

Important Definitions

Health Disparity

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

Source: U.S. Department of Health and Human Services, *Healthy People 2020, 2009*, U.S. Printing Office.

Health Equity

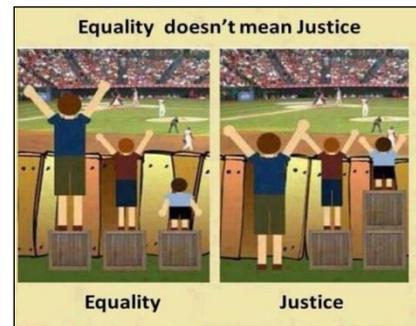
When all people have "the opportunity to 'attain their full health potential' and no one is 'disadvantaged from achieving this potential because of their social position or other socially determined circumstance.'"

Source: Braveman, P.A., *Monitoring equity in health and healthcare: a conceptual framework. Journal of health, population, and nutrition, 2003.*

Health Inequity

A difference or disparity in health outcomes that is systematic, avoidable, and unjust.

Source: Braveman, P.A., *Monitoring equity in health and healthcare: a conceptual framework. Journal of health, population, and nutrition, 2003.*



Mental Health Disparity (working definition)

SAMHSA currently defines it as the power imbalances that impact practices influencing access, quality, and outcomes of behavioral health care, or a significant disparity in the overall rate of disease incidence, prevalence, morbidity, mortality, or survival rate in a specific group of people defined along racial and ethnic lines, as compared with the general population (working definition).

Social Determinants of Health

The complex, integrated, and overlapping social structures and economic systems that are responsible for most health inequities. These social structures and economic systems include the social environment, physical environment, health services, and structural and societal factors. Social determinants of health are shaped by the distribution of money, power, and resources throughout local communities, nations, and the world.

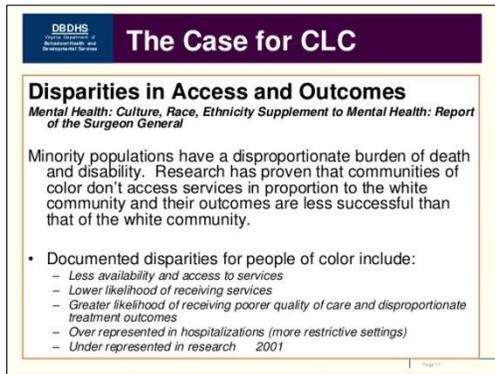
Source: Commission on Social Determinants of Health (CSDH), *Closing the gap in a generation: health equity through action on the social determinants of health. Final report of the Commission on Social Determinants of Health. 2008*, World Health Organization: Geneva.

Behavioral Health Disparities

Significant behavioral health disparities persist in diverse communities across the United States, including:

- Racial and ethnic groups
- Lesbian, gay, bisexual, transgender, and questioning (LGBTQ) populations
- People with disabilities
- Transition-age youth

- Young adults



The following are a few selected findings featured in the HHS Agency for Healthcare Quality and Research 2011 National Healthcare Quality Report and National Healthcare Disparities Report:

- Access to quality health care remains suboptimal, particularly for minority and low-income groups.
- Despite improvements in quality, access and disparities have not improved.
- Certain services, geographic areas and populations were found to be in serious need of improvements in quality and progress in disparities reduction.

Examples of Behavioral Health Disparities

Mental Health Service Use in the Past Year among Adults, by Race/Ethnicity and Service Type, 2008-2012

The overall pattern of differences (e.g., Asian adults having the least mental health service use, followed by black adults and Hispanic adults) was found in any mental health service use, prescription psychiatric medication use, and outpatient mental health service use. For inpatient mental health service use, however, black adults had a higher estimate of service use than white adults. Black adults had a higher estimate of prescription medication use compared with Hispanic adults (6.5 vs. 5.7 percent).

Any Mental Illness in the Past Year among Adults, by Race/Ethnicity, 2008-2012

Asian adults with AMI were the least likely to use any mental health services (18.1 percent), prescription medication (12.2 percent), or outpatient services (11.0 percent).

- White adults with AMI were more likely than black and Hispanic adults with AMI to use mental health services in the past year, regardless of poverty status.

Serious Mental Illness among Adults, by Race/Ethnicity, 2008-2012

- Estimates of the use of different types of mental health services by adults with SMI also varied by race/ethnicity. White adults with SMI were more likely than their black or Hispanic counterparts to use prescription medication (64.2 vs. 47.0 and 44.8 percent, respectively). The estimate for outpatient service use among white adults with SMI (45.3 percent) was higher than the corresponding estimate for Hispanic adults (33.6 percent).
- White adults with SMI were less likely to use inpatient mental health services compared with black adults with SMI (7.4 vs. 11.3 percent). White and Hispanic adults with SMI had similar estimates of inpatient mental health service use (7.4 percent).
- White adults with SMI who had a family income at 200 percent or more of the Federal poverty level were more likely to use mental health services than black or Hispanic adults with SMI who had a similar family income level (71.4 vs. 50.0 and 53.1 percent, respectively).

Various subpopulations face elevated levels of mental and substance use disorders, and experience higher rates of suicide, poverty, domestic violence, childhood and historical trauma, as well as involvement in the foster care and criminal justice systems. Historically, these diverse populations tend to have less access to care, lower or disrupted service use, and poorer behavioral health outcomes.
www.samhsa.gov/health-disparities.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2008-2012.

Explanations for Behavioral Health Disparities

Disparities are complex and simultaneously occurring factors such as a lack of access to health care; the need for a diverse health care workforce; institutional racism; provider bias; a lack of information on the part of the individual, family and community; and the need for culturally and linguistically competent care and programs. The following are the most researched and accepted causes of such disparities.

Socioeconomic Status

A link between poverty, low educational attainment and poorer health outcomes with increased morbidity and mortality is well established. Individuals with low income and educational attainment are less likely to have health insurance which is a predictor of better health overall. And individuals with low education were less likely to enroll in a health insurance program even if eligible (American Public Health Association, 2008).

Language and Culture

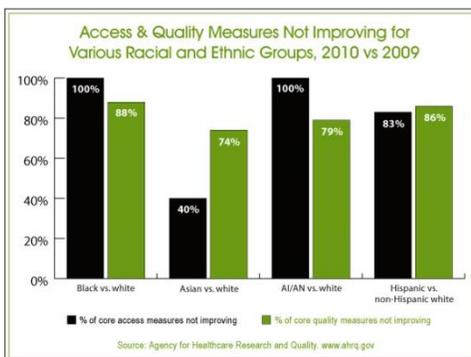
The lack of cultural competence and sensitivity among health and health care professionals has been associated with the perpetuation of health disparities (e.g., Geiger, 2001; Johnson, Saha, Arbelaez, Beach, & Cooper, 2004). Culture plays an important role in determining health related beliefs and practices. Effective health care delivery requires the application of knowledge of cultural health related beliefs, practices and health risks. For example, individuals from specific cultures may require screening for diseases that are more prevalent in that culture, react differently to a medication, or use traditional healing practices.

Limited knowledge of English makes it difficult to access providers with whom individuals can clearly and comfortably communicate and who can understand beliefs and understanding of health care. Understanding all of these things is essential to the treatment of mental and general medical disorders. Accurate screening, diagnosis, and treatment are entirely dependent on a linguistically accurate interview.

Research shows that having a health provider who does not speak the patient's primary language is an independent predictor of poor control of chronic disease and is a significant contributor to health disparities, lack of patient satisfaction, poor patient education, and patients' poor understanding of their disorders (Sanchez, 2015).

In terms of working with sexual minorities, a study of substance abuse treatment counselors' attitudes toward LGBT clients found that nearly half had negative or ambivalent attitudes toward these clients, and many lacked adequate knowledge about legal and social issues relevant to the population (Eliason, 2000).

Access and Utilization of Care



As an example of disparities in utilization of care, racial and ethnic minority populations initiate antidepressant medication treatment at a much lower rate than whites and are more likely to discontinue depression treatment without consulting their physician, even though they are as likely as non-Hispanic whites to have received a medication prescription from their primary care provider.

A number of studies have found Latina/Latino ethnicity to be a significant predictor of premature termination of outpatient drug abuse treatment (Agosti, Nunes, & Opecek-Welikson, 1996; Hser, Huang, Teruya, & Anglin, 2005; Kleinman, Kang, Lipton, Woody, Kemp, & Millman, 1992; Simpson, Joe, Rowan-Szal, & Greener, 1995; White, Winn, & Young, 1998). These studies have been conducted in various regions of the country, with individuals using a variety of substances, who sought treatment voluntarily, or

were mandated to treatment. Another study conducted on the East coast found that that Latinos/as in treatment for substance abuse were more likely than European or African Americans to drop out of therapeutic communities.

Health Insurance

Because health insurance support access to care and utilization of preventive care, it is important in behavioral health equity. However, minorities are far less likely than Whites to have private coverage and far more likely to be uninsured. Uninsured rates for Hispanics (30.7%) and blacks (20.8%) are higher than for non-Hispanic whites (11.7%). When racial and ethnic minorities had insurance, they were more likely to be covered by public rather than private insurance.

Hispanics were most likely to be uninsured (35.4%), followed by American Indians (27.3%), Blacks (25.6%) and Asians (21.2%). (Monheit AC & Vistnes JP (2000) *Race/Ethnicity and Health Insurance Status: 1987 and 1996. Medical Care Research and Review 57(Suppl 1): 11-35.*)

Utilization of Preventive Care

The uninsured are significantly less likely to have a primary care provider regardless of race, yet the disparity is larger for blacks and Hispanics. Having a usual source of care increases the chance that people receive adequate health services, such as preventive care. With adequate health care, health status disparities can be addressed.

Retrieved from www.childrenshealthcampaign.org/assets/pdf/Uninsured-Minority-Kids-at-Risk.pdf

Racism, Bias, and dynamics in the clinical encounter

Racism provides another reason for the health disparities of minorities. Negative stereotypes of minority racial/ethnic groups are common. Research demonstrates that structural racism is embedded in psychological diagnosis, testing and treatment <http://psychologybenefits.org/2014/10/27/johns-story-how-racism-and-classism-operate-within-the-mental-health-care-system/> .

Recognizing manifestations of racism in mental health is also essential. In her article, “Retooling Mental Health Models for Racial Relevance” Gail Golden examines ways in which “most mental health theories have failed to incorporate an analysis of societal oppression into their understanding of human behavior.” Accordingly, this failure has disadvantaged members of marginalized groups by measuring their behavior against what has been

The impact of racism on clients of color is pervasive, affecting all aspects of experience and development. So often the experience of racism has been internalized are not able to give voice to the experience that they've may have had.

established as “Eurocentric and privileged notions of normal.” This perpetuates a “diagnosis industry that inaccurately characterizes people of color from a perspective of deficits and pathologies. Resultantly, people of color are as misunderstood and “damaged by the Mental Health System as they are by every other system in this country” (Mental Health News, winter, 2011).

In sum, there three mechanisms that are likely operating in the clinical encounter. Bias (or prejudice) against minorities; greater clinical uncertainty when interacting with minority patients; and beliefs (or stereotypes) held by the provider about the behavior or health of minorities. Patients might also react to providers' behavior

associated with these practices in a way that also contributes to disparities.

The problem of behavioral health disparities is complex and no one causative factor or magic bullet to resolve the problem is realistic. It isn't difficult to ameliorate behavioral health disparities; it simply takes a long term commitment and willingness to hold individuals and organizations accountable. The answer lies in weaving together sets of priorities, programs, policies, and organizational and partner expectations that are measured over time and regularly revised to meet changing needs.

Roughly half of all black and Hispanic patients who enter publicly funded alcohol treatment programs complete treatment, compared to 62 percent of white patients, according to a new study by researchers from the University of Pennsylvania, Harvard Medical School and Cambridge Health Alliance. Comparable disparities were also identified for drug treatment program completion rates.

Cultural and Linguistic Competence as a Tool for Behavioral Health Equity

DBHDS utilizes cultural and linguistic competence as the primary strategy to address behavioral health inequities in Virginia. This is a recognized best practice across the nation for the elimination of disparities in health and health care (e.g., Betancourt, 2004; 2006; Brach & Fraser, 2000; HRET, 2011).



What makes an organization linguistically competent?

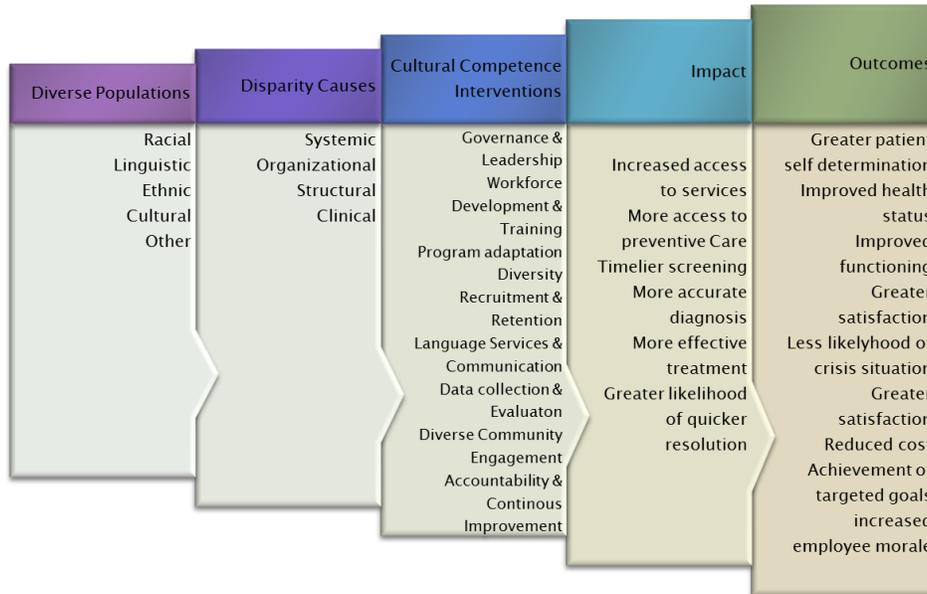
Offer TTY and other assistive technology devices	Offer materials in Alternative formats (e.g., audiotape, Braille, enlarged print)	Do we have policies in place regarding the use of interpreters and train staff on how to access and work with them	Use qualified translation services especially for legally binding documents	Print materials in easy to read, low literacy, picture and symbol formats	Understand how and when language selection happens for individuals who speak more than one language.
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DBHDS Division of Behavioral Health and Developmental Services

But all that really means is that the organization provides...

The services I need, from a perspective I can relate to, in a language I am comfortable with, at a location I can get to.

DBHDS Cultural and Linguistic Competence Disparity Reduction Strategy Logic Model



Understanding the causes and interventions from the logic model above, DBHDS has applied a cultural and linguistic competence framework to the elimination of behavioral health disparities using the National Standards for Culturally and Linguistically Appropriate Services (CLAS). Using three major levels of health care where

sociocultural barriers occur and contribute to racial/ethnic disparities, we can organize interventions to address disparities in behavioral health disparities.

Principal
Standard

Governance,
Leadership, and
Workforce

Communication
and Language
Assistance

Engagement,
Continuous
Improvement,
and
Accountability



Systemic

Systemic interventions for the reduction of disparities are laws and regulations that support the health and welfare of diverse communities. In terms of behavioral health equity, examples would be related to addressing the social determinants of health as well as building an expectation of equity and enforcement of such equitable care. For instance:

- Advocate for local and state funding to incorporate culturally and linguistically competent guidelines into proposals for programs for racial and ethnic minority children, youth, and families.
- Federal, state and local initiatives that increase awareness about Health Disparities
- Funding and program development that support health and safe behaviors in local communities
- Legislation that requires cross cultural competency training and/or checks for behavioral health providers
- Legislation that requires the use of only qualified and tested interpreters and translators.
- Legislation that requires the use of language services for individuals who are hearing impaired
- State initiatives that promote diversity and inclusion efforts in state and local government workforce
- Enforcement of such legislation

Organizational

Health care organizations are shaped by the leadership that guides them and the workforce that carries them forward. From this organizational standpoint, one factor that impinges on both the availability and acceptability of health care for members of minority racial/ethnic groups is the degree to which the organization both reflects the racial/ethnic composition of the general population and its ability to understand and bridge the cultural differences and similarities of the community it serves.

There is a plethora of anecdotal evidence that argues that the lack of diversity in the leadership and workforce of health care organizations results in structural policies, procedures, and delivery systems that create environments that create disproportionality for diverse populations in healthcare (Betancourt, 2005). For this reason, leaders must be intentional about finding ways to expand diversity and create multicultural and inclusive environments in their organizations. Below are some examples of methods for increasing organizational behavioral health equity.

Advance and sustain organizational governance and leadership that promotes cultural competence and health equity through policy, practices, and allocated resources.

- Have the board set goals on improving organizational diversity, providing culturally competent care, and eliminating disparities in care as part of the strategic plan.
- Require diversity awareness and cultural competency training mandatory for all senior leadership, management, staff, and volunteers.
- Incorporate the elimination of behavioral health disparities into the organization mission and vision
- Ensure that the necessary fiscal and human resources, tools, skills, and knowledge to support and improve culturally competent policies and practices in the organization are available.

Conduct Assessments of Community Health Assets and Needs

- Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
- Foster positive relationships and programs within racial and ethnic minority communities to increase awareness of mental health issues and prevent environmental factors that may place individuals at risk.

Collect and Maintain Demographic Data. Collect race, ethnicity, sex, language, and disability status data in a sensitive manner. Collect and maintain this data to:

- To accurately identify population groups within a service area
- To monitor individual needs, access, utilization, quality of care, and outcome patterns
- To ensure equal allocation of organizational resources
- To improve service planning to enhance access and coordination of care
- To assess and improve to what extent health care services are provided equitably

Partner with the Community

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

- Partner with local culturally diverse media to promote better understanding of available care and services and of appropriate routes for accessing services among all community members.
- Convene town hall meetings, hold community forums, and/or conduct focus groups (OUTSIDE OF YOUR TYPICAL MEETING PLACES!)
- Collaborate to reach more people, to share information and learn, and to improve services. Work with partners to advertise job openings, identify interpreting resources, and organize health promotion activities.
- Facilitate partnerships among physicians, mental and behavioral health providers, educators, community leaders, government agencies, and families to ensure development and implementation of culturally and linguistically competent and evidence-based prevention, early intervention, and treatment.

Recruitment and Retention

Minority populations are underrepresented in health care professions, and those providing care are less likely to be board certified than physicians who treat white patients. The availability of a properly trained mental health workforce is among the most pressing health care issues facing the nation, especially in rural, border, and frontier areas.

- Implement strategies to recruit, retain, and promote at all levels of the organization a diverse leadership that reflects the demographic characteristics of the populations in the service area.
- Conduct regular, explicit assessments of hiring and retention data, current workforce demographics, promotion demographics, and community demographics.
- Monitor work assignments and hire sufficient personnel to ensure a manageable and appropriate workload for bilingual/bicultural staff members.

Workforce Development

- Provide for internal multidisciplinary dialogues about language and culture issues.
- Promote mentoring opportunities.
- Promote diverse staff members into administrative or managerial positions where their cultural and linguistic capabilities can make unique contributions to planning, policy, and decision-making.
- Use nonclinical support staff in cultural broker positions only after providing sufficient training and recognition (e.g., compensation, job title, or description).
- Engage staff in dialogues about meeting the needs of diverse populations
- Incorporate cultural competency and cross cultural development into staff evaluations

Performance Measures

- Ensure that performance is being measured by race, ethnicity and preferred language at a minimum
- Evaluate education and training

- Establish accountability mechanisms throughout the organization, including staff evaluations, individuals' satisfaction measures, and quality improvement measures

Structural

The design and functioning of health care delivery systems—including intake processes, waiting times for appointments, referral mechanisms, and continuity of care—pose clear structural barriers to the quality of care for most people, but there are special barriers for diverse patient populations. These key aspects of health care system design, when developed in the absence of an appropriate sociocultural assessment of the population, can limit access to care. Structural cultural competence interventions would address many of these factors by implementing racial/ethnic data collection; developing specific quality measures for diverse patient populations; improving medical referral processes; and ensuring culturally and linguistically appropriate health education materials, signage, and health promotion and disease prevention interventions (Betancourt, 2003).

Some examples of interventions that can address disparities are:

- Collect individual demographic information such as: Race/Hispanic ethnicity, Primary language, and Religion, Limited English proficiency, preferred language for health communication, LGBT items (new), Sexual orientation, and gender preference.
- Create forms that are easy to fill out, and offer assistance in completing forms
- Review the registration and intake process for individuals who are English language learners to evaluate where additional barriers may be remedied.
- Ensure that cultural competence and language access plans are in place, active, and supported by leadership and administrative staff so that they are widely implemented by all sectors of the organization.
- Create financial incentives to promote, develop, and maintain accessibility to qualified health care interpreters.
- Create a line item in the budget for interpretation and translation services as an operating cost to establish the message that it is the cost of doing business just as paying is paying the electricity.
- Test materials with target audiences. For example, focus group discussions with members of the target population can identify content in the material that might be embarrassing or offensive, suggest cultural practices that provide more appropriate examples, and assess whether graphics reflect the diversity of the target community.
- Assess the language and communication proficiency of staff to determine fluency and appropriateness for serving as interpreters.
- Develop and implement policy and programs based on psychological and behavioral research ensuring that racial and ethnic minorities are empowered through culturally and linguistically informed and evidence-based strategies.
- Increase funding for training mental and behavioral health professionals and to train these professionals to become culturally and linguistically competent.
- Ensure that any vendors and/or subcontractors are:
 - using EBPs that are culturally adapted.
 - using evaluating staff for cross cultural skill sets and developing criteria for annual performance checks of such competencies.
 - using interpreters and translators when needed.
 - evaluating performance based on race, ethnicity and preferred language at a minimum.
- Establish a Community Health Worker or Promotoras de Salud program in the organization to bridge the gap between clinical staff and diverse communities.

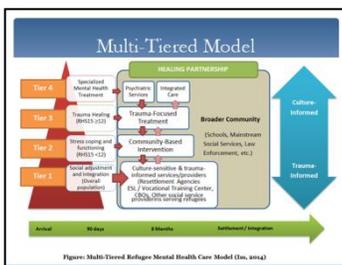


Clinical

Clinical barriers are related to the interaction between providers, individuals and families. When sociocultural differences between patient and provider are not navigated effectively; nuances in cultural behaviors, beliefs, mannerisms, approaches, and communication can create negative and long term impacts. Some ways that clinical barriers can be mitigated to increase behavioral health equity are as follows:

- Focus clinical training on the complexities and intersections of multiple statuses/identities (e.g., socioeconomic status, disability, and immigrant status) and how these may contribute to psychological health.
- Create an environment of open feedback for clinical staff.
- Develop social contracts with clinical staff that create an expectation of intercultural development. Staff understand that the expectation of inclusion and cultural competence is required for their employment regardless of their personal beliefs and biases.
- Celebrate success and support staff who are working to engage diverse populations.
- Use community informants to learn about historical racism and how it impacts the mental health of community members.
- Train and evaluate the level of understand that staff have of the power dynamics and privilege issues between individual and provider
- Require the use of evidence base practices that are suitable for multiple populations and ensure that staff are utilizing them as they are intended to be used.
- Ensure that staff are being evaluated for cross cultural skill sets in their performance evaluations.
- Develop mechanisms for competency checks and remediation plans for those who need it.
- Ensure that staff are using interpreters and translators when needed.
- From your community assessment, develop culturally appropriate programs to address gaps. Chicken Soup is not the only thing that cures a cold!

Current Initiatives to increase Behavioral Health Equity



Virginia Refugee Healing Partnership

The Refugee Healing Partnership is a collaborative effort of the DBHDS and VDH and is focused on addressing refugee risk factors and strengthening mental health partnerships in communities where refugees resettle. The partnership designs and disseminates programs and activities that:

- Promote positive mental health and cultural adjustment in the refugee community Create linkages between provider communities and the refugee communities
- Provide opportunities for trauma-informed education at the community level and culture-informed education at the provider level

Refugee Wellness Partnership Programs and Activities

Navigating Virginia's Behavioral Health System - A guidebook for Newcomers, Refugee Leaders, Community Support Partners & Volunteers.

Trauma-Informed Cross-Cultural Psychoeducation: Refugee Mental Health Training for Community Leaders (TI-CCP)

- TI-CCP was designed for mental health professionals to engage with and build capacity in refugee community leaders for community-based mental health and psychosocial support and to establish a close partnership and healing environment in the community.

Virginia Refugee Mental Health ESL Module

- In partnership with Old Dominion University, the Initiative has developed a 1 hour ESL module designed to introduce English language learners to concepts of mental health and wellness in English. The module is free for utilization by any ESL program.

Peer Support for Adolescent Refugees Project

Multicultural Suicide Prevention

Cultural Navigator Certificate Career Pathway

RHS-15 Refugee Mental Health Screening Referral Program with VDH

Regional Refugee Mental Health Councils that bring providers and refugee leaders together to discuss topics of relevance.

Qualified Bilingual Staff Program

The QBS Model & Program were designed by Kaiser Permanente National Diversity & Inclusion and adapted by DBHDS to capitalize on an organization's existing workforce diversity and ensure qualified linguistic services and culturally competent care at every point of contact. DBHDS adaptation is specifically designed to build terminology in behavioral health, substance abuse, and developmental services setting and discuss the unique role that bilingual staff may have interpreting in these settings.

This model has been recognized by the Robert Wood Johnson Foundation, the California Endowment, and award winner from the National Committee for Quality Assurance and the Migration Policy Institute. Two hundred bilingual providers and staff have been trained since the program was implemented at DBHDS in 2011. Qualified Bilingual Staff represent a critical link to providing effective communication and quality care to the limited-English proficient (LEP) communities we serve.

Behavioral Health Equity Innovative Achievement Award

An award to bring attention to behavioral health disparities and to recognize organizations or teams who are implementing promising methods that are promoting culturally and linguistically competent practices and focused on the reduction of disparities in racial, ethnic, and other disparate subpopulations.

National Minority Mental Health Awareness Month

The media contest is a mechanism to raise awareness about minority mental health and engage the community in stigma reduction to improve behavioral health equity among socially and culturally marginalized individuals seeking services in our system.

Cultural and Linguistic Competence Website and CLAS Courier

The OCLC website is designed to provide behavioral health providers with up to the minute material, toolkits, research, and training information about cultural competence, culturally adapted programming, language access, laws and regulations, data, demographics, strategic planning and more. The CLAS Courier is the monthly electronic publication with tools and articles geared for professionals promoting behavioral health equity.

www.dbhds.virginia.gov/professionals-and-service-providers/oclc

CLAS Academy

The CLAS Training Academy allows organizations to explore topics in organizational cultural and linguistic competence and begin a conversation about what training programs will provide the best return on investment. The Academy uses the National Standards for Culturally and Linguistically Appropriate Services as a framework for organizing our training.

OTHERS?