily on high-level infrastructure and leadership supports that promote cultural responsiveness throughout an organization. Field research emphasizes this as a critical starting point for laying a culturally responsive groundwork and fostering improvements at all levels (The Colorado Trust, 2013; Siegel et al., 2011). In order for organizations to successfully implement policy, that is, translate policy into practice, there needs to be guidance and support from the highest level of leadership that promotes a shift of practices throughout the organization:

"…the development of cultural competence begins at the top level of the organization, with an initial focus on systemic changes" *(SAMSHA, 2014).*

Critical components of *Organizational Leadership and Policy* include the following:

- Leadership Commitment and Organizational Mission
- Strategic Plan and Budget
- Internal Cultural Responsiveness Committee
- Organizational Self-Assessment

Leadership Commitment and Organizational Mission

Field literature emphasizes the importance of both leadership commitment and an organizational mission that reflect and communicate the value of cultural responsiveness. SAMHSA notes that a deep level of agency commitment is necessary to avoid displacement of cultural responsiveness onto clients and counselors, and to ensure meaningful and sustained improvements in service provision. Statements that communicate organizational values, vision and overarching mission provide a "conceptual framework" to guide practice (SAMSHA, 2014). The education of all levels of staff regarding these concepts and relevant policies is also critical.

The National CLAS Standards highlight the critical roles of strong leadership and clear organizational policy (see **CLAS standards 2 and 9**. OBH's rules are in alignment with the national CLAS standards in many areas, communicating that culturally responsive services are valued as well as requisite. However, commitment to upholding the CLAS standards at the OBH and provider levels could be more explicitly communicated in places. These areas are outlined in more detail throughout the remaining themes in this section of the report as appropriate.

Relevant CLAS Standards: Leadership Commitment & Organizational Mission

CLAS Standard 2: Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.

CLAS Standard 9: Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.

Additionally, the CLCPA assessment (completed by OBH in 2013), assessed staff perceptions about organizational mission and general awareness of policy. The commitment to this assessment serves as an indication of OBH leadership investment as well as commitment from staff to assess internal cultural responsiveness.

OBH Mission and Cultural Competence Mission

Mission: We are dedicated to strengthening the health, resiliency, and recovery of Coloradans through quality and effective behavioral health prevention, intervention and treatment.

Cultural Competence Mission: OBH seeks to improve culturally competent behavioral health care; develop stronger links between clients and services, more accurately and effectively meet client needs and improve client outcomes through provider support, to include development of resources, trainings and technical assistance.
www.colorado.gov/cs/Satellite/CDHS-BehavioralHealth/CBON/1251631906221

- Over half (56%) of OBH staff who participated in the CLCPA agreed that the organizational mission statement incorporates cultural and linguistic competence in service delivery, which communicates a high level expression of the value of cultural responsiveness with OBH.
- While many OBH staff were aware of policies, many participants were still not aware of specific OBH policies as they relate to cultural responsiveness. The CLCPA contains 36 items that assess participant awareness of the level of existing policy across specific areas (available response options: 'no policy,' 'informal policy,' 'developing policy,' 'formal policy,' 'I do not know'). A sample item is "Does your agency support a practice model that incorporates culture in the delivery of services?' See *Appendix D* for all policy survey items and response frequencies. Throughout the CLCPA assessment, there was an overall low level of staff awareness of policy related to cultural responsiveness. A range of 37-62% of respondents (across all policy-related survey items) reported not being aware of policy related to specific cultural responsiveness issues.

The separate survey conducted at the *2014 OBH Research Forum* also indicated room for improvement in providers' knowledge of their own organizational policies. While providers reported some awareness of overall organizational policies, this was less the case for policy related to cultural responsiveness: just 65% of surveyed providers agreed or strongly agreed that they were knowledgeable about their organization's policies related to cultural responsiveness; the remaining 35% disagreed they or indicated 'I don't know'. Provider focus group attendees further emphasized the need for more effective implementation of cultural responsiveness and that leadership investment should be demonstrated through the enforcement of relevant policies. Many noted the importance of designating cultural responsiveness as a critical priority due to limited resources and time as well as competing organizational priorities.

Strategic Plan and Budget

Literature emphasizes the importance of allocating financial resources for cultural responsiveness work, along with integrating related activities into the organizational strategic plan. Budgets that indicate specific line items for culturally responsive activities also communicate the work as a priority and allocate specific resources for carrying out critical activities. Additionally, a strategic plan that explicitly outlines goals related to cultural responsiveness and/or development of a cultural responsiveness plan creates necessary accountability to pursue intended changes. Many organizations consider cultural responsiveness activities to be embedded in or woven throughout strategic plans and budgets, but may lack explicit statements and relevant goals that drive the work forward (The Colorado Trust, 2012, 2013; Siegel et al., 2003).

CLAS Standard 2 (also referenced in the *Leadership Commitment and Organizational Mission* section above), emphasizes that health equity should also be promoted through the allocation of organizational resources. OBH invests in a position dedicated to cultural responsiveness work as well as in numerous activities. The review of OBH rules, however, did not reveal explicit language recommending or requiring agencies to designate internal resources to cultural responsiveness work, the amount of or recommended proportion of budget, etc.

Relevant CLAS Standards: Strategic Plan & Budget

CLAS Standard 2: Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources

Provider focus group attendees also indicated challenges with having adequate resources (both time and fiscal resources), to move cultural responsiveness work forward. Several noted the need to explicitly prioritize the work and to designate specific funds for carrying out key activities.

Internal Cultural Responsiveness Committee

Literature underscores the importance of an internal group or committee for sustaining and growing internal commitment to cultural responsiveness work and practices. This group or committee should include individuals from various parts of the organization who are dedicated to the issues and willing to lead related efforts at the organizational level. This group can serve as a leadership entity, assuming responsibility for identifying priority activities, consulting with community, and disseminating information and related guidance throughout the organization (SAMSHA, 2014).

Review of OBH policy and practices revealed that OBH has allocated resources for a permanent leadership position, the Manager of Culturally Informed and Inclusive Programs, as well as two key committees including: Providers for the Advancement of Cultural Competence Network (PACC) and the Cultural Competency Advisory Council (CCAC). Both committees are positioned to guide cultural responsiveness work at the state level and ongoing provider participation demonstrates interest and commitment on behalf of providers throughout the state. (Colorado DHS, OBH, 2015).

Providers who participated in the focus group also noted the critical importance of having a cultural advocacy or responsiveness committee that is committed to the work. They emphasized that key roles of the group would be to guide the internal reflection process and advance key activities, as well as provide support and consultation for staff implementing new practices. This consultation role would provide staff with a safe venue for discussing related questions or challenges, and allow for dialogue about potential solutions.

Organizational Self-Assessment

Once an organization initiates explicit cultural responsiveness efforts, it is vital to commit to ongoing assessment and transparency regarding the effectiveness of these efforts. Promoting open dialogue about progress fosters reflection and learning at all levels of the organization (U.S. DHHS, CDC, 2014).

"Cultural competence demands an ongoing commitment to openness and learning, taking time and taking risks, sitting with uncertainty and discomfort, and not having quick solutions or easy answers. It involves building trust, mentoring, and developing and nurturing a frame of reference that considers alliances across culture as enriching rather than threatening shared goals" *(Journey Mental Health Center, 2015).*

CLAS Standard 15 highlights the importance of transparency by encouraging organizations to share their progress in implementing the CLAS standards. While OBH rules do not explicitly mention this practice, the willingness to openly share policy analysis, learning efforts related to CLAS (e.g., OBH participation in a national learning collaborative) and internal assessment results, are all indicative of an organizational commitment to transparency.

Relevant CLAS Standards
CLAS Standard 15: Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

Provider insights mirrored guidance offered within the literature around reflective processes at the organization level. Provider survey results indicated that 67% of providers agreed or strongly agreed that their organization encourages open dialogue about cultural considerations and responsiveness in service delivery. Still, a large proportion of providers indicated neutrality or disagreement about the level of current open dialogue.

Providers in the focus group noted the importance of organizational assessment and examination of practices at all layers of the organization, from leadership to direct staff and from high level policies (e.g., mission) to policies that may unintentionally create barriers to service access (e.g., requirements for admission, intake procedures that can undermine patient investment or create discomfort, etc.). Providers emphasized the need to create a culture of transparency in which organizations are not fearful of exposing deficits and discussing challenges. Providers also noted the potential benefits of support from OBH for conducting the assessment, interpreting results and helping to determine action steps.

Additional areas of data collection and evaluation are discussed in the *Data Collection and Monitoring* section later in the report.

Potential Action Areas: Organizational Leadership & Policy*

Critical elements of culturally responsive Organizational Leadership and Policy include leadership commitment and mission and vision statements that clearly communicate and prioritize the value of cultural responsiveness; strategic plans and budgets that specify resources for related activities; organizational committees or groups dedicated to working on these issues; and ongoing organizational self-assessment to identify action steps and monitor progress toward goals.

- Potential modifications to OBH rules:
  - Consider explicit language recommending the allocation of internal provider resources to cultural responsiveness work and/or recommendation of a specified proportion of organizational budget as a current gold standard
  - Consider the addition of language that highlights the value of organizational transparency by encouraging providers to share progress in implementing the CLAS standards
- Promote knowledge and awareness of OBH policy at both the organizational (OBH) and provider levels; develop resources that summarize policy, resultant implications and guidance for implementation (e.g., user-friendly/accessible manuals or fact sheets)
- Support learning forums for providers to explore CLAS standards and assess organizational policies that align or conflict with the standards
- Re-administer the CLCPA assessment within OBH and develop long-term administration timeline to explore trends over time; promote a high level of staff participation through leadership support and communication efforts that share the goals for the survey and its role in larger cultural responsiveness efforts
- Foster organizational self-assessment and transparency by continuing to share OBH processes and data findings, and supporting and incentivizing provider-level transparency
- Standardize OBH support for providers administering the CLCPA; offer broad scale training and/or guidance documents for analyzing and interpreting organization-level assessment findings
- Support additional organizational self-assessment efforts by recommending and/or providing consultants with cultural responsiveness expertise who can guide organizations through self-assessment processes and identification of internal cultural responsiveness action plans

*These potential action areas were formulated based on the project findings highlighted above, as well as provider input gathered at the July 2015 OBH Research Forum (note that OBH may already be in the implementation process with some).

Key Theme 2: Workforce Development & Training

Workforce Development

SAMHSA's 2013 workforce report highlighted that racial/ethnic minority individuals account for a low proportion of mental health and substance abuse staff (e.g., 17.5% of social workers; 10% of counselors; 5% of psychologists) (DHHS, 2013), relative to the U.S. population and individuals receiving behavioral health services. According to the most recent 2010 U.S. census data, approximately 30% of the U.S. population belongs to a racial/ethnic minority group. SAMHSA has reported that racially diverse groups comprise about 40% of treatment admissions and this has been consistent over time (SAMSHA, 2011c). Less data are available on additional workforce demographic characteristics such as the proportion of staff representing diverse populations such as individuals with disabilities, LGBT communities, etc.

As with organizational policy, literature again cites the critical importance of leaders in supporting and guiding efforts to recruit and retain diverse staff. Several studies have indicated that managerial/leadership support of diversity-focused recruitment efforts and knowledge about the populations served are associated with more effective recruitment and retention efforts (Guerrero, 2010). SAMSHA further emphasizes that staff diversification efforts can be ineffective when focused only on short-term recruitment strategies and must involve a sustainable and comprehensive approach that includes marketing, mentoring programs, training, support networks and educational assistance (SAMSHA, 2014).

Research examining consumer perspectives on effective service provision indicates that participants receiving services commonly want to see their communities reflected in service provider organizations (Guerrero et al., 2011, 2012). Colorado consumers who participated in focus groups also noted the importance of feeling that staff understand and can identify with their community, and have some level of shared experience and cultural background. They also noted that identifying with their service providers helps them to feel welcome, comfortable and as if they "belong" in treatment, i.e., that treatment is intended for their communities versus only majority groups.

Staff diversity was cited as a priority in both consumer and provider focus groups; both participant groups also shared that a critical challenge in current service provision is a lack of diverse staff who reflect the communities served. Providers shared that cultural and linguistic responsiveness is a critical skill that should be incentivized through compensation for bilingual staff or those with extensive training and experience working with diverse populations. Providers indicated recruitment and retention of diverse staff to be among their top organization-level challenges.

CLAS Standard 3 supports the promotion of a diverse workforce at all levels, in order to be responsive to the local population. The review of OBH rules did not reveal specific policy or guidance regarding practices to recruit and retain a culturally diverse workforce.

Relevant CLAS Standards

CLAS Standard 3: Recruit, promote and support a culturally and linguistically diverse governance, leadership and workforce that are responsive to the population in the service area.

The Human Resources section of the CLCPA tool also assesses organizational representation of culturally and linguistically diverse staff, and OBH staff perceived some shortfalls in this area. While 82% of OBH respondents indicated that members of 'some' culturally diverse groups are represented on agency staff, 91% reported 'none' when asked about culturally and linguistically diverse individuals in specific key positions within the agency (e.g., board members). Relevant CLCPA assessment items are presented in Table 8 below.

Table 8. Relevant Cultural and Linguistic Competence Policy Assessment Items

	Item N	None	Some	Quite a few	Many
Are members of culturally diverse groups represented on the staff of your agency?	22	---	81.8%	13.6%	4.5%
Does your agency have culturally and linguistically diverse individuals such as: board members, center directors, senior management, physicians, clinical staff, administrative staff, clerical staff, support staff, consultants, or volunteers?	22	90.9%	---	4.5%	4.5%
	Item N	**Yes**		**No**	
Does your agency have procedures to achieve the goal of a culturally and linguistically competent workforce that includes staff recruitment, hiring, retention, promotion?	20	30%		70%	

Workforce Training

Given the need for increased diversity in the behavioral health workforce, training for the current workforce in the provision of culturally responsive services is even more critical (Anderson et al., 2003). The literature emphasizes an ongoing commitment to staff development in this area as vital to improving the cultural responsiveness of service provision. Training plans should not consist of a sole requirement that can be completed at a single time point but rather a continual professional development investment that evolves over time. Further, the designation of cultural responsiveness training as an expectation and requirement for staff at all levels is imperative (Siegel, Haugland, & Chambers, 2003; Guerrero, 2010). Training can consist of lectures, videos, role plays, case study discussions, dialogue sessions, ongoing supervision, and mentorship and additional learning opportunities. All can serve to increase provider self-awareness about one's own cultural beliefs and views toward others, knowledge and communication skills (Anderson et al., 2003).

CLAS Standard 4 enforces ongoing education and training related to cultural and linguistic responsiveness for staff at all levels. The review of OBH rules indicated that policy generally promotes staff training, particularly for services within specific populations. There were several areas of the rules related to personnel training, however, in which cultural responsiveness training could be more explicitly mentioned.

Relevant CLAS Standards

CLAS Standard 4: Educate and train governance, leadership and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

The Human Resources section of the CLCPA also assesses the extent and nature of staff training efforts related to cultural responsiveness. Although well over half of OBH staff indicated that 'some' resources support regular professional development for staff at all levels, over three-quarters of staff reported that there are no incentives for the improvement of cultural or linguistic competence. Further, nearly half indicated no training activities for culturally and linguistically competent health care are conducted. Relevant items are highlighted in Table 9 below.

Table 9: Relevant Cultural and Linguistic Competence Policy Assessment Items

	Item N	None	Some	Quite a Few	Many
Are there resources to support regularly scheduled professional development and in-service training for staff at all levels for the agency?	22	9.1%	68.2%	13.6%	9.1%
Does your agency have incentives for the improvement of cultural competence throughout the organization?	22	77.3%	18.2%	---	4.5%
Does your agency have incentives for the improvement of linguistic competence throughout your organization?	22	86.4%	9.1%	4.5%	---
Are in-service training activities on culturally competent health care (e.g., values, principles, practices, and procedures) conducted for staff at all levels of the agency?	22	45.5%	45.5%%	9.1%	---
Are in-service training activities on linguistically competent health care (e.g., Standards ADA mandates) conducted for staff at all levels of agency?	22	45.5%	50.0%	4.5%	---

Providers also placed great emphasis on the need for consistent and ongoing staff training and professional development opportunities through their responses to the quantitative and qualitative items on the Provider Survey, as well as within the PACC Network focus group. The lowest rated item on the Provider Survey related to training needs, with nearly half (44.1%) of provider respondents indicating they either disagreed or strongly disagreed that their organization provides adequate staff training.

Participants receiving services further highlighted the need for ongoing staff training to increase understanding of unique consumer experiences and backgrounds, promote equitable treatment across

consumers, and also to prevent staff "burnout" and its impacts on service provision. They suggested training and services for staff to recognize signs of burnout and to help staff feel continuously renewed and passionate about their work.

Potential Action Areas: Workforce Development & Training*

Workforce Development and Training involves a focus on the recruitment and retention of diverse staff who reflect the communities served by the organization, as well as workforce training at all levels in the provision of culturally responsive services. Training efforts should be viewed as a long-term investment in growing workforce skills and knowledge; key training areas include ongoing supervision/mentorship and professional development opportunities as well as formal training events.

- Potential modifications to OBH rules:
  - Consider the addition of specific policy regarding recommended provider practices to recruit and retain a culturally and linguistically diverse workforce, reflective of local populations served
  - Ensure that policy communicates clear expectations related to staff training and professional development; explicitly note culturally responsive training across all areas of the OBH rules (currently included in some rules)
- Implement internal workforce diversification efforts, and share learnings and progress
- Formalize a long-term strategic approach to OBH training offerings that considers a range of content areas and organizational readiness factors (e.g., a tiered approach to training)
- Ensure that key training opportunities are geographically accessible; explore and utilize technology-based approaches to increasing access for rural communities (e.g., Webinars, other online or computer-based training, etc.)
- Offer OBH leadership presence at training events to generate buy-in and communicate the value of cultural responsiveness training
- Standardize an approach to disseminating information about cultural responsiveness trainings and professional development opportunities (e.g., develop an online calendar or resource board; increase use of KONA social collaboration site, etc.); create or modify an existing web-based system or online database that lists recommended training materials, courses, potential community speakers and consultants
- Consider incentives for provider participation in training and for enhancing processes and structures to achieve workplace diversity benchmarks

*These potential action areas were formulated based on the project findings highlighted above, as well as provider input gathered at the July 2015 OBH Research Forum (note that OBH may already be in the implementation process with some).

Key Theme 3: Community Engagement & Partnerships

A great deal of current field research discusses practices related to engaging the community in designing and implementing programs. Community engagement has been defined as*: **"the process of working collaboratively with and through groups of people affiliated by geographic proximity, special interest, or similar situations to address issues affecting the well-being of those people"** (CTSA, 2011).* Literature emphasizes that without support and feedback from the community, services and supports will be ineffective in meeting community needs and priorities (Virginia DBHDS, n.d.).

"If health is socially determined, then health issues are best addressed by engaging community partners who can bring their own perspectives and understandings of community life and health issues to a project. And if health inequalities are rooted in larger socioeconomic inequalities, then approaches to health improvement must take into account the concerns of communities and be able to benefit diverse populations" *(CTSA, 2011).*

Different levels of community involvement can be considered based on organizational and community readiness and include a continuum of outreach, consultation, involvement, collaboration, and finally, shared leadership. Seeking community engagement and consultation has been emphasized in all areas of organizational functioning from policy development and program planning to service delivery, quality improvement, hiring and staff retention, staff professional development, etc. (Kagawa-Singer & Kassim-Lakha, 2003; Vandevelde, Vanderplasschen, & Broekaert, 2003).

CLAS standard 13 promotes community partnerships in all aspects of service provision. The review of OBH rules indicated that more explicit guidance and optimal standards could be added, specific to the level and nature of community engagement expected both internally and of providers.

Relevant CLAS Standards

CLAS Standard 13: Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.

The CLCPA tool also assesses the extent to which organizations involve community in their work.

- Over half of OBH staff surveyed indicated that the agency either 'sometimes' or 'regularly' conducts tailored activities to engage culturally diverse communities. When asked about the engagement of specific individuals, groups, or entities, however, responses ranged considerably. For example, human services agencies were indicated as 'regularly' engaged more than any other community group or entity. Still, 42% of OBH respondents reported that human services agencies are either 'sometimes' or 'regularly' engaged, while remaining participants reported these agencies are either 'seldom' (42%) or 'never' (nearly 16%) engaged. Further, many community groups or entities had substantially lower ratings; for example, half or more of OBH respondents reported that traditional healers or local business owners are 'never' engaged. Table 10 below highlights relevant CLCPA items.

Table 10. Relevant Cultural and Linguistic Competence Policy Assessment Items					
	Item N	**Never**	**Seldom**	**Sometimes**	**Regularly**
Does your agency conduct activities tailored to engage culturally diverse communities?	21	9.5%	33.3%	33.3%	23.8%
Does your agency reach out to and engage the following individuals, groups, or entities?					
Places of worship (e.g., temples, churches, kivas) and clergy, ministerial alliances, or indigenous religious or spiritual leaders?	21	23.8%	23.8%	33.3%	19.0%
Traditional healers (e.g., medicine men or women, curanderas, espiritistas, promotoras, or herbalists)?	20	50.0%	25.0%	20.0%	5.0%
Mental health providers, dentists, chiropractors, or licensed midwives?	19	31.6%	21.1%	26.3%	21.1%
Providers of complementary and alternative medicine (e.g., homeopaths, acupuncturists or lay midwives)?	20	50.0%	35.0%	10.0%	5.0%
Ethnic publishers, radio, cable, or television stations or personalities or other ethnic media sources?	21	28.6%	33.3%	23.8%	14.3%
Human service agencies?	19	15.8%	42.1%	5.3%	36.8%
Tribal, cultural or advocacy organizations?	21	4.8%	33.3%	42.9%	19.0%
Local business owners such as barbers/cosmetologists, sports clubs, restauranteurs, casinos, salons, and other ethnic businesses?	20	55.0%	30.0%	5.0%	10.0%
Social organizations (e.g., civic/neighborhood associations, sororities, fraternities, ethnic associations)?	20	30.0%	45.0%	15.0%	10.0%

Providers who participated in focus groups also noted the importance of seeking partnerships and consultation related to the provision of culturally responsive services. Additionally, providers emphasized the utility of cross-system collaboration for engaging partners in community approaches to problem resolution, utilizing cooperative strategies for outreach and referral processes, and sharing successful culturally responsive practices and strategies. As stated by The Centers for Disease Control and Prevention (CDC):

"a healthy community has well-connected, interdependent sectors that share responsibility for recognizing and resolving problems and enhancing its well-being" *(CSTA, 2011).*

Providers expressed that cross-system collaboration also facilitates understanding of services offered by other organizations and overall networking that enhances cooperative efforts. A critical consideration cited by providers was that of reaching providers who may not be engaged in formal networks and the need to consider multiple engagement strategies.

Potential Action Areas:
Community Engagement & Partnerships*

Community Engagement and Partnerships involves an intentional focus on cultivating community partnerships and seeking community consultation to inform the design and implementation of programming. This can include both formal and informal cross-provider collaborations as well as fostering meaningful engagement from diverse community groups in the planning and provision of services.

- Potential modifications to OBH rules:
  - Consider the addition of more explicit language and standards regarding the nature and level of community engagement expected of providers
- Pursue more formalized community partnerships to ensure community perspectives, input and recommendations are incorporated into the planning and implementation of services
- Allocate resources for the promotion of cross-system collaboration through networking, training and education events; include strategies for engaging partners who may not be connected with typical networks
- Promote use of collaborative systems (e.g., Linking Care) to enhance information-sharing and streamline referral processes across providers
- Encourage organizational assessment of relevant CLCPA items listed above to assess strength of community partnerships; require and/or incentivize inter-agency MOUs or formally documented partnerships
- Invest in larger qualitative efforts to engage participants receiving services in long-term state plan to improve cultural responsiveness and reduce behavioral health disparities

*These potential action areas were formulated based on the project findings highlighted above, as well as provider input gathered at the July 2015 OBH Research Forum (note that OBH may already be in the implementation process with some).

Key Theme 4: Education and Outreach

As discussed above in *Community Engagement & Partnerships*, some literature considers outreach as a part of community engagement. However, Colorado providers and consumers alike placed a great deal of emphasis on specific community education efforts. This was described as community education regarding behavioral health issues in general as well as about services offered, with the aim of improving overall access to services. The literature highlights that utilization of services can be impacted by a myriad of factors including cultural and familial factors (e.g., beliefs about treatment) referrals, networks and availability of services (Hernandez et al., 2009; Siegel et al., 2011b).

Providers and participants receiving services noted that efforts to share general information about behavioral health were also needed to promote awareness of mental health and substance abuse in general, improve rapport and relationships with the community, correct misperceptions about services, combat stigma, and promote help-seeking behavior. Further, they noted that information is required about the type and nature of services offered, promoting participant understanding of treatment processes and easing concerns about seeking treatment.

The CLCPA assessment completed by OBH staff revealed some disagreement about the use of culturally responsive resource materials to share health-related information with diverse communities; just over a quarter of OBH staff felt that the agency does this 'very often' or 'fairly often' while 60% indicated 'sometimes' and nearly 14% 'not at all' (See Table 12 below).

Table 12. Relevant Cultural and Linguistic Competence Policy Assessment Items

	Item N	Not At All	Sometimes	Fairly Often	Very Often
Does your agency use resource materials (including communication technologies) that are culturally and linguistically appropriate to inform diverse groups about health related issues?	22	13.6%	59.1%	13.6%	13.6%

General Behavioral Health Information

Both providers and participants receiving services highlighted the significance of community and/or culture-based beliefs and stigma related to mental health and substance abuse. Participants receiving services shared that there can be deeply rooted shame related to seeking formal treatment; some noted that behavioral health services are often considered a "last resort," due to beliefs that services only include the most intensive/extreme options such as inpatient hospitalization. Both providers and participants shared that state efforts should focus on educating communities and families about the importance of pursuing support early in the process and options to do so, to prevent the worsening of related problems.

Service Information

Participants receiving services also shared insights about the lack of trust that communities may have toward service providers or systems. They reported that this often stems from prior negative experiences, what they may hear from other community members (which may involve some truths, as well as long-standing community myths), and fear of systems in general. Some also shared experiences about being declined services because of failure to meet eligibility criteria or being unaware about the specific service options available. Participants recommended efforts to promote general awareness regarding the availability and types of services (from community education efforts to inpatient and outpatient services of all kinds); information about what services entail (i.e., what participants may expect for certain types of services); and eligibility criteria for services (e.g., insurance and residence requirements; symptom severity and presentation, etc.).

In terms of methods for community education, participants receiving services noted that they often receive information more effectively through peers and fellow community members, from initial treatment access to successfully engaging in treatment. Participants recommended utilizing small group, peer-to-peer approaches. Providers suggested small groups in libraries, schools or other popular community facilities to reach a broad range of community members at once. The literature also notes

that outreach should include both formal and informal approaches through media, community leaders and organizations (SAMSHA, 2014).

Potential Action Areas: Education & Outreach*

Community education and outreach efforts were strongly emphasized by the Colorado providers and participants receiving services who participated in this project. This encompassed community education regarding behavioral health issues, as well as the availability and nature of local behavioral health systems and services. Education and outreach are vital to increasing access to needed services which can be highly influenced by community or familial beliefs and experiences.

- Develop issue briefs or community education materials that providers can utilize to disseminate information about critical behavioral health issues to local communities
- Conduct or support local needs assessments that assess local knowledge related to behavioral health and community perceptions of key behavioral health issues
- Identify and promote provider awareness regarding relevant funding opportunities (e.g., federal initiatives through Health and Human Services or SAMHSA's Center for Substance Abuse Treatment) for outreach-related efforts

*These potential action areas were formulated based on the project findings highlighted above, as well as provider input gathered at the July 2015 OBH Research Forum (note that OBH may already be in the implementation process with some).

Key Theme 5: Service Delivery Modifications

The literature discusses service delivery modifications in numerous ways, the most expansive area being specific treatment interventions and assessment tools that have an established or growing evidence base with diverse populations. While research remains limited in this area, there is increasing recognition of the need to identify culturally responsive treatment interventions that have evidence of effectiveness with diverse populations. SAMSHA (2014) outlines numerous approaches and interventions and resources for treatment of diverse populations in, "*Improving Cultural Competence: Treatment Improvement Protocol* (TIP). The University of Denver, Graduate Psychology Department also drafted a compilation of treatment interventions and assessment tools in 2014 titled *Evidenced-based Practice with Diverse Populations: An Assessment and Treatment Review* (Contact Jane Flournoy at OBH for more information).

Rather than attempting to summarize the wide range of work in the area of treatment interventions, this report identifies several broad considerations and general approaches for service provision with diverse populations. The considerations outlined below were prevalent in the literature and were also raised by Colorado's providers and participants receiving services who took part in the focus groups. All reflect a general client-centered approach which requires ongoing modification or tailoring of services

for individuals as appropriate, versus periodic changes in practice. Key consideration areas include the following:

- Access Considerations
- Provision of Communication and Language Assistance
- Service Environment
- Rapport Building, Family Engagement and Peer Support

Access Considerations

First, the literature emphasizes that organizations lacking consciousness of cultural issues can fail to identify barriers to access that diverse groups may face (SAMHSA, 2014). Participants receiving services and providers alike shared at length about organizational approaches that can inhibit treatment access. Specific issues mentioned included the following:

- Limited information regarding processes for accessing treatment: many participants receiving services noted they either lacked information or had misinformation about how and where to access treatment, eligibility requirements, costs for treatment, etc. They also noted specific restrictions that had prevented their access to treatment at an earlier stage of illness. For example, many mentioned the challenges they faced in identifying a substance abuse treatment program that would accept clients before the problem had reached a certain level of severity. Several participants reported being turned away or sent to a different facility after a difficult journey finding the resources to seek help.
- Providers and participants receiving services reported that transportation issues and distance of facilities were common barriers to accessing services as well.
- Both providers and consumers shared that ongoing assessment of community barriers to access could increase provider awareness of access issues and inform responses.

Provision of Communication and Language Assistance

The literature stresses the importance of quality language and communication services and that interpreters and translators must also understand cultural nuances that can affect the meaning of language (Anderson et al., 2003). **CLAS Standards 5-8** require linguistically responsive services and language assistance as expected service delivery modifications when appropriate. The review of OBH rules revealed that these expectations are noted throughout but inconsistently applied across all relevant sections.

Relevant CLAS Standards

CLAS Standard 5: Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
CLAS Standard 6: Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
CLAS Standard 7: Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
CLAS Standard 8: Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

The CLCPA tool assesses the effectiveness of language assistance. Relevant items are highlighted below and indicate that OBH translation of materials is widely practiced; 75% of OBH staff indicated that the agency 'sometimes' or 'regularly' translates critical information into other languages. Further, nearly half of OBH staff agreed that the agency 'sometimes' or 'regularly' informs consumers about their rights to language assistance. Still, some key areas related to use of trained translation personnel and evaluation of translation quality were rated lower (see Table 13 below).

Table 13. Relevant Cultural and Linguistic Competence Policy Assessment Items

	Item N	Never	Seldom	Sometimes	Regularly
Does your agency inform consumers of their right to language access services under *Title VI of the Civil Rights Act of 1964* and as required by the CLAS Standards 4-7 Federal mandates for language access?	21	42.9%	9.5%	14.3%	33.3%
Does your agency translate and use patient consent forms, educational materials, and other information in other languages?	20	15.0%	5.0%	55.0%	25.0%
Does your agency use any of the following personnel to provide interpretation services: certified medical interpreters, trained medical interpreters, sign language interpreters?	21	47.6%	28.6%	19.0%	4.8%
Does your agency evaluate the quality and effectiveness of interpretation and translation services it either contracts for or provides?	21	47.6%	33.3%	9.5%	9.5%

Providers and participants receiving services also emphasized the importance of language accommodations. Consumers reported fear in seeking information about treatment and pursuing treatment in general, when they were uncertain about the availability of interpretative assistance.

Providers' recommendations that staff be incentivized for having language skills needed for diverse populations underscore the critical nature of language accommodations.

Service Environment

In addition to language considerations, the literature discusses a wide range of practices that help to create culturally relevant environments for participants receiving services. These can include translated materials as mentioned above (e.g., posters, signs, etc.), physical accessibility of the space, magazines, décor, and other materials that reflect the interests of local communities. It is important to note that these examples should never serve as a standalone strategy for improving overall cultural responsiveness. Any potential modifications to the service environment are only meaningful when part of a much larger, more comprehensive approach (SAMHSA, 2014; Siegel, et al, 2011).

OBH CLCPA results (see Table 14 below) indicate that over half of staff respondents agreed the agency makes an effort to post signs and materials in languages other than English. In terms of having work environment décor reflective of diverse groups in service areas, the majority of staff (84%) indicated 'barely' or 'not at all.' While it is important to closely examine all areas of the CLCPA assessment to gather a comprehensive picture of organizational cultural responsiveness, it is also important to note here that the majority of survey respondents were OBH staff working in administrative offices (which participants receiving services are less likely to access and utilize).

Table 14. Relevant Cultural and Linguistic Competence Policy Assessment Items

	Item N	Not at All	Barely	Fairly Well	Very Well
Does your work environment contain décor reflecting the culturally diverse groups in your service areas?	25	32.0%	52.0%	12.0%	4.0%
	Item N	**None**	**Some**	**Quite a Few**	
Does your agency post signs and materials in languages other than English?	26	15.4%	11.5%	42.3%	

Rapport Building, Family Engagement and Peer Support

Providers, participants receiving services, and the field literature all highlighted the significance of building trust and rapport between service provider and participant. Because so many providers may differ from their clients in terms of race/ethnicity, socioeconomic status and many other potential demographic characteristics, it is important to acknowledge the existence of difference and the possible factors impacting participant trust. Providers should foster open communication and acknowledge potential trust issues, to empower participants to share openly about issues that may influence the treatment relationship (Seigel et al., 2011b; Ngo-Metzger et al., 2006). Provider and consumer focus groups alike noted the power of this process in establishing a foundation for effective treatment and services.

Finally, family engagement and peer support were both critical areas mentioned as part of individualized services and potential treatment modifications. Well over half (62%) of OBH CLCPA survey respondents

felt that there are efforts to connect participants receiving services with their own natural support networks (see Table 15 below).

Table 15. Relevant Cultural and Linguistic Competence Policy Assessment Items

	Item N	Never	Seldom	Sometimes	Regularly
Do you connect consumers to natural networks of support to assist with health and mental health care?	21	9.5%	28.6%	47.6%	14.3%

While the literature and providers emphasized the importance of family engagement, focus group participants noted that peer support may be even more critical in many cases. They shared that a range of factors can determine whether family involvement in treatment will be seen as supportive and beneficial. For example, cross-generational differences in views on mental health and substance abuse as well as help-seeking behavior can negatively impact participant relationships with their families during the treatment process. Participants receiving services instead highlighted the need to integrate more peer support, more trained peer advocates and more overall involvement from peers who have shared backgrounds and experience (e.g., speakers, treatment mentors, etc.). The conflicting insights shared in this area again highlight the need for an individualized approach to service provision. Providers should maintain awareness that needs and desires for peer and family support differ significantly across consumers, and connections with natural support networks should be sought on an individual basis.

Potential Action Areas: Service Delivery Modifications*

Service Delivery Modifications, in the context of this report, aims to identify broad considerations and general approaches for service provision with diverse populations. All reflect a general client-centered approach which requires ongoing modification or tailoring of services for individuals as appropriate.

- Potential modifications to OBH rules:
  - Consider revisions to rules in all areas in which culturally and linguistically responsive language and communication is not explicitly noted
  - Ensure policy regarding language provisions for informed consent and any information to individuals receiving services
- Expand the promotion of the use of evidence-based service delivery practices through training, information and resources dissemination; include specific training elements on rapport building as well as family engagement and peer support
- Ensure that formal policy requires up-to-date information regarding best practices; any resultant recommendations for use of evidence-based practices by providers should consider validation with specific population(s) of interest

*These potential action areas were formulated based on the project findings highlighted above, as well as provider input gathered at the July 2015 OBH Research Forum (note that OBH may already be in the implementation process with some).

Key Theme 6: Data Collection & Monitoring

A final key theme involves the collection of data. While areas of improvement for state-level data collection are detailed in the *Exploring Behavioral Health Equity* section of this report, key considerations regarding organizational self-assessment and agency-level quality improvement measures are discussed here. All of evaluation components should work in conjunction to assess cultural competence efforts and their potential impact on service outcomes and equity for all consumers (Bhui, et al., 2007; Olavarria, et al., 2008).

First, **CLAS Standards 10-12** promote the use of data to evaluate CLAS-related and ongoing quality improvement activities, inform the delivery of culturally responsive services and monitor health equity and outcomes as a whole. OBH rules consistently mention cultural and linguistic considerations and appropriate policy as related to evaluation activities and data collection approaches. However, there is currently no requirement of provider organizations to evaluate compliance with CLAS standards or conduct any internal evaluation processes.

Relevant CLAS Standards

CLAS Standard 10: Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities

CLAS Standard 11: Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery

CLAS Standard 12: Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area

The CLCPA tool also assesses the consideration of cultural and linguistic differences when developing organization-level quality improvement processes; 40% of OBH staff participants reported the agency does this 'fairly' or 'very' well, with over half reporting 'barely' or 'not at all' (see Table 16 below).

Table 16. Relevant Cultural and Linguistic Competence Policy Assessment Items

	Item N	Not At All	Barely	Fairly Well	Very Well
Does your agency consider cultural and linguistic differences in developing quality improvement processes?	25	16.0%	44.0%	28.0%	12.0%

Provider focus group participants and attendees at the 2015 OBH forum shared interest in streamlining quality improvement processes (including client satisfaction measures) across agencies to ensure that the cultural responsiveness of services is adequately assessed. Providers also discussed that ongoing assistance with internal organizational assessment processes would be highly beneficial to monitoring

the progress of agency-level cultural responsiveness efforts (discussed in more detail within the *Organizational Leadership and Policy* section above*).*

Finally, providers strongly emphasized the need to have real-time access to client-level service data housed within the state systems, in order to reflect on populations served and outcomes within their own communities (statewide data collection efforts are discussed in more detail within *Findings Part I: Exploring Health Equity in Colorado*).

Potential Action Areas: Data Collection and Monitoring*

Data Collection and Monitoring as related to addressing behavioral health disparities, includes considerations about quality improvement measures; organizational self-assessment; and access to agency- or community-level service data (currently housed in state data systems).

- Consider long term plan to enhance evaluation capacity and sustainability at the provider level
- Continue to promote the use of organizational self-assessment tools (discussed further in the *Organizational Leadership and Policy* potential action areas)
- Identify a pool of recommended quality improvement measures at the provider level (e.g., measures of client satisfaction)
- Support providers in obtaining access to provider-level and community/regional-level data on an ongoing basis; assist with the interpretation of data and its implications for service provision

*These potential action areas were formulated based on the project findings highlighted above, as well as provider input gathered at the July 2015 OBH Research Forum (note that OBH may already be in the implementation process with some).

Conclusions

OBH commissioned this exploratory behavioral health equity report for the state of Colorado in recognition of existing disparities in behavioral health access, treatment retention and outcomes across diverse populations. Key goals of this work included broadening understanding of the issue of behavioral health equity in Colorado; and exploring potential responses to the issue, specifically those related to culturally responsive best practices for engaging, retaining and serving clients across cultural backgrounds.

This report is considered a preliminary step in exploring and addressing potential behavioral health disparities statewide and is intended to serve as a framework for identifying priority areas for action. As outlined in the introduction, the information in this report should be used for the following purposes:

- Generating dialogue among key behavioral health systems and service providers to: 1) promote transparency and open discourse about equity issues; and 2) identify appropriate action steps
- Identifying priorities for OBH action at the organizational policy level, and in support of providers statewide
- Enhancing the quality of ongoing data collection efforts to monitor disparities over time
- Informing related policy change efforts

Key recommendations were outlined in the corresponding sections of the report and included the following:

- **Provider training**, including information dissemination efforts, provision of standardized trainings and recommendation of training consultants
- **Provider technical assistance**, including guidance regarding organizational self-assessment and learning related to implementation of CLAS standards, as well as recommended quality improvement and client satisfaction measures
- **Community outreach, education and collaboration efforts** including the dissemination of general behavioral health information to build awareness and reduce stigma; and community partnership building activities to increase community engagement and enhance cross-provider collaboration and information sharing
- **Modifications to OBH rules** to more explicitly communicate the value of culturally responsive practices and/or share ideal standards and best practices
- **Continued promotion of transparency and dialogue** through OBH sharing of internal culturally responsive effort learnings; enhancement of knowledge regarding OBH policy

Findings from this report were presented at OBH's July 2015 Research Forum, attended by 60 providers. Following the presentation of findings, attendees engaged in dialogue regarding the key report themes and identified priorities as well as specific strategies that OBH could apply to support providers statewide. Where relevant, findings from this session were summarized in each *Potential Action Area*

section of this report. In Table 17 below, key themes are again outlined, with corresponding provider priority ratings. It is important to again note that some potential action areas may reflect work that OBH has already initiated; a summary of related OBH efforts therefore follows.

Table 17. Key Report Themes and Corresponding Priority Ratings

Key Report Theme	*2015 OBH Forum Priority Ratings**
Workforce Development & Training	21 mentions (16 rated as 1st or 2nd priority)
Organizational Leadership & Policy	17 mentions (14 rated as 1st or 2nd priority)
Service Delivery Modifications	13 mentions (7 rated as 1st or 2nd priority)
Data Collection & Monitoring	12 mentions (10 rated as 1st or 2nd priority)
Education & Outreach	10 mentions (6 rated as 1st or 2nd priority)
Community Engagement & Partnerships	7 mentions (3 rated as 1st or 2nd priority)

*Forum attendees were asked to select and rate their top three priority action areas among the six key report themes.

Planned follow-up steps from this report include OBH review of potential action areas considering the priorities identified in Table 17 above. Discussions and decisions about next steps should continue to include key provider and stakeholder groups such as the CCAC (Cultural Competency Advisory Council) and PACC (Providers for the Advancement of Cultural Competence) networks.

CURRENT OBH CULTURAL RESPONSIVENESS EFFORTS

OBH has initiated a range of activities related to improving the cultural responsiveness of behavioral health services statewide, including some that are reflected in the potential action areas. The potential action areas listed throughout the report may therefore reflect areas for OBH to sustain or expand work already in progress. Many providers who took part in data collection efforts for this project emphasized the role of OBH serving as a model for best practice statewide.
Current OBH cultural responsiveness efforts include, but may not be limited to, the following:

- **Cultural Competence Advisory Council**
  This group assists OBH with the "elimination of disparities in behavioral health outcomes through advisement of effective changes in policy, procedure and accountability by infusion of culturally and linguistically responsive and inclusive practices in behavioral health services" (OBH, 2015).
- **Providers for the Advancement of Cultural Competence (PACC) Network**
  Regional quarterly provider meetings, serving as "open forums in which providers and OBH can communicate about OBH activities related to cultural competency, as well as provider efforts, challenges, solutions and ideas about the current needs of their community, specific to culturally competent behavioral health care" (OBH, 2015).

- **Provider Training**
  OBH provides training related to cultural responsiveness in a range of key content areas, including the development of the "Culturally Informed Treatment" curriculum which is integrated into the state Certified Addictions Counselor training program. Additional training areas include:
    - Cultural Considerations for Behavioral Health Providers
    - Working with the Offender Culture
    - Considering the Impact of Generational Culture on Behavioral Health Practices
    - Military Culture
    - Stigma Across Culture
- **Information Dissemination**
  OBH shares information with providers and its networks about a wide range of trainings, forums, events, publications and other resources related to cultural responsiveness. OBH also disseminates critical information about key SAMHSA publications and guidance (e.g., TIP 59: *Improving Cultural Responsiveness: A Treatment Improvement Protocol)*
- **Organizational Assessment Technical Assistance**
  Upon request, OBH has offered *The Cultural and Linguistic Competence Family Organization Assessment (CLCFOA)* as well as the *Cultural and Linguistic Competence Policy Assessment (CLCPA)* for providers, and has assisted with the interpretation of results and identification of potential organization-level action areas.
- **CLAS Learning Collaborative**
  OBH is an ongoing participant of the national CLAS Learning Collaborative, a group of 15 states dedicated to sharing effective strategies and learnings for effective implementation of the CLAS standards (National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care)
- **Refinement of OBH Rules**
  OBH has committed to ongoing rule revisions to include clear guidance for behavioral health providers on definitions and record components designed to promote cultural responsivity; this affects designated mental health agencies and licensed SUD agencies due to required adherence to OBH Rules
- **Strategic Planning Efforts**
  OBH has partnered with both Colorado Mental Health Institutes to ensure cultural responsivity for individuals receiving services
- **Data Integrated Tool**
  OBH is undergoing a comprehensive change process to combine the state mental health (CCAR) and substance use (DACODS) system into one web-based data collection system that spans the entire behavioral health system, better integrates with health care professionals and other entities, and improves the nature and quality of client service data collected over time.

- **Community Education Efforts**
  The Cultural Competency Advisory Committee identified "Destigmatizing Behavioral Health Services Across Cultures" as a key area of priority work; next steps are to be determined
- **Research Partnerships**
  In addition to funding this Behavioral Health Equity Report, OBH has partnered with University of Denver to complete reviews of OBH policy in relation to National CLAS standards and *Evidenced-based Practice with Diverse Populations: An Assessment and Treatment Review*

ADDITIONAL RESOURCES PROMOTED BY OBH

OBH promotes the following resources for efforts related to improving the cultural responsiveness of statewide behavioral health services.

National Resources

- National Center for Cultural Competence
  - http://nccc.georgetown.edu/
- U.S. Department of Health and Human Services
  - http://www.childwelfare.gov/systemwide/cultural/services/mental.cfm
  - http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15
  - http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=3&lvlid=539
- The Dana Foundation
  - http://www.dana.org/news/cerebrum/detail.aspx?id=31364
- National Prevention Information Network
  - http://www.cdcnpin.org/scripts/population/culture.asp
- Office of Mental Health and Health Disparities
  - http://www.cdc.gov/omhd/amh/factsheets/mental.htm
- Mental Health America
  - http://www.mentalhealthamerica.net/go/action/policy-issues-a-z/cultural-competence
- American Psychological Association Guidelines for Psychological Practice with Lesbian, Gay, and Bisexual Clients
  - http://www.apa.org/pi/lgbt/resources/guidelines.aspx
- National Interpretation Certification Bodies:
  - http://www.certifiedmedicalinterpreters.org
  - http://www.cchicertification.org/
- National Council on Interpreting in Health Care
  - http://www.ncihc.org
- American Translators Association
  - https://www.atanet.org/
- Community Engagement
  - http://www.atsdr.cdc.gov/communityengagement/pdf/PCE_Report_508_FINAL.pdf

State Resources

- Colorado Office of Behavioral Health
    - OBH Cultural Competence and Behavioral Health
- Office of Health Disparities
    - http://www.cdphe.state.co.us/ohd/
- State of Colorado
    - http://www.colorado.gov/cs/Satellite/Best-Practices-V2/BPV/1216461738872
- Cultural Competency Consulting
    - http://www.culturalcompetencyconsulting.com/about_us.htm
- The Colorado Trust
    - http://www.coloradotrust.org/online-publications/additional-programs/equality-in-health-an-annotated-bibliography-with-resources-on-health-disparities-and-cultural-and-linguistic-competency/cultural-and-linguistic-competency-assessment-tools-performance-measurement

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Appendix A: Colorado CCAR and DACODS Data Analysis Summary

This appendix includes information regarding the preparation, analytic approach and decisions guiding the analysis of demographics, services, and outcomes assessed in multi-year datasets of Colorado Client Assessment Records (CCAR) and Drug/Alcohol Coordinated Data System (DACODS). Data explored in these analyses reflect only clients receiving services from OBH designated mental health and licensed substance abuse treatment providers, and may not be fully representative of Colorado's populations involved in behavioral health services. The appendix is organized into the sections listed below, separately by dataset (first DACODS, followed by CCAR).

- Data Received and Initial Error Analysis
- Data Review
- Data Preparation
    - Exclusion Decisions
    - Coding Decisions
        - Demographics
        - Service Characteristics
        - Diagnoses
        - Improvements in Outcomes
    - Aggregation and Analysis Decisions
- Decisions following Initial Analysis

Tables summarizing the results are included in **Appendix B**.

Appendix A (Continued): Colorado CCAR and DACODS Data Analysis Summary

DRUG/ALCOHOL COORDINATED DATA SYSTEM (DACODS)

Data Received and Initial Error Analysis

Raw DACODS data included all records for individuals admitted from 2008 to 2013. **Ultimately, a 5 year time frame of 2009-2013 was determined and analyses included only cases within this period.** Additional data after 2013 were also included for individuals admitted during this time frame. A total of 729,664 records were initially received, representing 425,285 unique individuals (identified by Client ID).

Admission dates ranged from January 1, 2008 to December 31, 2013. Number of admissions by year are represented in table 1.

Table 1. Number of Admissions per Year

Admission Year	N	%
2008	129,991	17.8
2009	128,596	17.6
2010	114,023	15.6
2011	116,703	16.0
2012	121,149	16.6
2013	119,202	16.3
Total	729,664	100.0

Discharge dates ranged from July 15, 2005 to December 26, 2014 with some records clearly containing invalid data.

Data Review

Each record in the data set was categorized by Type of Service (i.e., Admission Only, Completed A & D, or Detox). Table 2 shows the number of each type.

Table 2. Number of Records by Encounter Type

Type	N records	%
Admission Only	47,135	6.5
Completed A & D	356,112	48.8
Detox*	326,417	44.7
Total	729,664	100.0

*note that all 'detox' records have discharge dates recorded.

Appendix A (Continued): Colorado CCAR and DACODS Data Analysis Summary

Each record in the data set was also categorized by Modality (i.e., type of service received). Review of the dataset showed that Modality was categorized in two ways - Admit Modality 'Modality' was collapsed into smaller set of categories under Modality Category 'Category'. The relationship between Admit Modality, Modality Category, and Record Type (i.e., Encounter Type) were examined to assess incorrect data.

The Modality Category variable contains values relevant to the Admissions and Completed values on encounter type. 726 cases appeared to be incorrectly matched with 17 records categorized with a detox modality and admissions encounter type and 709 records categorized with a detox modality and completed encounter. The range of admission dates was the same for all types or records, i.e. 1/1/2009 - 12/31/2013.

Data were also assessed for duplicate records. The following duplication was found:

- 2864 records (.4%) have 2 or 3 entries per Admission with the same Modality Category.
- 8603 records (1.2%) have 2 or 3 entries per Admission with the same Record Type.
- 17590 (2.4%) of records have multiple entries for date of admission. A general review suggested that multiple records are due to changes in modality (e.g., admitted to outpatient services, then discharged from outpatient services and admitted to residential services). These records were retained for analysis.

The relationship between admission date, first offered appointment date and first contact date was also reviewed. The first offered appointment date is either earlier than or the same as the admission date, whereas the first contact date is either earlier than or the same as the admission date. These dates were difficult to interpret and were thus not analyzed as indicators of access to services at this time.

It is also important to note that because OBH does not consider Detox and DUI service modalities as forms of treatment, records indicating these modalities were only included when analyses were separated by service modality (i.e., these records were not included in reports of DACODS overall demographic information or key treatment indicators (Tables 1 and 2 in Appendix B).

After removing incorrect data, 584,465 records, representing 352,062 unique individuals were included in the dataset. When removing the additional 219,245 cases indicating Detox and DUI, a total of 132,817 remained for analyses.

The number of records and people removed at each step is included in Table 3 on the following page.

Appendix A (Continued): Colorado CCAR and DACODS Data Analysis Summary

Table 3. Number of Records Kept at Each Data Cleaning Step

Selection Step	# Records	N Lost	# People	N Lost
Raw dataset	729,664		425,285	
Limit dataset to admission dates in 2009-2013 (5-year calendar period)	599,673		356,575	
Delete records where Modality Category & Encounter Type don't match as unsure whether it is the Encounter Type value that is incorrect or the Modality Category value that is incorrect	598,947	726	356,183	392
Drop records that are one of multiple records with the same Admission Date + Modality Category as unsure if these are correct or bad data and small proportion of records	596,830	2,117	355,630	553
Drop records that are one of multiple records with the same Admission Date + Encounter Type as unsure if these are correct or bad data and small proportion of records	591,410	5,420	354,216	1,414
Drop records that are one of multiple records with the same Admission Date.	584,465	6,945	352,062	2,154
Total N Lost (from 2009-2013 dataset)		**15,208 2.5%**		**4,113 1.3%**
Drop Detox and DUI cases for calculations of overall demographic information and key treatment indicators.				219,245 62.3%

Data Preparation

Data were also reviewed for response options that didn't conform to the data entry guidelines presented in the DACODS manual. The following sections list exclusion, coding, and aggregation decisions and steps taken to prepare the data set for final analysis.

EXCLUSION DECISIONS

The following data points were cleaned as follows:

- Age data outside of 5-95 years was excluded
- Records with 'declined' for Sexual Orientation were excluded from analyses
- Lengths of treatment that were less than 0 (discharge occurring before admission) were excluded from analyses
- Values for Discharge Reason that did not conform to one of the 11 possible response options were excluded from analyses

Appendix A (Continued): Colorado CCAR and DACODS Data Analysis Summary

CODING DECISIONS

Demographics

- Ethnicity was reduced to yes/no categories
- Individuals with more than one Race selected were categorized as multi-racial

Service Characteristics

- Treatment Modality (or type of treatment) was coded from sixteen into nine categories, according to the following:
    - Differential Assessment (0= Differential Assessment)
    - Residential: (3= Therapeutic community/TC; Intensive residential/IRT; Transitional residential/TRT; 11= Medically managed inpatient other than detox
    - ORT (6= Opioid replacement therapy/ORT)
    - Outpatient (7= Traditional Outpatient/OP; 9= Intensive Outpatient/IOP)
    - STIRRT (8= STIRRT)
    - Day Treatment (10= Day treatment/DAY)
    - Minors in Possession (16= Minors in Possession/MIP Treatment)

Improvements in Outcomes

Improvement scores in five areas (see table 4 below for definitions) were calculated to assess change from admission to discharge. Improvements scores were only calculated for individuals with a score of 2 or more (scores range from 1-4) at Admission within each category. Individuals with a score less than 2 would not be able to show improvement at discharge as they did not present with the issue initially. Individuals were coded as having improved with a score lower at discharge than admission (higher scores indicate greater problems).

Table 4. Definition of Improvement Areas

Improvement Area	Definition
Role Performance	Identifies the clinician's assessment of the client's functioning in the educational or employment setting at the time of admission.
Mental Health	Identifies the clinician's assessment of the client's medical or physical level of functioning at the time of admission.
Physical	Identifies the clinician's assessment of the client's medical or physical level of functioning at the time of admission
Family	Identifies the clinician's assessment of the client's skills and functioning level in the family setting at the time of admission.
Interpersonal	Identifies the clinician's assessment of the client's social skills and ability to function in positive relationships at the time of admission.

Appendix A (Continued): Colorado CCAR and DACODS Data Analysis Summary

AGGREGATION AND ANALYSIS DECISIONS

Data were aggregated person-level (one record per person) in the following way:

- Demographic values were kept from the first admission.
- Disability was recorded as yes if the individual was ever coded as having a disability.
- Average length of treatment, proportion of discharges categorized as Treatment Completions and Treatment Referrals, and average Treatment Progress were calculated across admissions.
- Improvement in functioning was calculated as the percent of visits showing improvement in each area.

Appendix A (Continued): Colorado CCAR and DACODS Data Analysis Summary

COLORADO CLIENT ASSESSMENT RECORDS (CCAR)

Data Received and Initial Error Analysis

Raw CCAR data included all records for individuals with admission dates from 2008 to 2013. **Ultimately, a 5 year time frame of 2009-2013 was determined and analyses included only cases within this period.** A total of 899,932 records were initially received, representing 250,607 unique individuals (identified by Unique ID). Multiple records existed for individuals within the same service episode. Record types included Admission Records, Updates (annual or interim/reassessment), Discharge Records, and Evaluation Records. The number of records and unique individuals represented by each type are shown in Table 1.

Table 1. Number of Records by Record Type

Type	N (records)	%
Admission	274,376	30.5
Updates	332,944	37.0
Discharge	242,809	27.0
Evaluation	49,803	5.5
Total	899,932	100.0

The range of dates varied according the record type, with some records clearly entered with errors. The range of dates is shown in Table 2.

Table 2. Range of Dates by Record Type

Type	N	Minimum	Maximum
Effective Date	899,932	2008	2013
Admission Dates	899,932	1958	2013
Update Dates	899,932	2008	2014
Discharge Dates	292,612	2008	2014

Appendix A (Continued): Colorado CCAR and DACODS Data Analysis Summary

Data Review

Each update record was coded with an Update Type (i.e., reason why the update record was submitted). The majority of updates are Annual or Interim/Reassessment updates; small proportions are related to Psych Hospital admissions & discharges (see Table 3).

Table 3. Reasons for Update Records

Reason	N	%
1: Annual	211,480	23.5
2: Interim/Reassessment	113,050	12.6
3: Psych Hosp. Admission	4,962	.6
7: Psych Hosp. Discharge	3,441	.4
8: Res Treatment Change of Level	10	.0
9: DOC/Community Parole	1	.0
Total	332,944	37.0

Data were also assessed for duplicate records. The following duplication was found:

- 529,014 records have multiple entries for the same admission date likely because many are updates or discharges. 370,918 individuals have only 1 entry per admission date.

After removing incorrect data (see Table 4), 273,054 records, representing 191,747 unique individuals were include in the dataset. Number of records and people removed at each step is included in table 4.

Table 4. Number of Records Kept at Each Data Cleaning Step

Selection Step	# of Records	N Lost	# of People	N Lost
Raw dataset	899,932		250,607	
Limit dataset to admission dates in 2009-2013 (5-year calendar period)	616,670		195,821	
Delete Update records as most are annual or interim updates (thus, retain Admissions, Discharges, and Evaluation records)	450,587		194,948	
Delete records with the same Admission Date + Action Type as can't be sure whether this is accurate or an error.	445,127 (232,040 Admission; 172,073 Discharge; 41,014 Evaluation)	5,460	194,501	447
Merge admission and discharge records, deleting any discharge records that don't match to an Admission record.	273,054 remaining (64,517 Admission Only; 167,523 Admission and Discharge; 41,014 Evaluation)	4,550	191,747	2754
Total N Lost (from 2009-2013 dataset)		**10,010 2.2%**		**3,201 1.6%**

Appendix A (Continued): Colorado CCAR and DACODS Data Analysis Summary

Data Preparation

Data were also reviewed for response options that didn't conform to the CCAR data entry or best practice guidelines. The following sections list exclusion, coding, and aggregation decisions and steps taken to prepare the data set for final analysis.

EXCLUSION DECISIONS

The following data points were cleaned as follows:

- Age data outside of 5-95 years was excluded
- Records with 'declined' for Sexual Orientation were excluded from analyses
- Length of treatment was calculated as number of days between the admission date and discharge date. No length of treatment data were included for clients without a discharge date.
- Values for Discharge Status that did not conform to one of the 3 possible response options were excluded from analyses
- Values for Discharge Reason that did not conform to one of the 11 possible response options were excluded from analyses

CODING DECISIONS

Demographics

- Ethnicity was reduced to yes/no categories. Data varied to some extent across records within clients with 5885 duplicates out of 273,054 records. The information recorded at the first episode in the data set were retained for analysis.
- Individuals with more than one Race selected were categorized as multi-racial. Race categorized as 'other' was excluded from analyses to better match DACODS data. 52,239 records were missing Race data. Data varied to some extent across records within clients with 2983 duplicates out of 273,054 records. The information recorded at the first episode in the data set were retained for analysis.
- Marital status varied to some extent across records within clients with 9022 duplicates out of 273,054 records. The information recorded at the first episode in the data set were retained for analysis.
- Consideration of Language (chosen by provider) was coded into yes/no and also contained duplication across records within clients. The information recorded at the first episode in the data set were retained for analysis. It is important to note that this item asks providers to note if language is a consideration in the case; providers did not specifically note the language that is spoken by the client or family.

Appendix A (Continued): Colorado CCAR and DACODS Data Analysis Summary

Diagnoses

- Co-occurring disorders were calculated as having both a mental health and substance abuse diagnosis at admission. Diagnoses were calculated using DSM-IV codes.

Improvements in Outcomes

Improvement scores in five areas (see table 5 below for definitions) were calculated to assess change from admission to discharge. Improvement scores were only calculated for individuals with a score of 3 or more (scores range from 1-9) at Admission within each category. Individuals with a score less than 3 would not be able to show improvement at discharge as they did not present with the issue initially. Individuals were coded as having improved with a score 3 or more points lower at discharge than admission (higher scores indicate greater problems).

Table 5. Definition of Improvement Areas

Improvement Area	Definition
Physical Health	Extent to which a person's physical health or condition is a source of concern
Family	Extent to which issues within the individual's identified family and family relationships are problematic
Interpersonal	Extent to which a person establishes and maintains relationships with other
Role Performance	Extent to which a person adequately performs his/her occupational role.
Mental Health	Rate the severity of the person's mental health symptoms

Aggregation and Analysis Decisions

Data were aggregated at the person-level (one record per person) in the following way:

- Demographic values were kept from the first admission.
- Co-occurring mental and substance use diagnoses was recorded as yes if the individual was ever coded as having a co-occurring disorder across all records for that individual in the data set.
- Disability was recorded as yes if the individual was ever coded as having a disability.
- Average length of treatment and proportion of discharges categorized as Treatment Completions and Treatment Referrals were calculated across admissions.
- Improvement in functioning was calculated as the percent of unique client records that demonstrated improvements (decrease in ratings) from admission to discharge.

Appendix A (Continued): Colorado CCAR and DACODS Data Analysis Summary

Decisions Following Initial Analysis

Additional decisions regarding data quality and inclusion of data in the final analyses were made once results of the initial analysis were available. These decisions included:

- Sexual Orientation and Marital Status were excluded in the analysis of culturally diverse group differences for all indicators, due to the following reasons:
    - to be consistent with the DACODS analyses
    - a small sample size for sexual orientation was observed
    - marital status varied significantly across episodes of care
- Veteran status variable was not a usable field as there were very few non-missing values in the CCAR data set.

Decisions Following Initial Analysis

Additional decisions regarding data quality and inclusion of data in the final analyses were made once results of the analysis were available. These decisions included:

- Sexual Orientation and Marital Status were excluded in the analysis of culturally diverse group differences for all indicators, due to the following reasons:
    - to be consistent with the CCAR analyses
    - a small sample size for sexual orientation was observed
    - marital status varied significantly across episodes of care
    - Income Source was excluded from analysis as it was not available on the CCAR for comparison and it was unclear how to categorize the responses.
- Children were excluded when examining access, service, and outcome variables as the records for this age group in DACODS was very small (62).

Appendix B: Colorado CCAR and DACODS Data (2009-2013)

Table 1. DACODS (Drug/Alcohol Coordinated Data System) Participant Demographic Data

For the following demographic information, detox and DUI clients were excluded from analyses as OBH does not define these modalities as forms of treatment. **(N = 132,817)**

		N	%	% CO Population*
Age Group	Child: <12	54	0.0	16.4
	Adolescent: 12 thru 17	14055	10.6	7.8
	Young Adult: 18 thru 24	28863	21.7	9.7
	Adult 1: 25 thru 44	65367	49.2	28.4
	Adult 2: 45 thru 64	23678	17.8	26.7
	Older Adult: 65+	792	0.6	10.9
	Total	132809	100.0	100.0
	Missing	*8*		-
Gender	Male	89350	67.3	49.7
	Female	43428	32.7	50.3
	Total	132778	100.0	100.0
	Missing	*39*		-
Ethnicity	Not Hispanic	98705	74.5	79.9
	Hispanic	33728	25.5	20.1
	Total	132778	100.0	100.0
	Missing	*384*		-
Race	American Indian Alaska Native	3879	2.9	2.0
	Asian	761	0.6	3.5
	African-American	10122	7.7	4.8
	Native Hawaiian Pacific Islander	514	0.4	0.3
	White	114524	86.8	86.3
	Multi-Racial	2067	1.6	3.1
	Total	349472	100.0	100.0
	Missing	*950*		-
	Mean	Median	Range	
Age	33.64	31	6-95	

		N	%
Sexual Orientation	Heterosexual	538	96.8
	Gay-Lesbian	8	1.4
	Bisexual	9	1.6
	Other	1	0.2
	Total	566	100.0
	Missing	*132261*	
Marital Status	Never Married	76603	57.7
	Married	24216	18.2
	Separated	7859	5.9
	Widowed	1948	1.5
	Divorced	22191	16.7
	Total	132817	100.0
	Missing	*0*	
Veteran Status	Not Veteran	126298	95.1
	Is Veteran	6519	4.9
	Total	132817	100.0
	Missing	*0*	

*United States Census Bureau/American FactFinder, 2010 Census. U. S. Census Bureau, 2010. Web 29 June 2015 http://factfinder2.census.gov

Appendix B (Continued): Colorado CCAR and DACODS Data (2009-2013)

Table 2. DACODS (Drug/Alcohol Coordinated Data System) Key Indicators by Participant Demographic Characteristics

Note: Rates of each health variable are presented for each demographic group. For example, on average, 13.7% of Adolescents served by the state were recorded as having a disability of some type. Similarly, Adolescents had an average length of stay of 86.8 days. **(N=132,817)**

	Overall	Age Group					Gender		Ethnicity		Race						Veteran	
		Adol	YA	Adult I	Adult II	OA	M	F	Non-H	H	AIAN	Asian	AfAm	NHPI	White	Multi	not Vet	Vet
Percents																		
Disability	15.4	13.7	10.2	15.4	22.5	23.2	12.9	20.5	16.3	12.6	14.9	10.0	18.7	17.3	15.0	15.4	15.1	21.5
Insured	60.7	72.8	61.3	57.5	61.1	74.5	60.9	60.3	60.4	61.4	60.5	62.2	64.0	64.8	60.3	59.6	60.4	66.0
Multiple Tx Episodes	22.1	17.7	21.6	24.3	19.7	11.6	20.7	25.0	21.7	23.7	20.3	16.0	21.7	28.0	22.3	22.5	22.3	18.1
Means																		
# of Tx Episodes	1.4	1.3	1.4	1.5	1.4	1.2	1.4	1.5	1.4	1.4	1.4	1.3	1.4	1.5	1.4	1.4	1.4	1.3
Length of Tx - Days	119.0	86.8	104.5	128.1	131.7	116.7	119.6	117.6	119.3	118.3	123.7	125.4	117.1	96.9	119.1	115.5	118.7	124.7
Percents																		
% Tx Completions	55.3	61.5	56.1	52.6	57.5	66.0	55.4	55.1	56.0	53.1	51.7	61.0	49.4	55.8	55.9	54.9	55.1	57.9
% Tx Referrals	8.4	8.7	7.5	8.7	8.7	7.9	7.7	10.0	8.7	7.6	7.5	7.9	7.9	4.9	8.5	9.1	8.4	8.3
% Tx Non Completions	36.3	29.8	36.5	38.7	33.8	26.1	37.0	34.9	35.3	39.2	40.9	31.1	42.8	39.3	35.6	36.0	36.4	33.8
Tx Progress (Scale: 1-3)	1.9	1.9	1.9	1.9	2.0	2.1	1.9	1.9	1.9	1.9	1.9	2.0	1.8	1.9	1.9	1.9	1.9	2.0
% Improvement - Family	29.5	21.0	29.5	29.7	31.4	49.1	29.3	30.2	30.2	27.6	26.7	31.7	19.9	21.3	30.7	31.9	29.3	33.5
% Improvement - Interpersonal	30.6	22.6	30.9	30.7	32.4	47.9	30.0	32.0	31.2	28.9	25.7	30.5	20.6	33.3	31.9	30.8	30.3	35.1
% Improvement - Role Performance	31.8	23.0	31.3	31.8	34.9	46.7	31.4	32.7	32.6	29.3	28.6	32.7	20.5	36.0	33.1	29.8	31.3	39.2
% Improvement - Physical Health	34.9	29.3	36.9	35.0	33.8	47.9	34.8	35.1	35.2	33.9	28.4	36.4	25.2	36.0	36.2	35.2	34.5	40.8
% Improvement - Mental Health	30.2	26.1	28.8	30.1	33.1	41.2	28.9	33.3	31.5	26.4	22.7	18.1	27.5	28.0	30.9	34.2	30.1	32.0

Age Group Categories: Adolescent 12-17 (Adol); Young Adult 18-24 (YA); Adult 1 25-44; Adult 2 45-64; Older Adult 65+ (OA)

Ethnicity Categories: Non-Hispanic (Non-H); Hispanic (H)

Race Categories: American Indian Alaska Native (AIAN); Asian; African-American (AfAm); Native Hawaiian Pacific Islander (NHPI); White, Multi-racial (Multi)

Appendix B (Continued): Colorado CCAR and DACODS Data (2009-2013)

Table 3. DACODS (Drug/Alcohol Coordinated Data System) Service Modalities by Participant Demographic Characteristics (N= 352,062)

	Overall	Age Group					Gender		Ethnicity		Race						Veteran	
		Adol	YA	Adult I	Adult II	OA	M	F	not H	H	AIAN	Asian	AfAm	NHPI	White	Multi	not Vet	Vet
Mean # of Episodes																		
Detox	1.96	1.26	1.26	1.84	2.92	2.03	2.10	1.58	1.95	2.02	3.35	1.22	2.24	1.59	1.91	1.47	1.98	1.90
Residential	1.16	1.08	1.17	1.17	1.14	1.12	1.13	1.19	1.16	1.16	1.15	1.24	1.14	1.21	1.16	1.14	1.16	1.15
ORT	1.25	1.12	1.24	1.27	1.23	1.33	1.25	1.26	1.25	1.30	1.24	1.36	1.39	1.14	1.25	1.34	1.25	1.27
Outpatient	1.22	1.17	1.23	1.23	1.18	1.07	1.20	1.25	1.21	1.24	1.21	1.14	1.19	1.20	1.22	1.21	1.22	1.16
STIRRT	1.05	1.07	1.06	1.05	1.03	1.00	1.05	1.05	1.05	1.05	1.06	1.10	1.04	1.06	1.05	1.10	1.05	1.04
Day Treatment	1.06	1.12	1.02	1.01	1.01	1.00	1.07	1.04	1.05	1.09	1.06	1.00	1.16	1.00	1.05	1.09	1.06	1.04
DUI	1.15	1.15	1.18	1.15	1.12	1.08	1.15	1.15	1.15	1.17	1.17	1.10	1.17	1.19	1.15	1.18	1.15	1.14
Differential Assessment	1.03	1.04	1.03	1.03	1.02	1.05	1.02	1.04	1.03	1.03	1.03	1.03	1.02	1.04	1.03	1.04	1.03	1.03
Minor in Possession	1.01	1.01	1.01	n/a	n/a	n/a	1.01	1.01	1.01	1.02	1.02	1.00	1.00	1.00	1.01	1.01	1.01	1.00
Mean Length of Tx - Days																		
Detox	0.89	2.03	0.62	0.87	1.19	1.05	0.83	1.07	0.93	0.75	0.74	0.38	0.98	0.29	0.90	1.78	0.90	0.88
Residential	64.16	89.00	55.36	67.19	59.69	31.72	70.45	53.52	62.71	70.23	59.65	64.34	88.66	66.90	62.07	78.88	64.57	59.18
ORT	260.33	195.20	212.54	254.28	323.40	351.40	251.76	274.63	261.98	254.85	286.94	224.49	275.17	187.07	261.42	171.34	261.73	238.33
Outpatient	136.61	115.03	126.82	141.42	146.91	137.74	135.99	137.92	137.69	133.82	133.99	142.97	133.05	131.75	136.94	139.27	136.68	135.09
STIRRT	15.65	14.90	15.73	15.19	17.11	13.33	15.24	16.74	16.24	14.30	13.11	12.74	13.36	13.03	16.11	17.85	15.76	13.49
Day Treatment	73.50	93.09	61.17	63.97	40.40	40.67	75.05	69.79	68.17	89.08	106.43	165.40	84.62	28.00	69.93	100.81	74.05	53.64
DUI	195.15	135.43	171.19	201.04	215.00	206.73	196.41	191.48	195.59	193.92	192.04	191.80	176.95	173.71	196.42	186.60	195.13	195.36
Differential Assessment	38.20	11.31	41.45	39.92	45.95	75.79	44.23	28.09	40.05	32.92	77.06	41.15	37.02	29.25	36.18	43.79	35.93	75.28
Minor in Possession	16.32	15.30	15.76	n/a	n/a	n/a	17.01	14.90	14.65	21.39	19.55	11.98	14.43	3.05	16.74	8.17	16.16	32.66
Proportion of Tx Visits																		
Detox	0.34	0.03	0.34	0.34	0.42	0.40	0.35	0.31	0.34	0.33	0.45	0.36	0.37	0.67	0.33	0.14	0.31	0.58
Residential	0.04	0.07	0.04	0.04	0.04	0.05	0.04	0.06	0.05	0.03	0.04	0.02	0.05	0.02	0.04	0.07	0.05	0.03
ORT	0.01	0.00	0.01	0.02	0.02	0.01	0.01	0.02	0.02	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.01
Outpatient	0.22	0.53	0.19	0.22	0.18	0.11	0.21	0.24	0.21	0.23	0.21	0.14	0.28	0.09	0.21	0.34	0.23	0.10
STIRRT	0.01	0.00	0.01	0.01	0.01	0.00	0.01	0.01	0.01	0.01	0.01	0.00	0.02	0.02	0.01	0.01	0.01	0.01
Day Treatment	0.00	0.02	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.01	0.00	0.00
DUI	0.32	0.07	0.35	0.33	0.31	0.40	0.33	0.29	0.31	0.33	0.20	0.42	0.22	0.17	0.33	0.31	0.33	0.26
Differential Assessment	0.04	0.10	0.04	0.04	0.03	0.03	0.03	0.05	0.04	0.03	0.07	0.02	0.03	0.01	0.04	0.07	0.04	0.02
Minor in Possession	0.02	0.18	0.03	n/a	n/a	n/a	0.01	0.02	0.02	0.01	0.01	0.02	0.01	0.01	0.02	0.05	0.02	0.00

Age Group Category Abbreviations: Adolescent 12-17 (Adol); Young Adult 18-24 (YA); Adult 1 25-44; Adult 2 45-64; Older Adult 65+ (OA)
Ethnicity Category Abbreviations: Non-Hispanic (Non-H); Hispanic (H)
Race Category Abbreviations: American Indian Alaska Native (AIAN); Asian; African-American (AfAm); Native Hawaiian Pacific Islander (NHPI); White, Multi-racial (Multi)

Appendix B (Continued): Colorado CCAR and DACODS Data (2009-2013)

Table 4. CCAR (Colorado Client Assessment Record) Participant Demographic Data (N=191,747)

		N	%	% CO Population*
Age Group	Child: <12	32499	17.6	16.4
	Adolescent: 12 thru 17	37614	20.3	7.8
	Young Adult: 18 thru 24	21444	11.6	9.7
	Adult 1: 25 thru 44	59401	32.1	28.4
	Adult 2: 45 thru 64	29865	16.1	26.7
	Older Adult: 65+	4206	2.3	10.9
	Total	185029	100.0	100.0
	Missing	*6718*		-
Gender	Male	87007	45.4	49.7
	Female	104740	54.6	50.3
	Total	191747	100.0	100.0
	Missing	*0*		-
Ethnicity	Not Hispanic	140775	73.6	79.9
	Hispanic	50530	26.4	20.1
	Total	191305	100.0	100.0
	Missing	*442*		-
Race	American Indian Alaska Native	5855	3.7	2.0
	Asian	2137	1.3	3.5
	African-American	15104	9.5	4.8
	Native Hawaiian Pacific Islander	740	0.5	0.3
	White	133703	84.3	86.3
	Multi-Racial	1021	0.6	3.1
	Total	158560	100.0	100.0
	Missing	*33187*		-
	Mean	Median	Range	
Age	28.17	25.29	6-95	

		N	%
Sexual Orientation	Heterosexual	1816	94.7
	Gay-Lesbian	29	1.5
	Bisexual	22	1.1
	Other	50	2.6
	Total	1917	100.0
	Missing	*189830*	
Marital Status	Never Married	129854	67.7
	Married	26225	13.7
	Separated	8365	4.4
	Widowed	3322	1.7
	Divorced	23981	12.5
	Total	191747	100.0
	Missing	*0*	
Veteran Status	Not Veteran	3571	98.7
	Is Veteran	47	1.3
	Total	3618	100.0
	Missing	*188129*	
Language	No	178576	94.4
	Yes	10614	5.6
	Total	189190	100
	Missing	*2557*	

*United States Census Bureau/American FactFinder, 2010 Census. U. S. Census Bureau, 2010. Web 29 June 2015 http://factfinder2.census.gov

Appendix B (Continued): Colorado CCAR and DACODS Data (2009-2013)

Table 5. CCAR (Colorado Client Assessment Record) Key Indicators by Participant Demographic Characteristics (N=191,747)

	Overall	Age Group						Gender		Ethnicity		Race						Language	
		Child	Adol	YA	Adult I	Adult II	OA	M	F	not H	H	AIAN	Asian	AfAm	NHPI	White	Multi	Not Issue	Is Issue
Percents																			
Co-Occurring	15.9	0.4	11.2	21.6	24.7	21.4	5.1	18.4	13.8	17.0	12.7	21.8	10.5	18.4	14.7	16.3	15.8	16.6	4.0
Disability	14.7	15.4	14.6	16.4	14.4	15.5	9.2	18.7	11.4	15.7	12.2	19.0	12.6	19.2	13.2	15.0	15.6	14.7	16.2
Multiple Treatment Episodes	25.4	26.9	30.1	26.2	25.5	22.6	13.7	26.0	25.0	26.8	21.9	29.3	24.2	31.6	29.2	26.5	24.7	26.3	16.3
Means																			
# Tx Episodes	1.4	1.6	1.7	1.6	1.6	1.5	1.3	1.6	1.5	1.6	1.4	1.6	1.6	1.8	1.7	1.6	1.6	1.6	1.3
Length of Tx - Days	210.3	237.7	196.4	177.3	207.4	229.4	217.6	206.0	213.3	213.3	201.2	203.7	202.4	207.1	201.3	212.8	214.2	209.3	225.1
Percents																			
Tx Completions	73.0	70.6	70.2	77.0	76.7	72.2	66.0	72.0	73.9	72.9	73.4	75.2	67.8	72.8	74.3	72.7	76.1	73.2	68.0
% Tx Referrals	24.6	27.0	27.5	20.9	20.9	25.3	31.9	25.6	23.8	24.8	24.1	22.2	29.7	24.8	22.9	25.0	20.3	24.4	29.8
% Tx Non Completions	2.3	2.4	2.3	2.1	2.4	2.5	2.1	2.4	2.3	2.3	2.5	2.6	2.5	2.3	2.9	2.4	3.6	2.4	2.2
% Improvement - Family	38.4	41.1	42.0	36.0	35.4	38.3	42.2	38.2	37.4	38.2	35.9	32.0	36.4	33.8	32.1	38.6	28.7	37.6	41.3
% Improvement - Interpersonal	37.9	43.7	41.7	37.7	35.5	38.9	40.7	39.2	37.8	38.9	36.2	33.7	36.4	34.5	33.5	39.3	30.2	38.2	42.9
% Improvement - Role Performance	43.6	46.7	45.8	43.3	42.1	46.2	47.2	44.5	44.1	44.8	41.9	38.9	44.4	39.7	44.7	45.1	37.2	44.2	46.9
% Improvement - Physical Health	33.2	43.4	43.7	36.0	31.8	30.1	28.8	36.2	33.3	34.8	33.4	32.3	36.6	31.7	34.7	35.1	27.5	34.4	38.5
% Improvement - Mental Health Symptom Severity	51.0	53.7	53.1	51.2	50.0	54.7	56.0	51.9	52.3	52.8	49.2	47.9	54.2	47.6	49.9	53.1	46.6	52.0	56.4
% Improvement - Recovery	42.6	45.4	46.3	42.8	42.1	47.1	50.6	44.2	44.4	45.1	41.0	39.0	47.6	40.3	39.4	45.4	36.7	44.2	46.3
% Improvement - Functioning	46.9	49.3	49.8	48.0	47.6	51.6	50.8	49.2	49.2	50.1	45.3	44.6	47.4	45.9	46.5	50.2	42.0	49.1	51.8

Age Group Category Abbreviations: Adolescent 12-17 (Adol); Young Adult 18-24 (YA); Adult 1 25-44; Adult 2 45-64; Older Adult 65+ (OA)
Ethnicity Category Abbreviations: Non-Hispanic (Non-H); Hispanic (H)
Race Category Abbreviations: American Indian Alaska Native (AIAN); Asian; African-American (AfAm); Native Hawaiian Pacific Islander (NHPI); White, Multi-racial (Multi)

Appendix C: National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care

The National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations to:

Principal Standard:
1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Governance, Leadership, and Workforce:
2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.

3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.

4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance:
5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.

6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.

7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.

8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement, and Accountability:
9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.

10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.

11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.

12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.

13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.

14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.

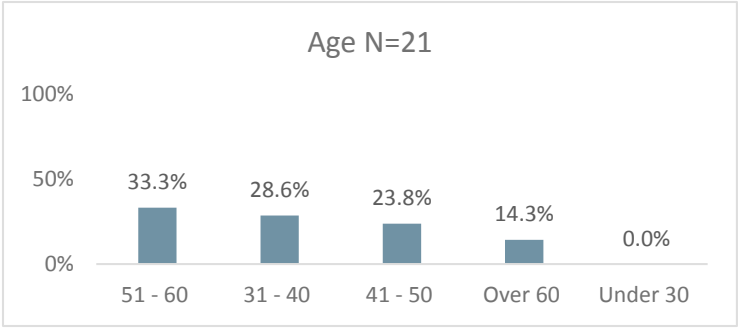
15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

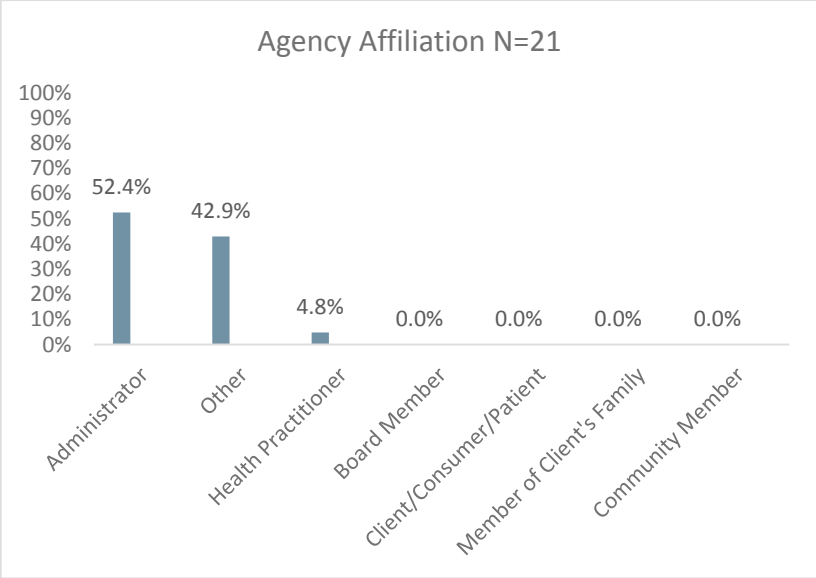
Retrieved from: https://www.thinkculturalhealth.hhs.gov/content/clas.asp

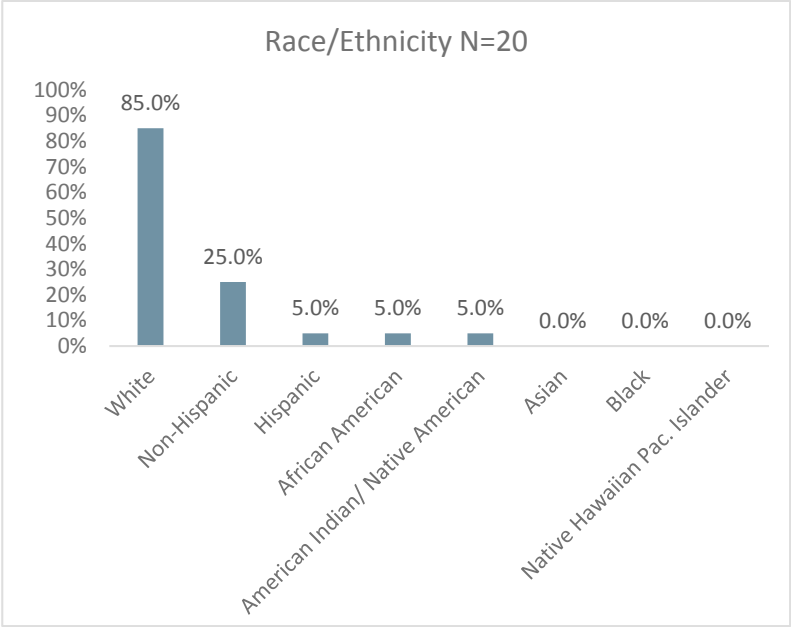
Appendix D: Cultural and Linguistic Competence Policy Assessment (CLCPA) – Office of Behavioral Health 2013 Assessment Results

Part I. CLCPA Participant Demographics

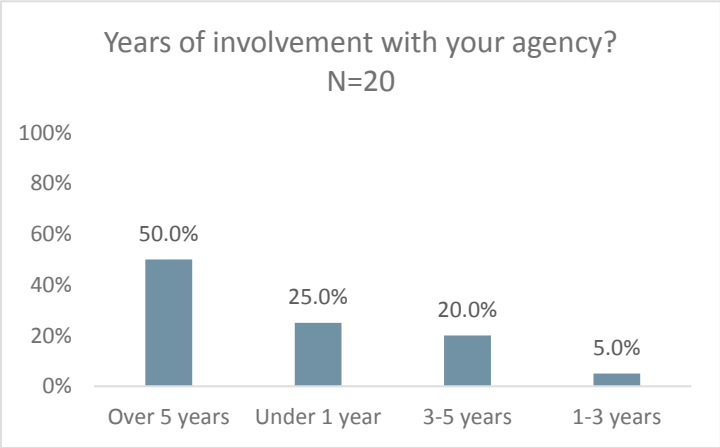
Gender N=21		
	Item N	%
Female	10	47.6%
Male	11	52.4%

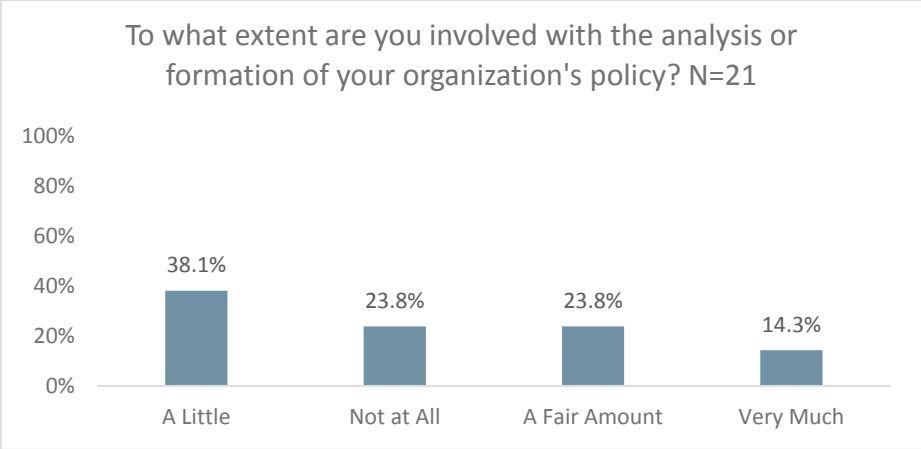


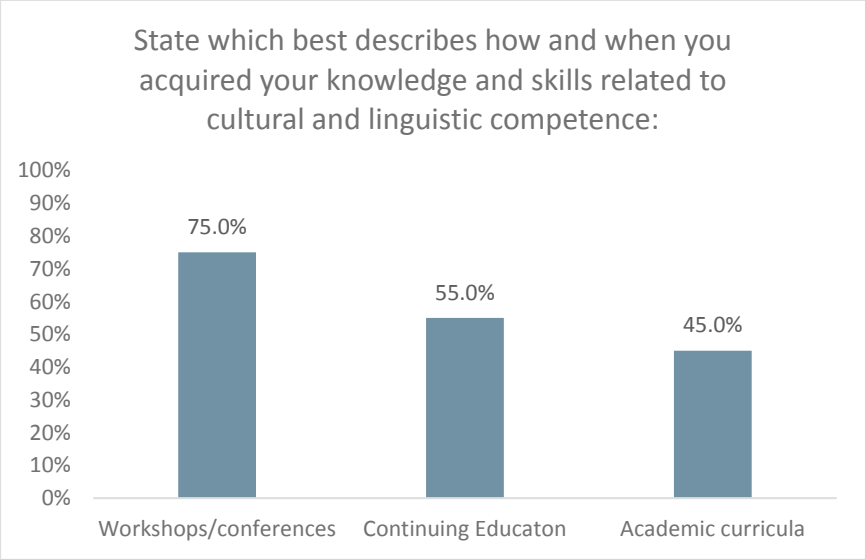




Appendix D (Continued): CLCPA Office of Behavioral Health 2013 Assessment Results







Appendix D (Continued): CLCPA Office of Behavioral Health 2013 Assessment Results

Part II. Item Level Frequencies

Knowledge of Diverse Communities						
	Item N	**Not At All**	**Barely**	**Fairly Well**	**Very Well**	
1. Is your agency able to identify the culturally diverse communities in your service area?	30	--	23.3%	53.3%	23.3%	
	Item N	**No Policy**	**Informal Policy**	**Developing Policy**	**Formal Policy**	**Don't Know**
Is there supporting policy?	30	6.7%	20.0%	16.7%	20.0%	36.7%
	Item N	**Not At All**	**Barely**	**Fairly Well**	**Very Well**	
2. Is your agency familiar with current and projected demographics for your service area?	30	3.3%	33.3%	50.0%	13.3%	
	Item N	**No Policy**	**Informal Policy**	**Developing Policy**	**Formal Policy**	**Don't Know**
Is there supporting policy?	30	13.3%	20.0%	20.0%	3.3%	43.3%
	Item N	**Not At All**	**Barely**	**Fairly Well**	**Very Well**	
3. Is your agency able to describe the social strengths (e.g., support netowrks, family ties, spiritual leadership, etc.) of diverse cultural groups in your service area?	30	6.9%	37.9%	44.8%	10.3%	
	Item N	**No Policy**	**Informal Policy**	**Developing Policy**	**Formal Policy**	**Don't Know**
Is there supporting policy?	30	17.2%	13.8%	17.2%	3.4%	48.3%

Appendix D (Continued): CLCPA Office of Behavioral Health 2013 Assessment Results

Knowledge of Diverse Communities (Continued)	Item N	Not At All	Barely	Fairly Well	Very Well	
4. Is your agency able to describe the social problems (e.g., dispersed families, poverty, unsafe housing, etc.) of diverse cultural groups in your service area?	29	3.4%	37.9%	34.5%	24.1%	
	Item N	**No Policy**	**Informal Policy**	**Developing Policy**	**Formal Policy**	**Don't Know**
Is there supporting policy?	29	13.8%	17.2%	10.3%	13.8	44.8
	Item N	**Not At All**	**Barely**	**Fairly Well**	**Very Well**	
5. Is your agency to describe health disparities among culturally diverse groups in your service area?	29	6.9%	34.5%	41.4%	17.2%	
	Item N	**No Policy**	**Informal Policy**	**Developing Policy**	**Formal Policy**	**Don't Know**
Is there supporting policy?	29	27.6%	13.8%	6.9%	10.3%	41.4
	Item N	**Not At All**	**Barely**	**Fairly Well**	**Very Well**	
6. Is your agency able to describe the languages and dialects used by culturally diverse groups in your service area?	28	10.7%	50.0%	28.6%	10.7%	
	Item N	**No Policy**	**Informal Policy**	**Developing Policy**	**Formal Policy**	**Don't Know**
Is there supporting policy?	29	27.6%	13.8%	6.9%	6.9%	44.8%
	Item N	**Not At All**	**Barely**	**Fairly Well**	**Very Well**	
7. For the culturally diverse groups in your service area does your agency know the health beliefs, customs and values?	29	6.9%	55.2%	31.0%	6.9%	
	Item N	**Not At All**	**Barely**	**Fairly Well**	**Very Well**	
8. For the culturally diverse groups in your service area does your agency know the natural networks of support?	28	7.1%	50.0%	32.7%	10.7%	

Appendix D (Continued): CLCPA Office of Behavioral Health 2013 Assessment Results

Knowledge of Diverse Communities (Continued)	Item N	Not At All	Barely	Fairly Well	Very Well	
9. For the culturally diverse groups in your service area does your agency identify help-seeking practices?	28	3.6%	53.6%	35.7%	7.1%	
	Item N	**Not At All**	**Barely**	**Fairly Well**	**Very Well**	
10. For the culturally diverse groups in your service area does your agency identify the way illness and health are viewed?	28	3.6%	57.1%	32.1%	7.1%	
	Item N	**Not At All**	**Barely**	**Fairly Well**	**Very Well**	
11. For the culturally diverse groups in your service area does your agency identify the way mental health is perceived?	28	3.6%	50.0%	32.1%	14.3%	
	Item N	**No Policy**	**Informal Policy**	**Developing Policy**	**Formal Policy**	**Don't Know**
For the previous questions 7-11, is there supporting policy?	29	27.6%	17.2%	17.2%	3.4%	34.5%
Organizational Philosophy						
12. Does your agency have a mission statement that incorporates cultural and linguistic competence in service delivery?	27	**Yes** - 55.6%		**No** - 44.4%		
	Item N	**Not At All**	**Sometimes**	**Fairly Often**	**Very Often**	
13. Does your agency support a practice model that incorporates culture in the delivery of services?	26	11.5%	50.0%	23.1%	15.4%	
	Item N	**No Policy**	**Informal Policy**	**Developing Policy**	**Formal Policy**	**Don't Know**
Is there supporting policy?	29	11.1%	11.1%	14.8%	63.0%	37.0%

Appendix D (Continued): CLCPA Office of Behavioral Health 2013 Assessment Results

Organizational Philosophy (Continued)	Item N	Not At All	Barely	Fairly Well	Very Well	
14. Does your agency consider cultural and linguistic differences in developing quality improvement processes?	25	16.0%	44.0%	28.0%	12.0%	
	Item N	**No Policy**	**Informal Policy**	**Developing Policy**	**Formal Policy**	**Don't Know**
Is there supporting policy?	26	26.9%	15.4%	11.5%	11.5%	34.6%
	Item N	**Not At All**	**Barely**	**Fairly Well**	**Very Well**	
15. Does your agency advocate for culturally diverse consumers regarding quality of life issues (e.g., employment, housing, education) in your service area?	25	24.0%	36.0%	24.0%	16.0%	
	Item N	**No Policy**	**Informal Policy**	**Developing Policy**	**Formal Policy**	**Don't Know**
Is there supporting policy?	26	23.1%	11.5%	15.4%	7.7%	42.3%
	Item N	**Not At All**	**Barely**	**Fairly Well**	**Very Well**	
16. Does your agency systematically review procedures to insure that they are relevant to delivery of culturally competent services?	25	28.0%	48.0%	12.0%	12.0%	
	Item N	**No Policy**	**Informal Policy**	**Developing Policy**	**Formal Policy**	**Don't Know**
Is there supporting policy?	26	23.1%	19.2%	11.5%	3.8%	42.3%
	Item N	**Not At All**	**Barely**	**Fairly Well**	**Very Well**	
17. Does your agency systematically review procedures to insure that they are relevant to delivery of linguistically competent services?	25	32.0%	44.0%	16.0%	8.0%	
	Item N	**No Policy**	**Informal Policy**	**Developing Policy**	**Formal Policy**	**Don't Know**
Is there supporting policy?	26	26.9%	15.4%	7.7%	7.7%	42.3%

Appendix D (Continued): CLCPA Office of Behavioral Health 2013 Assessment Results

Organizational Philosophy (Continued)	Item N	Not At All	Barely	Fairly Well	Very Well	
18. Does your agency help consumers get supports they need (flexible service schedules, childcare, transportation, etc.) to access health care?	25	28.0%	44.0%	16.0%	12.0%	
	Item N	**No Policy**	**Informal Policy**	**Developing Policy**	**Formal Policy**	**Don't Know**
Is there supporting policy?	26	19.2%	15.4%	3.8%	19.2%	42.3%
	Item N	Not At All	Barely	Fairly Well	Very Well	
19. Are there structures in your agency to assure for consumer and community participation in program planning, service delivery, evaluation of services, quality improvement, hiring practices, performance appraisal, customer satisfaction?	25	16.0%	32.0%	36.0%	16.0%	
	Item N	**No Policy**	**Informal Policy**	**Developing Policy**	**Formal Policy**	**Don't Know**
Is there policy that supports community and consumer participation?	26	3.8%	19.2%	7.7%	26.9%	42.3%
	Item N	**Not At All**	**Barely**	**Fairly Well**	**Very Well**	
20. Does your work environment contain décor reflecting the culturally diverse groups in your service area?	25	32.0%	52.0%	12.0%	4.0%	
	Item N	**No Policy**	**Informal Policy**	**Don't Know**		
Is there supporting policy?	26	46.2%	11.5%	42.3%		
	Item N	**None**	**Some**	**Quite a Few**		
21. Does your agency post signs and materials in languages other than English?	26	15.4%	11.5%	42.3%		
	Item N	**No Policy**	**Informal Policy**	**Developing Policy**	**Formal Policy**	**Don't Know**
Is there supporting policy?	26	23.1%	11.5%	7.7%	7.7%	50.0%

Appendix D (Continued): CLCPA Office of Behavioral Health 2013 Assessment Results

Personal Involvement in Diverse Communities						
	Item N	**Sometimes**	**Fairly Often**	**Very Often**	**Not At All**	
22. Does your agency identify opportunities within culturally diverse communities for you to attend cultural or ceremonial functions?	24	29.2%	54.2%	4.2%	12.5%	
	Item N	**Not At All**	**Sometimes**	**Very Often**		
23. Does your agency identify opportunities within culturally diverse communities for you to purchase goods or services from a variety of merchants (either for personal use or job-related activities)?	23	56.5%	34.8%	8.7%		
	Item N	**Not At All**	**Sometimes**	**Fairly Often**		
24. Does your agency identify opportunities within culturally diverse communities for you to subcontract for services from a variety of vendors?	23	34.8%	30.4%	34.8%		
	Item N	**Not At All**	**Sometimes**			
25. Does your agency identify opportunities within culturally diverse communities for you to participate in recreational or leisure time activities?	23	73.9%	26.1%			
	Item N	**Not At All**	**Sometimes**			
26. Does your agency identify opportunities within culturally diverse communities for you to participate in career awareness days?	23	60.9%	39.1%			
27. Does your agency identify opportunities within culturally diverse communities for you to participate in community education activities?	23	17.4%	60.9%	17.4%	4.3%	
	Item N	**No Policy**	**Informal Policy**	**Formal Policy**	**Don't Know**	
For questions 22-27, is there policy that supports your participation within culturally diverse communities?	23	34.8%	8.7%	4.3%	52.2%	
	Item N	**Not At All**	**Sometimes**	**Fairly Often**	**Very Often**	
28. Does your agency identify opportunities for you to share with colleagues your experiences and knowledge about diverse communities?	23	30.4%	60.9%	4.3%	4.3%	
	Item N	**No Policy**	**Informal Policy**	**Formal Policy**	**Don't Know**	
Is there supporting policy?	23	34.8%	8.7%	4.3%	52.2%	

Appendix D (Continued): CLCPA Office of Behavioral Health 2013 Assessment Results

Resources and Linkages						
	Item N	Not At All	Sometimes	Fairly Often	Very Often	
29. Does your agency collaborate with community-based organizations to address the health and mental health related needs of the culturally and linguistically diverse groups in the service area?	22	40.9%	---	31.8%	27.3%	
	Item N	No Policy	Informal Policy	Developing Policy	Formal Policy	Don't Know
Is there supporting policy?	22	4.5%	18.2%	9.1%	18.2%	50.0%
	Item N	Not At All	Sometimes	Fairly Often	Very Often	
30. Does your agency work with social or professional contact (e.g., cultural brokers, liasons) that help you understand health and mental health beliefs and practices of culturally diverse groups in the service area?	21	33.3%	52.4%	4.8%	9.5%	
	Item N	No Policy	Informal Policy	Developing Policy	Formal Policy	Don't Know
Is there supporting policy?	22	18.2%	9.1%	4.5%	13.6%	54.5%
	Item N	Not At All	Sometimes	Fairly Often	Very Often	
31. Does your agency establish formal relationshpis with these professionals and/or organizations to assist in serving culturally and linguistically diverse groups?	22	22.7%	36.4%	22.7%	18.2%	
	Item N	No Policy	Informal Policy	Developing Policy	Formal Policy	Don't Know
Is there supporting policy?	22	13.6%	13.6%	---	13.6%	59.1%
	Item N	Not At All	Sometimes	Fairly Often	Very Often	
32. Does your agency use resource materials (including communication technologies) that are culturally and linguistically appropriate to inform diverse groups about health related issues?	22	13.6%	59.1%	13.6%	13.6%	
	Item N	No Policy	Informal Policy	Developing Policy	Formal Policy	Don't Know
Is there supporting policy?	22	18.2%	13.6%	---	13.6%	54.5%

Appendix D (Continued): CLCPA Office of Behavioral Health 2013 Assessment Results

Human Resources						
	Item N	**None**	**Some**	**Quiet a few**	**Many**	
33. Are members of culturally diverse groups represented on the staff of your agency?	22	---	81.8%	13.6%	4.5%	
	Item N	No Policy	Informal Policy	Developing Policy	Formal Policy	Don't Know
Is there supporting policy?	22	22.7%	---	----	27.3%	50.0%
	Item N	**None**	**Some**	**Quiet a few**	**Many**	
34. Does your agency have culturally and linguistically diverse individuals as: board members, center directors, senior management, physicians, clinical staff, administrative staff, clerical staff, support staff, consultants, or volunteers?	22	90.9%	---	4.5%	4.5%	
	Item N	**No Policy**	**Informal Policy**	**Developing Policy**	**Formal Policy**	**Don't Know**
Is there policy that supports recruitment of diverse staff, board members, consultants and volunteers?	22	27.3%	4.5	---	22.7%	45.5%
	Item N	**None**	**Some**	**Quiet a few**	**Many**	
35. Does your agency have incentives for the improvement of cultural competence throughout the organization?	22	77.3%	18.2%	---	4.5%	
	Item N	**No Policy**	**Informal Policy**	**Developing Policy**	**Formal Policy**	**Don't Know**
Is there supporting policy?	21	33.3%	4.8%	---	4.8%	57.1%
	Item N	**Yes**		**No**		
36. Does your agency have procedures to achieve the goal of a culturally and linguistically competent workforce that includes staff recruitment, hiring, retention, promotion?	20	30.0%		70.0%		
	Item N	**No Policy**	**Informal Policy**	**Developing Policy**	**Formal Policy**	**Don't Know**
Is there policy that supports achieving a culturally and linguistically competent workforce?	21	19.0%	4.8%	---	23.8%	52.4%

Appendix D (Continued): CLCPA Office of Behavioral Health 2013 Assessment Results

Human Resources (Continued)	Item N	None	Some	Quiet a few	Many	
37. Are there resources to support regularly scheduled professional development and inservice training for staff at all levels for the agency?	22	9.1%	68.2%	13.6%	9.1%	
	Item N	None	Some	Quiet a few	Many	
38. Are inservice training activies on culturally competent health care (e.g., values, principles, practices, and procedures) conducted for staff at all levels of the agency?	22	45.5%	45.5%%	9.1%	---	
	Item N	**None**	**Some**	**Quiet a few**	**Many**	
39. Are inservice training activities on linguistically competent health care (e.g., Standards ADA mandates) conducted for staff at all levels of agency?	22	45.5%	50.0%	4.5%	---	
	Item N	**No Policy**	**Informal Policy**	**Developing Policy**	**Formal Policy**	**Don't Know**
For questions 37-39, is there policy that supports professional development and inservice training for all staff?	22	22.7%	18.2%	---	13.6%	45.5%
	Item N	**None**	**Some**	**Quiet a few**	**Many**	
40. Does your agency have incentives for the improvement of linguistic competence throughout your organization?	22	86.4%	9.1%	4.5%	---	
	Item N	**Never**	**Seldom**	**Sometimes**	**Regularly**	
41. Do you use a health assessment or diagnostic protocols that are adapted for culturally diverse groups?	21	28.6%	23.8%	33.3%	14.3%	
	Item N	**No Policy**	**Informal Policy**	**Developing Policy**	**Formal Policy**	**Don't Know**
Is there supporting policy?	21	4.8%	4.8%	4.8%	23.8%	61.9%
	Item N	**Never**	**Seldom**	**Sometimes**	**Regularly**	
42. Do you use health promotion, disease prevention, and treatment protocols that are adapted for culturally diverse groups?	21	14.3%	28.6%	38.1%	19.0%	
	Item N	**No Policy**	**Informal Policy**	**Developing Policy**	**Formal Policy**	**Don't Know**
Is there supporting policy?	21	19.0%	9.5%	4.8%	14.3%	52.4%

Appendix D (Continued): CLCPA Office of Behavioral Health 2013 Assessment Results

Human Resources (Continued)	Item N	Never	Seldom	Sometimes	Regularly	
43. Do you connect consumers to natural networks of support to assist with health and mental health cases?	21	9.5%	28.6%	47.6%	14.3%	
	Item N	**No Policy**	**Informal Policy**	**Developing Policy**	**Formal Policy**	**Don't Know**
Is there supporting policy?	21	23.8%	4.8%	4.8%	19.0%	47.6%
	Item N	Never	Seldom	Sometimes	Regularly	
44. Do you differentiate between racial and cultural identity when serving diverse consumers?	21	14.3%	23.8%	33.3%	28.6%	
	Item N	**No Policy**	**Informal Policy**	**Developing Policy**	**Formal Policy**	**Don't Know**
Is there supporting policy?	21	28.6%	4.8%	---	14.3%	52.4%
	Item N	**Never**	**Seldom**	**Sometimes**	**Regularly**	
45. Does your agency inform consumers of their right to language access services under Title VI of the Civil Rights Act of 1964 – Prohibition Against National Origin Discrimination and as required by the CLAS Standards 4-7 Federal mandates for language access?	21	42.9%	9.5%	14.3%	33.3%	
	Item N	**No Policy**	**Informal Policy**	**Developing Policy**	**Formal Policy**	**Don't Know**
Is there supporting policy?	21	28.6%	4.8%	---	14.3%	52.4%
	Item N	**Never**	**Seldom**	**Sometimes**	**Regularly**	
46. Does your agency use any of the following personnel to provide interpretation services: certified medical interpreters, trained medical interpreters, sign language interpreters?	21	47.6%	28.6%	19.0%	4.8%	
	Item N	**No Policy**	**Informal Policy**	**Developing Policy**	**Formal Policy**	**Don't Know**
Is there policy for the provision of interpretation services for consumers with limited English Proficiency and those who are deaf or have hearing impairments?	20	15.0%	5.0%	---	30.0%	50.0%

Appendix D (Continued): CLCPA Office of Behavioral Health 2013 Assessment Results

Human Resources (Continued)	Item N	Never	Seldom	Sometimes	Regularly	
47. Does your agency:						
Translate and use patient consent forms, educational materials, and other information in other languages?	20	15.0%	5.0%	55.0%	25.0%	
Ensure materials address the literacy needs of the consumer population?	20	25.0%	25.0%	20.0%	30.0%	
Assess the health literacy of consumers?	20	30.0%	35.0%	30.0%	15.0%	
Employ specific interventions based on the health literacy levels of consumers?	20	40.0%	30.0%	20.0%	10.0%	
	Item N	**No Policy**	**Informal Policy**	**Developing Policy**	**Formal Policy**	**Don't Know**
Is there policy that addresses translation services, literacy and health literacy?	21	33.3%	---	---	13.3%	47.6%
	Item N	**Never**	**Seldom**	**Sometimes**	**Regularly**	
48. Does your agency evaluate the quality and effectiveness of interpretation and translation services it either contracts for or provides?	21	47.6%	33.3%	9.5%	9.5%	
	Item N	**No Policy**	**Informal Policy**	**Developing Policy**	**Formal Policy**	**Don't Know**
Is there supporting policy?	21	38.1%	---	---	9.5%	52.4%
	Item N	**Never**	**Seldom**	**Sometimes**	**Regularly**	
49. Does your agency conduct activities tailored to engage culturally diverse communities?	21	9.5%	33.3%	33.3%	23.8%	
	Item N	**No Policy**	**Informal Policy**	**Developing Policy**	**Formal Policy**	**Don't Know**
Is there supporting policy?	21	23.8%	9.5%	---	14.3%	52.4%

Appendix D (Continued): CLCPA Office of Behavioral Health 2013 Assessment Results

Engagement of Diverse Communities						
	Item N	**Never**	**Seldom**	**Sometimes**	**Regularly**	
50. Do agency brochures and other media reflect cultural groups in the service area?	21	4.8%	28.6%	38.1%	28.6%	
	Item N	**No Policy**	**Informal Policy**	**Developing Policy**	**Formal Policy**	**Don't Know**
Is there supporting policy?	21	23.8%	9.5%	---	9.5%	57.1%
	Item N	**Never**	**Seldom**	**Sometimes**	**Regularly**	
51. Does your agency reach out to and engage the following individuals groups or entities in health and mental health promotion and disease prevention initiatives:						
A. Places of worship (e.g., temples, churches, kivas) and clergy, ministerial alliances, or indigenous religious or spiritual leaders?	21	23.8%	23.8%	33.3%	19.0%	
B. Traditional healers (e.g., medicine men or women, curanderas, espiritistas, promotoras, or herbalists)?	20	50.0%	25.0%	20.0%	5.0%	
C. Mental health providers, dentists, chiropractors, or licensed midwives?	19	31.6%	21.1%	26.3%	21.1%	
D. Providers of complimentary and alternative medicine (e.g., homeopaths, acupuncturists or lay midwives)?	20	50.0%	35.0%	10.0%	5.0%	
E. Ethnic publishers, radio, cable, or television stations or personalities or other ethnic media sources?	21	28.6%	33.3%	23.8%	14.3%	
F. Human service agencies?	19	15.8%	42.1%	5.3%	36.8%	
G. Tribal, cultural or advocacy organizations?	21	4.8%	33.3%	42.9%	19.0%	
H. Local business owners such as barbers/cosmetologists, sports clubs, restauranteurs, casinos, salons, and other ethnic businesses?	20	55.0%	30.0%	5.0%	10.0%	
I. Social organizations (e.g., civic/neighborhood associations, sororities, fraternities, ethnic associations)?	20	30.0%	45.0%	15.0%	10.0%	

Appendix E: Regional Stakeholder Meeting Focus Group Guide

Introductions, Information and Consent Process

Background and Definition of Terms

First, we would like to work together as a group to define some of the terms we'll be talking about today and ensure that we are all on the same page and talking about the same things when these terms come up in our discussion today. *Facilitator will use flip chart to document and keep pages around the room for reference.*

1. What does the term **behavioral health** mean to you? What types of services are included in BH services?
   Ensure that the following areas are mentioned in discussion: 1) behavioral health includes both mental health and substance abuse services; 2) services can include services offered to the general community re: education; inpatient and outpatient mental health and substance abuse services – e.g., residential programs, hospital treatment, individual and group counseling

2. What does the word **culture** mean to you? What kinds of things are part of a person's cultural background? (*If participants pause/get stuck after mentioning racial ethnic background, ask:* What are aspects of culture in addition to race/ethnicity that make up who we are, our belief and value systems, etc.)
   Talk briefly about all of the elements of cultural background – ensure that the following areas are mentioned in the discussion: Race/ethnicity, gender, religion, disability, sexual identity and preference, geography, education, income

3. If we are to talk about "achieving equity in behavioral health services", or "equitable treatment" in behavioral health services, what does the word **equity** mean to you in this context?

Access to Services and Treatment (gaps and opportunities)

First, we'd like to talk with you about the kind of behavioral health services that you think are needed in your community and how people access these services when they need them.

4. What services do you think your community needs to have "good" mental health and reduce problems with substance abuse?
   a. To what extent do you feel those services/programming are currently available in your community? Do you feel that there are enough of the services that you mentioned? What is missing?

5. From your personal experience and thinking about other people you know in your communities and families, please talk about any challenges people have in accessing/using these services when they need them.
   Probe in following areas: geography/location; discomfort accessing services for family/cultural reasons; prior negative experiences/distrust in system/rapport with provider; perceived inclusion or rejection from treatment agency; language; cost; time; family obligations/child care; accommodations for specific groups (e.g., pregnant women, transgender individuals, individuals with disabilities)

Appendix E (Continued): Regional Stakeholder Meeting Focus Group Guide

   a. Are there any particular groups or types of people in your community that you think might face the most challenges with getting treatment when they need it?

6. What do you think would help people get the right behavioral health services when they need them? Please think about what would help people feel more comfortable accessing services, and also what other support, resources or changes people would need.

Treatment Retention and Outcomes (gaps and opportunities)

Part of this study is to also learn about the experiences of people who have accessed mental health or substance abuse services. Again, we know that people in this group may or may not have accessed the same types of services but we ask that you think about both your own experience and that of other people you know, and please share whatever you feel most comfortable sharing.

We'd now like to talk about once people start receiving behavioral health services, why they may or may not stay in treatment or continue receiving services. We know that many people often stop their services or treatment before they had planned/before they originally wanted or intended.

7. What do you think might be challenges for people with staying in treatment or continuing to receive services one they have started?
   a. Are there any particular groups or types of people in your community that you think might face the most challenges with staying in treatment when they need it?

8. What do you think would help people stay in treatment/continue receiving services when they need it?

9. Going back to our definition of culture earlier in the discussion, what does "culturally responsive services" mean to you?
   a. What do you think providers can do to improve services for people from different cultures and backgrounds?

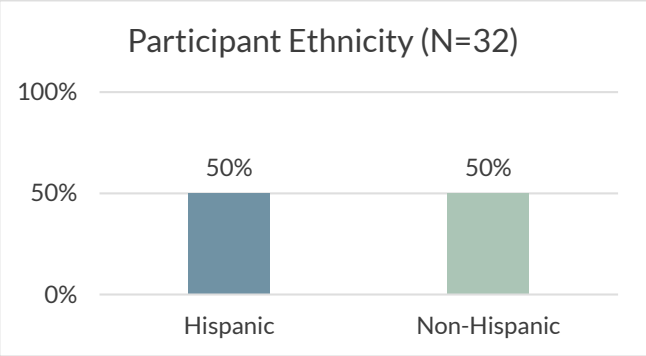
10. What do you think the Office of Behavioral Health/The State can do to help people and communities have equal access to quality services that they need?

Summary

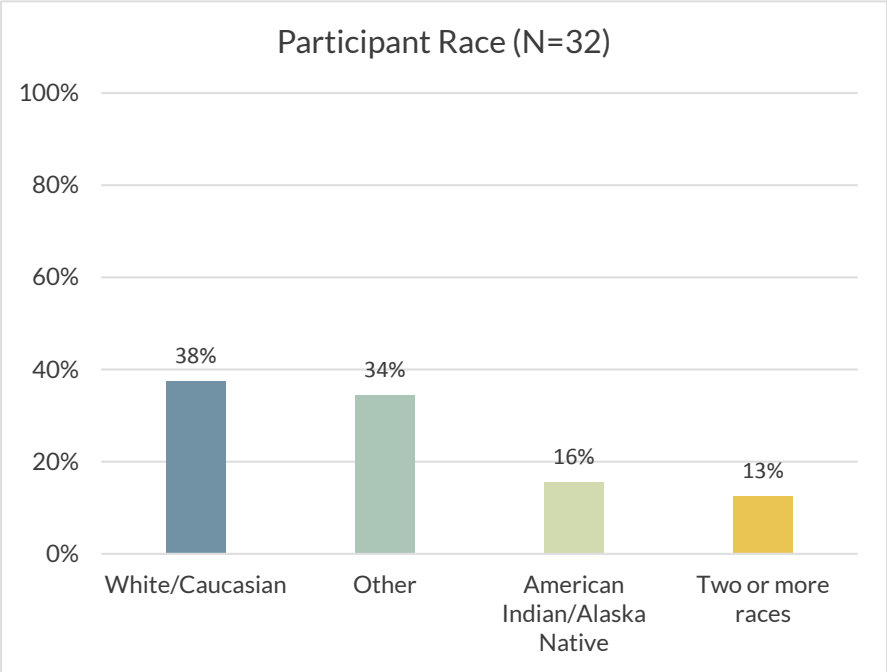
11. Of all the things we discussed today, what did you feel was the most important and why?

Appendix F: Regional Focus Group Demographic Survey

Participant Gender (N=32)	
Male	22%
Female	78%

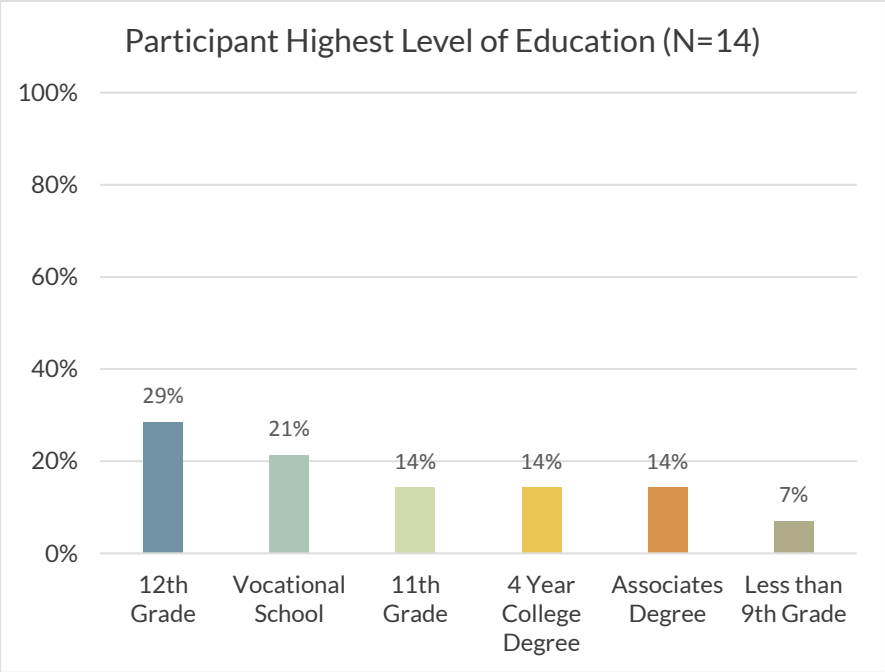


Participant Ethnicity (N=32)	
Hispanic	50%
Non-Hispanic	50%

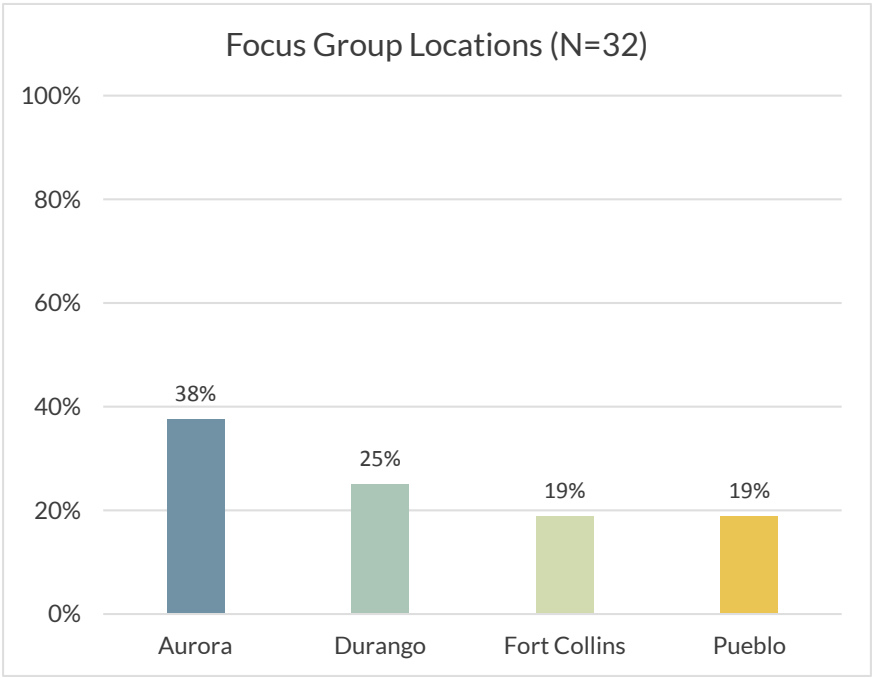


Participant Race (N=32)	
White/Caucasian	38%
Other	34%
American Indian/Alaska Native	16%
Two or more races	13%

Appendix F (Continued): Regional Focus Group Demographic Survey



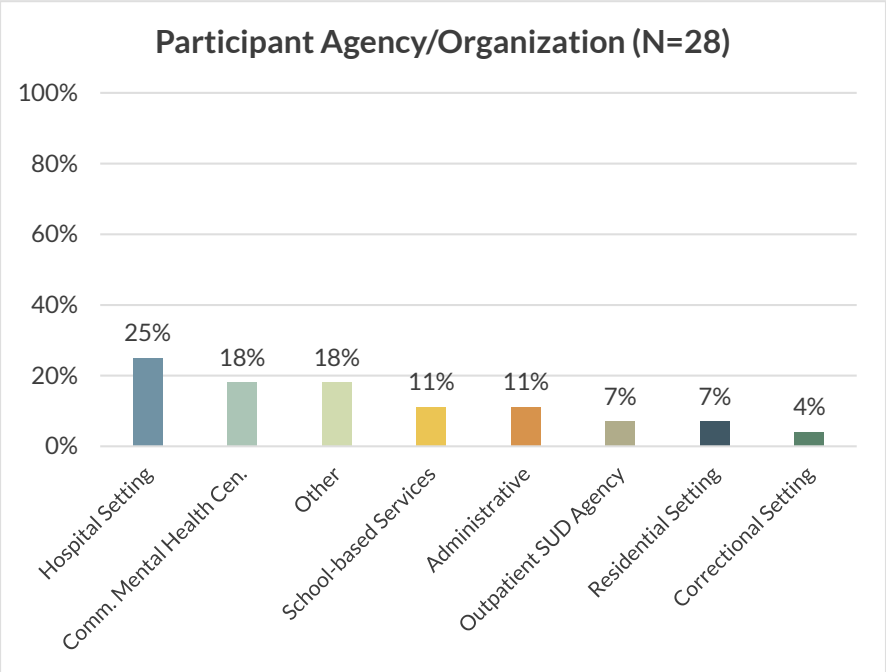
Participant Highest Level of Ed. (N=14)	
Less than 9th Grade	7%
11th Grade	14%
12th Grade	29%
Vocational School	21%
Associates Degree	14%
4 Year College Degree	14%



Focus Group Locations (N=32)	
Aurora	37%
Durango	25%
Fort Collins	19%
Pueblo	19%

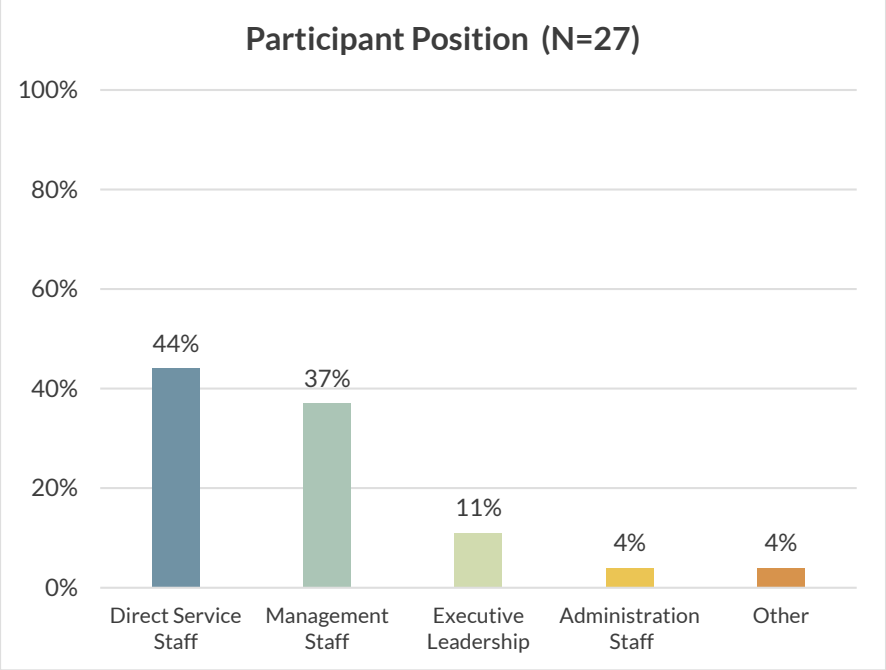
Appendix G: Provider Survey, OBH Forum - July 2014

Participant/Agency/Organization Characteristics



Participant Agency/Organization	
Outpatient SUD Agency	7%
Community Mental Health Center/Specialty Clinic	18%
Hospital Setting	25%
Residential Setting	7%
Correctional Setting	4%
School-based Services	11%
Administrative	11%
Other*	18%

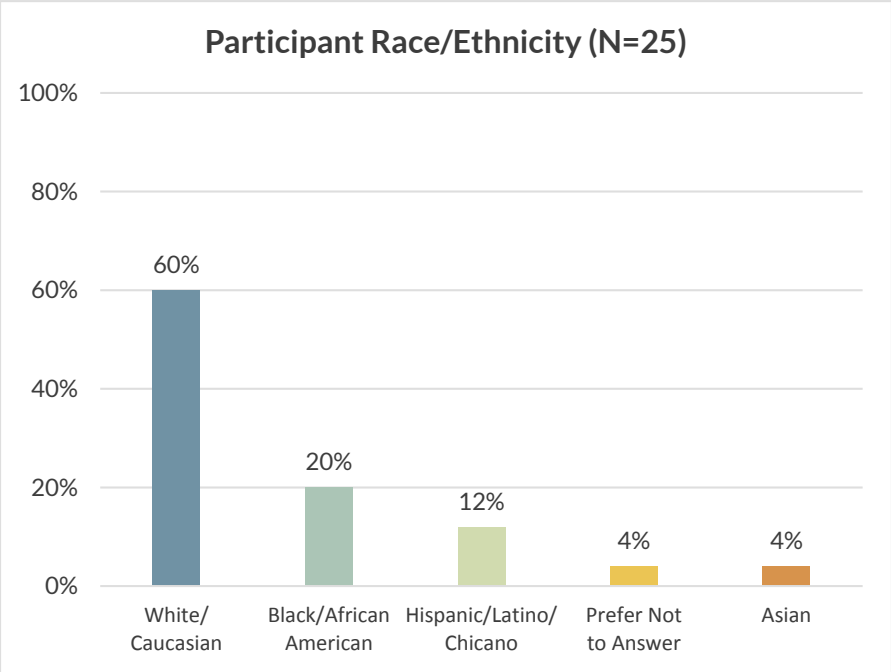
*Other responses included higher education; homeless services; human services; non-profit; program evaluation; public health



Participant Position	
Executive Leadership (e.g., director; board member)	11%
Management Staff (e.g., program manager)	37%
Direct Service Staff (e.g., counselor; other direct service delivery staff)	44%
Administrative Staff (e.g., reception)	4%
Other (please describe)	4%

Participant Gender	
Male	11%
Female	85%
Other	--
Prefer not to answer	4%

Appendix G (Continued): Provider Survey, OBH Forum - July 2014



Participant Race/Ethnicity	
White/Caucasian	60%
Of Hispanic Origin, Latino or Chicano	12%
Prefer Not to Answer	4%
Black/African American	20%
Other	--
Asian	4%
American Indian/Native American or Alaska Native	--
Native Hawaiian or Pacific Islander	--

	Item N	Disagree or Strongly Disagree	Agree or Strongly Agree	Neutral, Don't Know or Does Not Apply	Mean Score
1. I believe that equal access to culturally responsive behavioral health services is a critical challenge in Colorado	34	0%	94.1%	5.8%	4.67 (N=33)
2. I believe that my agency/organization provides culturally responsive services to the diverse groups within its community.	33	12.1%	66.6%	21.2%	3.64 (N=33)
3. My agency/organization encourages open dialogue about cultural considerations and responsiveness in our service delivery.	33	21.2%	66.7%	12.1%	3.70 (N=33)
4. My agency/organization provides adequate staff training related to cultural responsiveness.	34	44.1%	35.3%	20.5%	2.94 (N=32)
5. I am knowledgeable about my agency/organization's policies related to cultural responsiveness	34	14.7%	64.7%	20.5%	3.80 (N=30)
6. I feel comfortable asking clients (those to whom I provide services) about how their cultural background may be relevant to how they receive services.	33	9.1%	90.9%	0%	4.12 (N=33)
7. My agency/organizations incorporates cultural considerations into service delivery	32	12.5%	62.5%	25%	3.74 (N=31)

Appendix G (Continued): Provider Survey, OBH Forum - July 2014

Qualitative Responses

Greatest Agency Challenges

- Lack of awareness
- Lack of prioritization and focus from leadership
- Available resources (time and money)
- Staff reflecting population served
- Staff turnover
- Training

Resources Needed

- Leadership support
- Awareness raising as key issues
- Guidance/requirements, prioritization of issue
- Staff diversity efforts
- Mandatory training ongoing
- Dialogue

Greatest Barriers for Colorado

- Lack of awareness about the importance and depth of the issue
- Workforce development: currently limited staff who reflect populations served
- Diverse leadership
- Access to quality data
- Prioritization of the issue
- Lack of available resources