Using Critical Race Theory to Guide Quality Improvement in a Specialty Outpatient Program for First

Break Psychosis

Leslie Wright

Oregon Health and Sciences University School of Nursing

NURS 703B: DNP Project

Tara O'Connor, DNP, PMHNP-BC

March 21, 2022

Abstract

Racial disparities have existed in mental healthcare for too long without meaningful improvement. These disparities are at least partially related to the disregard for patient experiences unique to those who identify as young, and Black, Indigenous and People of Color (BIPOC), and who are systematically left out of patient feedback processes. Critical Race Theory suggests racism is ordinary, and the unique experiences of BIPOC-identifying patients are valuable and should guide quality improvement in the mental healthcare sector. The site for this project was an two-year, outpatient treatment program ("program") for youth experiencing their first episode of psychosis in the Pacific Northwest. This project aimed to center the experiences of the program's BIPOC clientele in future quality improvement projects by capturing their experiences and satisfaction of services via survey. The project team reached out to clients by phone and text over a four-month period, aiming for a 50% response rate. Clients filled out a survey independently or participated in a semi-structured phone interview. Response rates and quantity of feedback improved with text/phone outreach, and via phone interviews. Thematic analysis revealed a diversity of perspectives on how program staff engage clients around their racialized identity, and the salience of one's racial identity to the provision of services. Overall, patient feedback surveys did lead to valuable data on BIPOC patient experiences within the program, but surveys may unintentionally limit feedback and communicate unexamined assumptions.

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The United States' (US) mental healthcare sector produces some of the worst care disparities for patients who identify as Black, Indigenous and People of Color (BIPOC) with little improvement over the last 20 years (Institute of Medicine, 2002). From 2013 to 2018, White Americans were overrepresented among mental health service consumers despite the roughly equivalent need across racial groups (Cook et al., 2017; Substance Abuse and Mental Health Services Administration, 2018). Even with equal access to psychiatric treatment, gaps persist in improvement, recovery, and satisfaction rates between BIPOC and White communities (Maura & Mamani, 2017; Meyer & Zane, 2014). Oregon ranks second last in the US for mental healthcare due to the highest prevalence of mental illnesses paired with poor access to care (Mental Health America, 2021). Therefore, there is a clear need to address patient satisfaction for BIPOC identifying patients receiving mental health services in Oregon.

Available Knowledge

Feedback as a quality improvement (QI) strategy is not new, but its application in reducing racial disparities in mental health is under-studied. Despite robust stated interest in patient feedback, most surveys are tailored to the setting and population, without a standardized way to assess such feedback (Miglietta et al., 2018). Further, research exploring strategies to improve patient feedback consistently fails to address the systematic underrepresentation of BIPOC voices, especially among younger populations, thus perpetuating the overrepresentation of older, white patients (Compton et al., 2019; Klein et al., 2011; Miglietta et al., 2018).

There is a small body of research exploring strategies to improve patient feedback among underrepresented communities. Asking relevant questions is critical. Recommendations for areas of focus include attitude and adequacy of communication from staff and practitioners, self-ratings of a patient's health status, behaviors, and other aspects of care (Sheldon et al., 2007). When patients are

not required to perform follow up work such as mailing a survey back, response rates may improve

(Toomey et al., 2019). Financial incentives have long been a strategy to improve patient response rates:

fixed and prepaid financial incentives versus promised or lottery-based incentives improve response

rates for phone-based surveys (Halpern et al., 2011; Mercer et al., 2015). Finally, a critical part of

soliciting patient feedback is to ensure it guides service offerings. This requires translating data to

quality improvement opportunities, disseminating the results to staff and stakeholders, and creating an

inclusive space to formulate data-informed improvement strategies (Kumah et al., 2017). Without an

intentional focus on transforming BIPOC patient feedback into improved services, these experiences can

unwittingly reinforce race-based disparities in care.

Rationale

Racial disparities are at least partially related to the disregard for young, BIPOC patient

experiences who are systematically left out of patient feedback processes that have not been optimized

for their engagement (Compton et al., 2019; Klein et al. 2011). Originating within legal scholarship

during the 1970's, Critical Race Theory (CRT) can be understood as both a movement and a framework

for critical examination of systems to identify the foundational relationships between power, race, and

racism that serve to protect US social hierarchies and violence (Delgado & Stefancic, 2017). CRT can be

organized around five tenets: racism is ordinary, racism benefits white-identifying people materially and

psychically, race is a social construct and not a biological truth, identities and context intersect to

influence unique racialized experiences (intersectionality), and the resulting unique, racialized stories

are a valuable and critical part of understanding racism (Delgado & Stefancic, 2017). CRT has been

applied to legal and educational systems, and more recently, medical scholars have begun advocating

for its application to medical systems (Delgado & Stefancic, 2017; Tsai & Crawford-Roberts, 2017;

Zewude & Sharma, 2021). Used as the theoretical foundation for this project, CRT asserts that racism

exists within and around the site for this project, a Pacific Northwest specialty outpatient program for

youth experiencing psychosis, to benefit white staff and clients. The unique experiences of BIPOC

identifying program clients are valuable and staff should center these experiences in antiracist program

improvements.

Ad-hoc patient satisfaction surveys are common practice, thus the BIPOC survey created by

program staff is consistent with other approaches to solicit patient experience data. Despite the paucity

of evidence on patient experiences driving antiracist quality improvements, the recommendations that

do exist provide sufficient information to trial such efforts in a small, specialized community mental

health program for young adults experiencing first episode psychosis (FEP).

Specific Aims

This QI project aims to center the experiences of the program's BIPOC clientele by capturing

their experiences and satisfaction of service offerings via survey. The objective is to increase response

rates from 9% to 50% over three months. This data will be used to inform future antiracist program and

care delivery improvements to better serve current and future clientele.

<div align="center">**Methods**</div>

Context

The site for this QI project is a two-year, outpatient wrap-around treatment program for youth

experiencing FEP in an urban county in the Pacific Northwest. Two of the 11 program staff identify as

BIPOC. As of October 2021, 48.3% (n=36) of the 85-client caseload identify as BIPOC: 25.9% are African

American or African, 10.6% are Latinx, 2.4% are Asian or Indian, 2.4% are Native American, and 1.2% are

unspecified. As part of a larger County-wide initiative to end racism, two BIPOC identifying staff

spearheaded the creation of a survey for BIPOC clients with input and support from the whole team. The

purpose of the survey was to assess clients' perceived level of support interpersonally and to evaluate

the adequacy of support for general health and functionality needs. Between January and March 2021,

program staff shared responsibility to ask BIPOC clients to complete the survey. The initial effort showed

poor response rates, with only three (8%) responding.

Intervention

No changes were made to the survey which already reflected relevant questions for the target

population. The 45-question survey included a combination of a Likert-style scales of agree-to-disagree,

yes-no questions, and open-ended responses, and took 10-20 minutes to complete via phone call (see

Appendix A for the survey). One person was responsible for all text and phone outreach to the

program's BIPOC clients to increase survey responses. A meeting with each therapist to confirm contact

preferences and assess for outreach appropriateness was completed prior to starting outreach. For

every contact, the project team attempted to obtain survey responses at the time of outreach to imitate

the experimental conditions in Toomey et al. (2019). If unreasonable, a future appointment was made to

complete the survey via phone. Clients who preferred to answer independently were sent a link to the

survey via email or text. Survey responses were collected via Google surveys. If the survey was

completed via phone call, all questions were read verbatim to mimic the experience of an independent

responder as closely as possible. Patient quotes were captured when possible. Respondents were

offered a $15 gift card to their choice of Fred Meyer, Panda Express, Dutch Bros, or Subway for

participating, but due to County administrative requirements, these were not provided at the time of

the survey.

Study of the Interventions

Identifying strategies to improve patient feedback among young, BIPOC individuals experiencing

psychosis brings value to the study of patient feedback as a QI tool. The response rate and completeness

of the BIPOC survey, the average number of outreach efforts, avenue of communication, and setting of

survey completion were tracked to assess the efficacy of outreach strategy and feedback attainment.

Further, using the CRT framework, the content of all responses from BIPOC clients were considered

valuable and critical for antiracist program improvements, regardless of verbosity or ideas shared. Any responses provided a reasonable proxy for patient engagement. Engagement and all answers were weighted equally and analyzed and summarized for QI recommendations.

Measures

The response rate to the client feedback survey, and the quantitative and qualitative survey content was the primary outcome measure for this project. Progress measures included how the survey was completed (semi-structured phone interview or independent completion), the completeness of the survey determined by the number of questions answered, and the number and method of outreach efforts per client. Balance measures were defined as participant openness determined by the presence of qualitative responses and including a name for follow-up.

Analysis

Outreach efforts occurred between September 2021 and week one of January 2022. All data was gathered via Google surveys populated to Google Sheets and Excel for data analysis; Google Suite is the approved tool for the county. Survey completeness was determined by the number of unanswered multiple-choice questions and the presence of open-ended questions. Open-ended questions were evaluated using a thematic analysis process for qualitative data outlined in the six-phased recommendations of Braun and Clarke (2006).

Ethical Considerations

Participation in the survey was anonymous and voluntary, which was stated in writing and verbally prior to starting the survey. For the clients who elected to share their name, applicable security requirements per HIPPA were followed. For transparency and trust, the project goals, to improve services and care delivery, were shared with respondents. This presents an ethical responsibility to use the patient feedback for the intended and explicitly stated purposes; if no changes are made, it risks

eroding the trust of BIPOC participants with this specialty program, and with the mental health system.

(See Appendix B for OHSU's Institutional Review Board Determination.)

Results

Of the 36 initially identified clients, six were excluded from outreach: four were inappropriate to contact for different reasons and two responded prior to this project, leaving 30 clients to contact. At the end of the outreach period, there were 19 additional responses for a total of 21 responses across all efforts. The final response rate was 58.3%. Responding clients received 1.7 outreach attempts on average. Non-responders received 2.3 outreach attempts on average. Neither phone nor text outreach was more effective, although text messages were used more frequently as a means of outreach. In terms of completeness, all surveys included some quantitative data and, of the 22 open-ended questions, 62% had at least five responses. Excluding the existing surveys, the majority of respondents (73%) completed the survey over the phone. Surveys completed by phone had twice as many open-ended responses compared to online completions, 14 versus seven responses, respectively. Nine clients (42.8%) opted to include their name for follow-up.

Three weeks into outreach, it became clear that questions regarding specific services (e.g., "My identity is included in...") included an assumption of the salience of one's racial identity to adequate treatment. Several respondents shared reactions to these questions like "my identity doesn't mean anything," and "definitely when I was doing medication it was about medication." These responses indicated the term "identity" was vague and/or some did not feel the inclusion of their racial identity was necessary to the effective delivery of services. No responses captured these thoughts. After consultation with the primary survey creators, the project team added an additional question to ask respondents to self-identify their racial, ethnic, or cultural identity with the intent to prime respondents to consider the salience of their racialized identity (See Appendix C). As a result, five responses did not capture the participants' racial identity.

There was an abundance of qualitative and quantitative data across the 21 responses. The vast majority of clients agreed the mental health treatment they received is individualized and respects their race and ethnicity (see Figure D1). Overall, half responded "strongly agree" to the statement that their identity was included in various services, while a quarter of individuals responded "I'm not sure" to these same questions. Therapy and Psychiatry services stood out with the most favorable responses, while Nursing and Screening into the program had the poorest ratings (see Figure D2). Qualitative responses indicated there was no option for "mixed race" during the screening process.

Regarding programming, general health care, school and education, and other social supports or advocacy were areas where clients felt the most supported. Internet access, phone access, food, and utilities arose as areas of less concern (see Figure D3). Seven percent of respondents reported an unmet need, largely clumped in housing, transportation, or hygiene support. Thematic analysis uncovered an underlying need for financial security across unmet needs. Those who responded "not a concern" cited living with a family member helped meet those needs. For example, one participant stated, "At the end of the month, all my bills hit me…so everything is tight…I ain't going to turn down nothing like that." Desire for social connection also arose as a need.

Larger thematic analysis found four core themes across survey responses. First, individuals felt supported, accepted, and connected to program staff. These responses included sub themes of appreciation for culturally specific therapists, trust in staff responsiveness to needs, and feeling respected and accepted. One respondent stated, "Having a counselor that looked like me helped the counseling process. I know my mom likes that having [someone] look like you can help, even if you can't see it right up front." There was a theme of unmet needs with occasional feelings of frustration toward staff. One person replied "Strongly disagree. I do ask for food and stuff like that sometimes, and they say it's a struggle to get it or you have to plan." Additionally, clients recognized the presence of a majority white staff, but the feedback about this reality was diverse: some felt appreciative to have this

verbalized by staff, some shared a desire for more BIPOC staff, and others revealed it felt like a barrier to their care. One respondent shared "It's certain ways that people talk, it seems like when it comes to race, I don't feel like people are giving enough care...I can't tell if people really care about that or they are just doing their job." Finally, many responses indicated that racial identity was not relevant to the care they received through the program but did not mind about being asked about it. One quote summed this up, "I think that considering that my cultural background isn't at the forefront of my daily experience as it is for other people of different backgrounds, perhaps a different idea is to have a check in on ethnic background or cultural experiences in therapy meeting or psychiatry meetings...this would make me feel more comfortable bringing something up if there was something." (See Figure D4, D5).

Discussion

Summary

The aim of increasing survey responses from 9% to 50% was exceeded by 12% during the outreach period, indicating text and phone outreach and offering the survey via phone was effective at increasing response rates and quantity of feedback. Further, phone administered surveys were more effective at eliciting patient experiences, demonstrated by a two-fold increase in qualitative responses. It is unclear if offering a gift card for participation incentivized responses, though receiving the gift card was more than two months removed from participation in the survey. Many respondents indicated trust and openness toward staff and reported a generally positive experience in the program and appreciation for the support they have received. There were some areas for improvement in services, particularly regarding supplies used in activities of daily living, though this likely reflects financial strain many clients experience.

The thematic analysis revealed a diversity of perspectives on how staff engage clients around their racialized identity, and the salience of one's racial identity to the provision of services. Some clients appreciated that conversations of race and racism emerged during specific services, in particular

therapy, peer services, and psychiatry services, while others indicated they might appreciate more curiosity from staff regarding their racialized experience. Many participants felt more neutral about their race being a focus of conversation. Additionally, there was confusion at the meaning or intent of questions regarding their identity, and some communicated they do not look to the program to explore their racial identity. In response to how the program might improve therapy services to be "more inclusive of race and ethnicity," one person stated, "No but I don't think it really needs to be. It just needs to be normal. Unless it's brought up, we're talking about something political like that. I could talk about it if I wanted to, but I probably wouldn't." A handful of participants felt the program improve, and one participant specifically mentioned wanting to work with a more racially diverse staff.

Interpretation

Direct outreach to young, BIPOC clients who have a strong relationship to an outpatient program appears to be an effective way to elicit feedback. Further, conversation provides richer data than a survey filled out independently. Looking to CRT, this framework points to the value of narratives from those who identify as BIPOC, and a survey format may not be the best tool to elicit one's full experience in a program. Consistent with the first tenet of CRT, that racism is the norm rather than an anomaly, the survey questions communicated an assumption regarding the salience of one's race. This resulted in participant confusion and incomplete information regarding their experience in the program, potentially reflected in weakly positive or neutral responses (e.g., "They are doing the best they can"). A survey is directed and somewhat myopic by nature, thereby limiting the amount of data that can feasibly be gathered. Looking to CRT, future QI efforts might consider utilizing a different tactic to elicit patient feedback that centers BIPOC clients in the process of designing what and how feedback is gathered while also eliciting their experience as patients. One option is Community-Based Participatory Research, a research paradigm where community members drive key questions and interventions

alongside stakeholders to ultimately improve community health and eliminate health disparities (Minkler & Wallerstein, 2008).

Despite these limitations, the survey captured valuable experience data that can improve the program. Respondents were highly satisfied with the services and staff, indicating the program is doing a good job meeting the needs of BIPOC clients at baseline. To improve, staff should consider using curiosity to initiate conversations about race and indicate their openness and ability to talk about racial identity while recognizing not all clients will want to engage. Participants should be offered an option to identify as bi- or multi- racial. Diversity in staff matters, and ongoing efforts to hire team members that reflect the racial demographics of the program should be made. Respondents were interested in connecting socially and building community, perhaps reflecting pandemic-related isolation. Financial assistance for daily living may bolster supports for clients.

Limitations

The site for this project is a specialized program specifically for young adults experiencing FEP, many of whom are interacting with the mental health system for the first time. This limits application to other BIPOC identified mental health consumers by age, time spent in the mental health system, inpatient experiences, and diagnosis. Further, the sample was from a predominately white urban population in a west-coast city that lends itself to unique racialization and racialized experiences which may not apply appropriately in other urban populations.

In terms of the intervention of a survey exploring BIPOC patient experiences, there are a few important notes. The language surrounding antiracism is steeped in academia and does not always translate well to explain the lived experience of BIPOC identifying individuals. This potentially contributed to the confusion of respondents with questions about their identity being "included" in the program's services, and one's relationship with their own racial identity is highly individual. This limitation may have been amplified by the constraints of surveys as a patient feedback tool. Questions

were directed at specific areas pre-identified by the program team, which may have limited relevant topics or themes of feedback. Further, as a White identifying person, I bring my own conscious and unconscious biases to conversations of race, potentially limiting respondents' willingness or interest to explore how racism might manifest within the program. Finally, there is the possibility of participation bias due to clients not feeling invested in supporting program improvements, being too psychiatrically ill to engage, not having a consistent means of communication, or other reasons.

Conclusions

Despite the unique context, this QI project is a small step in filling a void in mental health care: how to radically shift our mental health system to meaningfully address unmet mental health needs of BIPOC identifying patients and eradicate health disparities. Critical Race Theory provides a useful framework to understand the foundational role of racism in our systems, and the process to undo it. Valuing and centering the experiences of people whose identities have been racialized and devalued matters and should continue to be a point of investment in QI projects and research. Individualized surveys are a classic tool for patient feedback and did lead to valuable data on BIPOC patient experiences within the program, especially through semi-structured interview. However, surveys may unintentionally limit feedback and communicate unexamined assumptions.

Funding

No outside funding was provided for this project. The program budget covered the cost of gift cards.

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Appendix A

Survey Content

Dear ▬ Participant,

We are seeking feedback about your experience in ▬ services so that we can improve our services to better meet the needs of our clients of color. Thank you for taking the time to complete this. At the end you will have the option to include your contact information if you would like us to follow up with you.

Please circle a response for the following questions.

1. My mental health treatment in ▬ is individualized and respects my race and ethnicity.

Strongly agree	*Agree*	*I'm not sure*	*Disagree*	*Strongly disagree*

    Please share any feedback or tell us more about your answer:

    _____
    _____
    _____

RESOURCES
The following questions relate to areas where additional support may be needed.
****

2. Are we giving you the level of support you need related to **Housing**? (finding new housing, rent support, getting on Section 8 list when it opens, etc.)

Yes	*No*	*Not a concern at this time*

    If no, how can we better support you? (for example: check in with me more often about this area, offer more help in connecting to the resources, etc.)

    _____
    _____

3. Are we giving you the level of support you need related to **Utilities**? (electricity, heating, water, etc.)

Yes	*No*	*Not a concern at this time*

    If no, how can we better support you? (for example: check in with me more often about this area, offer more help in connecting to the resources, etc.)

    _____
    _____

4. Are we giving you the level of support you need related to **Food Security**? (food boxes, food bank, other food resources, applying for SNAP benefits, etc.)

Yes | No | Not a concern at this time

If no, how can we better support you? (for example: check in with me more often about this area, offer more help in connecting to the resources, etc.)

_____

_____

5. Are we giving you the level of support you need related to **Phone Access**? (connecting to resources that can provide a cell phone, etc.)

Yes | No | Not a concern at this time

If no, how can we better support you? (for example: check in with me more often about this area, offer more help in connecting to the resources, etc.)

_____

_____

6. Are we giving you the level of support you need related to **Internet Access**? (connecting to resources that offer low cost internet access)

Yes | No | Not a concern at this time

If no, how can we better support you? (for example: check in with me more often about this area, offer more help in connecting to the resources, etc.)

_____

_____

7. Are we giving you the level of support you need related to **Transportation**? (Tri met Honored Citizen ID, Ride to Care, permit/license fees, learning bus/Max routes, etc.)

Yes | No | Not a concern at this time

If no, how can we better support you? (for example: check in with me more often about this area, offer more help in connecting to the resources, etc.)

_____

_____

8. Are we giving you the level of support you need related to **Hygiene**? (access to laundry, learning how to do laundry, providing hygiene products such as shampoo, conditioner, toothpaste, toothbrush, deodorant, condoms, etc.)

    Yes | *No* | *Not a concern at this time*

    If no, how can we better support you? (for example: check in with me more often about this area, offer more help in connecting to the resources, etc.)

    _____

    _____

9. Are we giving you the level of support you need related to **General Health Care**? (connecting with a primary care provider, dentist, optometrist, and/or other health provider, sexual health, physical activity, information on health topics like acne, nutrition, sprains, burn care, etc.)

    Yes | *No* | *Not a concern at this time*

    If no, how can we better support you? (for example: check in with me more often about this area, offer more help in connecting to the resources, etc.)

    _____

    _____

10. Are we giving you the level of support you need related to **School/Education** (study techniques, organization, connecting with school accommodations, assistance with school supplies, reconnecting to school, learning about and connecting with alternative school options, etc.)

    Yes | *No* | *Not a concern at this time*

    If no, how can we better support you? (for example: check in with me more often about this area, offer more help in connecting to the resources, etc.)

    _____

    _____

11. Are we giving you the level of support you need related to **Other Social Supports and Advocacy** (peer resources, gender affirming resources, legal aid, immigration, domestic violence, sexual assault, addiction recovery, etc.)

    Yes | *No* | *Not a concern at this time*

    If no, how can we better support you? (for example: check in with me more often about this area, offer more help in connecting to the resources, etc.)

    _____

    _____

12. Any **Other** areas you would like support in?

_____

_____

████ SERVICES

We want to be sure that your race and ethnicity is a valued part of all ████ services. Race and ethnicity refers to your cultural background (Black, Asian, Latinx, etc.). The following questions are about the different services you may be involved in.
****

13. My race and ethnicity were included in the **screening process** for accessing ████ services with
████████████████

Strongly agree	Agree	I'm not sure	Disagree	Strongly disagree

How can we improve our screening process to be more inclusive of race and ethnicity?

_____

_____

14. My race and ethnicity is included in my ████ **therapy services** with ████████████

Strongly agree	Agree	I'm not sure	Disagree	Strongly disagree

How can we improve our therapy services to be more inclusive of race and ethnicity?

_____

_____

15. My race and ethnicity is included in my ████ **psychiatry services** with ████████████

Strongly agree	Agree	I'm not sure	Disagree	Strongly disagree

How can we improve our psychiatry services to be more inclusive of race and ethnicity?

_____

_____

16. My race and ethnicity is included in my ████ **nursing services** with ████

Strongly agree	Agree	I'm not sure	Disagree	Strongly disagree	I don't use this service.

How can we improve our nursing services to be more inclusive of race and ethnicity?

_____

_____

17. My race and ethnicity is included in my ▇▇ **peer services** with ▇▇

Strongly agree	Agree	I'm not sure	Disagree	Strongly disagree	I don't use this service.

How can we improve our peer services to be more inclusive of race and ethnicity?

_____

_____

18. My race and ethnicity is included in my ▇▇ **supported employment services** with ▇▇▇▇▇.

Strongly agree	Agree	I'm not sure	Disagree	Strongly disagree	I don't use this service.

How can we improve our supported employment services to be more inclusive of race and ethnicity?

_____

_____

19. My race and ethnicity is included in my ▇▇ **occupational therapy services** with ▇▇▇

Strongly agree	Agree	I'm not sure	Disagree	Strongly disagree	I don't use this service.

How can we improve our occupational therapy services to be more inclusive of race and ethnicity?

_____

_____

20. My race and ethnicity is included in **Multi Family Group**.

Strongly agree	Agree	I'm not sure	Disagree	Strongly disagree	I don't use this service.

How can we improve our Multi Family Group service to be more inclusive of race and ethnicity?

_____

_____

(Continued on back of page)

FINAL THOUGHTS ON ███

****

21. Overall, what is ███ doing well?

_____

_____

_____

_____

22. How do you feel ███ could be better? What are some areas for growth?

_____

_____

_____

_____

23. Have you experienced microaggressions or racism within ███ services?

Yes _No_

If yes, would you feel comfortable telling us about the experience so we can address it?

_____

_____

_____

_____

If you would like, you can provide your name so we can follow up with you:

_____

Program and names redacted for confidentiality.

Appendix B

NOT HUMAN RESEARCH

August 24, 2021

Dear Investigator:

On 8/24/2021, the IRB reviewed the following submission:

Title of Study:	Using Critical Race Theory to Guide Quality Improvement in a Specialty Outpatient Program for First Break Psychosis
Investigator:	Tara O'Connor
IRB ID:	STUDY00023238
Funding:	None

The IRB determined that the proposed activity is not research involving human subjects. IRB review and approval is not required.

Certain changes to the research plan may affect this determination. Contact the IRB Office if your project changes and you have questions regarding the need for IRB oversight.

If this project involves the collection, use, or disclosure of Protected Health Information (PHI), you must comply with all applicable requirements under HIPAA. See the HIPAA and Research website and the Information Privacy and Security website for more information.
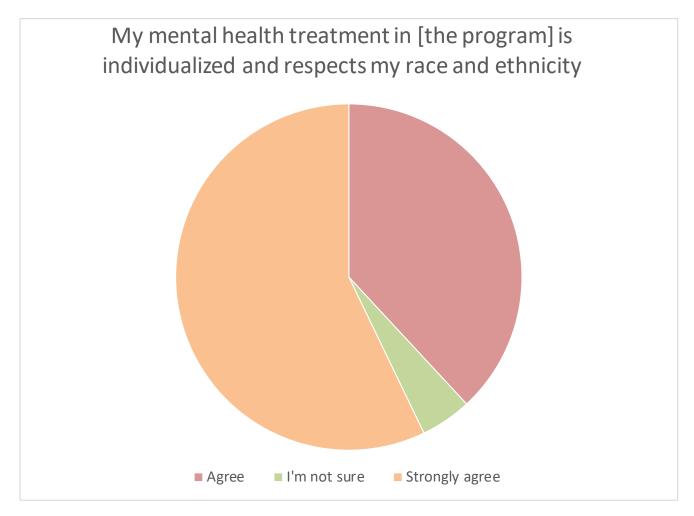
Sincerely,

The OHSU IRB Office

Appendix C

Additional Question

1. How do you identify in terms of your race, culture, heritage, ethnicity, etc.? (ex. Mexican, Indigenous, Nigerian, Black, Vietnamese, Central American, Afro-Latinx, Mixed Race….) [open text field]

This question was added at the beginning of the [Program] SERVICES section.
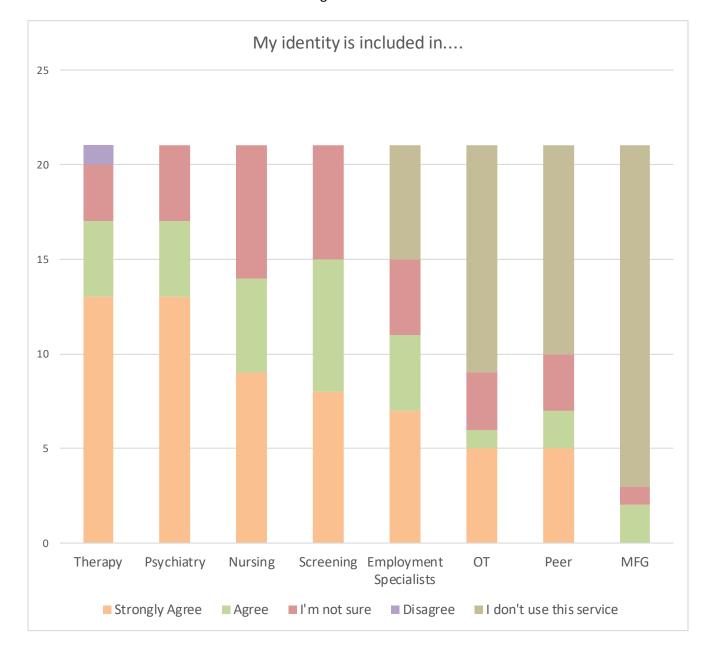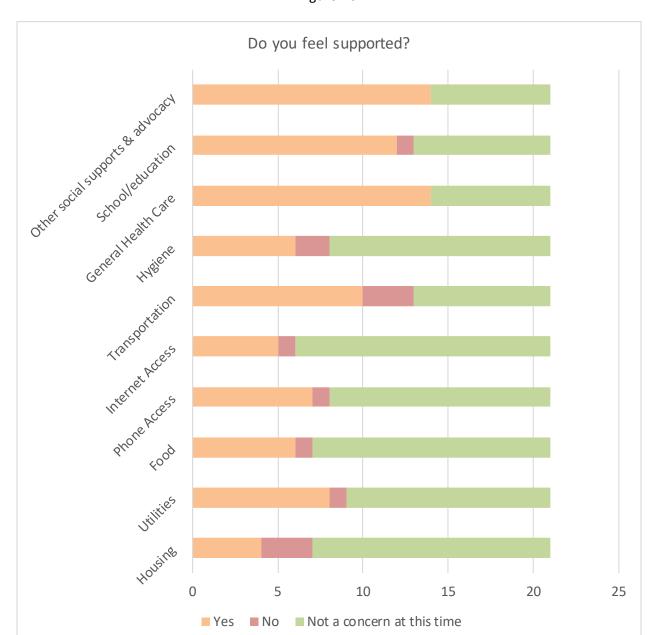
Appendix D

Figure D1

My mental health treatment in [the program] is individualized and respects my race and ethnicity

■ Agree   ■ I'm not sure   ■ Strongly agree

Figure D2

My identity is included in....

Legend: Strongly Agree | Agree | I'm not sure | Disagree | I don't use this service

Categories: Therapy, Psychiatry, Nursing, Screening, Employment Specialists, OT, Peer, MFG

Figure D3

Do you feel supported?

Figure D4

Qualitative responses were edited to better capture similar answers and identify themes. For example, responses that included "helping me" and "helped me" were combined to "helped-me" to be recognized by the word cloud technology. The program name was replaced with "program" for confidentiality.
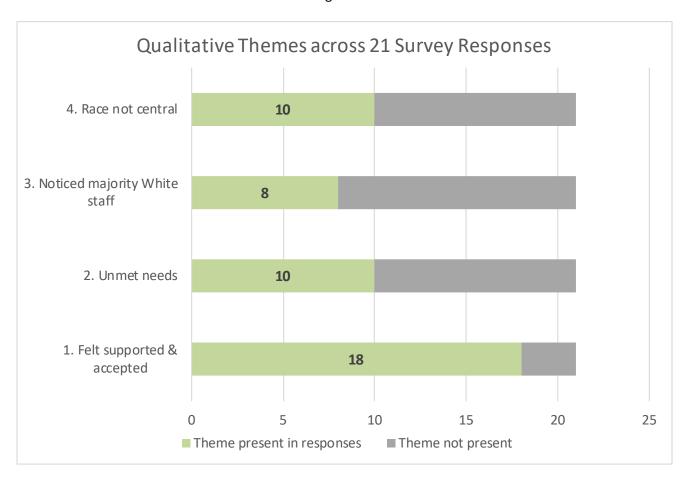
Figure D5

Qualitative Themes across 21 Survey Responses

Legend:
- Theme present in responses (green)
- Theme not present (gray)

Theme	Theme present in responses
4. Race not central	10
3. Noticed majority White staff	8
2. Unmet needs	10
1. Felt supported & accepted	18

X-axis: 0, 5, 10, 15, 20, 25