

Substance Use Disorders Technical Assistance for Culturally and Linguistically Appropriate Treatment Services for African American Transitional Aged Youth and Adult Beneficiaries

African Americans in Alameda County Needs Assessment Report

Prepared for:

State of California
Health and Human Services Agency
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Policy and Fiscal Division

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ATTACHMENT A: SUD Service Providers Online Survey Results

ATTACHMENT B: Preliminary ACBHCS Key Informant Interview Report

1. EXECUTIVE SUMMARY

The Alameda County Needs Assessment was conducted between April 2017 and June 2017 in order to guide planning for technical assistance (TA) and training efforts to support Alameda County Behavioral Health Care Services (ACBHCS) to deepen its culturally responsive system of substance use disorders (SUD) treatment for African American transitional aged youth (TAY) and adults. ONTRACK Program Resources (ONTRACK) conducted the needs assessment in two stages and collected information from four general sources:

- Online SUD treatment provider surveys
- ACBHCS key informant interviews
- SUD treatment provider key informant interviews
- SUD treatment beneficiary focus groups

The Online SUD Treatment Provider Needs Assessment Survey, and the Preliminary ACBHCS Key Informant Interview reports were submitted previously on May 1, 2017. They are incorporated in this report as Attachment A (Online survey report) and Attachment B (ACBHCS key informant report).

This section of the needs assessment report is an elucidation of the qualitative portion of the larger needs assessment based on thirteen (13) Key Informant Interviews--nine (9) with Alameda County level staff and four (4) with SUD providers. In addition, four focus groups were conducted with SUD beneficiaries. The information culled from these engagements will inform DHCS of both County, and provider-level perspectives of treatment service enhancement needs for African adults and transitional-aged youth. The interviews were designed to gather information in regard to the following outcomes:

- To understand what knowledge ACBHCS staff have of CLAS standards
- To understand what motivates SUD staff to implement CLAS standards and reduce disparities among African American TAY and adult populations
- To understand how well SUD staff believe the needs of African American TAY and adults are met
- To understand the degree to which CLAS standards have been internally implemented into the policies, procedures and practices of ACBHCS
- To understand the degree to which ACBHCS ensures that its contracted service providers implement CLAS standards to better serve its clients in general, and African American TAY and adults, in particular
- To determine what are the barriers to beneficiaries successfully completing treatment

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- **To determine the training and technical assistance needs of ACBHS**
- **To determine the training and technical assistance needs of ACBHC's contracted providers**

All participants were engaged in a discussion concerning the capacities and challenges of substance use disorder treatment services among African Americans, and culturally proficient approaches to recovery in Alameda County. Challenges include that there are no TAY specific SUD programs within ACBHCS; the most recent cultural competency plan is dated 2010; lack of transgender (trans) and LGBTQ affirming treatment settings; lack of data concerning program completion by beneficiaries; lack of clarity around the need for cultural competency (aside from non-English language language) among agency staff.

2. Methodology & Participant Profile

Participation in the Key Informant Interviews and focus groups was strictly voluntary. SUD beneficiaries were given an incentive of a \$25 Target gift card for focus group participation. Will Walker, CLAS project Manager, with the support of Peggy Thomas conducted all key informant interviews and three of the focus groups. ONTRACK consultant, Willy Wilkinson, conducted a focus group for transgender/LGBTQ beneficiaries. Each focus group and key informant interview lasted between one to two hours.

1.1 Key Informant Interviews

The thirteen (13) key informant interviews included representatives from:

- ACBHCS SUD/MH management and leadership
- TAY community service providers
- Community-based SUD treatment service provider administrators, and staff
- African American Steering Committee
- TAY specific programming

1.2 Focus Groups

Four (4) focus groups comprised of African American beneficiaries were drawn from include the following demographics:

- Adults, including women with children
- LGBTQ adults, including TAY
- Criminal justice-involved clients, and adjudicated TAY youth
- TAY men and women

Participants were given or shown a copy of a description of CLAS standards and their purpose to “advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and healthcare organizations.” The focus group sessions were recorded to ensure effective data collection. Staff determined that key informant interviews would not be recorded. During each session, the facilitator took notes on salient topics that key informants and focus group participants either emphasized or been stated by past informants and had become a recurring theme. After each session, information was coded by sorting the data into conceptual components so that the key points and themes could be identified.

3. Key Informant Interviews: ACBHCS

3.1 ACBHCS, Outcome #1: Cultural Competence and Equity

The purpose of this outcome is to understand how key players within ACBHCS understand the meaning and purpose of “health equity” and cultural competence. Is there a general meaning and mission around ensuring that SUD racial disparities are reduced and that cultural competency is a feature of the agency and its providers? The following question(s) from the protocol addressed this issue. (Appendix A)

Question #1: What is Health Equity?

Informants defined Health equity” in numerous ways. Many noted that it is a term used in Mental Health more frequently than SUD. One defined it very broadly: “I’m more broad. Looking at health not just of primary care but of community, financially stable with stable employment. Living in trauma free environments with healthy policies and guidelines for living.” Most all of the other informants defined health equity programmatically and said it is not a term that is frequently used within the agency.

One key informant was careful to distinguish inequity from inequality: “There is a difference between inequality and inequity. You can’t just treat people the same, they may require different things to get to equal, to outcomes.” The same informant noted numerous times that “API [Asian Pacific Islander] populations are at 1.7%, they are our lowest. [The] Main problem is access.”

Conversely, most informants defined equity as ensuring all people received the same level of access and services. One informant stated succinctly, “I see health stated, “We talk about health disparities all the time. Clearly African American lot, LGBTQ. We are looking at all groups and ensuring all get their fair share. Young adults are overrepresented in justice. Our largest clinic is at Santa Rita jail. Young people who should be getting services rather than jail.” One informant was careful to distinguish a personal definition of “health equity” opportunity to all residence of Alameda who are in need of behavioral health care services regardless of race, language, etc. Parental/family status. Organizationally, it shows up in contract language more and more. I’ve noticed more responsiveness. We increasingly talk about it and encourage it.”

Some key informants (KI) spoke specifically about health equity as an intentional action to produce equal outcomes for all in need of services. “Health equity is removing the barriers. Identify them then eliminate them to give people the opportunity to thrive fully. Equity being

fair. Giving them the same opportunities. Equal access, healthcare benefits opportunities. A different KI wanted to note that health inequity is about access and stated that “health equity is about disparities. Rectifying disparities. The Feds. hold us to accessibility.

Access. They want to ensure that there isn’t a segment of population who are not getting services.”

There was no consensus on what health inequity is, but the overall impression from informants is that it has something to do with ensuring an equal level of access. One informant stated directly that it is a matter of understanding than usage: “There is no common language around racial and economic inequities. People have heard the terms, but there are some people who have been in the system a long time and don’t get it. Some people have asked for a discussion about race as a way for us at the county to better understand and discuss the dynamics our providers experience daily but many just don’t want to have it.”

Question #2: What is your definition of cultural competence and why or why not do you think it should be a matter of policy and practice at the county level?

Informants tended not to give a definition of cultural competence. Those who did offer definitions thought that the term was inadequate. One informant asked, “What is the “it?” We most often come back to language. We have a significant population that speaks a non-English language. This has been a real challenge for us, perhaps the largest. It’s also about having service providers who see the complexity in serving different peoples. Whether it’s because of historical racism. Being comfortable enough to talk about it. Race is a thing many can’t talk about. And others want to talk about it too much.

Others offered different definitions of the term. “I prefer cultural humility because it makes one an on-going learner, and proficiency and competency assumes an end point.”

Another informant agreed that cultural competency was insufficient and offered cultural humility as an alternative. “I don’t use the term cultural competence. I use the term cultural humility: respect differences and commonalities and I am not the authority on all cultures. It’s for me to understand other cultures exist. It should be a matter of policy, a part of our ethos in every aspect in the agency. Culture should exist in the system, and every individual should make it their responsibility. Javarre [the Ethnic Services Manager] can’t be the only one, then the stereotypes of him occur. “We should practice what we preach. Both the provider and the agency should be held to an equal standard. The proof is in the practice. How you operationalize it matters.”

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Another suggested that cultural competency was too facile. "You can look at it from different lenses and points of view. I don't like the term. It's linear. That is a shallow approach of understanding the depth of experience, of understanding the environment and living healthy. I like the term cultural responsiveness. Understanding people's history and culture. It is important. We need to go beyond competency to adequately think about the needs of our TAY populations...deeper lens and reach. Cultural competency is not enough."

One informant saw cultural competency similarly as "being able to culturally relate to different cultures," because everybody doesn't have to come from the same place." This informant went further to state a theme that other informants discussed: cultural competence as a capacity to come to grips with both internally and externally.

"When I hear the term it's about external missions and goals. What about our internal mission and goals? I don't think it's important to administration. They say it some times, but usually in relationship to the clinics. They treat us like shit inside, then talk about cultural competence on the outside." Another informant seemed to confirm the sentiment that cultural competence is often seen as a competency relegated to a requirement for the providers: "when we talk about cultural competency we are talking about providers. As administrators we need to make sure our providers are culturally competent."

We've organized policies to provide CLAS assessments and trainings." One informant noted that cultural competence generally comes up for those in SUD when discussing matching of provider staff with services for specific populations. The informant stated, "We've had some debates here and in the field. We've had debate about whether race, sexual practice, language matching is necessary. I think it helps but is limited. And even when one does match, there is still the myth that all African Americans are the same, all Armenians are the same." The same person held that the cultural/racial matching "debate" ebbed and flowed based on whether clients were being matched with service providers who matched clients racially and culturally. "I believe that this conversation overwhelms the conversation of clients when there is no matching at all. When there is some matching the discussion gets more sophisticated and effective. We need to be careful of assumptions."

One participant's comment can be taken to summarize what may be at stake, and maintained that cultural competency was as important in the agency as among providers. "Cultural competence means that you are consciously and deliberately knowledgeable about the cultural influences and norms of the groups that you serve. In interacting with them and as a matter of basic humanity. People who administer the contracts make decisions every day about who

should get contracts to work with a diverse community. And they sometimes do this without cultural competency.

The person continued to discuss the impact of the absence in cultural competency on the provider community. "Money follows where people feel they have confidence in the provider. That confidence is sometimes based on people who look like them. They are quick to say, "I don't have confidence..." Without cultural competence, they think African Americans are sometimes incompetent and don't receive contracts because of the lack of confidence. Until competency was part of the audit and something you could get dinged on, nobody would really be doing things around the CLAS standards. I think the big challenge is people aren't comfortable talking about it."

Cultural competency was also viewed as an external force pressed upon the agency. "Organizationally, competency is an external, political force. The old paradigm of diversity is not enough. The providers and many of us are at that place." One informant spoke of the challenges to cultural proficiency at the county-level as a matter of changing leadership. "Five years ago we were on our way to conducting cultural competency trainings across our system but because of change of leadership within Behavioral Health it didn't happen. The training was based on the California Brief Multicultural Scale (CBMS). The new leadership has problems with discussing racial disparities.

Some think our former Ethnic Services Director was moved out, and viewed as an angry Black woman because she said we need to address race, we need to address disparities. We need White leaders to step up." Another informant simply eschewed a definition and spoke of cultural competency personally. "I want to learn and I want to learn the culture to be respectful. There are generalizations that can be made and when they are it is harmful. Cultural competency [as a term] is thrown around. When people use the term here, we may not be describing the same thing. We have a staff with different languages that I can't afford to learn. So, I don't know if it's even possible to be competent. The non-white population is more culturally competent. They have to be. I don't, it's an invisible knapsack, a privilege I have."

3.2 ACBHCS, Outcome #2: CLAS Standards Implementation

This outcome seeks to understand the degree to which CLAS standards have been internally implemented into the policies, procedures and practices of ACBHCS. What are the internal policies and practices that ensure the CLAS standards are implemented and met? The following question(s) from the protocol addressed this issue.

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Question #3. What has been done to recruit, retain, and promote a culturally and linguistically diverse leadership and staff attuned to the needs of the provider and service community? What key leadership positions are responsible that CLAS standards are met?

Question #4 How does the agency infuse culturally and linguistically appropriate goals, policies, and management accountability throughout the agencies planning and operations?

Question #5 Does ACBHCS have a cultural competence or CLAS plan?

Question #7 Does the ACBHCS have a Cultural Competency Committee?

Every interviewee stated that there was not enough being done to recruit and retain a culturally and linguistically diverse leadership attuned to the service and provider community needs. Two of them stated directly that nothing was happening and stated that the county was doing nothing. "They might fulfill a quota. It's more than recruiting; it's how you treat diverse people once they are inside... [they] treat us like we are not qualified, minimize our work every day. Another reiterated this position that not enough was being done to recruit and retain a diverse staff: "I've been seeing a strong pool of African Americans being pushed out. Some not completing probationary period. Across leaders all white males, except maybe one Filipino, and one white woman. Those over the systems of care are white men. We met last week with the supervisors and asked why is it so white. Rebecca Gephardt, the interim Health Care Director said that there are no qualified people of color out there seeking these jobs." Other informants were less categorical in their responses. One stated that "efforts come and go. The service providers pretty much match African American [representation in the] County, at about 12%."

As an example of an effort for our service providers, we piloted a new model within direct services for the reentry population. We required that people with lived experience have to make up 50% of the staff. The staff of the programs/agencies changed and became more diverse. This shows that change can come from bottom up to top down. We also funded a self-assessment tool for mental health providers to assess their diversity. Unfortunately, SUD doesn't have innovation funds." Another informant stated that not much was being done to recruit a linguistically diverse staff. The informant stated, "leadership is not doing much linguistically. They don't offer an incentive for people with different languages. Everyone who speaks a non-English language should be designated bi-lingual. I felt inferior here for a time.

Concerning who is responsible for the Cultural Competence Plan, there did appear to be some confusion concerning who was responsible that CLAS standards are met. Two informants stated that it is everyone's responsibility. One stated, "Everybody is with no exception. The decision-

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makers. We get some trainings and it is all talk. I see all white men and no linguistic diversity. If I close my eyes and listen, it matters, open my eyes it does not [emphasis, the informants]. Another stated that the “operational leads are responsible for the implementation of CLAS standards.... Some may see Javarre as responsible, but he has not been here long enough to accomplish all that needs to be done now.”

Another informant reiterated the notion that there was no singular person who is able to implement the CLAS Standards at the county-level. The informant stated “There is no key leadership responsible for the standards. We had a manager (Gigi) who was provisionally in the position who had to be classified as senior program specialist (10 years in position). The new Ethnic Services Manager doesn’t have the authority to make it [CLAS] a substantial aspect of the organization.” This informant recounted a story that suggested that the resistance is structural. “There is a leadership group, just beneath the executive level. People at that level asked for a discussion about race internally.

The response was terrible, one person said just ‘tell me what I can and can’t say.’ I think the problem is structural. There are people who want to stay longer than they have the passion to get things done. They know they are getting a fixed retirement that is set, so they just want to hold on. This is a major structural issue. Now we just contract out the things that people don’t have the passion for. People are territorial; stake out their territory. System needs a structure that allows us to work around bottlenecks. We need to be adaptive and dynamic to meet the cultural needs of our populations.”

An additional informant reiterated the challenge of CLAS implementation at the county level. The informant recounted, “there is an item on our agendas for cultural sharing. It came up in a meeting and the new interim asked if the cultural sharing item should remain on the agenda going forward. The conversation lasted 45 minutes and most of the attendees wanted the item off the agenda. Some honestly stated that they were uncomfortable. There will be a presentation made on why it’s important for those of us who work at the County. Yet, another person recounted the history of the cultural sharing item on the standing agenda of the Senior Leadership Team. “Matthew Mock visited and he had us go around and do cultural sharing. We combined this into our meetings. Once or twice a month we meet for two hours. This is precious time. We have sharing time. It drove home how different we are. Yet, it links us at a basic level. There is a visceral recognition that we bring culture into the workplace. It [cultural sharing] has done what we wanted it to accomplish. We have a mission and value statement. This is who we are and CLAS is part of it. The same informant also wondered if the significance of cultural competency learned through the sharing filtered throughout the organization: “Maybe it doesn’t filter down that this is for real.”

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One informant who has been with the Agency for a significant amount of time summarized the history of responsibility for CLAS/cultural competency as, "All Leadership is responsible, though we say Ethnic Services, but there are 30-40 key leaders. It starts at the top and we are falling short. You can count people of color in room, on one hand. It has to start with the Behavioral Health Director. When the Ethnic Services Manager is left out, that role becomes a voice in the dark. If the Behavioral Health Director and the Ethnic Services Manager is aligned, it spreads throughout the organization. That alignment doesn't exist.

Ethnic Services now reports to the Medical Directors Office. Can you get all the authority you need from this reorganization? New interim two months ago did a new org. chart, and a lot of things were moved around. The position of Ethnic Services Manager has lived in 4-5 places over the years." Still another echoed the sense that leadership should be diffuse, a personal and professional commitment of all employees: "It's so sad. The fact that we have someone responsible for CLAS is a strength. It's a strength that someone is looking and someone is holding the system accountable. Challenge is its one person. It should be a higher level person. It's such meaningful work if it doesn't permeate through the system it will get lost in the meaningful work we do. Technically we all should be leading this. For my...work I work collaboratively with him. I think we can do better as a system."

Contrary to some of the previous informants, someone else believed that there were substantial things being done concerning CLAS implementation at the county-level. "The Ethnic Services Manager, Javarre, is responsible for CLAS. Since he's been there, he's been given staff. And he's taking the bull by the horns. Trying to get CLAS and cultural competency agency wide. We need education and a consistent message from the top. He can't do it alone." In an interview with the Ethnic Standards Manager, he informed the interviewer that he has been given "temporary staff" to assist in cultural competence efforts.

There was no general consensus concerning a means to infuse cultural competency in the agency. An informant went so far as to assert that, other than compliance with specific mandates, the mechanisms are such that "only loud obnoxious people can infuse them during planning."

Another stated, "there is not much infrastructure. It's being created. There are really no policies. A culturally responsive committee is in development, but there is no effective means for decision-making. The policies have to be developed and then taken to executive committee. This is not a meaningful, strong mechanism. Executives should be part of the process at every stage. Conversely, another informant believed that something significant was happening at the

agency with regards to cultural competency.” The informant stated, “I know we do have a plan and we’re rolling it out. Javarre is updating it. We weren’t good at writing policies and procedures. We now have a policy and procedure template, goes to QA who gives it a number, then it goes to the Expanded Leadership/Administration of 30+ leaders, then to Quality Improvement and is distributed across the organization for implementation.”

Informants agreed that there is a cultural competence plan, but only one had a recollection of what is in it and if it was up to date. All agreed that there was no comprehensive plan across the agency. One stated that “there is a cultural competency plan, currently its 2013. The cultural competency plan is separate and may not be a part of the larger plan. It definitely does not encompass both Mental Health and SUD.” For still another informant all that mattered is that the cultural competence was not a constitutive part of the life of the organization. “All I know is that there is no plan I have at the ready, at my fingertips, something I see, taste or hear.”

The county assesses the implementation of CLAS related standards of providers through an annual assessment instrument in which a number of questions related to CLAS are asked. But still this is not enough as viewed by one of the informants who suggested a strategic approach to infusing cultural competency throughout the organization. “You have to start with the Expanded Leadership Group. We need their buy-in. If we start in community, but don’t get the people at top buying in, we fail. The group needs some sort of session that gets them ready to see the importance. Whenever we start to talk about race and culture it works for a minute then goes away. It can’t just be Ethnic Services. The leaders have to be comfortable to share.”

3.3 ACBHCS Outcome #3: Meeting the SUD Needs of African American Adults

The purpose of this outcome is to understand the degree to which ACBHCS ensures that its contracted service providers implement CLAS Standards to better serve its clients in general, and African American TAY and adults, in particular. The following questions from the protocol addressed this issue.

Q. 8. Overall, how well do you feel that ACBHS providers’ meet the cultural needs of its African American TAY beneficiaries?

Q. 9. Does ACBHCS analyze data collected by SUD service providers to monitor access and outcomes by racial/ethnic, TAY or LGBTQ cultural populations?

Q. 10. How is data used to allocate resources and eliminate healthcare disparities?

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One of the most important issues noted concerning transitional aged youth with SUD is that there is no system of care for them within Alameda County SUD. Informants noted that ACBHCS has no "TAY system of Care, and there is no AOD TAY-specific services. TAY is a part of the Child and Young Adult System and the individuals who are the most seriously mentally ill and highly traumatized. The merger happened last month." Another staff person within mental health stated, "we don't have substance use treatment services geared to TAY. We have adolescent and TAY services. There is no place to send them with SUD specialty. There is mental health but they are not good with SUD; it is a particular issue. For SUD we send them to adult programs. Some of the mental health is pretty high end. Young adults. EBST programs 18-21. The majority go into adult substance use."

In general, informants thought providers met the cultural needs of African American adults and TAY somewhat well. One informant noted that the county "counts numbers well," but asked "how do you determine quality?" The county uses a standardized assessment tool, the CANS (Child and Adolescents Needs and Strengths) and the ANSA (Adult Needs and Strength Assessment) to measure quality. The tool includes a cultural factor domain to measure program impact on clients. The system to measure program quality serving African American TAY and Adults is not uniform.

Several informants stated that the county has extensive data that is "made available upon request." One person noted, "Some of us have requested dashboards and looked at some of the indicators concerning how well we are serving our TAY. The challenge is we don't have enough people looking at the data. Nobody is saying: 'this program is working for this population and not with others.'" One person stated that data they have collected concerning how well African American TAY are being served has allowed the department to make an argument for prevalence in substance abuse rates among clients, aged 18-24. The informant stated that "the substance use rates are highest for that age. Where are they being served in our system. No one adult provider stood out as predominantly serving TAY. We are looking for grants that are TAY specific. We do use data to look at quality. The disparity between TAY and other population penetration rates. I'm using prevalence to build an argument for more funding for our TAY population. The system for measuring quality in the county measures penetration/access but does not measure program retention."

Given that the system appears to be most concerned with penetration rates, one informant notes, "it is a challenge to measure outcomes with our current measures. The bar for measuring access just went up. The way we do it now is by waiting lists. We know which services have waits and which don't. Based on the wait list, we budget accordingly." However,

the bar for measuring treatment outcomes, according to one informant, is poised to improve since "EQRO [external quality review] standards are beginning to incorporate retention as a component in measuring the quality of services provided to clients.

The lack of measuring retention rates of African American beneficiaries may not only be an issue of technical ability determining measures according to one informant who views it as a lack of will and concern. "I think we serve them [African Americans] somewhat well. But nobody really talks about African Americans and the needs of African Americans. They aren't talking about retention rates. When I look in the room with the exception of Magnolia, the orgs. are mostly run by white folks, and it's sad to say, because it shouldn't matter, but that means there is largely silence about the specific needs of African Americans that determine their success in treatment."

3.4 ACBHCS Outcome #4: CLAS Training and Consulting Needs

These questions were asked to determine the CLAS related training needs within Alameda County Behavioral Health and its contracted providers.

Q. 11. How do you determine the training needs of your staff as it relates to CLAS?

Q. 12. What types of training would your Behavioral Health team, and your contracted providers benefit from that would improve their ability to better serve the African American TAY populations?

The capacity to determine the training needs of ACBHC staff as it relates to CLAS is an internal challenge for the agency. According to one informant, efforts to survey staff was initially approved by the agency's former deputy director, but has since been placed on "pause."

Informants suggested that the department has the following training related to cultural competency/CLAS:

Racial literacy and awareness development

"Everyone should be able to talk about race, ethnicity and culture easily. Currently there are some staff who won't even identify clients or people by their race, etc. How can we speak of African American TAY needs if we can't exercise this basic capacity?"

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"We aren't too bad compared to a lot of places. We have well-meaning people and we need patience with those who want to avoid explicit discussion of race. We've been down this road before and people get uncomfortable."

"Our leadership is blatantly disrespectful to staff of color. The culture is toxic. How can we make effective decisions about service providers if we can't get past this internally?"

"People in HR need training because they are front lines and make decisions. This doesn't look good."

"We need help in understanding cultural humility. Some people need help on understanding the system. Our "high end" systems: jails, hospitals black males are largely Black males."

I only see CLAS come up during audits not planning. There will be no change in the organizational will to address the needs of African Americans or in which providers receive contracts until this changes."

Training for programs serving non-English speaking persons

"I don't think the support should just be for African Americans. Our Latino population is large and growing. One-third of beneficiaries are Latino. We struggle most with linguistic."

"We need language support for our service providers. The city of Fremont alone has multiple languages."

"What kind of T/A. We need to become comfortable talking about race. Understand implicit bias. Racism is a relationship toxin."

Training for women with children

"I know as a fact we have been approached by perinatal treatment providers seeking training opportunity to help staff learn specific tips and pointers and information relevant to serving pregnant and perinatal issues, custody, relationships, SUD, etc. Women training women to train women. The Nuts and bolts stuff."

4. Key Informant Interviews: Substance Use Disorder Providers

4.1 Outcome #1: Cultural Competence and Equity

The purpose of this outcome is to understand how some providers understand the meaning and purpose of equity and cultural competence. Do providers feel equipped to address the cultural competence needs of African American beneficiaries? The following question(s) from the protocol addressed this issue. (Appendix B)

Question #1 Do any of your programs target African Americans?

Question #4 What do you consider to be YOUR, greatest challenge(s) in outreaching, engaging, and effectively serving African American adults and TAY in Alameda County?

Question #5 Does your agency have a cultural competence plan? Does the Plan include specific strategies for staff development related to cultural competency, specifically for working with African Americans?

Two of the four key informants asked that the report of information gleaned from interviews not in any way disclose their identity. The two informants who requested that the information reported be conveyed in a way that masked their identities, expressed fear that their candidness could lead to a lack of funding in the future. Consequently, this section will not follow the same format as the previous section.

According to informants, the traditional treatment modalities are not effective with African Americans. Given that ACBHCS informants attest that measuring retention—and by extension—success is at best, challenging—this claim is significant, if not demonstrable. The informants suggested that community defined solutions had better promise given the historical segregation of African Americans and, now a “gentrification in the funding,” which has led to no targeted funding for African American clients. A provider stated, “the medical model does not work for us. The medication research was done on thirty-five-year-old white men. African Americans are so frequently misdiagnosed and given the wrong medication. Blacks people need a cultural framework that works for them. Medical model is doing more harm than good.”

In keeping with the effort to seek equity and cultural competence, another informant stated that “equity is not only about people receiving the same level of care, it’s about results that rid us of these unconscionable disparities. Cultural responsiveness does this because it honors and recognizes cultural strength and nuances particular to that group, African Americans.” Better

than taking something from a European culture and modifying it, is using strengths from within a culture, vetted by the culture and rooted in it through community adaptations that are responsive to local transformations.”

In making the case for culturally specific programming one informant stated that African Americans are more likely to “struggle with cultural identity and stereotypes that do not allow them to deal with immediate causes of PTSD, for instance, in ways other individuals might. So, you have to use a strength-based approach because they see themselves as coming from a deficit. We use empowerment, strength-based [approaches]. We tap into helping them see their strengths. Help them find what’s good in them as an African American TAY. Systemically, the county needs targeted programs. Working with African Americans in this group is different; poor academic success, etc. We have to be able to address the cultural piece, discrimination, oppression, justice involvement.”

The participants all felt that traditional programming did not make African Americans feel comfortable leading to them not completing treatment. One spoke of developing an “African American holistic services center that focused on mental wellness. The Center would apply “African-centered practices that were more welcoming, healthy, and affirming, a place where we don’t have to apologize for our presence, our tone, our voice. Dr. Ken Hardy [a renowned Black psychologist] would assist us on how to deliver these holistic wellness services.” For the informants, the lack of targeted funding to support these efforts of community define practice is a sore point. This became apparent in their discussion of how funds through the Innovations Grants Program, funded by the Mental Health Services Act, have been allocated or not allocated at all.

In 2009, as a response to inconsistent outcomes with African Americans in treatment, ACBHCS leaders commissioned a “utilization study” to explore the “myriad issues affecting behavioral healthcare services within the African American community” (<http://acinnovations-cedar-14-app.herokuapp.com/secondRound2011>). The study resulted in the African American Utilization Report: Goals and Recommendations, Winter, 2011. (http://acinnovations-cedar-14-app.herokuapp.com/pdfs/AlamedaAARreport_FINAL.pdf). The report, according to the ACBHCS website, delineated several areas of focus that could be addressed through “existing BHCS programs.” The areas were: outcome measures, clinical trainings and practices, and workforce development. ACBHCS continued the study by funding twelve innovation fund projects focused on African American clients.

Three of the four informants made reference to the African American Utilization report. According to these informants 1.2 million dollars is being held for programs targeting African

American clients. This “2nd round” of innovation funding that has, according to accounts not been allocated, is both “holding programs hostage” and not serving the African American community the funds were designated to support. Their explanation for the withholding of the funds has to do with the transitions in leadership that has occurred in the past four years from leaders who racially matched the community that makes up the majority of the service population and a “lack of caring or belief in community defined practice. In the words of one provider: The county needs to allow services to be designed and developed in a way that is more responsive to the African American community. Hiring more African American males in particular. Providing funding to African American providers. We need more Black providers to bill for Medi-Cal, [and] more Blacks to have a voice in their service treatment. They need to stop holding Black service providers hostage so they won't speak up. Mary Thomas infused 1.2 million dollars for African American innovations under the Mental Health Services Act.”

As a result of the Innovation Study an African American Steering Committee has been developed. By all accounts, the Steering committee has had a troubled relationship to BHCS and serves much more, at best, as an advisory committee than a “steering committee.”

4.2 Outcome #2: CLAS Training and Consulting Needs

These questions were asked to determine the CLAS related training needs within Alameda County Behavioral Health and its contracted providers. The following question(s) from the Providers’ Protocol addressed this issue.

Question 6: What components of your agencies CLAS Plan can be improved upon to enhance service delivery and positive outcomes for African Americans in your program?

Question 7: How might a CLAS plan assist your organization with developing ancillary relationships within the greater African American community?

Question 8: Please explain what type of support you might need to improve your understanding, compliance, and effective implementation of the CLAS Standards?

All of the providers interviewed worked in organizations that had an organization-wide cultural competence plan. Three of the four providers had received technical support from ONTRACK Program Resources to develop the plan. According to one of the providers: we’ve had a cultural competence plan for close to 10 years. We also have a committee that meets once a month to discuss cultural competency. The plan is for the entire organization and program specific....we have cultural competence training once a year.” Another provider noted that they “have a plan

but it has not been updated in about three years.” The informant continued by stating that they’d like to see more African American specific training but we have real challenges with staff working with LGBTQ. They are tougher to work with than other African American clients.”

One of the providers discussed how they’d been able to retain a commitment to CLAS standards. “We started with senior management looking at their own biases, etc. The Board, management and employees all took a survey on what Cultural Competence means two months ago. The results showed that we needed to revise the plan. I think having management involved is the key with staff input and evaluation. We are evaluating the whole process: what management is doing, how it’s trickling down to staff; we get staff input.

The providers requested the following types of training:

Training for serving African American specific training

“It’s necessary that these young people see themselves as something positive and not just deficits. We need training of staff on the assets of African Americans so they can see these young people themselves as assets. Sometimes we are the most important mirror they have.”

“It’s about self-care. These systems want to keep you inside. They need us to survive. Responsiveness means we adapt, not them. They don’t want us to be able to care for ourselves. We need training that helps us create our own community places where we can care for members of our community in holistic ways. Dr. Nobles, for instance, is designing a Wellness Hub for West Oakland. It’s in the design phase. You shouldn’t have to be a Dr. Wade Nobles to get a contract, but that’s how they are. We always have to be twice as good as everyone else.”

“The county needs to promote the ‘community-based learning’ support for African Americans that came out of the Innovations Project. Can you help us find ways to use what we’ve learned with other providers?”

“We’ve been getting support that offers strategies but not for just Blacks. It’s more general. The general strategies we’ve come up with don’t work for Blacks. When strategies don’t work, people blame the person [client].”

Anti-bias Training and Cultural Competency Support

“Some of these providers and the county need a cultural competence training that gives them the correct definition of what cultural competence means from a minority perspective. These

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people will tell you 'we are one. I look at you just like anyone else, no different.' Please! I just saw you speak to these strangers like you're old friends." Until they get over that, African American clients will not be served by this system."

"The system is in silos so we get no cross-cultural, cross-disciplinary training. We need a training that is comprehensive spiritual, employment community based wrap around services. And SUD doesn't want any more drug offenders or addicts as counselors. They want a high school diploma, transcripts, and other criteria. They don't want people who know first-hand the lives people have lived and can relate to them."

5. Focus Groups: Clients/Beneficiaries

5.1 Transitional Aged Youth Focus Groups

Two focus groups were conducted with a total of twelve (12) transitional aged youth who participated in TAY specific programs funded by ACBHCS. This section of the report details the content of those discussions. (Appendix C)

Paths to TAY Programming/Treatment:

The young people took multiple paths into TAY programs. Not all of the participants went into the program because they were suffering from substance use disorders. Some were mandated; some entered to address issues of anger management, and still others were court mandated. Both programs appear to have attracted these specific young people through programs that allowed them to do something they enjoy. Substance abuse prevention/intervention programming is then introduced through the asset-based programming.

Male: "My mom tried to find care for me. I went to a therapist. Therapist referred me to rehab (Thunder Road). I didn't complete the rehab plan and went to 9th grade already using heroin, ecstasy and pot. I then then went to AA when I was 15. I couldn't relate I was the youngest person there. I'm 23 now. I understand how AA works more now. I found out about this program I'm currently in from my friend who works here."

Female: My probation officer told me to attend here as a court mandate. Since I've been here, I was with a counselor doing anger management with me. The drug counseling was a part of the anger management. Those program doesn't tell you that there is a drug treatment program or counseling. We have discussions about drugs here. Healthy eating and sexual practices are the biggest thing here." In response to these comments, the facilitator presented the group with flyers that advertised substance abuse counseling programming offered by the agency. Every participant in unison, nearly shouted, "nobody looks at the handouts on the front desk."

Female: "I heard about this program through a staff person here who is friend of the family. I had certain talent and they had a program that allowed me to dance, so I came. Since I started dancing, I heard about Sister's Circle. It's all girls who go through a lot, support each other, and solve problems. We talk about drugs in there some, but it's not why I joined it."

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Male I was at the Boys and Girls club first, but then heard about this program. It is more community oriented and doesn't charge. I'm here because somebody heard me singing and told me about the program."

Male: "I came from Michigan. I came out here struggling at 21, my sister put me on, then I came up here 24-7. I at a 4th grade reading level, took a GED class (YUexcel) here and they improved my reading level, and now I'm going to College. Education has been most important thing here for me. I smoke but I don't have a problem with it. Everybody smokes."

Female: I was referred by my school. My coordinator told me about the program. They heard me singing, and so they referred me to the program. I have a therapist. We talk about drugs some times."

What Participants Want in a Treatment Program

Participants wanted a variety of things from a treatment program. Most all needed stability, a counselor/therapist they could relate to and feel understood, and to be taken as an African American individual with talents, and not stereotyped.

Male: "I was in Narcotics Anonymous. The one thing I learned was about a higher power. I'm now motivated because I know what my career path is. I can't do labor anymore. Software engineering is my path."

Male: "When I was 16 I was in an addictive personality program which they integrated with substance abuse. I was in Louisiana and they were harsh. Beat me up emotionally, gave me logical reasons not to do drugs, alcohol, etc. I have a personality that being hard on me worked."

Female: "Programs need to diversify. I'm female and my counselor is a Black male. I'm not sharing my sexual history with him. They do have a woman counselor, but they gave me the male. We don't have Mexican counselors, Black females, different races to relate to. I also need a match. I won't open up to someone who doesn't get me."

Male: I'm a Black, Mexican Muslim and it's Ramadan tomorrow and the treatment person or counselor who doesn't understand why this is important to me, I can't identify with the person." I need somebody I can identify with."

Female: "All I can say is Y'all need to diversify."

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Female: "I look for stability. I need structure, not just a random place to be. I look for community and someone I can relate to. I prefer somebody of my gender and race. They don't necessarily have to have gone through the same drug problems as me."

Male: "This program is a one stop shop. They used to have a program that helped you stop doing drugs and alcohol. Those people left. The program helps us by helping us do things we love. And you meet people who like things you do. The Man Up program. Dj'ing, singing, and we have a GED program. There used to be more people. There was more professionalism. They have therapy here. But I wouldn't come here if I wanted to stop doing drugs. The environment was different, staff was everywhere."

Female: "One problem I face is homelessness with my child; I'm having problems with my foot, I was shot; Being a single mom and trying to make sure he's a success."

Male: "There is a lot of information here about condoms, but not drugs. I can stop when I want to. It's medication. Dr. recommended. My drug is marijuana and that drug is legal. Cocaine is not. Weed is good, old grey head white people doing it. So, we can do it. People grow up to be good people: doctors, judges." [The facilitator asked the participant if he'd known people who have gone to jail for possessing marijuana.] I know people who have been taken to jail for it. I think it's good and bad. I heard on the news that it helps a 3-year-old baby stop his seizures. But people also spend too much money on it. That's when it's bad. But they can't tell us not to do it when everybody is doing it. Ricky Williams smokes weed and they say the weed slowed him down. It wasn't. I think cigarettes are worse than marijuana."

Female: "A lot of African Americans have been locked up for drugs. My cousin went to jail for smoking a joint, and went back to jail for smoking."

Male: "Yeh, they look at us as criminal because we do what everyone else does. Racist cops looking, slowing down looking, then pulling off laughing because they made us flinch. I'm African American with dreads, when I go get a job, I'm judged."

Female: "For me as a peer, since I work with newcomers, drugs are a yes and no. Some people smoke to look cool. I don't think they know the dangers. Here you only learn about it if you ask."

What Works in Programs/Treatment

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Male: "It's expensive. Good help costs money. Before they even talk to you, they give you pharmaceuticals."

Male: "The substances in our bodies aren't the problem. They want to control chemicals in my body. They gonna give me Dayquil to get me over my addiction to Nyquil. They want to treat the drug not cure us. I didn't know you can get turnd on Nyquil. Cure the symptom not the problem."

Female: "They do nothing really around changing our wills, motivating us. I smoke because I have a lot of free time. I'll never do cocaine or heroin. But they say weed is gateway. For some people it is medical; for some it's a matter of the will."

Male: "I completed addictive personalities program in Brentwood. Focus was on self-harm, they found the root cause. I had issues with my birth family. They got me through it. They had a lot of counselors and made sure we were with the right one. If one wasn't working they moved quickly to move you to another, but they did a lot to make sure the first one worked."

Female: "They actually listened to me. They did not attempt to medicate me before evaluating me. And they regularly checked in with both my mental and physical well-being."

Male: "I suffer with Depression anxiety and PTSD: I need a secure setting, stability; Happiness; People who care, want to be here and be their real selves. I can smell out a phony. You show you love people. I don't think people really care what the youth think."

Female: "I need respect, not just basic mutual, authenticity. Don't give me the white people television show stuff. I don't like people who do things cause they get paid. Because you say you care doesn't mean you care; show me the effort, the realness, if you sound like your book and you're just writing stuff down, you ain't empowering me. You gotta get in our hearts that'll give the power. Relatability! I can't go to no white woman and say, me and my momma... She won't get it."

Male: "YEEEESSSSSSSS, YESSSSSSS. Respect is huge. It is huge. I come from a structured background. When I was at Thunder Road, my white counselor said to me "what's up, after I said good morning." That shit makes me so mad. They think they relating by speaking slang. I said good morning, not 'what up?' My addictive personalities program, they were going to put me in a group that was all low-income black. I was adopted by whites, I spoke up and said don't do that. I feel like there is always prejudice, assumptions about what program I should be in." They grouped me with people of my own race. The intention is malicious when you group us by race. This is a pattern in programs. Evaluate first."

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Female: "In terms of my drug program I started with a woman who stuck a stereotype on me. She said, 'do you think its those girls you hang around with are the problem.' She had never met my friends, just seen us when they picked me up."

Female: "Finding myself... I need a counselor I can truly talk to."

Female: "White people are ignorant when they try to slang and be like they are black and can relate. One of the best counselors is just her white, middle class self and shows she cares and wants to understand. There's nothing she won't do for us if she can. She's real, doesn't tell us exactly what we need. She takes us as individuals. People tell me I talk so white."

Male: "When it comes to African Americans and hybrids like myself, white people need to take the back seat, you may not have to [do] that with other diverse groups, but with us, 'KNOW ME.' Don't stereotype, we need to take the lead in our own strategies to heal. If they want to get in the front of us when we protesting and the cops come. That's how they can help. Get in the front line."

Male: My greatest challenge is stable housing. I'm 24 and no longer can have any transitional housing. The amount of closed doors I get when I look for a job. Finding myself through finishing school. Drugs, stable home and a job. Just focusing more on myself. I allow my environment to shape too much of what I do. Like racism, it can be discouraging. Depression is real. And it seems like it's gonna get worse."

Female: "I'm still in my therapy class, every Monday. It's been healthy. The therapist gave me a plan. They set goals for me. Race is never an issue here."

5.2 Focus Group: Mixed Group Adult, Including Women with Children

Demographics

This focus group was conducted with a total of nine (9) adults, ranging in age between eighteen (18) and forty-nine (49). Four (4) of the participants were female. One (1) was transgender (male to female), and four (4) were male. All had been incarcerated at some point in their lives. Three of the women had been court mandated to treatment. This section of the report details the content of those discussions.

Pathway to Treatment

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Participants had multiple pathways to treatment. Some were court mandated, others were part of a program while incarcerated and continued in the program upon release.

Female: "I had a recent relapse, and I went back into treatment because now I have a baby and I need to be able to stay clean for her. I heard about the program through CPS."

Female: "I was mandated, all of us were," pointing to two other participants.

Transgender (male to female): I was at the east Oakland Community Living Shelter. I'm transgender. Look at me. I wanted to be where the women were. I didn't want to be with other transgender, but they only allow me in the rooms with other people who were transgender. I ended up here after years in and out of jail for prostitution.

Male: "Turned myself into the salvation army and I did meetings there. And computer work. They keep it real." A.A. is a joke. The people are narrow and uptight. I also used Goodwill. If you're homeless and stick with the program, they give you a wardrobe opportunity. I picked up suits, worked the computers and did mind mapping.

Male: "I was released from Santa Rita. Had no insurance and no primary care. I got with program Roots and was able to get Medi-Cal, and a DL [driver's license]. I'm learning patience. I want it now. On the streets, the money comes fast and it goes fast. I don't have the patience for the slow money. If Roots hadn't been on the inside, I wouldn't have gone to them when I got out."

What's Needed in Programs

Male: "It's the behavior modification that's needed and that means we need to have more intense classes."

Female: "Has to be a place that allows children. I can't be without my child. And no Blackout for a month. Need GED help and employment."

Female: "there can't be any sugar coating, just keep it real with out talking down to me."

Female: "They need to be trained. They won't let women come in my room because I'm a lesbian, so I can't be alone with women with my door closed, they have to be open. They are rude."

Male: “They gotta believe in me. The power is all mine to change, but I can’t be in a place where they treat you like you’re no good and they’re just here for money. Some of ‘em act like they just got outa treatment themselves.”

Transgender: “I got in a fight because someone yanked me outa a bed. They didn’t even listen to what I said. They just kicked me out because I didn’t fit their criteria anyway—trans and Black. They need to be trained to understand.

Male: “Programs need to be away from the liquor stores and away from the neighborhoods where I get my drugs in the first place. We don’t need to be in programs in the same neighborhoods that we got into trouble.”

5.3 African American Transgender (Trans) Focus Groups

In keeping with cultural responsiveness and the request of the consultant who performed the focus group with African American transgender people in the presence of an ONTRACK staff person, the following section is the full report prepared by ONTRACK consultant Willy Wilkinson.

Introduction

African American transgender people have a high incidence of substance use, misuse, and abuse, yet respectful, culturally competent treatment options for this population are extremely limited in Alameda County. The combination of anti-trans bias and structural and individual racism is devastating for this population.

The National Transgender Discrimination Survey found that 26% of 6,456 transgender respondents nationwide (all races) used substances to cope with the stress of discrimination based on gender identity and expression. Of those who experienced family rejection, 32% of respondents (all races) used substances to cope.¹

Thirty-four percent of African American trans people live in extreme poverty, reporting an annual household income of less than \$10,000. Forty-one percent of African American trans people have experienced homelessness at some point in their lives. Forty-nine percent (nearly half) of African American trans people have attempted suicide. One-fifth of respondents were

¹ Jaime Grant, Lisa Mottet, and Justin Tanis, “Injustice at Every Turn: A Report of the National Transgender Discrimination Survey” (Washington, DC: National Center for Transgender Equality and the National Gay and Lesbian Task Force, 2011). Accessed May 26, 2017.

http://www.thetaskforce.org/downloads/reports/reports/ntds_full.pdf

HIV-positive, and 10% did not know their HIV status. Twenty-six percent of African American trans respondents were unemployed, and half of black trans people have been compelled to sell drugs or engage in sex work for income at some point in their lives.² A study of African American transgender women in Oakland found that participants used substances in order to engage in sex work.³

African American transgender people indicate that they need residential substance use disorder treatment in Alameda County, yet some treatment organizations have expressly denied services to African American trans people simply because of who they are, in direct violation of California law. In 2016 a representative from the California Department of Health Care Services expressly informed a substance abuse treatment provider in Alameda County that they must only provide treatment in accordance with birth sex. It is extremely problematic when state representatives are advising local treatment organizations to discriminate in violation of state law.

On May 17, 2017 African American trans people met in Oakland for a focus group to discuss access to substance use disorder treatment in Alameda County. Forty percent of the participants had been denied treatment because of their trans status. Participants underscored the need for affirming, trans-competent treatment options with providers who understand their challenging life circumstances as people who are struggling to survive. They seek disability-accessible treatment from providers who recognize the stressors they experience as African Americans. They seek treatment in locations not surrounded by liquor stores, that utilize modalities that are affirming rather than shaming. One participant stated a preference for harm reduction approaches as opposed to abstinence-based.

Participants would like to see wraparound services that provide substance use disorder treatment with expertise in medical addiction treatment, shelter for homeless and marginally housed people, mental health support, medical care, health education on sexually transmitted infections and transition-related surgery, access to PrEP, job skills training and employment opportunities, safety support while engaging in sex work, and childcare. Mobile support and late-night shelter hours were also suggested. Participants overwhelmingly stated the need for social support in LGBTQ communities, especially transgender communities.

² Jaime Grant et al. Injustice at Every Turn: A Look a Black Respondents in the National Transgender Discrimination Survey. Accessed May 26, 2017.

<http://nbc.org/sites/default/files/trans-adjustment-web.pdf>

³ Toru Nemoto et al. Substance Abuse and HIV Risk Behaviors Among Transgender Women in the San Francisco Bay Area. Accessed May 26, 2017.

https://caps.ucsf.edu/uploads/pubs/presentations/pdf/nemoto_apha.pdf

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Recruitment

Willy Wilkinson organized the date, time, and location for two focus groups—one for trans people (all identities) and the other for men who have sex with men. The consultant secured a room at Oakstop, a known venue that is both African American and LGBTQ-friendly, as well as centrally located in downtown Oakland across the street from BART. The consultant recruited for the focus groups by contacting organizations, providers, Facebook groups, and individuals by email, social media, phone, and in person. Flyers were distributed to mental health providers, substance use disorder treatment facilities, LGBTQ service providers, healthcare organizations, transitional age youth service organizations, and other organizations throughout Alameda County. Organizations included: AIDS Project East Bay (three locations), Tri-City Health Center's Trans Vision program in Fremont, Public Health Institute, First Fund for Youth, Pacific Center for Human Growth, Gaylesta (LGBTQ therapist organization), Ark of Refuge, the Crush Program, East Bay AIDS Center, Alta Bates Summit Medical Center, and the Berkeley Free Clinic.

The consultant sought out and discovered a homeless encampment in downtown Oakland where many trans women and gay men live. Though there were many people at the encampment who were enthusiastic about participating in the two groups, they were displaced on the day of the focus group and were not able to attend. On the afternoon of the focus group, the city of Oakland removed the belongings of people who live in these encampments, and potential participants were busy securing their belongings and tent homes.

In the end, five participants showed up for the trans group. The insights, feedback, and suggestions that they provided were rich with wisdom and expertise.

Participant Demographics

Each participant filled out a two-page info sheet at the beginning of the focus group. The results are as follows:

Participants ranged in age from twenty-nine to fifty-six, with a median age of forty-six. Three identified as transgender women, one identified as female, and one identified as gender nonconforming, intersex and trans. This last person is on the female-to-male spectrum, while the other four are on the male-to-female spectrum. Two identified as straight/heterosexual, one identified as same-gender loving, one identified as bisexual/pansexual, and one identified as gay and queer. None indicated that they have children.

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Three stated that they had safe/stable housing; two did not. Of these two, one stated that she is living with an old friend. The other person wrote, "Recently no-fault evicted for the 4th time in 5 years due to economic hardship. Currently seeking long-term and stable, trans-safe housing."

Four out of the five participants indicated that they have been a victim of domestic violence. Of these four, three did not seek or receive domestic violence services. One wrote, "I didn't know if there were services available." The other person stated that they had accessed self defense classes, counseling services, social support, and therapy.

Two out of five do not have a high school diploma. One stated that she is currently in school.

One indicated that she is currently in substance use disorder treatment, which she began on the day of the focus group. She returned to treatment after a relapse. Two, including this individual, indicated that they have accessed substance use disorder treatment in the past. Three have never accessed treatment. One individual wrote, "Harm reduction and peer support are helping with alcohol dependence. 12 [step] programs have been unsuccessful due to lack of trans-competence or non-shaming ideologies."

Four out of five indicated that they have support in their recovery. One wrote, "I go to weekly Moderation Management meetings, attend trans support groups, and self-regulate, and am currently looking into Naltrexone for medical intervention." Two indicated that they receive support from family and friends. Of these, one indicated that she has a "strong support system."

None of the participants were on probation or parole, though one wrote that her probation officer "always wanted me to be in treatment."

Path to Addiction

Some participants described how they were introduced to drugs and alcohol at a young age.

"My parents wanted a break from begging, so they gave us alcohol and drugs. Even though I drunk the beer, it didn't do nothing to me."

"Someone turned me on to drugs when I was a teenager. All of a sudden I was hooked and then twenty-five years passed."

Challenges of Addiction

Participants described moments of being out of control when they were hitting bottom with their addiction, and their concerns about not being able to remember what had happened.

“I fall. There’s nowhere to go but up. Nothing changes. Everything is still the same. I bought a pint. I was gonna share it with my friend, but she wasn’t home. So I drank that whole thing. I got so drunk. I woke up and I said, ‘Where are my shoes at?’ Someone parked me in front of Crossroads, took my shoes, took my \$20, and left me somewhere safe.”

“I knew I had hit bottom when I didn’t know if I had been hit by a car. I texted my friends, ‘Did I get hit by a car last night?’ I was slick. I worked with kids. I went to work ‘til 2. Between that time I would get ripped. No one knew. They thought I was good.”

Why Participants Sought Treatment

Those who sought treatment described feeling overwhelmed by their addiction.

“I got sick and tired of being sick and tired.”

Awareness of Treatment Options

Trans-competent substance use disorder treatment is limited in Alameda County, so it’s not surprising that many have not accessed treatment. Three of the participants were not aware of substance use treatment options. One heard about treatment options through Merritt College and other substance use treatment organizations. The other conducted research on the Internet.

“I heard from Dr. Love at a substance abuse counseling class at Merritt College. But I relapsed. I went to EORC. First I called Walden House. Then I went to Cherry Hill.”

“When I first started seeking out treatment I asked the community because I thought who better to direct me to treatment than other trans people and people of color, and I got the same generic answers that I got on the Internet. It wasn’t until I was hitting rock bottom and on the Internet at 3am trying to figure out what to do, that I could actually find something that fit with me, but I still haven’t found anything.”

What Participants Seek in a Treatment Program

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Participants want a program with treatment approaches that are respectful, culturally competent in an intersectional way, and competent on addiction treatment and larger public health issues. Participants with disabilities described the need for accessibility as a primary concern.

“I have to find a place that’s handicap accessible, has a place for me to plug in my wheelchair and has ramps and bars in the bathtub. My situation is a little more complicated. This chair is killing me. It ran out of juice three times. I found myself pushing this motherfucker down 87th Street!”

Another participant articulated the gaps in service that they experience because of a lack of cultural competency, as well as expertise in the treatment of addiction.

“If it’s a place that’s affirming to me as a person of color, they don’t know shit about being queer and trans. If they know everything about being queer and trans, they don’t know the ins and outs of navigating opiate or alcohol abuse. I have to choose. Do you know your science, or do you know how to treat me as a queer person of color?”

Lack of Treatment Options

Participants overwhelmingly agreed that viable treatment options are limited or non-existent in Alameda County.

“There is nothing that knows how to deal with me as a person of color, as a trans person, and as someone with access needs. I know white people who are having a great time getting sober.”

Intake Process

Participants were asked if the intake process addressed questions that were relevant to their life. One participant expressed concern about the way in which drugs were discussed at intake, which seemed counterproductive to creating a supportive environment for recovery.

“They asked if you had coke or heroin, which one would you take? Don’t make me think about the damn drug! That’s why I’m here!”

Denial of Service Because of Trans Status

Participants underscored the glaring lack of treatment options for them as African American trans people, two of whom disclosed that they are living with disabilities. Two participants were flat-out denied treatment because of their trans status.

“I was going to go to Treasure Island. I was really drugged out and I said, ‘OK, I’m ready to stop.’ They said, ‘Pack your stuff. We’re coming to get you now. We just need a piece of ID.’ When I said my name and that my ID was different, she said they couldn’t take me. She said, ‘Oh I didn’t know.’ She said she’d make some calls for referrals. When they found out I was trans, they just stopped.”

“The time I tried to access a study for men who slept with men, they turned me away once they found out I was trans. They were excited about working with me. I didn’t say I was trans. I figured that would get me kicked out. They were literally getting ready to prescribe the medicine for me and when they got my blood work back, they were like, ‘What’s going on here?’ I had passed every other thing, the screening, the risk level, the ability to take it, all this, that, and the other. And the second they found out I was trans, they said we can’t see you. It was a paid study, so that would have been access to money for me, and access to medication, Naltrexone to stay off liquor. It was the first time I ever felt good about being a drunk. I was beating everyone else in the race to get access to this thing. Once they got back my blood work, they caught things that were specific to not-natal males. This was before I had a hysterectomy. I was about to get sober. I made friends. We were all gonna get sober together. So I came out, and then I left and tried not to go get a drink. They wouldn’t even negotiate with me. I’m part of the demographic you want. You all liked me until you realized that I was different, but my liver is not.”

What Works in a Treatment Program: Cultural Competency

Participants agreed that treatment programs that are respectful, culturally competent, and positive are most effectual.

“Trans competency and overall cultural competency and how that relates to public health. Environmental factors that cause me to use. I know I can’t touch drugs because my parents were addicts and I was born on a speed ball. I knew that at an early age when drugs were being offered to me. If people had access to that information about themselves. Being on T [testosterone] has changed my relationship to addiction. We’re not being given the skills to cope at these places because they’re not meeting us as trans people, as people of color, as people with disabilities.”

What Works in a Treatment Program: Harm Reduction

One participant described the need for treatment programs that do not require abstinence.

“I go to Moderation Management. It’s not abstinence-based, because that doesn’t work for me. It’s a harm reduction model. They’re no steps. I don’t have to go there with my tail between my legs if I do relapse. There’s support around that, support rather than shame.”

What Works in a Treatment Program: Residential Accommodations

Participants stressed the need for residential treatment settings as more effective than outpatient.

“My husband died of alcohol poisoning. My mother was really heavy into drinking. It was really hard. Everybody kept pushing her to get help. My uncle’s liver is shot. Me, I got mental health help. I went to Walden House. When you have the opportunity to come and go, that don’t help. You gotta be in a residential program. We need long-term programs to help the girls get off of alcohol and drugs.”

“How do we work toward something that is more sustainable for this population? We need residential treatment.”

What Doesn’t Work in a Treatment Program: Lack of Cultural Competency

Participants expressed concerns about gendered treatment settings that are not trans-affirming and LGBTQ-affirming, and lack overall cultural competency and addiction expertise.

“One place was so gendered. They separate people up as men and women.”

“I can’t talk about the things that trigger me to drink. People go, ‘Oh that’s just your issue.’ I’m like, ‘No, it’s fuckin’ white supremacy! I’m not drinking just because I’m an addict. I’m drinking because people are fucking with me for being black!’ I go to a place, and I don’t believe half the shit they’re saying. But I stay sober. I self-regulate. I’m definitely not out there. They don’t know I’m queer and trans. It’s safer to not be out.”

What Doesn’t Work in a Treatment Program: Confrontational Treatment Approaches

Participants stressed that treatment programs that use “tough love,” guilt, and shame as treatment modalities are ineffectual for them.

“Cherry Hill is complicated. You got the twelve steps. What you call that when they try to change you? They tear you down and build you up. Real aggressive, up in your face. I don’t like that. I snap. You don’t know what’s coming at ya. I call it attack therapy.”

“Unnecessary tough love under the guise of getting you clean. That doesn’t work for me.”

“When they shame you, that’s the easiest thing to make me drink.”

What Doesn’t Work in a Treatment Program: The 12-Step Model

One participant underscored the way in which the 12-Step model is not effective or empowering, particularly the idea that one must declare their powerlessness.

“I couldn’t get past Step 3 because I refused to admit that I was powerless over alcohol. I don’t believe that. I believe that if I truly decide to make this decision, I would make this decision. I stayed on the same step for months and months and months because I wouldn’t say it. I’m an adult. I worked too hard for this body, I worked too hard for my life to say I don’t have control over myself. I don’t believe that I’m not accountable. I believe that I should be accountable, and that’s how I’m gonna be sober.”

Alternatives to Treatment

Two participants stated that they were able to stop using on their own, in part because of a lack of treatment options. One quit without assistance, and another quit through the power of prayer.

“I was a functional addict. I made sure my bills were paid. I could work and take care of business. But I just couldn’t handle it anymore. I would call someone and say, I need a ride. I would get that ride and go get it. But then I would say, ‘So and so, come get it.’ I stopped having the desire. When they [the treatment facility] wouldn’t take me, I quit cold turkey.”

“I heard of Walden House. But I always felt that I’d seen so many people go to treatment, and then they come out and they relapse. I saw this pattern over and over again with my own family. I just felt like it would be a big let-down and it wouldn’t be helpful to me. For years I prayed to God. Even in the midst of my addiction, I prayed, ‘God, deliver me from this drug because it has a strangle hold on me. I believe there is no man or program that can rescue me or save me like you could.’ I had an ah-ha moment when I realized I had to find the power

within myself. After God delivered me one Christmas, it totally left my life. And it's never come back, I never had a relapse. This power through prayer. God filled me up and told me I didn't have to be that person anymore. And he set me free from tobacco at the same moment. It's been seven years and no relapse. But you have to want to be clean. All I knew for twenty-five years was smoking crack."

Support in Recovery: Spirituality and Social Support

Participants stated that supportive friends and family help them stay sober. One participant said that God helps her in her recovery.

"My spiritual healer, my God, helps me. The determination to not get caught up in that lifestyle. My girlfriends and my family are very supportive. When there are times when I feel like I was to relapse, if I'm angry about something, they're there to tell me, 'Just calm down, take a deep breath. Life is full of situations like that and you don't have to use.'"

Challenges to Recovery: Lack of Adequate Social Support

At the same time, participants agreed that a lack of social support is their biggest challenge to recovery. Many participants feel unsupported by the trans community. There is concern that many LGBTQ people socialize in settings that involve alcohol and drugs.

"When I try to talk to people about things I'm going through, and things I'm struggling with, either harm reduction, or moderating my use, it doesn't make sense to them. 'This is my life. Why aren't you taking me seriously?' I spend most of my time alone or wanting to be alone. When I go out, everybody's like, 'We haven't seen you in a while. Let's get a shot.' I say no, and that's not respected. In my scene that's mostly queer-dominated, that's normal, and it's abnormal to say no. So it almost becomes like you're weird for saying no. So I keep to myself. 'Why don't we see you out?' 'Because every time I'm out, you all want to do drugs and drink!' I want to interact with other trans people and queer people of color in a social situation that's not geared towards drinking."

"I'm socially awkward, so it's been hard to reach out to people from my past. I'm in my fifties, and I figure they got their own thing going on and I don't feel like they really care. I get home and it's just me. I'm so much of a loner. Sometimes a negative response from someone you think is a good friend can turn you off. If I reach out to my friends I've known for twenty-seven years, and tell them what's going on in my life, but they watching TV and not listening to the

phone, you feel like you don't have their attention, so I just shut them out...Trans people are very fickle. I feel like it's a competition always. Who looks better. So I travel in my own lane."

"My addiction is pills. When I'm real jittery, I call someone. But I can't run to the LGBT community, because I've known all my life that I couldn't count on them. A lot of times, a lot of girls are not for you unless you got something for them. But you gotta know who your friends are. You got to know who you can count on, and who not."

"As far as the trans community, I don't have friends that I can count on either. There's one you talk to every now and then, or they're shady and you don't hear from them. Either they're watching their favorite shows, or they're busy. So you don't really have in the trans community girls that will talk to somebody, to say, 'Sister, I'm going through something.' I don't have anybody like that, that I can talk to. But I have other friends, heterosexual people that know it's hard to beat an addiction. They listen and give good advice."

Challenges to Recovery: Health Care Access

Participants stressed the need for medical care related to gender transition, and the negative impact of a lack of access to medically necessary care. The current political climate has led at least one participant to worry that she will lose trans-affirming health insurance coverage in California. Access to transition-related care is affirming to one's sense of self, reduces psychological distress, and has a positive effect on substance use risk. In addition, surgery has motivated people who are addicted to nicotine to stop using; surgeons strongly encourage patients to quit smoking in order to improve wound healing.

"I'm almost at the finish line [with medical transition] and I'm worried about losing coverage. I have a lot of anxiety about it. I stopped cigarettes because of surgery."

Challenges with the Sponsor Model

One participant described a disappointing experience with a sponsor that seemed more harmful than helpful.

"I had a sponsor. He was a real dumbass. He was cis [person's gender matches assigned sex at birth], white, and gay. We could not have been more ill-matched. The issues in his life was what he was doing up in Guerneville, and the issues in my life were like, oh, I'm getting displaced. The doctor's trying to deny my surgery on the grounds that I'm not the gender I say I am. These things were just boring to him. He was like, 'Can you try to work harder?' I'm like, 'Have you

tried being black and trans and getting a job?’ You’re supposed to be affirming me and helping me. You’re supposed to be the bridge to sobriety. I’m supposed to walk over your back and reach out my hand and get sober and be like, ‘Thanks for the lift, white man!’ I just thought it was a joke. It mimicked abusive relationships I’ve been in. I felt like it was a codependency thing. This is everything my therapist is trying to get me out of. I can’t rely on one person to be like, you stay sober. Then I will get back in the habit of attempting to please that person. I can’t be seeking the praise and approval from someone who didn’t give a shit about me and didn’t understand that I was coming to our meetings drunk!”

Program Vision: Wraparound Services

Participants were asked about their vision for a dream program, to which they readily responded with a plethora of sound suggestions. There is a clear need for wraparound services, which address the multiple life challenges that trans people experience. Participants would like to see drug treatment in neighborhoods that are not surrounded by liquor stores, or near locations where people cop their drugs. Their dream program would provide shelter, medical care, emotional support, health education, job skills building and employment opportunities, safety support, and childcare, in addition to medical addiction management. They would like to see mobile support, as well as a facility that is open overnight, from late night to the morning.

Program Vision: Appropriate Location

“You should not have to walk through places where you score your drugs to go to your meeting. My meeting is in the TL, and I’m like, there’s my favorite liquor store. It puts you back in it. Even for me, I get a physical buzz. And I have to tell myself, no, I’m walking to the meeting. It’s easier for you to show up if you don’t have to walk through the place where you score your drugs.”

“A facility that’s not surrounded by liquor stores.”

Program Vision: Mobile Support

“Mobile support looking for trans people who are sleeping on the streets. Pick them up and bring them to a warm bed and make sure they have a good bath and clean clothes. Hook them up with the right medical facilities. Hook them up with mental health.”

“An RN to ride around and treat anything.”

Program Vision: Addiction Treatment

“Residential program to help with drug addiction.”

“The pill that you take and it gives a bad taste when you drink.”

“Trans-competent and substance abuse-competent.”

“Maybe someplace that has access to the medical parts of substance abuse. Detox. It is psychological, but there is withdrawal. When I was trying to dry out, that was the hardest part for me because I needed something to physically stop shaking. And I didn’t have access because I didn’t have insurance. There’s economic disparities.”

“Whoever gets assigned to the girls, they can't be a drinker. They can't say, let's go out and get a drink.”

Program Vision: Shelter for Homeless and Marginally Housed Trans People

“I’d like to see a shelter for transgender women, first and foremost. I was sleeping in the streets for six years, off and on. Right around the corner from the park where I slept, there was a shelter. We used to go there and eat, they’d give us a sermon at 6:00 in the evening, but after that, it was like, get the hell out of there. We didn’t have beds. We had to go into the streets and sell our bodies, UNLESS we came in as our biological sex, and no way was that going to happen.”

“I would like to see a place where trans can go, a drop-in center, late night, when they don’t have no place to go, where they can sleep. You’re working the streets, and you have a place where you can freshen yourself back up, take a shower. Open late night to morning.”

Program Vision: Health Care for Prevention of HIV and other STIs

“Access to PrEP, the shots so you don’t have to take the pill.”

“More access to trans-competent sex education. PrEP won’t protect you from syphilis. People are running around doing everything. The rates of STIs are going up.”

Program Vision: Mental Health Support

“A support group to talk about issues. I’m a very introverted person. I don’t like to tell people stuff that’s going on with me, but if I could have someone to talk to...”

DHCS African American SUD TA CLAS Project

“Mental health support. Help with transference. I transferred my addiction. When I shopped, I got a buzz because I didn’t deal with my transference.”

“Someone to talk to who could relate to what we’re going through, substance abuse and trans issues too. Clinical psychologist, maybe.”

Program Vision: Health Education

“A program to educate people about sex reassignment surgery. I only get therapy and hormones. I don’t go to a class and get education. We need to know how long it’s going to be before we get our nerves back, how long it’s gonna take, what it’s gonna look like.”

“We need to know what to look for if our body isn’t feeling proper.”

Program Vision: Job Skills Training and Access to Employment Opportunities

“Job training, education so you can get your GED.”

“Job skills training. You’re more likely to be productive.”

Program Vision: Safety Support

“Maybe a number for people to check in. People are less likely to be harmed when those tricks know that this girl has someone they’re checking in with.”

Program Vision: Childcare

“Trans males who got children, a daycare center for LGBT people with children

6. Needs Assessment Summary

The Needs Assessment data collection process consisted of both an online survey and the qualitative report based on key informant interviews and focus groups. Taken together, they suggest recommendations in four specific areas to improve African American access, experience and outcomes in SUD programs:

- 1) ACBHCS CLAS Plan update and internal cultural competency and equity training
- 2) Systemwide (ACBHCS and service provider) anti-racial bias training
- 3) Culturally responsive multi-disciplinary-wraparound systems and services
- 4) LGBTQ cultural competency training

Cultural Competence Training with a Focus on African Americans

The online survey revealed that 59% of providers would like an overview of the CLAS standards that focused on how to incorporate them into SUD programs and services for African Americans. The online survey also indicated that “African American cultural competency” was identified as the highest-ranking TA and training need. Additionally, all informant groups, ACBHCS staff, SUD service beneficiaries and providers, spoke of the need for cultural competency.

In both key informant interviews and focus groups, there were no common definitions of terms related to a cultural competence framework or concepts of health equity. Most respondents did not have a precise definition or understanding of what the various terms mean, and approached terminology related to cultural competence from a personalized perspective, without having precise knowledge of what it entails.

Providers and beneficiaries were more specific in suggesting that cultural competency should be learned from the perspective of African American peoples. Providers and clients also suggested that cultural competence is not enough where racial bias manifested itself in stereotypes that complicated successful service delivery.

Community-Based Wrap Around Services

Key informants, including TAY, transgender, and women with children and men, spoke of the need for comprehensive services that are embedded in community and provide a sense of material, social stability. This correlates with the providers’ identifying “lack of wrap around” as the most cited “Major” service barrier to serving African Americans.

Anti-Racial Bias

Informants strongly suggested that racial bias was a major obstacle to the successful treatment of African Americans. Providers, in general, viewed it as a “root cause” of many of the challenges that faced African Americans with SUD. Key informants at ACBHCS also suggested that the inability to discuss race did not permit the agency to adequately address the needs of the county’s most overrepresented service group.

TA and Training Recommendations

ONTRACK will work collaboratively with the project team at DHCS, ACBHCS and SUD service providers to deliver specialized TA and training within the four priority areas:

- ACBHCS CLAS Plan update and internal cultural competency and equity training
- ACBHCS and service provider African American anti-racial bias training
- Culturally responsive multi-disciplinary-wraparound systems and services
- LGBTQ cultural competency training

Specific Process and Service Recommendations

- Require participation of key ACBHCS management in CLAS plan update processes
- Provide TA for SUD providers for agency-specific CLAS assessments and CLAS plan development or updates to meet national and state standards
- Facilitate African American cultural competence TA and training for SUD service providers for serving women, LGBTQ, TAY, and adults with a strength-based, social justice and trauma-informed approach
- Work with culturally responsive consultants to develop and implement an ongoing beneficiary engagement and feedback strategy plan
- Provide TA to ACBHCS and service providers increase community awareness of SUD resources, and strengthen ties to education, employment, housing and other core survival system resources
- Pilot a weeklong institute for all ACBHCS contractors whose service population is disproportionately African American that combines anti-African American racial bias with cultural proficiency, and the implementation of culturally congruent and community-embedded wrap around services. ACBHCS could make good on their investment to the African American Utilization Study results in a way that creates something more sustainable and widespread.

ATTACHMENT A

SUD Service Provider Online Survey Report

**Implementation of the
Culturally and Linguistically Appropriate Services (CLAS) Program**

Needs Assessment Survey Results

**Behavioral Health Care Services of
Alameda County
May 1, 2017**

**Submitted by
ONTRACK PROGRAM RESOURCES**

Performed under contract with the California Department of Health Care Services

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Executive Summary

This report summarizes the results from a 53-question survey that was conducted in April 2017, as part of a needs analysis for Alameda County, by ONTRACK Program Resources. The survey was administered at the beginning of a project to implement a state-sponsored program for Culturally and Linguistically Appropriate Services (CLAS) for African Americans. It was designed to be the first of two survey-based data collection efforts, with the second survey scheduled for administration near the end of the year in 2018.

Data for the survey were collected from a voluntary sample of 22 counseling managers and professionals who worked in field office for treatment of substance abuse disorders (SUD) in a variety of non-profit organizations the Greater San Francisco Bay Area. As of this writing, the survey was still open to prospective participants, so the study's sample size might increase. If additional responses are acquired, they can be incorporated into these results at a later time, as appropriate.

Throughout the survey, however, subjects appeared to provide thoughtful responses and that was a good sign for the reliability of the survey data for later use.

Methodology

Subjects

A total of 22 people participated in the survey, drawn from 19 treatment centers for substance abuse and mental health in the Greater Bay Area. Two subjects apiece worked in each of three firms, resulting in the number of organizations represented being smaller than the number of people who participated.

Participation in the survey was limited only to paid employees of healthcare delivery organizations that dealt with substance abuse, mental health, HIV, and at least some members of minority racial and ethnic groups in Alameda County. Participation was strictly voluntary, and the sampling of subjects was neither random nor stratified. To our knowledge, the sample was based entirely on self-selection and all responses were self-report. While it's entirely possible that some participants took part in the survey only after being directed or encouraged by other people in their respective or affiliated organizations, that possibility was not closely monitored.

Most subjects were officers and managers in their respective organizations, and their job titles are shown in the table for Question 5 results. The

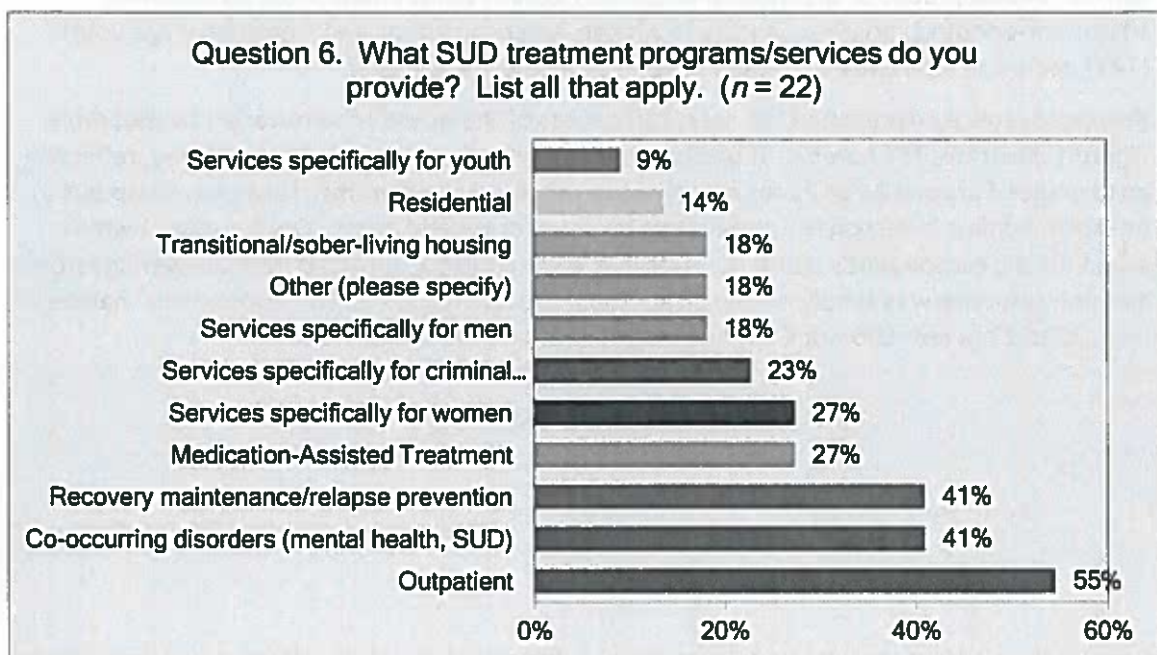
Question 5. Title in organization of person primarily responsible for completing this survey:		
Answer Options	Response Percent	Response Count
Executive Director/CEO	22.7%	5
Clinical Director	27.3%	6
Program Manager	13.6%	3
Other (please specify)	36.4%	8
<i>answered question</i>		22
<i>skipped question</i>		0

category of "other" job title received the most responses, and the seven write-in job titles included Director of Operations (3), Director of Administration (2), Treatment Center Director, a case manager, and an accountant (one write-in response was missing).

Question 3 of the survey inquired about the counties served by each participant's employer. Responses are shown in table of Question 3 responses and they indicated that, in addition to serving Alameda County, participants' sponsoring organizations served six other counties in the greater Bay Area.

Question 3. What counties do you serve (Check all that apply):		
Answer Options	Response Percent	Response Count
Alameda	100.0%	22
Contra Costa	22.7%	5
San Francisco	4.5%	1
San Mateo	9.1%	2
Solano	4.5%	1
Napa	4.5%	1
Other (Santa Clara)	4.5%	1
<i>answered question</i>		22
<i>skipped question</i>		0

A list of the participants' treatment programs and services was provided by Question 6. In that item's results, it can be seen that a slight majority (54.5%) of subjects said that their organizations provided outpatient services of some kind. Co-occurring disorders and the combination of recovery maintenance and relapse prevention were the next more frequently indicated (with 41% each), followed by medication-assisted treatment and services specifically for women (27% each). Each of the remaining services were indicated by fewer than one quarter of the survey sample.



Administration

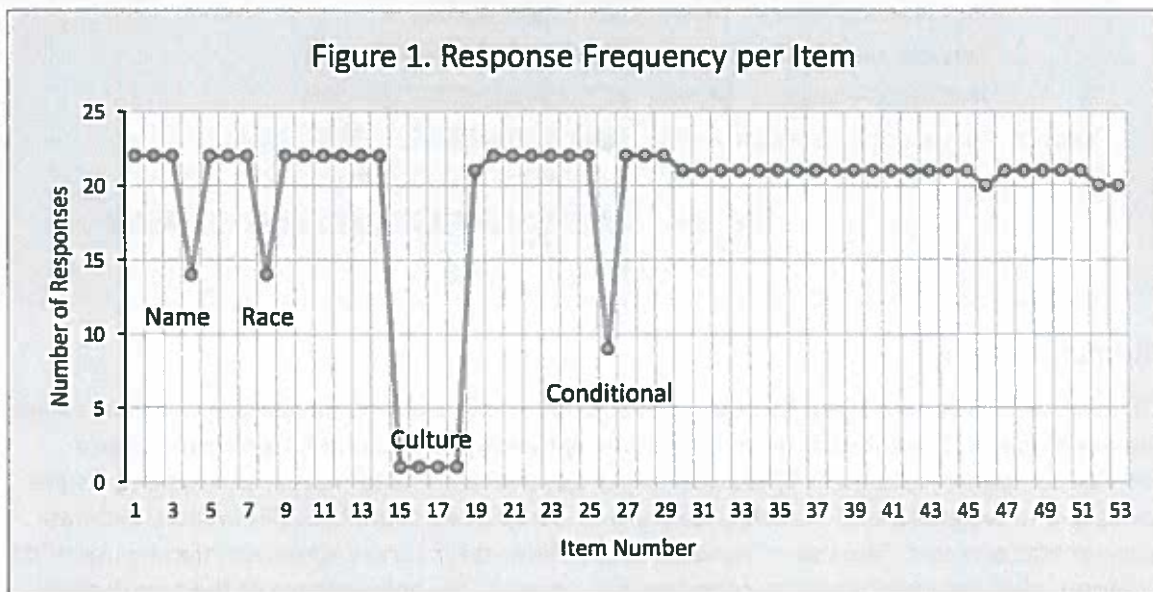
The survey was administered through the use of a commercial internet service company called SurveyMonkey. The company is an online survey development cloud-based software as a service company, founded in 1999. SurveyMonkey provides customizable surveys and a suite of back-end programs that include data analysis, sample selection, bias elimination, and data representation tools. The use of SurveyMonkey allowed for survey administration by use of the internet, allowing participants to complete the survey at the convenience of their work desks and without the need for travel, meetings, or other types of expense. All participants were invited to complete the surveys on company time (i.e., compensated time) during normal working hours.

The size of the population from which the sample was drawn was not precisely known at the time administration began, but it was estimated to be approximately 40 to 50 people. If that estimate was accurate, then the survey's 22 participants provided an overall response rate of between 44 and 55 percent. Generally, such a response rate would be fully acceptable for surveys based entirely on volunteers.

The Survey Questionnaire

The questionnaire contained 53 items, mostly consisting of “multiple choice” item formats. A demographic section at the beginning of the questionnaire required fill-in responses for agency name, agency address, and respondent name. Many of the multiple choice questions also solicited open-ended comments to gather clarifying information. In addition to a section on demographics, the questionnaire contained sections that addressed topics related to CLAS, record keeping practices, organizational policies against harassment and discrimination, treatment-oriented services available to African American adults and transitional age youth (TAY), technical assistance and training needs, and the survey itself.

Response rates across each of the main topic areas of the questionnaire varied considerably. Figure 1 illustrates the number of participant responses per each item in the survey, reflecting an average of around 21 or 22 for responses to nearly all of the items. However, sharp but unexplained dips in response numbers can be seen for several items. On Question 4 which asked for the respondent’s name, for example, eight subjects refrained from answering entirely and one response was simply nonsensical. Thus, useable responses for respondents’ names fell from 22 to 13 (a reduction of 41%) in a sample that already was quite small.



In a similar manner, eight subjects failed to respond to Question 8 of the survey. That item asked about the race and ethnicity of the population served by the employing organization. It also can be seen from Figure 1 that responses to four items (Questions 15 through 18) were almost missing entirely – with one response each. Those four items dealt with cultural skills and capabilities of the organization’s employees.

Finally, one additional item (Question 26) showed only nine responses. That item was conditional, however, and it required a “Yes” response to the preceding question (Question 25)

in order for a response to be accepted. Thus, a reduction was expected in the number of responses.

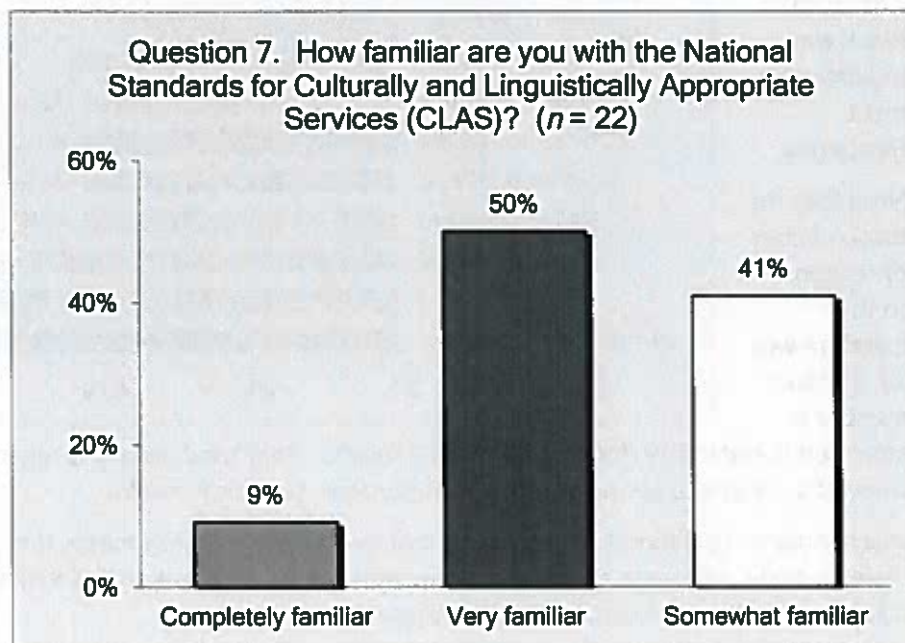
Aside from the one conditional item (Question 26), there are no obvious reasons to explain the such sharp differences in response rates between items in the questionnaire. We might speculate along the lines of the following:

- The purpose and uses of the survey results might have been misunderstood by the survey participants.
- The questions might have been intimidating or confusing in some way.
- Normal, random fluctuations in the survey data only *appear* to be elevated because of the small sample size, but they would very likely diminish if a larger sample of subjects were available.

The plausibility of any such speculations certainly can be argued. Unfortunately, however, we can offer no degree of confidence or certainty about any of them.

Question 7 was the final demographic item in the survey and it concerned respondents' familiarity with CLAS national standards.

In the figure for Question 7, it can be seen that all participants said they were at least somewhat or more familiar with CLAS standards. Exactly one-half of the sample indicated they were "very" familiar with the standards, while 41 percent said they were "somewhat" familiar, and 9 percent said they were "completely" familiar. No respondents indicated that the standards were not familiar to them.

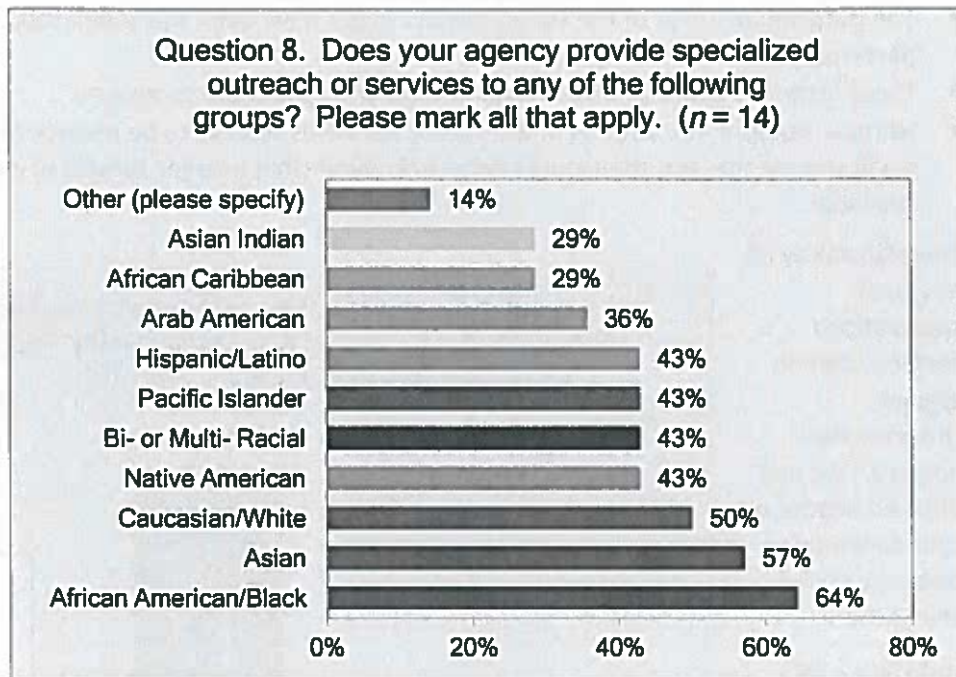


Results

Culturally and Linguistically Appropriate Services (CLAS) Program

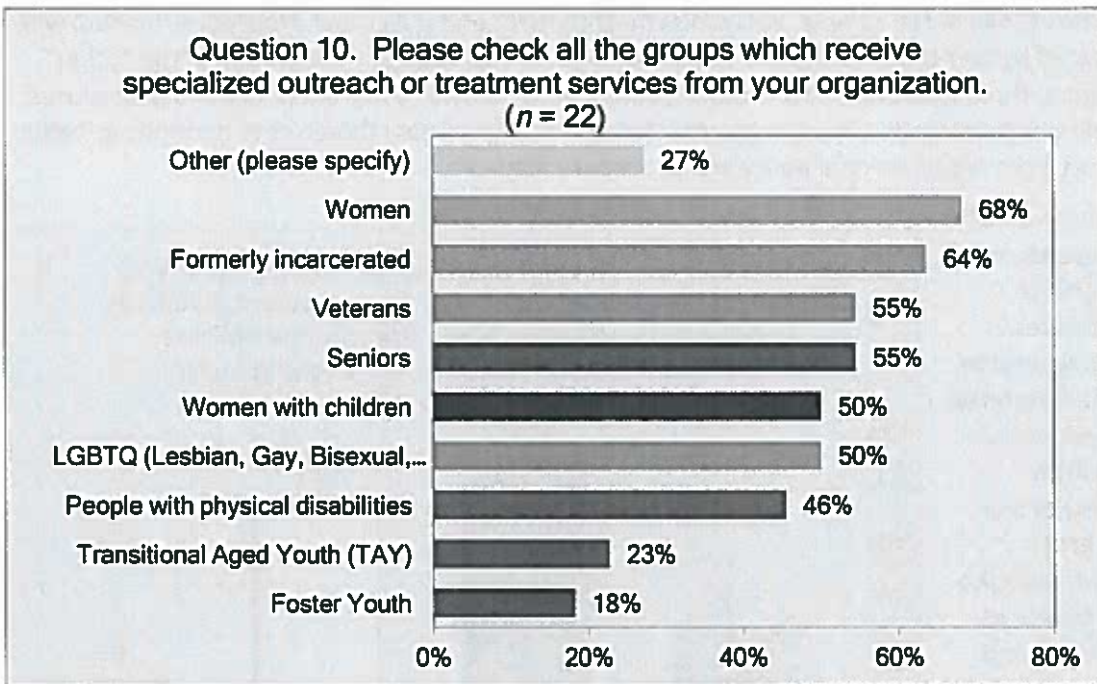
The first question in the survey that addressed the CLAS-related practices of the subjects' organizations showed that a wide range of racial and ethnic groups received specialized outreach or services. In the figure, it can be seen that the group labelled African American or Black was indicated the most frequently.

Note that the total number of responses to this question was 14, and that number is indicated in red in the chart of Question 8 results. That total usually is regarded as being too small of a sample to allow for much confidence in statistical results.



In response to Question 9, a statement that overall their agency meets the cultural needs of their clientele, everyone responded in the affirmative. The majority (68%) agreed with that statement and the remainder (32%) strongly agreed to it.

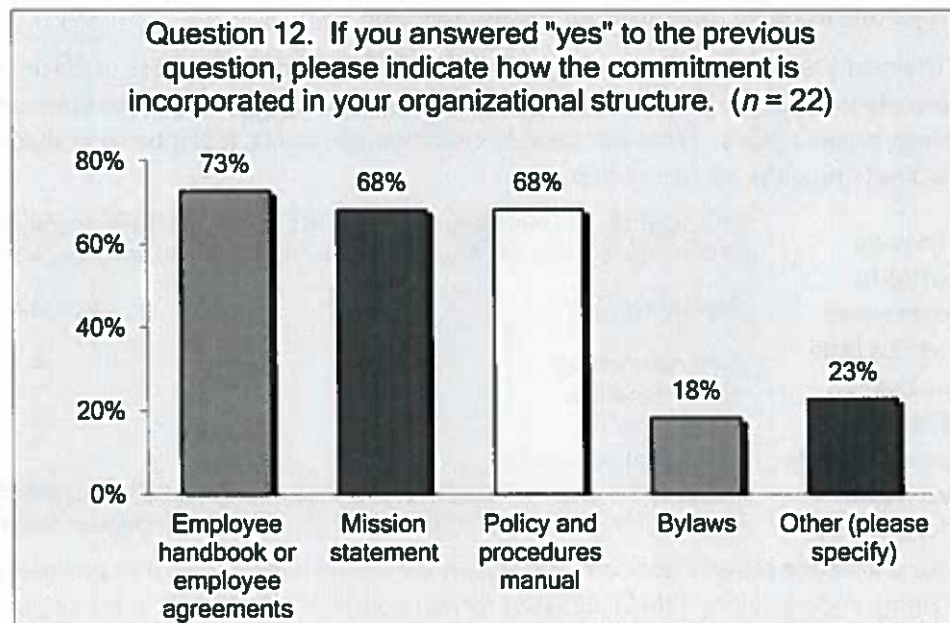
Question 10 in the questionnaire asked respondents to indicate all social groups (from a list that was provided) receiving specialized outreach or treatment services. Results to this item can be seen in Figure 5. Women (68%) and the formerly incarcerated (64%) each were indicated by more than half of the respondents, as were veterans (55%), and seniors (55%). Women with children and LGBTQ each were indicated by 50 percent, followed closely by people with disabilities (46%). In the "Other" category, the most frequently mentioned group was the homeless (2 responses, or 9%) while another two responses indicated groups with specific types of disability (mental and deaf) that apparently were not included in the group called people with physical disabilities.



The respondents were nearly unanimous in affirming that their organization explicitly identified cultural competence as a goal, as measured by their responses to Question 11. The sole exception to this finding indicated that cultural competence was a goal that was adopted specifically for

or by staff training, as opposed to adoption by "the organization."

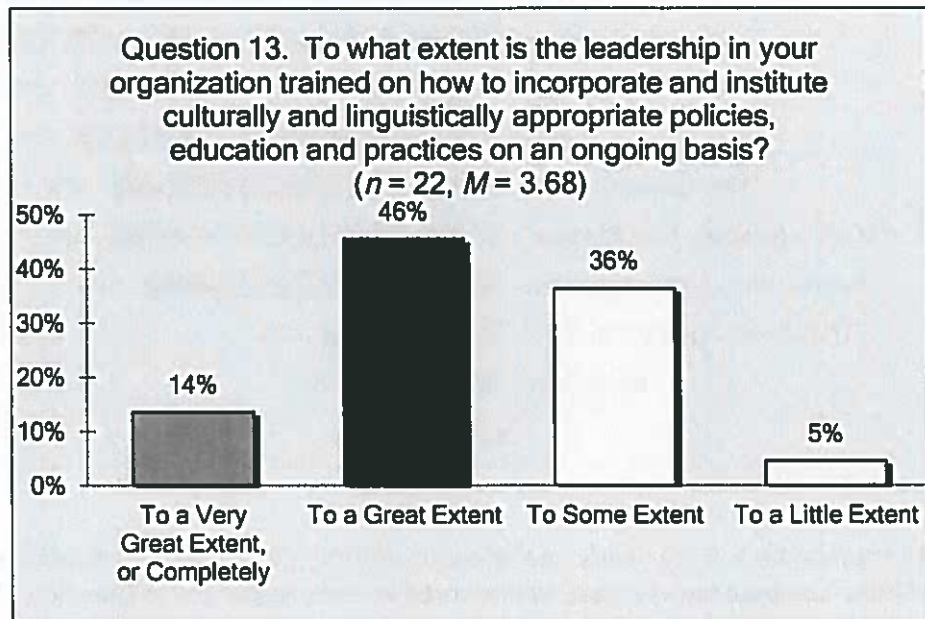
Question 12 followed up on this topic to acquire more detail. It showed that the goal of cultural competence was incorporated



into the participants' organizations by a variety of means which are portrayed in Figure 6. The category of employee handbooks or employee agreements was indicated by nearly three-

quarters (73%) of the sample, while mission statement and policy and procedures manual were indicated by two-thirds (68%) of the participants. Of the five responses found in the “other” category, three referenced staff training and one mentioned “program policy and procedures” as additional methods. Thus, it appears that some subjects saw those other methods as being distinct from organizational policy and procedure manuals.

Question 13 was an assessment of leadership capabilities in areas related to CLAS. Responses ranged from 2 (to a little extent) to 5 (a very great extent) with the bulk of ratings given to 2 or 3 on the response scale. The weighted average for this item was 3.68



which was a little higher than the scale midpoint. From this, it appears that leadership was regarded as being trained about moderately well.

The next item asked whether each of three formal policies that were in place to ensure a diverse workforce. Responses to all three policies were affirmative (of them being in place) for most organizations. From the table of Question 14 results, it can be seen that many subjects did not know the correct response.

The two write-in comments were a little unclear so they are provided here verbatim: “We ensure

Question 14. Are there formal policies in place to ensure a diverse workforce that reflects the cultural and linguistic profile of the communities you serve?				
Answer Options	Yes	No	Don't know	Response Count
Staff recruitment	15	4	3	22
Hiring decisions	15	4	3	22
Promotions	10	5	6	21
Other (please specify)				2
<i>answered question</i>				22
<i>skipped question</i>				0

our workforce reflects our community, but we do have formal written policies to that end”; and “Hiring and recruiting PRACTICES (not formal policies).” (Emphasis in the original.)

One response each was provided to Questions 15 through 18. Those four items related to cultural understanding and responsiveness of the organization. Results for those items are not

useable and are not further discussed here. We will note that this collective non-response was not anticipated, and an option for write-in comments was not provided to any of the four questions.

All but one person responded to Question 19, with the majority (61%) answering in the negative.

The five write-in comments are provided in full:

Question 19. If cultural competence training is required for all employees, is there a required minimum number of hours explicitly stated in your policy?

Answer Options	Response Percent	Response Count
Yes	23.8%	5
No	61.9%	13
Don't know	14.3%	3
Please describe the requirement for cultural competence training:		5
	<i>answered question</i>	21
	<i>skipped question</i>	1

- We have an annual training and also we will do additional training as issues arise.
- We ensure at least 30% receive cultural competence training each year.
- Participate in formal cultural competence training annually, ongoing training at programs as training opportunities arise.
- Annual training on Cultural Responsiveness, Ethics (includes code of conduct, confidentiality, & rights of persons served, Reporting), etc.
- Regular in-house trainings, at least quarterly

Question 20 showed that the use of assessments on CLAS-related practices was very moderate. The mean of the scaled responses was 2.95, which was equivalent to the third response option of To Some Extent.

Question 20. To what extent do you conduct assessments to evaluate the needs of your organization for sustaining CLAS-related practices?

Answer Options	Response Percent	Response Count
To a Very Great Extent, or Completely	0.0%	0
To a Great Extent	27.3%	6
To Some Extent	45.5%	10
To a Little Extent	22.7%	5
To a Very Little Extent, or Not at All	4.5%	1
Please provide any comments that you think might be helpful:	1	1
	<i>answered question</i>	22
	<i>skipped question</i>	0

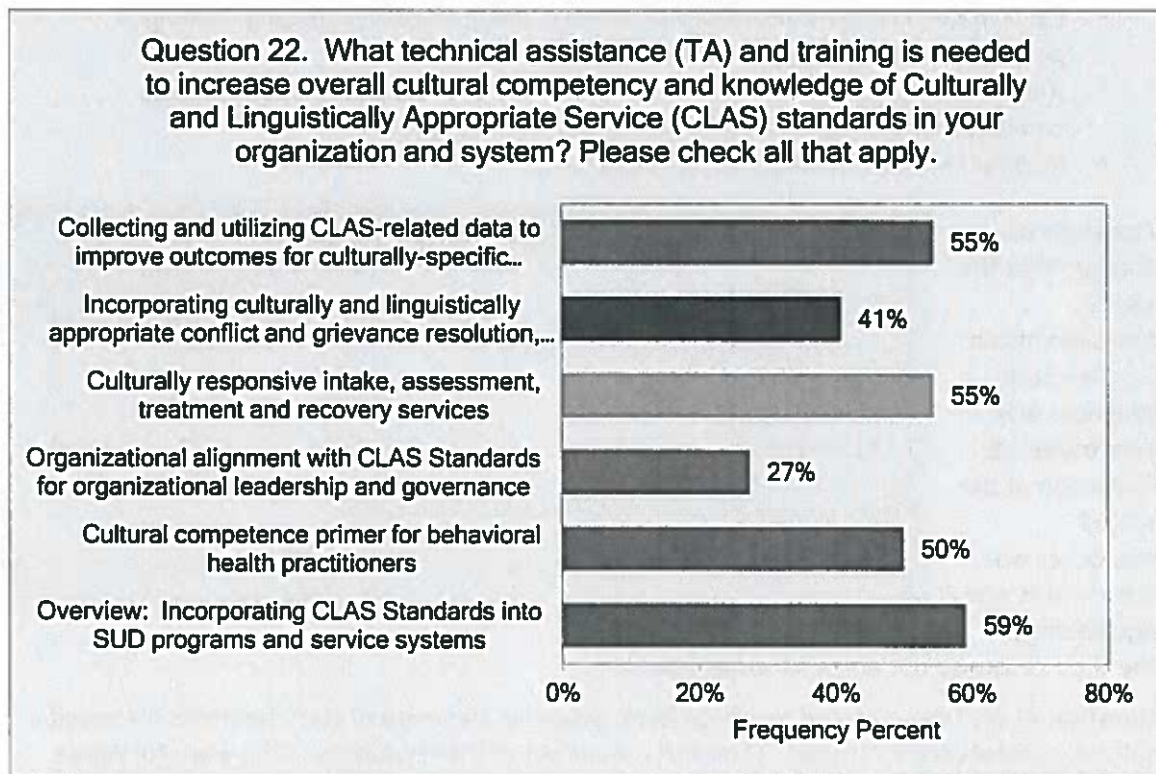
Question 21 also was a scaled response item, assessing the need of staff members for specific cultural competence strategies. Over three-quarters of the responses (77%) were for Agree and Strongly Agree. The mean of the scaled responses, accounting for all responses to the scale, was 3.95 or Agree.

Question 21. Our staff members need specific cultural competence strategies in order to serve particular racial, ethnic, and cultural populations.

Question 22 followed up on the topic of staff development needs, though it was more specifically related to needs for technical assistance and training.

Answer Options	Response Percent	Response Count
Strongly Agree	22.7%	5
Agree	54.5%	12
Neither Agree nor Disagree	18.2%	4
Disagree	4.5%	1
<i>answered question</i>		22
<i>skipped question</i>		0

The chart of results shows that an Overview course of CLAS standards integration received the most responses at 59 percent. It was followed by Collecting and Using Data and Culturally Responsive Intake, both at 55 percent, and a Cultural Competence Primer at 50 percent. One write-in comment read, "Translation services for documents so they can be available at programs and on website in the threshold languages of the three counties."



Question 23 asked for an assessment of each subject's organization's workforce recruitment strategy related to CLAS. All subjects made responses, and over three-quarters of the responses were Effective or Very Effective and no responses were negative. The mean of this scaled response item was 3.95, which was equivalent to the "Effective" response option. One comment offered read, "Still struggling to get enough qualified Spanish speakers."

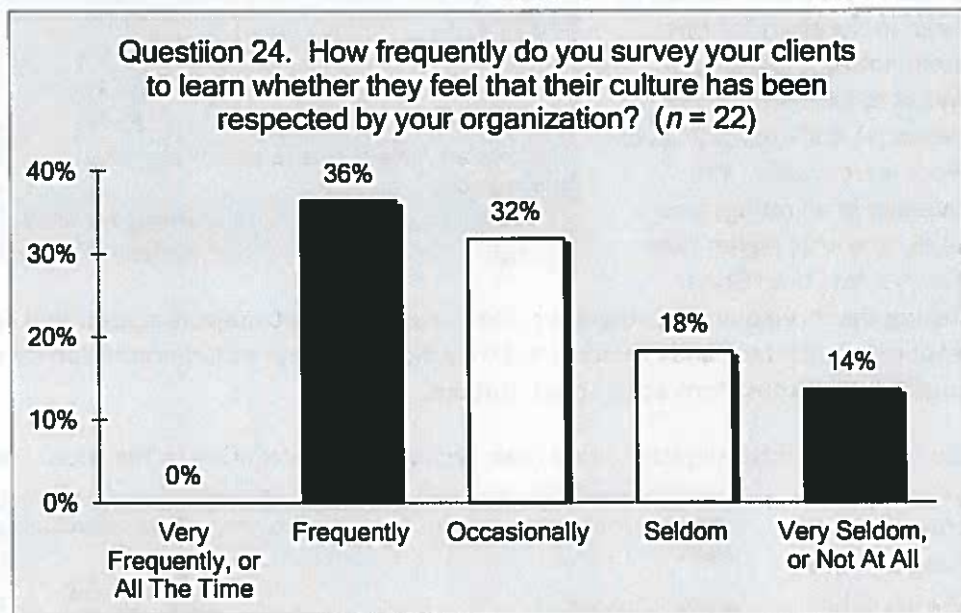
Question 24 asked how frequently subjects' organizations use surveys to gather client data. Responses ranged from "Very Seldom" to "Frequently" with

Question 23. How do you rate the effectiveness of your organization's workforce recruitment strategy in promoting the cultural and linguistic diversity of your staff?

Answer Options	Response Percent	Response Count
Very Effective	18.2%	4
Effective	59.1%	13
Neither Effective nor Ineffective	22.7%	5
Please add any comments that you think might be helpful:		1
<i>answered question</i>		22
<i>skipped question</i>		0

no one indicating the "Very Frequently" option. The number responding below the midpoint (7) of the rating scale was about the same as those above the midpoint (8)." The mean of all responses was 2.91, about the value of "Occasionally" on the response scale.

Question 25 asked whether subjects' organizations survey client perceptions of language needs being adequately met. Responses were a little on the negative side: Yes (41%) to No (59%).



Question 26 was a follow-on to Question 25, asking the Yes responders (who survey clients about language). All nine of the eligible subjects gave responses. Five comments also were provided: At intake; I think Spanish; and Spanish (3).

Question 26. If you answered "yes" to the previous question, are surveys available in languages other than English?

Answer Options	Response Percent	Response Count
No	11.1%	1
We have no regular practice in the use of languages other than English	33.3%	3
Yes (please specify which languages are used)	55.6%	5
<i>answered question</i>		9
<i>skipped question</i>		13

Record Keeping Practices

Question 27 asked whether subjects' organizations kept records of clients' race and ethnicity. Responses were nearly unanimous – all but one subject replied Yes, so recordkeeping appeared to be a universal practice.

Recordkeeping on client retention rates was less favorable, however. Question 28 asked, "Does your organization track client retention rates by race or ethnicity?" Seven (32%) of the 22 respondents indicated yes and the remaining 15 (68%) said no to Question 28.

Some clarification of record keeping practices was provided by Question 29, which addressed the quality of those practices. As can be seen in the chart for this item, ratings ranged from Weak to Excellent on the response scale (no ratings of Poor were made). The average of all ratings was 3.36, or a little higher than Fair but less than Good.

Question 29. Please rate the quality of records kept by your organization on the language services or cultural requirements of individual clients (e.g., dietary restrictions, gender pronoun preferences, translation service needs).

Answer Options	Response Percent	Response Count
Excellent	9.1%	2
Good	40.9%	9
Fair	27.3%	6
Weak	22.7%	5
If records are limited, please specify any cultural data recorded:		1
	<i>answered question</i>	22
	<i>skipped question</i>	0

Taking the three questions together, then, it appears that subjects agreed that records were kept on clients' race and ethnicity, but they did not always include retention rates and their quality was inconsistent across organizations.

Question 30 asked subjects to rate their organization's attention to the social strengths of the surrounding community.

Results ranged from a Little Extent" to a Very Great Extent with nearly one-half (48%) rating "To Some Extent" at the midpoint of the response

To what extent is your organization able to describe the social strengths (e.g. support networks, spiritual leadership, family ties) of the cultural communities in your service area?

Answer Options	Response Percent	Response Count
To a Very Great Extent, or Completely	19.0%	4
To a Great Extent	23.8%	5
To Some Extent	47.6%	10
To a Little Extent	9.5%	2
Please provide any comments that you think might be helpful:		0
	<i>answered question</i>	21
	<i>skipped question</i>	1

scale. The average across all responses was 3.35, or a little higher than the midpoint.

Question 31 asked subjects to rate the extent to which their organizations use exit surveys of their clients to learn about challenges or alternative plans. The full range of the response scale was used this time, from Very Little to Very Great extent. The

Question 31. To what extent does your organization administer exit surveys when clients complete or discontinue their services to learn about challenges or plans for recovery supports?			
Answer Options	Response Percent	Response Count	
To a Very Great Extent, or Completely	9.5%	2	
To a Great Extent	38.1%	8	
To Some Extent	19.0%	4	
To a Little Extent	14.3%	3	
To a Very Little Extent, or Not at All	19.0%	4	
Comments		2	
		<i>answered question</i>	21
		<i>skipped question</i>	1

most common response was Great Extent and it received just over one-third (38%) of the total. The average across all responses was 3.52, or midway between Some and Great extent.

Harassment and Discrimination Policies

The next six questions dealt with organizations' harassment and discrimination policies. The first four of those items (i.e., Questions 32 to 35) allowed only Yes or No responses.

Questions 32 and 34 asked whether official policies were in place. Question 32 addressed harassment based on sexual orientation and sexual

Questions 32 through 35		Percent Yes	Percent No	Yes	No	n
32	Does your organization have an official policy on harassment based on sexual orientation or gender identity?	95.2	4.8	20	1	21
33	Are there clear procedures in place for staff who have complaints about cultural discrimination or harassment?	90.5	9.5	19	2	21
34	Are there official policies in place for reasonable accommodations for people with disabilities?	95.2	4.8	20	1	21
35	Are there clear procedures in place for clients who have complaints about cultural discrimination or harassment?	90.5	9.5	19	2	21

preferences, and Question 34 related to making accommodations for the physically handicapped. On both questions, all but one subject answered to the affirmative – that their organizations did have an official policy in place.

Questions 33 and 35 asked whether clear procedures were in place for people who might wish to file a formal complaint about discrimination or harassment based on culture. Question 33 was in reference to staff members while Question 35 referenced clients as the prospective complaint filers. To both questions, all subjects except two were in the affirmative. All of the four items had no write-in provisions for explanations about no responses.

Questions 36 and 37 assessed of how well organizational procedures for administering discrimination and harassment complaints were working for internal staff and clients,

respectively. Ratings made to both questions ranged from Neither Well nor Poor (the scale midpoint) to Very Well (the highest allowed). The averages of ratings given to both Question 36 and Question 37 were the same: 4.14 ($n = 21$), or slightly higher than “working well.” Thus, subjects generally appeared to believe their organization’s complaint procedures were effective.

Question 38 inquired about subjects’ desire for their organization to receive training on National CLAS standards. Four-fifths of the

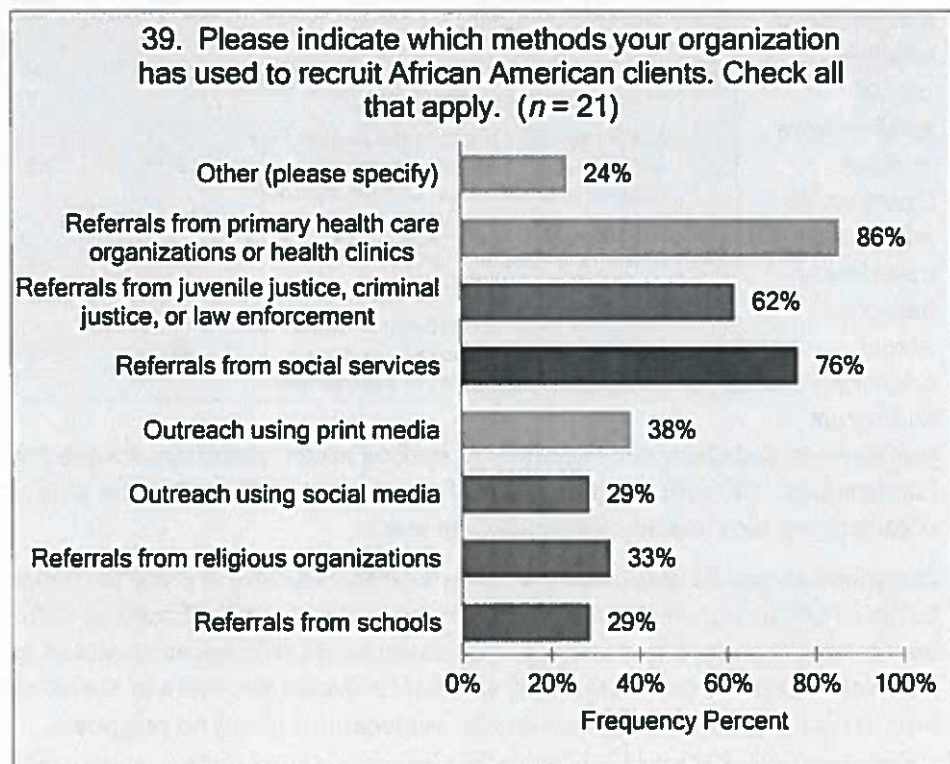
Question 38. Would you like your organization to receive training in the National CLAS Standards?		
Answer Options	Response Percent	Response Count
Yes	81.0%	17
No	14.3%	3
Don't know (Please explain)	4.8%	1
<i>answered question</i>		21
skipped question		1

sample (81%) indicated that they would like to receive training. The one “Don’t know” respondent commented, “We have been receiving training from some local trainers. Not sure the breath of everything you train in.”

Services for African Americans

The next series of questions related to different aspects of services that subjects’ organizations provide to African American clients.

Question 39 asked subjects to identify any methods they used to recruit new African American clients by selecting from an established list. Referrals from other service agencies and facilities received the largest number of responses starting with



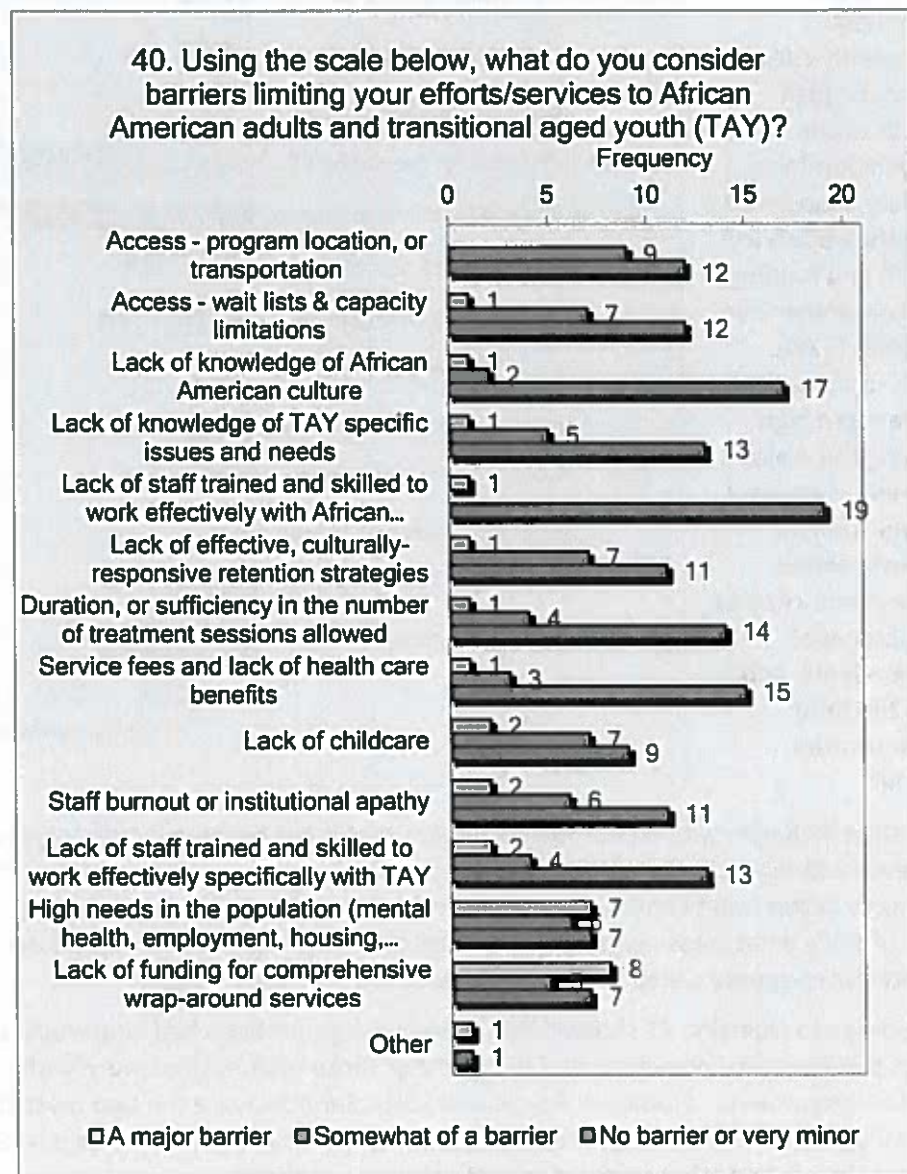
primary health care and clinics (86%), followed by social services (76%), and criminal justice-

related services (62%). Five write-in comments to Question 39 were comprised of the following:

- Other SUD programs or residential facilities
- Tabling at community events, outreaching at neighborhood schools, and collaborating with other cbo's.
- In custody
- former clients, staff
- African Amer. client levels => local demographics

Question 40 inquired about barriers that subjects' organizations encounter in providing services to African American clients. Lack of Funding for Wrap-Around Services and High Needs of the Population were the most cited as being "Major" service barriers.

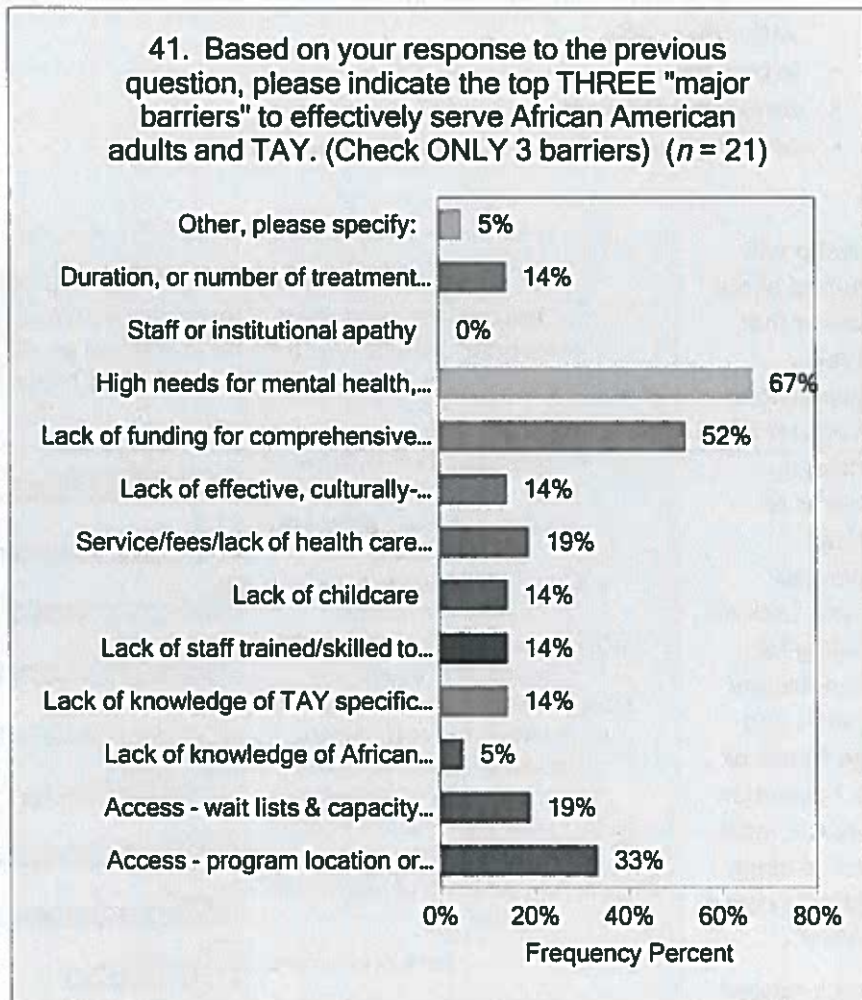
Access-related issues were most frequently indicated as "Somewhat" barriers, and they included location, transportation, capacity, and lack of child



Lack of culturally responsive strategies also was indicated here.

Among the most cited minor barriers were lack of trained staff, limited knowledge of African American culture, health care service fees, and capabilities related to TAY. One write-in comment said, "Being a prevention, non-mandated program, it is challenging to recruit and retain individuals without them being referred to our organization."

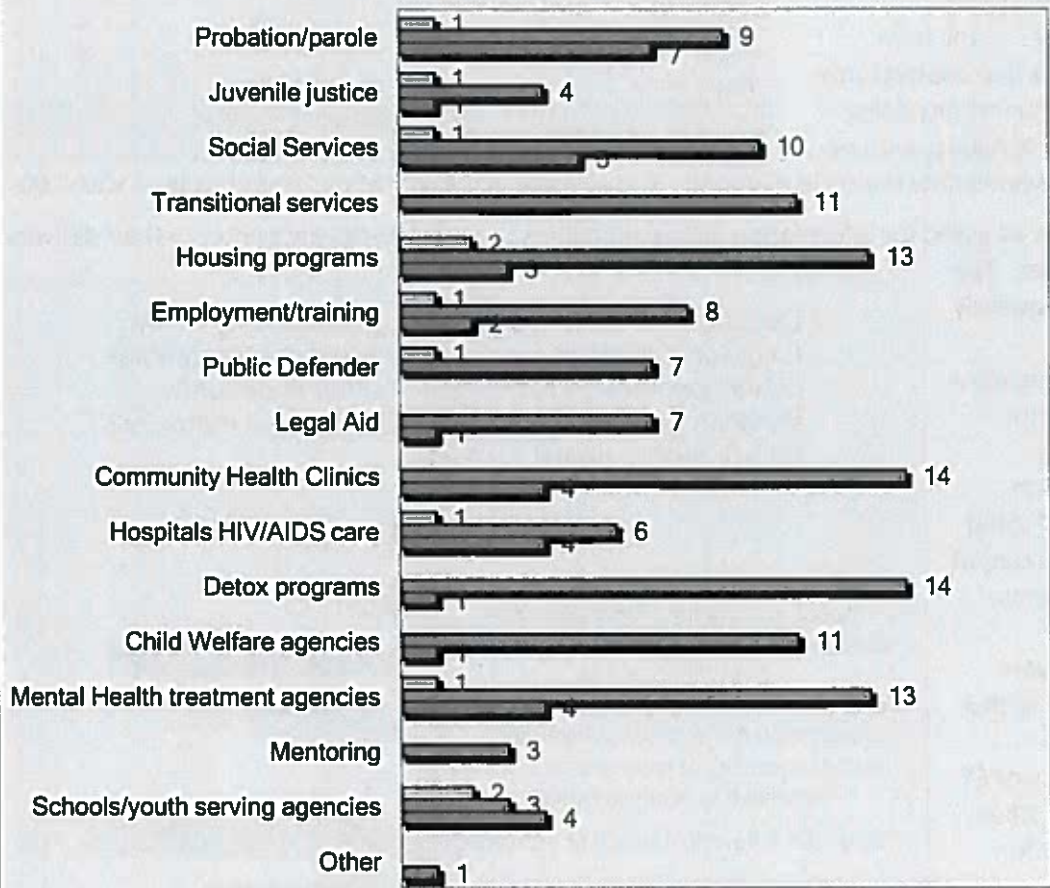
Question 41 made an attempt to identify the most important needs as seen from subjects' perspective. The two most frequently cited were the high needs of the population for a variety of social and healthcare services (67%) and funding for comprehensive services (52%). Both of those issues were rated high among the major barriers presented in Question 40. Access-related issues were cited by 33 percent of respondents, and it was the third highest rated barrier.



Question 42 began with an acknowledgement that it has become increasingly common and necessary for agencies, organizations, and even clients to work as partners or multi-disciplinary teams to better meet community needs. It then continued with the following questions will help identify what cross-agency relationships are currently established, and areas where greater inter-agency collaboration and service integration is needed.

Responses to Question 42 showed that subjects' organizations had numerous relationships with other public service providers, and that most of those relationships were without formal or written agreements. Probation-Parole and Social Services were the two most cited with for formal agreement or contract. Note that the chart of Question 42 results is a rather "busy" one so response options that received zero checks are not shown.

42. Please indicate what agencies and organizations you currently have established relationships with to better serve African American clients. (n = 21)

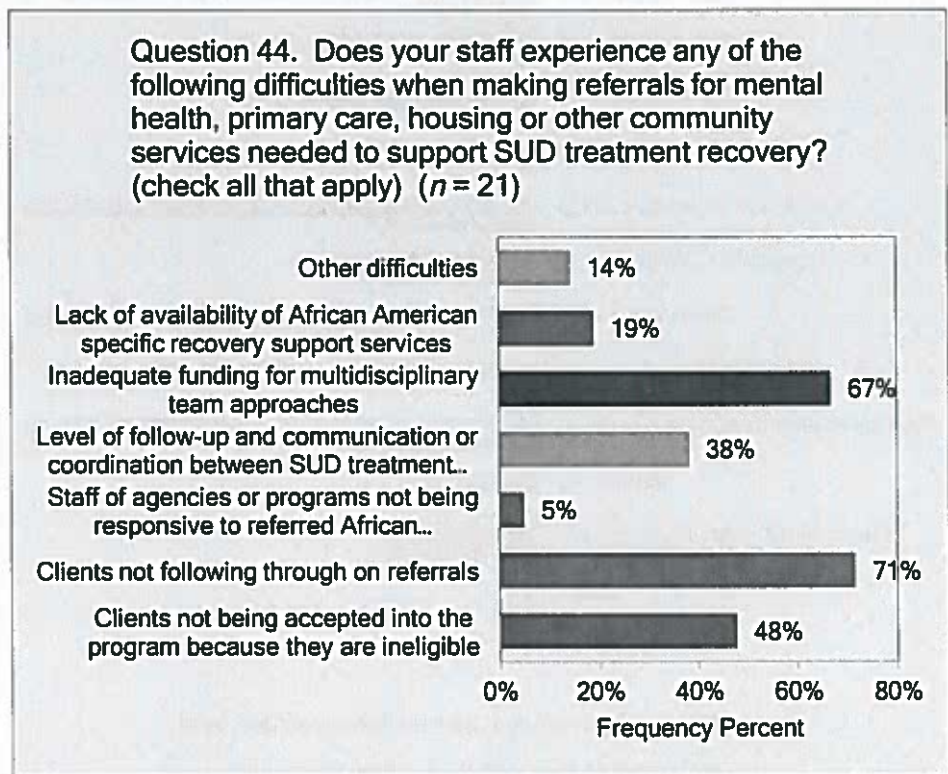


- Currently seeking a partnership agreement with
- Current partner without a formal agreement
- Current partner with a Memorandum of Agreement/contract

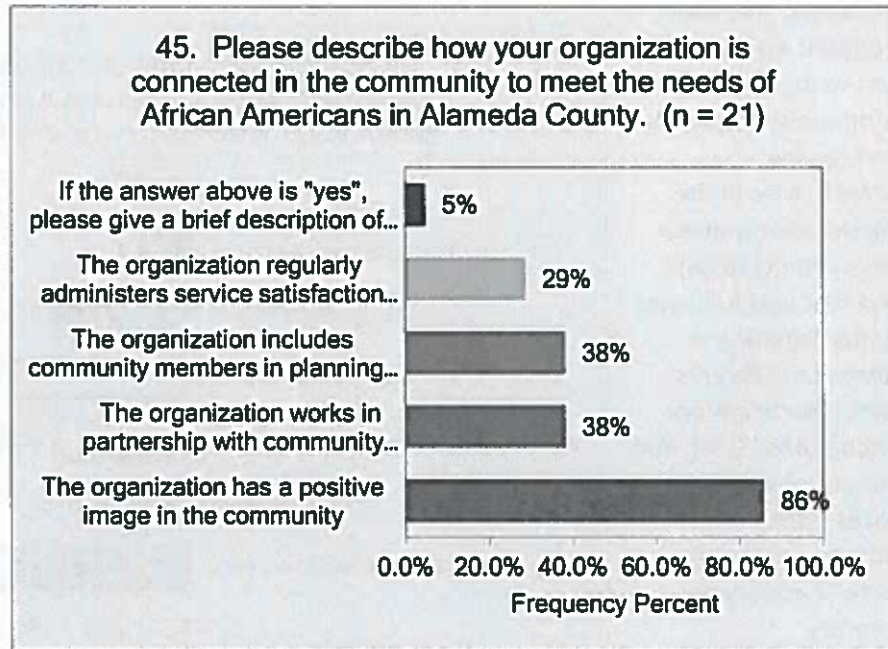
Question 43 was designed to assess subject's views of their organization's performance in meeting the cultural needs their African American clients. Responses to the item indicated that subjects saw their organizations doing well in this regard, with no ratings given below the scale midpoint. The average across all ratings from this item was 4.00.

Question 43. How well do you feel that your organization meets the cultural needs of its African American clients?		
Answer Options	Response Percent	Response Count
Very Well	23.8%	5
Well	52.4%	11
Neither Well or Poorly	23.8%	5
Poorly	0.0%	0
Very Poorly	0.0%	0
<i>answered question</i>		21
<i>skipped question</i>		1

Question 44 asked for information about difficulties that employees encounter in their delivery of services. The most frequently noted difficulties were "Clients not following through on referrals" cited by 71 percent of respondents, and "Inadequate funding" with a citation frequency of 67 percent. Client eligibility for program services (48%) was the third most frequently cited difficulty. Three write-in comments stated: "Patient stated having problems with other services once they found out they are on Methadone"; "Client's age (older adults)"; and "This does not apply to our organization, as we provide prevention programs."

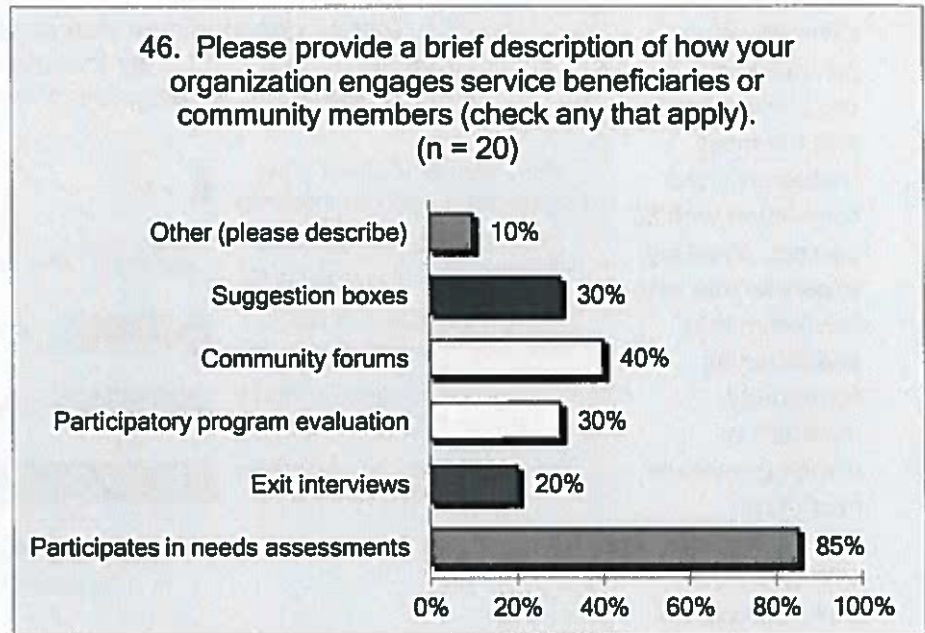


Question 45 asked about community connections for organizations to meet the needs of their African American clientele. A positive image in the community was the most frequently cited connection with 86 percent. Working in partnership with the community and including community members in planning were the next most frequently cited with 38 percent each. Six write-in comments were offered and they read as follows:



- We conduct quarterly client and staff satisfaction survey's
- We are an FQHC; clients serve on board of directors, we are a critical part of the community safety net, and we conduct comprehensive annual patient satisfaction surveys.
- Through referrals, resource coordination, case managements, etc.
- St. Mary's Center is a community partner and hosts many cultural specific programs: Kwanza, Martin Luther King Jr Day, Phillipino Independence day, National Women's Day, Eradication of Poverty Day, and others.
- Our agency has an outcome management process. We collect outcome data in the areas of client satisfaction, program effectiveness, program efficiency, service access, referral source satisfaction, and staff satisfaction.
- Exit plan is part of treatment; includes evaluation of services received

Question 46 asked how the subjects' organizations engage service beneficiaries and community members. The most frequent means used was to involve community members and service beneficiaries in the organization's need assessments (85%), and that was followed by participating in community forums (40%), participatory evaluations (30%), and the use of suggestion boxes (30%). Two write-in comments were "Exit surveys recently implemented" and "Council of Elders advisory board."

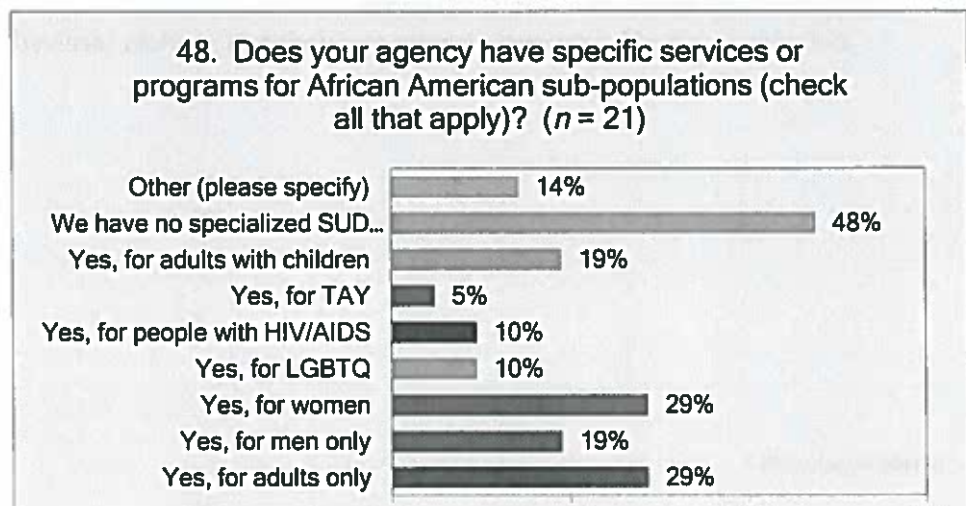


Question 47 asked about the confidence of employees when they interacted with African American clients. All but one response was Agree or Strongly Agree with the item wording, indicating that respondents were favorable in their opinions. The average across all responses was 4.43.

Question 47. My organization's staff members appear to be confident in their ability to work effectively with African American clients?

Answer Options	Response Percent	Response Count
Strongly Agree	47.6%	10
Agree	47.6%	10
Neither Agree nor Disagree	4.8%	1
Comment:		0
<i>answered question</i>		21
<i>skipped question</i>		1

Question 48 asked about specific services
Survey Results 2017



and programs for African American clients. About one-half (48%) of the subjects indicated that they did not offer any specialized SUD services. Programs for adults only and for women followed closest behind in frequency with 29% apiece. Three write-in comments said the following:

- We target all low income persons in our community and do not have services that are specific to any sub population.
- We provide excellent services to all
- For young men

Responses made to Question 49 indicated that subjects saw their organizations as being well informed and responsive to social problems in their service areas. All responses were at or above the

midpoint on the response scale and the average across all ratings was 4.10 (i.e., To a Great Extent).

Technical Assistance and Training

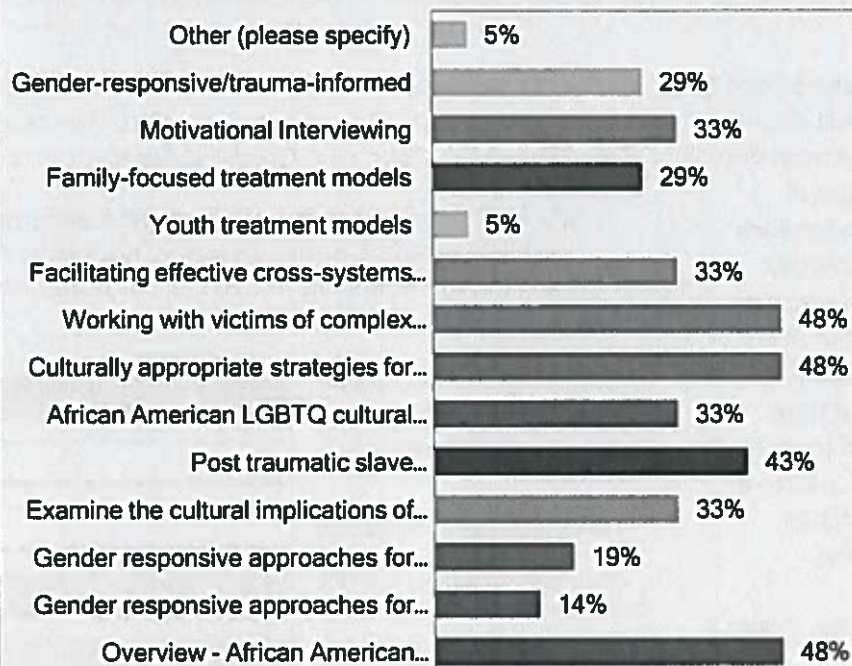
Question 50 asked about the needs for technical assistance and training to

Survey Results 2017

Question 49. To what extent is your organization knowledgeable and responsive to the social problems (e.g. racism, housing affordability, gentrification, poverty, etc.) that disproportionately affect African Americans seeking SUD services in your service area?

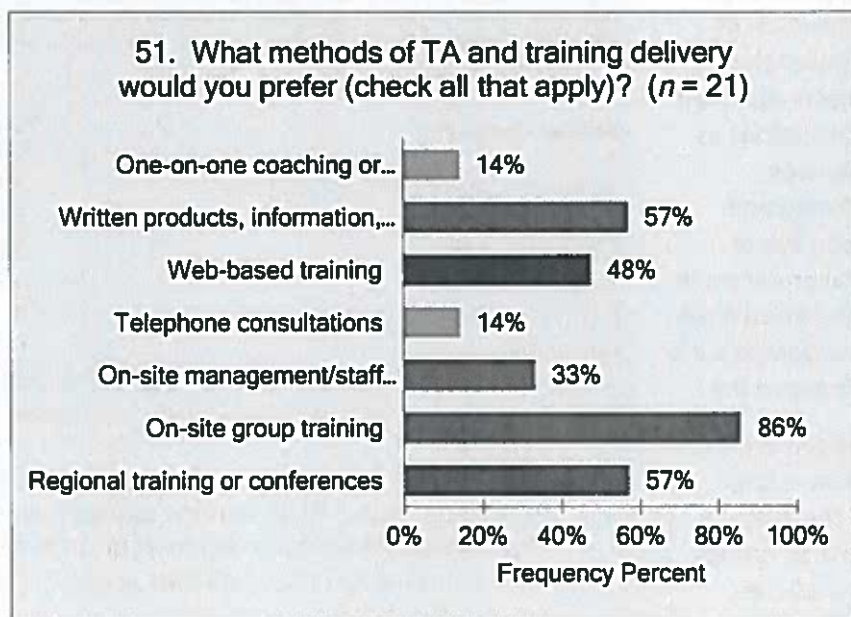
Answer Options	Response Percent	Response Count
To a Very Great Extent, or Completely	23.8%	5
To a Great Extent	61.9%	13
To Some Extent	14.3%	3
To a Little Extent	0.0%	0
To a Very Little Extent, or Not at All	0.0%	0
Comment:		0
<i>answered question</i>		21
<i>skipped question</i>		1

50. What technical assistance and training is needed to provide better SUD service delivery and outcomes for African Americans within your organization and community (check all that apply)? (n = 21)



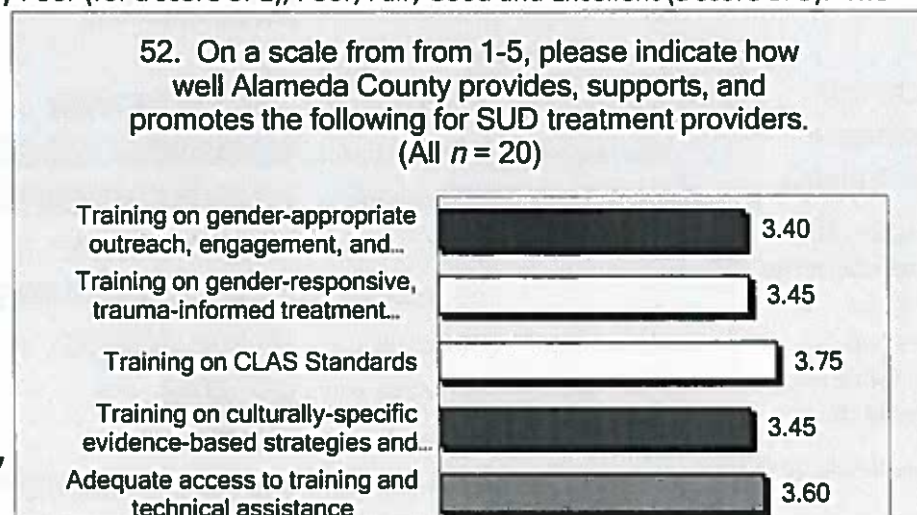
provide better SUD service delivery and outcomes for African American clients. The most frequent responses were Overview - African American Cultural Competency, Culturally appropriate strategies for relapse prevention, and Working with victims of complex trauma, each with 48% percent frequency. Post traumatic slave syndrome and effects of historical trauma was the next most frequently cited with 43 percent. One write-in comment said "A bit of all the above."

Question 51 asked about subjects' preferences with regard to training and TA delivery. The three most frequently cited methods were on-site group training (86%), written products and updates (57%), and regional training or conferences (57%).



Question 52 use a 5-point Likert-type response scale and asked subjects to assess the quality of Alameda County services and support for SUD treatment providers. The response scale anchors ranged from Very Poor (for a score of 1), Poor, Fair, Good and Excellent (a score of 5). The averages of ratings for each characteristic being rated are shown in the graph for Item 52, and they ranged from a low of 3.40 to a high of 3.75.

All of the



ratings were about half-way between Fair and Good on the response scale. Two write-in comments stated:

- With a limit of 1 or 2 people per site, that's not enough training, and the training is not robust enough to make attendees trainers when they bring it back to our site.
- Not aware of County Trainings on these issues.

Question 53 was the final item, and it asked subjects to assess the adequacy of the survey questionnaire in addressing issues of linguistic and culturally appropriate treatment for African American service beneficiaries. No

Question 53. I think that these survey questions adequately addressed the most important issues in our linguistic and culturally appropriate treatment services for African American adult and transition age beneficiaries.

Answer Options	Response Percent	Response Count
Strongly Agree	10%	2
Agree	60%	12
Neither Agree nor Disagree	30%	6
Disagree	0%	0
Strongly Disagree	0%	0
Please add any comments that you think might be helpful:		1
	<i>answered question</i>	20
	<i>skipped question</i>	2

negative ratings were made, and all ratings were at the scale midpoint or higher. The average across all ratings was 3.80, or the low side of "Agree". One write-in comment said, "African Amer. is NOT big local population: HISPANIC/LATINO."

Discussion

The sample used in this survey was too small to allow a confident interpretation of its results. We can only hope that it can serve as a valid basis of comparison for the planned post-project assessments. However, such difficulties are not uncommon in field research, and sometimes we simply must make the best with what we can get. From that perspective, a sample of 22 is easily better than a sample of 21 and it far better than having no sample at all.

In general, responses to the survey's scaled items indicated moderate to slightly favorable opinions about how things are happening. On a number of scaled items, no negative responses were made at all, and there were no indications of truly burning issues. As a whole, however, the ratings given to scaled items also allowed that there probably was ample room for a few improvements to be made.

For the categorical items (i.e., check all that apply), sufficient variability occurred among responses to indicate that most (if not all) subjects participated diligently and that they thoughtfully considered their options and answers. In nearly all of the check-all-that-apply questions, each of the response options that were provided by the questionnaire were selected by one or more subjects. We interpret that to indicate that subjects were not simply rushing through the items and checking the most convenient responses. We also note that subjects provided write-in comments to nearly all of the questions that solicited them.

We believe that all of these indicators are favorable with regards to the reliability and consistency of the survey results. Participants were actively engaged in the process and invested their efforts to provide meaningful information.

ATTACHMENT B

Preliminary ACBHCS Key Informant Interview Report

**Implementation of the
Culturally and Linguistically Appropriate Services (CLAS) Program**

Preliminary Key Informant Interview Report

**Behavioral Health Care Services of
Alameda County
May 1, 2017**

**Submitted by
ONTRACK Program Resources**

Performed under contract with the California Department of Health Care Services

1. INTRODUCTION

ONTRACK Program Resources conducted eight (8) Key Informant Interviews between April 20 and April 28, 2017 involving various staff members of Alameda County's Behavioral Healthcare Services, including: managers, program specialists, and coordinators. The interviews are a central component of a county-wide needs assessment designed to guide planning for a technical assistance (TA) and training effort to support Alameda County Behavioral Health Care Services (ACBHCS) deepen its culturally responsive system of substance use disorders (SUD) treatment for African American transitional aged youth and adults.

Due to scheduling challenges, the County Alcohol and Drug Administrator and the Interim Director of Transition Age Youth System of Care were not interviewed for this preliminary reporting of the Key Informant interviews. The SUD Administrator has been scheduled to be interviewed on May 1, 2017. The comprehensive report to be submitted on June 1 will include recommendations and a summation of needs once the perspectives of these key county players have been ascertained.

The key informant interviews with county-level employees will be complemented by focus groups and key informant interviews with SUD service providers who are in contract with the county to provide such services. These interviews will be conducted during the month of May and included in an integrated report in June.

The discussion was designed to gather information from county-level employees in regard to the following outcomes:

- To understand what knowledge ACBHCS staff have of CLAS standards
- To understand what motivates SUD staff to implement CLAS standard and reduce disparities among African American TAY and adult populations
- To understand how well SUD staff believe the needs of African American TAY and adults are met
- To understand the degree to which CLAS standards have been internally implemented into the policies, procedures and practices of ACBHCS
- To understand the degree to which ACBHCS ensures that its contracted service providers implement CLAS Standards to better serve its clients in general, and African American TAY and adults, in particular
- To determine the training and technical assistance needs of ACBHCS
- To determine the training and technical assistance needs of ACBHCS's contracted providers

2. METHODOLOGY & PARTICIPANT DEMOGRAPHICS

2.1 Participation in the interviews was limited only to paid employees of ACBHCS. Six worked within SUD, two worked in Mental Health. Participation was strictly voluntary. Participants were given or shown a copy of a description of CLAS standards and their purpose to "advance

health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and healthcare organizations”

2.2 Eight participants took part in the Key Informant Interviews:

- Three women and five men
- Five identified themselves as managers
- Two identified themselves as Program Specialists
- One identified as a coordinator
- Six identified as working within SUD
- Two identified as working in Mental Health

3. INTERVIEW RESULTS

Outcome 1: To understand how key players within the organization understand health equity and cultural competency

3.1 What is health equity and cultural competence?

Q. 1. What is your definition of health equity?

“Health equity” was defined in numerous ways by informants. Most all said it is not a term that is frequently used within the organization. One key informant was careful to distinguish inequity from inequality: “There is a difference between inequality and inequity. You can’t just treat people the same, they may require different things to get to equal, to outcomes.” The same informant noted numerous times that “API [Asian Pacific Islander] populations are at 1.7%, they are our lowest. [The] Main problem is access.”

Conversely, most informants defined equity as ensuring all people received the *same level of access and services*. One informant stated succinctly, “I see health equity as no difference in quality and type of service and dosage.” Another informant stated, “we talk about health disparities all the time. Clearly African American and Latino are the lowest. And other groups underrepresented. We talk about diversity a lot, LGBTQ. We are looking at all groups and ensuring all get their fair share. Young adults are overrepresented in justice. Our largest clinic is at Santa Rita jail. Young people who should be getting services rather than jail.”

One informant was careful to distinguish a personal definition of “health equity” from the usage within the county. “Personally, it means providing equal access and opportunity to all residence of Alameda who are in need of behavioral health care services regardless of race, language, etc. Parental/family status. Organizationally, it shows up in contract language more and more. I’ve noticed more responsiveness. We increasingly talk about it and encourage it.”

Some key informants (KI) spoke specifically about health equity as an intentional action to produce equal outcomes for all in need of services. “Health equity is removing the barriers. Identify them then

eliminate them to give people the opportunity to thrive fully. Equity being fair. Giving them the same opportunities. Equal access, healthcare benefits opportunities. A different KI wanted to note that health inequity is about access and stated that "health equity is about disparities. Rectifying disparities. The Feds. hold us to accessibility. Access. They want to ensure that there isn't a segment of population who are not getting services."

There did not appear to be a consensus on what health inequity is, but the overall impression from informants is that it has something to do with ensuring an equal level of access. One informant stated directly that it is a matter of understanding than usage: "There is no common language around racial and economic inequities. People have heard the terms, but there are some people who have been in the system a long time and don't get it. Some people have asked for a discussion about race as a way for us at the county to better understand and discuss the dynamics our providers experience daily but many just don't want to have it."

Q. 2. What is your definition of cultural competence and why or why not do you think it should be a matter of policy and practice at the county level?

Informants tended not to give a definition of cultural competence. Those who did offer definitions thought the term was inadequate. One informant asked "What is the "it?" We most often come back to language. We have a significant population that speaks a non-English language. This has been a real challenge for us, perhaps the largest. It's also about having service providers who see the complexity in serving different peoples. Whether it's because of historical racism. Being comfortable enough to talk about it. Race is a thing many can't talk about. And others want to talk about it too much. Others offered different definitions of the term. "I prefer cultural humility because it makes one an on-going learner. Proficiency and competency assumes an end point."

Another suggested that cultural competency was too facile. "You can look at it from different lenses and points of view. I don't like the term. It's linear. That is a shallow approach of understanding the depth of experience, of understanding the environment and living healthy. I like the term cultural responsiveness. Understanding people's history and culture. It is important. We need to go beyond competency to adequately think about the needs of our TAY populations. Deeper lens and reach. Cultural competency is not enough." Another saw cultural competency similarly as "being able to culturally relate to different cultures," because everybody doesn't have to come from the same place." This informant went further to state a theme that other informants discussed: cultural competence as a capacity to come to grips with both internally and externally.

"When I hear the term its about external missions and goals. What about our internal mission and goals? I don't think it's important to administration. They say it some times, but usually in relationship to the clinics. They treat us like shit inside, then talk about cultural competence on the outside."

Another informant seemed to confirm such a sentiment, "when we talk about cultural competency, we are talking about providers. As administrators we need to make sure our providers are culturally competent. We've organized policies to provide CLAS assessments and trainings." One informant spoke as cultural competency as an external force being forced onto the county. Organizationally, competency

is an external, political force. The old paradigm of diversity is enough. The providers and many of us are at that place.”

One informant spoke of the challenges to cultural proficiency at the county-level as a matter of changing leadership. “Five years ago we were on our way to conducting cultural competency trainings across our system but because of change of leadership within Behavioral Health it didn’t happen. The training was based on the California Brief Multicultural Scale (CBMS). The new leadership has problems with discussing racial disparities. Some think our former Ethnic Services Director was moved out, and viewed as an angry Black woman because she said we need to address race, we need to address disparities. We need White leaders to step up.”

Another informant simply eschewed a definition and spoke of cultural competency personally. “I want to learn and I want to learn the culture to be respectful. There are generalizations that can be made and when they are it is harmful. Cultural competency [as a term] is thrown around. When people use the term here, we may not be describing the same thing. We have a staff with different languages that I can’t afford to learn. So, I don’t know if its even possible to be competent. The non-white population is more culturally competent. They have to be. *I don’t, It’s an invisible knapsack, a privilege I have.*”

Outcome 2. To understand the degree to which CLAS standards have been internally implemented into the policies, procedures and practices of ACBHCS

3.2 What are the internal policies and practices that ensure the CLAS standards are implemented and met?

Q. 3. What has been done to recruit, retain, and promote a culturally and linguistically diverse leadership and staff attuned to the needs of the provider and service community? What key leadership positions are responsible that CLAS standards are met?

Q. 4. How does the agency infuse culturally and linguistically appropriate goals, policies and management accountability throughout the agencies planning and operations?

Q. 5. Does ACBHCS have a cultural competence or CLAS plan?

Q. 7. Does the ACBHCS have a Cultural Competency Committee?

Every interviewee stated that there was not enough being done to recruit and retain a culturally and linguistically diverse leadership attuned to the service and provider community needs. Two of them stated directly that nothing was happening and stated that the county was doing “nothing. They might fulfill a quota. It’s more than recruiting, it’s how you treat diverse peoples once they are inside. [They] treat us like we are not qualified, minimize our work every day. Another reiterated this position that not enough was being done to recruit and retain a diverse staff: “Nothing. And no evidence that they are. I’ve been seeing a strong pool of African Americans. being pushed out. Some not completing probationary period. Across leaders all white males, except maybe one Filipino, and one white woman. Those over the systems of care are white men. We met last week with the supervisors and asked why is

it so white. Rebecca Gephardt, the interim Health Care Director said that there are no qualified people of color out there seeking these jobs.”

Other informants were less categorical in their responses. One stated that “efforts come and go. The service providers pretty much match African American. County at about 12%.” As an example of an effort for our service providers, we piloted a new model within direct services for the reentry population. We required that people with lived experience have to make up 50% of the staff. The staff of the programs/agencies changed and became more diverse. This shows that change can come from bottom up to top down. We also funded a self-assessment tool for mental health providers to assess their diversity. Unfortunately, SUD doesn’t have innovation funds.”

Another informant stated that not much was being done to recruit a linguistically diverse staff. The informant stated that “leadership is not doing much linguistically. They don’t offer an incentive for people with different languages. Everyone who speaks a non-English language should be designated bilingual. I felt inferior here for a time.

There did appear to be some confusion concerning who was responsible that CLAS standards are met. Two informants stated that it is everyone’s responsibility. One stated, “Everybody is with no exception. The decision-makers. We get some trainings and it is all talk. I see all white men and no linguistic diversity. *If I close my eyes and listen, it matters, open my eyes it does not* [emphasis, the informants]. Another stated that the “operational leads are responsible for the implementation of CLAS standards.... Some may see Javarre as responsible, but he has not been here long enough to accomplish all that needs to be done now.”

Another informant reiterated that there was no singular person who was positionally able to implement the CLAS Standards at the county-level. The informant stated “There is no key leadership responsible for the standards. We had a manager (Gigi) who was provisionally in the position who had to be classified as senior program specialist (10 years in position). The new Ethnic Services Manager doesn’t have the authority to make it [CLAS] a substantial aspect of the organization.” This informant recounted a story that suggested that the resistance is structural. “There is a leadership group, just beneath the executive level. People at that level asked for a discussion about race internally. The response was terrible, one person said just ‘tell me what I can and can’t say.’ I think the problem is structural. There are people who want to stay longer than they have the passion to get things done. They know they are getting a fixed retirement that is set, so they just want to hold on. This is a major structural issue. Now we just contract out the things that people don’t have the passion for. People are territorial; stake out their territory. System needs a structure that allows us to work around bottlenecks. We need to be adaptive and dynamic to meet the cultural needs of our populations.” An additional informant reiterated the challenge of CLAS implementation at the county level. The informant recounted that “there is an item on our agendas for cultural sharing. It came up in a meeting and the new interim asked if the cultural sharing item should remain on the agenda going forward. The conversation lasted 45 minutes and most of the attendees wanted the item off the agenda. Some honestly stated that they were uncomfortable. There will be a presentation made on why it’s important for those of us who work at the County.

One informant who has been with the Agency for a significant amount of time summarized the history of responsibility for CLAS/cultural competency as “All Leadership is responsible, though we say Ethnic Services, but there are 30-40 key leaders. It starts at the top and we are falling short. You can count people of color in room on one hand. It has to start with the Behavioral Health Director. When the Ethnic Services Manager is left out, that role becomes a voice in the dark. If the Behavioral Health Director and the Ethnic Services Manager is aligned, it spreads throughout the organization. That alignment doesn’t exist. Ethnic Services now reports to the Medical Directors Office. Can you get all the authority you need from this reorganization? New interim 2 months ago did a new org. chart, and a lot of things were moved around. The position of Ethnic Services Manager has lived in 4-5 places over the years.”

Still, one informant saw that there were substantial things being done concerning CLAS implementation at the county-level. “The Ethnic Services Manager, Javarre, is responsible for CLAS. Since he’s been there, he’s been given staff. And he’s taking the bull by the horns. Trying to get CLAS and cultural competency agency wide. We need education and a consistent message from the top. He can’t do it alone.” In an interview with the Ethnic Standards Manager, he informed the interviewer that he has been given “temporary staff” to assist in cultural competence efforts.

There was no general consensus concerning a means to infuse cultural competency in the agency. An informant went so far as to assert that, other than compliance with specific mandates, the mechanisms are such that “only loud obnoxious people can infuse them during planning.”

Another stated that “there is not much infrastructure. It’s being created. There are really no policies. A culturally responsive committee is in development, but there is no effective means for decision-making. The policies have to be developed and then taken to executive committee. This is not a meaningful, strong mechanism. Executives should be part of the process at every stage. Conversely, another informant believed that something significant was happening at the agency with regards to cultural competency. The informant stated that “I know we do have a plan and we’re rolling it out. Javarre is updating it. We weren’t good at writing policies and procedures. We now have a policy and procedure template, goes to QA who gives it a number, then it goes to the Expanded Leadership/Administration of 30+ leaders, then to Quality Improvement and is distributed across the organization for implementation.”

Informants agreed that there is a cultural competence plan, but only one had a recollection of what is in it and if it was up to date. All agreed that there was no comprehensive plan across the agency. One stated that “there is a cultural competency plan, currently its 2013. The cultural competency plan is separate and may not be a part of the larger plan. It definitely does not encompass both Mental Health and SUD.” For still another informant all that mattered is that the cultural competence was not a constitutive part of the life of the organization. “All I know is that there is no plan I have at the ready, at my fingertips, something I see, taste or hear.”

The county assesses the implementation of CLAS related standards of providers through an annual assessment instrument in which a number of questions related to CLAS are asked. But still this is not enough as viewed by one of the informants who suggested a strategic approach to infusing cultural

competency throughout the organization. “You have to start with the Expanded Leadership Group. We need their buy-in. If we start in community, but don’t get the people at top buying in, we fail. The group needs some sort of session that gets them ready to see the importance. Whenever we start to talk about race and culture it works for a minute then goes away. It can’t just be Ethnic Services. The leaders have to be comfortable to sharing. We don’t measure retention, really. SUD is almost entirely grant funded. So we staff according to Mental Health funds. People in SUDS. They applied for an SUD waiver. We did an analysis of risk. Many SUDS wouldn’t measure up to managed care, and evidence. Many people like this went through the programs and overly identify with the system. Commitment to keeping existing providers. The waiver would have allowed us to expand services, and fund.

Outcome 3. To understand the degree to which ACBHCS ensures that its contracted service providers implement CLAS Standards to better serve its clients in general, and African American TAY and adults, in particular

Q. 8. Overall, how well do you feel that ACBHCS providers’ meet the cultural needs of its African American TAY beneficiaries?

Q. 9. Does ACBHCS analyze data collected by SUD service providers to monitor access and outcomes by racial/ethnic, TAY or LGBTQ cultural populations?

Q. 10. How is data used to allocate resources and eliminate healthcare disparities?

In general, informants thought providers met the cultural needs of African American adults and TAY somewhat well. One informant noted that the county “counts numbers well,” but asked “how do you determine quality?” The county uses a standardized assessment tool, the CANS (Child and Adolescents Needs and Strengths) and the ANSA (Adult Needs and Strength Assessment) to measure quality. The tool includes a cultural factor domain to measure program impact on clients.

The system to measure program quality serving African American TAY and Adults is not uniform. Several informants stated that the county has extensive data that is “made available upon request.” One person noted, “some of us have requested dashboards and looked at some of the indicators concerning how well we are serving our TAY. The challenge is we don’t have enough people looking at the data. Nobody is saying: ‘this program is working for this population and not with others.’”

One person stated that data they have collected concerning how well African American TAY are being served has allowed the department to make an argument for prevalence in substance abuse rates among clients, aged 18-24. The informant stated that “the substance use rates are highest for that age. Where are they being served in our system. No one adult provider stood out as predominantly serving TAY. We are looking for grants that are TAY specific. We do use data to look at quality. The disparity between TAY and other population penetration rates. I’m using prevalence to build an argument for more funding for our TAY population.

The system for measuring quality in the county measures penetration/access but does not measure program retention. One person stated, we don’t track LGBTQ. But we do look at penetration by race

and age. We don't measure retention however, "EQRO [an organization that performs external quality review] standards are beginning to incorporate retention as a component in measuring the quality of services provided to clients."

Outcome 4. To determine the CLAS related training needs within Alameda County Behavioral Health and its contracted providers

Q. 11. How do you determine the training needs of your staff as it relates to CLAS?

Q. 12. What types of training would your Behavioral Health team, and your contracted providers benefit from that would improve their ability to better serve the African American TAY populations?

The capacity to determine the training needs of ACBHC staff as it relates to CLAS is an internal challenge for the agency. According to one informant, efforts to survey staff was initially approved by the agency's former deputy director, but has since been placed on "pause."

Informants suggested that the department has the following training needs:

Racial literacy and awareness development

- "Everyone should be able to talk about race, ethnicity and culture easily. Currently there are some staff who won't even identify clients or people by their race, etc. How can we speak of African American TAY needs if we can't exercise this basic capacity?"
- "We aren't too bad compared to a lot of places. We have well meaning people and we need patience with those who want to avoid explicit discussion of race. We've been down this road before and people get uncomfortable."
- "Our leadership is blatantly disrespectful to staff of color. The culture is toxic. How can we make effective decisions about service providers if we can't get past this internally?"

Training for programs serving non-English speaking persons

- "I don't think the support should just be for African Americans. Our Latino population is large and growing. One-third of beneficiaries are Latino. We struggle most with linguistic."
- "We need language support for our service providers. The city of Fremont alone has multiple languages."
- "What kind of T/A. We need to become comfortable talking about race. Understand implicit bias. Racism is a relationship toxin. Another is we need help in understanding cultural humility. Some people need help on understanding the system. Our "high end" systems: jails, hospitals black males are largely Black males."

Training for women with children

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- **“I know as a fact we have been approached by perinatal treatment providers seeking training opportunity to help staff learn specific tips and pointers and information relevant to serving pregnant and perinatal issues, custody, relationships, SUD, etc. Women training women to train women. The Nuts and bolts stuff.”**