



Section III

Disparities in Services Are Eliminated.

New Freedom Commission
Related Recommendation

- 3.1 Improve access to quality care that is culturally competent.**
- 3.2 Improve access to quality care in rural and geographically remote areas**

Overview

*Disparities in Geographically
Remote Areas*

In a transformed system, all Americans will share equally in the best available services and outcomes, regardless of race, gender, ethnicity, or geographic location. Substance abuse and mental health care will be highly personal, respecting and responding to individual differences and backgrounds. The workforce will include members of ethnic, cultural, and linguistic minorities who are trained and employed as service providers. People who live in rural and remote geographic areas will have access to professionals and other needed resources. Advances in treatments will be available in rural and less populated areas. Racial and ethnic minority citizens comprise a substantial and vibrant segment of the U.S. population, enriching our society with many unique strengths, cultural traditions, and important contributions. Unfortunately, the mental health and addictions treatment system has not kept pace with the diverse needs of racial and ethnic minorities, often under serving or inappropriately serving them. Specifically, the system has neglected to incorporate respect or understanding of the histories, traditions, beliefs, languages, and value systems of culturally diverse groups. Misunderstanding and misinterpreting behaviors have led to tragic consequences, including inappropriately placing minorities in the criminal and juvenile justice systems. While the prevalence and incidence of serious problems related to mental health and substance abuse among adults and children are similar in rural and urban areas, the experience of individuals in those areas differs in important ways. In rural and other



Disparities in Geographically Remote Areas (cont'd)

geographically remote areas, many people with mental illnesses or addiction disorders have inadequate access to care, limited availability of skilled care providers, lower family incomes, and greater social stigma for seeking treatment than their urban counterparts. As a result, rural residents with treatment needs:

- Enter care later in the course of their disease than their urban peers,
- Enter care with more serious, persistent, and disabling symptoms, and
- Require more expensive and intensive treatment responses.

For rural racial and ethnic minorities, these problems are compounded by their minority status and the shortage of culturally competent or bilingual providers in these medically underserved areas. Rural areas also suffer from chronic shortages of treatment professionals. Virtually all of the rural counties in this country have a shortage of practicing psychiatrists, psychologists, and other mental health and substance abuse treatment professions. Of the 1,669 Federally designated mental health professional shortage areas, more than 85% are rural. These professional shortage problems are even worse for children and older adults.

The importance of Culturally Competent Staff

Addressing barriers caused by differences in culture, race and ethnicity can reduce disparities in services. Culturally competent services are “the delivery of services that are responsive to the cultural concerns of racial and ethnic minority groups, including their language, histories, traditions, beliefs, and values.” Cultural competence in substance abuse treatment and mental health treatment is a general approach to delivering services that recognizes, incorporates, practices, and values cultural diversity. Its basic objectives are to ensure quality services for culturally diverse populations, including culturally appropriate prevention, outreach, service location, engagement, assessment, and intervention.



Background Information

Care systems can respond to the needs of ethnic and racial minority populations by implementing services based on standards for person-centered practices, thus building trust, increasing cultural awareness, and responding to cultural and linguistic differences.

Oklahoma is home to a culturally diverse population. Caucasians make up approximately 75 percent of the Oklahoma population, followed by Native Americans (7.4%), African-Americans (7.1%) and Hispanics (6.6%). People from multiple racial groups comprise 5.7 percent of the population, other racial groups 2.7 percent, Asian, 1.6 percent, and Pacific Islander .10 percent. When compared to the U.S. population, Oklahoma has a higher percentage of Native Americans and people from multiple racial groups (U.S. Census Bureau, 2006).

This culturally diverse population creates cultural and linguistic needs within Oklahoma service systems. The 2005 American Community Survey found that 4 percent of Oklahomans speak English less than “very well,” with the majority of these individuals speaking Spanish in the home (U.S. Census Bureau, 2006). Similarly, ODMHSAS non-English speaking consumers overwhelmingly prefer Spanish over other languages. It should be noted that less than 1 percent of ODMHSAS clients are non-English speaking compared with 8 percent of the population (U.S. Census Bureau, 2006), which may indicate a perceived or actual lack of services for non-English speaking individuals, or racial/ethnic stigma.

Another cultural and linguistic need in Oklahoma is substance abuse and mental health services for clients who are hard of hearing. In a National Health Interview Survey in 2004, an estimated 7.7 percent of deaf people mentioned depression, anxiety or emotional problems that caused difficulty with activities



**Background Information
(cont'd)**

(NHIS, 2004). The number of people in Oklahoma who are hard of hearing is unknown, but statistics from ODMHSAS indicate that, among the 21,818 clients who received ODMHSAS-funded mental health services, 53 (0.24%) indicated they were hard of hearing. Among the 14,521 who received ODMHSAS-funded substance abuse treatment, 16 (.11%) indicated being hard of hearing or deaf. These numbers may also indicate a perceived or actual lack of services for hard of hearing clients.

According to the 2004 National Survey of Substance Abuse Treatment Services State Profile (N-SSATS), there were 59 facilities in Oklahoma capable of providing services in either sign language and/or a language other than English, including both public and private facilities. A total of 56 facilities offered services for the hearing impaired. Of those facilities with other language capabilities, 22 facilities had staff or on-call interpreters for Spanish speaking consumers, and 5 facilities had this coverage for Native American languages (SAMHSA, 2005).

A small percentage of direct care staff are bilingual. In FY 2005, two percent of ODMHSAS Administrative staff were bilingual, five percent of Psychological or Counseling Services staff, five percent of Case Management Services staff, and nine percent of Medical Services staff, with the majority of bilingual staff speaking Spanish. While these numbers have improved over the past five years, it should be noted that the location of Spanish speaking service providers does not necessarily coincide with the location of Spanish speaking clients. There also continues to be a need in Oklahoma for more Native American speaking and Sign Language capable staff.

Access to services based on geographic location was highlighted throughout the Oklahoma Needs Assessment and Resource Inventory Report (see Chapters 4, 5, and 6 for maps illustrating



Strategic Developments

service usage and availability). Overall this report indicated a need for services in rural and/or peripheral counties, with the Northwest region and Southeast region of Oklahoma most often the areas with fewest available services.

In 2005, ODMHSAS established a position for a Cultural Competence Coordinator to provide leadership around the provision of culturally competent care. The department also made more cultural competency training available. In 2006, a Cultural Competency Advisory Team was assembled, consisting of representatives of a range of cultural, racial and ethnic groups (not necessarily from the mental health or substance abuse fields), and including consumers and family members. The team was charged with addressing needs identified by the department, advising the department on promising practices for improving cultural competence, and educating their own communities about substance abuse and mental health issues.

There are several state-certified programs throughout Oklahoma with a cultural emphasis. The Chickasaw Nation Alcohol and Drug Program is a 21 to 28 day residential treatment program for adult Native Americans. The Muscogee (Creek) Nation Behavioral Health and Substance Abuse Services (BHSAS) is an outpatient substance abuse program that believes “respect for culture and involvement in our Indian communities is essential to the success of our program.” Seventy percent of staff at this facility are Native Americans with extensive educational backgrounds. The Latino Community Development Agency (LCDA) Adolescent Outpatient Substance Abuse Program provides individual and family counseling, group treatment, and crisis intervention and case management for individuals in the Latino community. Many other programs, both public and private, include a cultural emphasis. These programs include, but are not limited to: Citizen Pottawatomie Nation Health Complex, Community Adolescent Rehabilitation Effort (CARE) for Change,



**Work Group
Recommendations**

Children's Behavioral Health

COPE, Inc., Inter Tribal Substance Abuse Prevention and Treatment Center, and Quapaw Tribal Family Services.

Develop competency standards for staff training.

Create a study to determine discrepancies in access to behavioral health services.

Identify groups with limited access and include them in the public comment process.

Coordinate behavioral health efforts between Smart Start Oklahoma, the Intensive Care Coordinators (ICC) for Early Intervention, Tribal Women, Infant and Children (WIC) program, Tribal Head Start, and Better Baby Care.

Analyze current barriers and challenges to early and easy access.

Develop a plan for comprehensive early childhood health systems that coordinates screening, assessment and intervention systems for children ages 0—8.

Provide interdisciplinary training and set standards to improve competencies of staff for providing strengths-based services to young children.

Implement Systems of Care and Communities of Care in new communities.

Systems of Care staff will partner with the Oklahoma Commission on Children and Youth to expand the Systems of Care program through school-based social services.

Adult Services

Develop regional plans for ensuring adequate services in rural areas across the state.

Assess the technical capabilities for use of web-based services in underserved areas of the state.

Facilitate a process to upgrade technical infrastructures prior to the implementation of electronic information systems.

Develop and promote partnerships with Tribal and other culturally



Criminal Justice

diverse entities.

Develop a program to educate and enhance workforce cultural competencies for serving Oklahoma populations.

Identify funding and service plans for Mobile Crisis Teams in rural areas of Oklahoma.

Expand secure stabilization center services across the state.

Identify and develop strategies for partnering with culturally diverse faith-based services and consumer advocacy groups.

Workforce Development

Develop a planning partnership with higher education and the vocational system to address barriers and supporting factors for students entering behavioral health as a career (curriculum, marketing, career planning, etc.).

Develop regional plans to address specific types of workforce staffing needs by regions of the state.

Analyze pay structures related to workforce recruitment and retention in key service roles and geographic areas.

Identify staffing needs for professional and paraprofessional services by geographic areas.



Action Plan to eliminate disparities in services.

Goal III.A: Improve the health of minorities and historically under served individuals who receive mental health and substance abuse services and supports.

Strategies

1. *Establish strategic and on going process to increase services and collaboration to Native Americans in Oklahoma.*

2. *Increase the number of minorities and historically under served individuals who receive mental health and substance abuse treatment services and supports.*

Action Plans

- a. Request Oklahoma-based and national level technical assistance to develop framework for planning that is respectful and inclusive of Tribal Organizations, Indian Health Services, and individual Native Americans.
 - b. Convene meetings to move forward with planning process based on technical assistance recommendations per 2.a. above.
 - c. Prepare status report for Governor’s Transformation Advisory Board.
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- a. Conduct analyses to identify specific service areas, consumers, and types of service needs of minorities and historically underserved individuals.
 - b. Engage agency liaisons and consumers to adapt, develop or adopt standards, evidence-based outreach and service delivery strategies for of minorities and historically underserved individuals.
 - c. Present recommended innovations (item b) to the Governor’s Transformation Advisory Board for adoption by the partner agencies.

Goal III. B: Ensure that cultural competence is addressed and strengthened within the care-giving workforce.

Strategies

1. *Coordinate cross-agency efforts to improve and ensure cultural competency.*

Action Plans

- a. Collect state agency specific cultural competency plans or strategies as available from state agencies that are represented on the Governor’s Transformation Advisory Board.
- b. Utilize ODMHSAS Cultural Competency Coordinator and Task Force to review plans and analyze for strengths and needs, including issues related to racial and ethnic diversity as well as sexual orientation and language competencies.
- c. Host multiple agency meeting to share findings, identify common needs, and develop partnerships for moving forward with multiple agency projects.
- d. Request technical assistance as indicated.

Eliminating Disparities



2. Increase the number of trained and certified and licensed workforce members who are culturally competent.

- a. Partner with post-secondary institutions to develop and expand the cultural competence curriculum for professionals entering the mental health and substance abuse workforce.
- b. Engage the Oklahoma State Department of Health and other agencies to establish or enhance standards for licensing and certification for mental health and behavioral health professionals who are culturally competent.
- c. Partner with Governor's Transformation Advisory Board and other partner agencies to examine and develop recommendations for state agencies on behavioral health cultural competence training and development.

Goal III.C: Improve care in rural Oklahoma.

Strategies

1. Increase the number of persons in rural settings who receive mental health and substance abuse treatment services and supports.

Action Plans

- a. Collaborate with Turning Point, Community Action Agencies, Oklahoma Primary Care Associates, Office of Rural Health, Indian Health Services, and the Oklahoma Commission on Children and Youth to utilize existing data that will assist collaboration in understanding and developing strategies to reduce barriers and challenges to receiving services and supports in rural areas.
- b. Utilize existing programs, such as Turning Point, Community Action Agencies, OCCY, and established formal and informal community groups to identify and engage local points of contact in obtaining consumer input on needed behavioral health services and support in rural areas, as well as identifying avenues for information dissemination on the availability of services.
- c. Partner with media outlets and informal community groups to inform rural individuals about available services
- d. Identify medical community partners and other community partners to expand the local capacity to use technology and telemedicine.
- e. Investigate agreements with bordering states on accessing behavioral health services.

2. Eliminate disparities in the availability of mental health and substance abuse service and support options in rural areas.

- a. Engage Governor's Transformation Advisory Board partnership agencies to review current disparity data (needs assessment, databases, and reports, analytic maps) to identify service gaps in the continuum of care for rural areas.
- b. Identify primary care providers in rural areas to develop screening, referral, and collaborative relationships with substance abuse and mental health providers.
- c. Develop a strategic plan with the Primary Care Association and the Federally Qualified Health Centers to increase linkage and improve access to substance abuse and mental health services.



Section IV

Early Screening, Assessment, and Referral to Substance Abuse Treatment and Mental Health Services are Common Practice.

New Freedom Commission
Related Recommendations

- 4.1 Promote the health of young children.**
- 4.2 Improve and expand school mental health and substance abuse services programs.**
- 4.3 Screen for co-occurring mental health and substance use disorders and link with integrated treatment strategies.**
- 4.4 Screen for mental health and substance use/abuse disorders in primary health care, across life span, and connect to treatment and supports.**

Overview

In a transformed system, the early detection of mental health and substance use problems in children and adults — through routine and comprehensive testing and screening — will be an expected and typical occurrence. At the first sign of difficulties, preventive interventions will be started to keep problems from escalating. Quality screening and early intervention will occur in both readily accessible, low-stigma settings, such as primary health care facilities and schools, and in settings in which a high level of risk exists for mental health or substance use problems, such as criminal justice, juvenile justice, and child welfare systems. Both children and adults will be screened for mental health needs and substance abuse during their routine physical exams.

For consumers of all ages, early detection, assessment, and links with treatment and supports will help prevent problems from worsening. Service providers across settings will also routinely screen for co-occurring mental illnesses and substance use disorders. Early intervention and appropriate treatment will also improve outcomes and reduce pain and suffering for children and adults who have or who are at risk for co-occurring mental and addictive disorders. Early detection of disorders will result in substantially shorter and less disabling courses of impairment. Currently, no agency or system is singularly responsible or