

# Addressing the Complex and Pernicious Problem of Disparities in Behavioral Health Care<sup>1</sup>

*“Powerful, complex relationships exist between health and biology, genetics, and individual behavior, and between health and health services, socioeconomic status, the physical environment, discrimination, racism, literacy levels, and legislative policies. These factors, which influence an individual’s or population’s health, are known as determinants of health.”*

— Healthy People 2020

## Introduction

Disparities in behavioral health care remain an entrenched problem that defies easy solutions. The apparent intractable presence of disparities in access, utilization, and quality for vulnerable, marginalized children, youth, and their families are truly complex, and as such present ongoing challenges to the mental health field. The same challenges are echoed in other child-serving systems—“disproportionality” in child welfare, “disproportionate minority contact” in juvenile justice, and “the achievement gap” in education. In response to these concerns, there is a growing body of knowledge about what causes disparities and how to effect change.

A welcome contribution to this change has been the movement within the Department of Health and Human Services that developed and is implementing its *HHS Action Plan to Reduce Racial and Ethnic Health Disparities* (2011). From that plan, the Substance Abuse and Mental Health Services Administration (SAMHSA) created the Office of Behavioral Health Equity that now requires a “Disparities Impact Statement” from grantees documenting the nature of existing disparities and plans to address those disparities. Further, the Office of Minority Health has updated the *National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care* (National CLAS Standards, 2013) that now explicitly incorporates behavioral health into the conceptualization of health. In addition, there is more focus on these issues within the general public in reaction to the intense debate on matters such as immigration, lethal force by police against persons of color, and transgender rights.

For those leaders and advocates who are ready to devote their energy to make a difference, the questions remain, “how”, and “what should we do”? There are no simple answers to those questions. Disparities in behavioral

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health are caused by multiple factors, but each entity within the web of services and supports for children, youth, young adults and their families<sup>2</sup> in marginalized communities, has the capacity and responsibility to contribute to the solution. This practice brief offers points for consideration and action to improve the potential for success.

The brief will explore the concept of disparities in behavioral health and health care, share national data, identify resources and questions to discern the presence of disparities, delineate contributing factors of disparities, and offer potential strategies to tackle those factors. It is the hope that the reader will be able to use this information to affirm or revise existing plans and/or to create a meaningful organizational/system disparities reduction plan.

## Disparities

On the surface, a disparity is nothing more than “the quality or state of being different” (Miriam-Webster, n.d.). People may differ in height. Communities may have differences in population. Agencies may differ in function. Neither of these examples suggests any intrinsic judgments of “good” or “bad”. However, within health and social sciences the term has emerged to convey differences or inequalities that are “not good”. Whitehead (1991) postulated a model of progression of inequalities from those that are relatively neutral, inevitable, natural and unavoidable, to those that are avoidable, unnecessary and/or unfair created by people individually or societally. The seven facets of Whitehead’s progression are presented as follows:

1. *Natural, biological variation*
2. *Health-damaging behavior that is freely chosen*
3. *Transient health advantage of one group over another when one group is first to adopt a health promoting behavior*
4. *Health damaging behavior in which degree of choice of lifestyle is severely restricted*
5. *Exposure to unhealthy, stressful living and working conditions,*

6. *Inadequate access to essential health services and other basic services*
7. *Natural selection or health related social mobility, involving the tendency for sick people to move down the social scale* (Whitehead, 1991, p. 5)

The further down the list, the more likely that forces external to the individual are contributing to differential outcomes. Items 4, 5, and 6 may be considered as consequences of societal forces that may be deemed unjust. In summary, health inequities are “differences in health which are not only unnecessary and avoidable, but in addition, are considered unfair and unjust” (Whitehead, 1991, p. 5). This understanding of disparities or inequities in health as being unjust is captured in work of the World Health Organization and is seen in the definition used by US. Department of Health and Human Services (2008) for *Healthy People 2020*.

*“Health disparity is a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group, religion, socioeconomic status, gender, age, mental health, cognitive, sensory, physical disability, sexual orientation or gender identity, geographic location or other characteristics historically linked to discrimination or exclusion”* (U.S. Department of Health and Human Services, 2008, p. 46).

This definition associates health differences with differential treatment based on marginalized status within United States society. A further refinement in the understanding of disparities is the difference between disparities in health status and disparities in health care. Disparities in health *status* are those “differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions” (Smedley, Stith, & Nelson, 2003, p.4). By contrast, disparities in health *care* refers to “differences in quality of health care not due to access related factors or clinical needs, preferences, and appropriateness of intervention differences in health care needs or preferences.” (Smedley, Stith, & Nelson, 2003, p. 4).

<sup>2</sup>Throughout this document “children, youth, young adults and their families” will be referenced as “youth and families” to acknowledge the voice and developmentally appropriate participation of children and their families in advocacy, service planning, implementation and evaluation.

There is acknowledgement that there will be differences in treatment from person to person due to differences in the clinical situation of the person. Similarly, there will be differences based on preferences expressed by well-informed patients. However, there are at least two primary contributors to healthcare disparities. One category includes the policies, regulations, procedures, structures, operations, and funding decisions that promote inequity. A second category includes outcomes generated by stereotypes or biases of individuals—those who have the responsibility to develop and implement policies, and of those who are responsible for the direct delivery of services and supports. (Smedley, Stith, & Nelson, 2003).

Not only is the goal to reduce the unjust differences in health and health care, but also to achieve “health equity”. The World Health Organization (2008) describes health equity as “equal access to available care for equal need, equal utilization for equal need, and equal quality of care for all”. Within SAMHSA funded programs, these elements of equity are reflected and expanded upon in the required *Disparities Impact Statement* that calls for documentation of disparities, coupled with a relevant plan of action in domains of *access, use and outcomes* for marginalized populations. (Huang, 2014).

## Disparities in Behavioral Health

The Affordable Care Act describes both disparities in health status and disparities in health care in its definition of disparities. In Health Reform Law: P.L. 111- 148 as amended by P.L. 111-152, a

*“Health disparity population’ is [a population for which there is] “a significant disparity in the overall rate of disease incidence, prevalence, morbidity, mortality, or survival rates in the population as compared to the health status of the general pop, in addition,...[it] includes populations for which there is a significant disparity in the quality, outcomes, cost, or use of healthcare services or access to or satisfaction with such services as compared to the general population.” (PHSA Sec.485E).*

In 2001 the Surgeon General (U.S. Department of Health and Human Services, 2001) made its groundbreaking declaration regarding the disparities in *mental* health services for “minority” persons, indicating that,“(1) Minorities have less access to and availability

of mental health services, (2) minorities are less likely to receive needed mental health services, (3) minorities in treatment often receive a poorer quality of mental health care, and (4) minorities are underrepresented in mental health research.” (p. 3). Although there is limited data that document and clarify current behavioral health status and service utilization for marginalized populations, SAMHSA (2015a, 2015b, 2015c) has used its national studies to gather information on differences in behavioral health status and access to services. These studies track youth and adult substance use, youth depression, adult suicidality, and adult serious mental illness. For example, in 2014, 11.4% of adolescents aged 12-17 had at least one major depressive episode in the year prior to the survey. The prevalence was at 12% for non-Hispanic whites, 11.5% of Hispanics, and 9 % for non-Hispanic blacks. However, 46.1% of the whites received treatment, 40.6 % of the blacks received treatment, and only 33.1 % of Hispanics received treatment (SAMHSA, 2015a). These numbers are in contrast to the previous year in which 41.6% percent of whites received treatment, 28.6% of blacks received treatment, and 36.9% of Hispanics received treatment. (SAMHSA, 2015b). In addition, the Agency for Healthcare Research and Quality (AHRQ) has been collecting and analyzing disparities in health, but has a limited focus on disparities in behavioral health. Clearly, continued data collection and analysis will be required to understand the fluctuations in prevalence and service experience across all groups and unique to each demographic group. What is evident is that there are a variety of differences in experiences and clinical and functional outcomes related to cultural identity.

## Take a Look at Your Data

Any effort to address disparities requires documenting the disparities that exist within a defined community and/or organization. Although there may be a general sense that marginalized populations may have a poor experience, it is analysis of data comparing the experience of identified populations to other populations or to the population as a whole that will clarify the specific domains to be examined. On any domain, there may be issues that are equally problematic regardless of the population. For example,

waiting time for a psychological evaluation may be 4 weeks for everyone regardless of cultural identity. This may be a problem to address, but not an indicator of disparities. However, if waiting time for a psychological evaluation was 4 weeks for the residents of neighborhood A—that happens to be predominantly African American, and 2 weeks for the residents of neighborhood B—that happens to be predominantly white, there is a difference in experience that requires further study. The understanding of specific disparities in any given community requires the ability to identify relevant domains and obtain population-specific data in those domains.

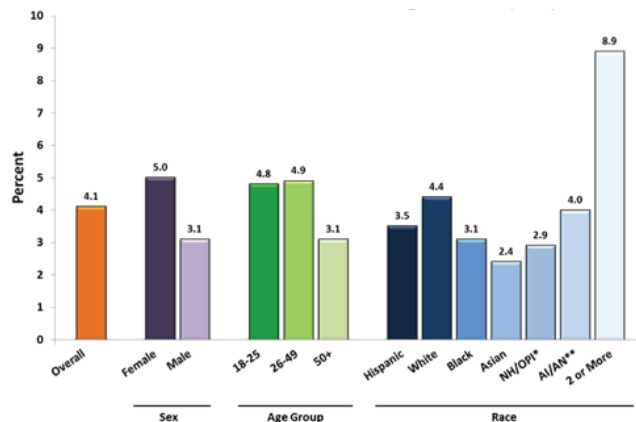
A major challenge to communities is the inconsistency in definitions of data fields. HHS has developed definitions for use in national health surveys for the collection of race, ethnicity, language, sex and disability data (USDHHS, 2011) and SAMHSA suggests the use of this framework to grantees. As more and more organizations, state and local institutions use the same data fields, the easier it will be to have accurate assessments of challenges and progress.

## Disparities in Mental Health Status

Consider the following potential domains for analysis—incidence, prevalence and mortality. These domains provide the baseline to discern the presence of differences. Further analysis is necessary to discern the degree to which those differences are a function of societally generated disadvantage.

- **Incidence**—the number of newly diagnosed cases of a disease or malady. Example—The rate of illegal drug use in the last month among youth ages 12 and up in 2014 was 12.4% for African Americans, 14.9% for Native Americans and Alaska Natives, 4.1% for Asian Americans and 15.6 % for Native Hawaiians or other Pacific Islanders, compared to the national average of 10.2%. (SAMHSA, n.d.)
- **Prevalence**—the number or percentage of cases of a disease within a population. See the chart below for examples of data that reveals differences between populations. In this case, 4.1% of the US Adult population has a serious mental illness, but 8.9% of persons who identify as belonging to two or more races have a serious mental illness.

Prevalence of Serious Mental Illness Among U.S. Adults (2014)



Data courtesy of SAMHSA

\*NH/OPH = Native Hawaiian/Other Pacific Islander  
 \*\*AI/AN = American Indian/Alaska Native

Image from <http://www.nimh.nih.gov/health/statistics/prevalence/major-depression-among-adolescents.shtml>

- **Mortality**—the number of deaths due to disease. In 2012, the suicide rate among American Indian and Alaska Native adolescents and young adults between the ages of 15 and 34 (31 per 100,000) is 2.5 times higher than the national average for that age group (12.2 per 100,000). (SAMHSA, n.d.)

It is the general understanding within the behavioral health community that with some exceptions, the incidence and prevalence of behavioral health disorders is equally distributed across racial and ethnic groups. It is well documented that the suicide rate is higher in rural communities than in urban communities (Hirsch, 2015). Suicide rates of Asian American adolescents and young adults is higher than in white youth and young adults (Albright & Chung, 2002). Suicide rates are higher for LGBTQ youth as compared to heterosexual youth (CDC, 2014; Willging, Salvador, & Kano, 2006). American Indian youth (15-19) have highest rates of death by suicide (Smalley, Yancey, Warren, Naufel, Ryan, & Pugh, 2010). Although there are multiple pathways to explain these differences, societal factors such as institutional oppression and social determinants of mental health are implicated. In addition, there is concern about the Surgeon General’s observation in 2001 relating to differences in access, utilization and quality regardless of the incidence or prevalence of distress. The burden to the individual, family, community and society is great in the absence of easily accessible, quality service.

## Disparities in Mental Health Services

These are examples of service system disparities. Rural youth experience significant challenges with availability and access to mental health services as compared to non-rural communities. They are more likely to have fewer visits to a mental health practitioner and more likely to use a medical physician. (Albright & Chung, 2002). Persons who are LGBTQ2-Spirit are more likely to be denied mental health services and more likely to be placed in residential treatment settings (Centers for Disease Control, 2014; Willging, Salvador & Kana, 2006). African American and Latino children are less likely than white children to receive needed mental health services and psychotropic medication. Whites are twice as likely as blacks and Latinos to initiate needed care. The disparities in mental health expenditures between Latino youth and white youth are increasing (Lê Cook, Barry & Busch 2012). They reflect differences in access, utilization and quality.

Jackson's "Five A's + 1" Matrix for Behavioral Health Disparities<sup>3</sup>, describes domains for examination of disparities in behavioral health services. Consider the questions for each domain, potential sources of data and example of strategies that would contribute to solutions.

### 1. **Availability**—*Does it exist?*

Does the service exist where people live their lives (where they live, work, study, play, shop worship, etc.)? This could apply to a programmatic feature such as therapeutic foster care, a specific evidence based treatment, such as Functional Family Therapy, or a behavioral health provider office. Tools like geo-mapping provide a visual image of service gaps by community. Once the gaps are identified, communities can embark on policy and financial strategies required to expand the service array and ensure the appropriate distribution of services.

### 2. **Awareness**—*Does the community know that it exists?*

Do the people who might need the service know that the service exists? This requires knowledge of how members of given cultural communities receive information that they will act upon. Community surveys and focus groups provide one source of

information. Comparison of the demographics of those utilizing services with the demographics of potential eligible users will yield information of population gaps. Social marketing programs using the appropriate languages, valued conduits and respected spokespersons will probably be successful in conveying information that will be both received and retained. For example, in some communities, radio is more effective than mass mailings, and radio personalities and ministers are more effective than government officials.

### 3. **Accessibility**—*How convenient is it to obtain and use the service?*

In this case, accessibility refers to the ease of access and convenience to obtain the service and use of the service. Consider factors such as the referral process, waiting period for an initial appointment, waiting time onsite. Consider travel access. If youth and families travel by car, what is the distance, parking options and costs? If they travel via public transportation, what are the routes, transfers, time for travel and costs? Can services be offered in the home, at school, at recreation center? Are there appropriate interpretation services available? Are written materials in the appropriate language(s) at the appropriate reading levels? Are there childcare services available? Are the policies and procedures within and between health departments, private health care offices, behavioral health centers, juvenile justice, child welfare, schools, employers, etc., facilitators or barriers to gain entry to needed services. In general, service systems should evaluate the "hassle" factors involved in the logistics of participating in services.

### 4. **Affordability**—*Can the consumer afford the service?*

*Can the "best" provider afford to offer the service?* Consider the out of pocket expenses to the family. What is the fee schedule and the pricing policy? What are the options regarding sliding fee scales, co-payments, deductions, and exclusions? For families receiving publicly funded services, what are the criteria and documentation requirements for eligibility? How easy or difficult (e.g., copy of birth certificate or certified birth certificate with raised seal) is it for

<sup>3</sup> Presented by Vivian H. Jackson in its original form at Center for Mental Health Services Initiative to Eliminate Mental Health Disparities Meeting, Rockville, MD, 2008. Addition made based on feedback from participants at subsequent presentations.

the family to address the logistics to become eligible and maintain eligibility? What are the challenges for immigrants (documented and undocumented) and refugees regarding service eligibility? Comparison of the demographics of the actual enrollment with the demographics of the estimated eligible population provides clues to service gaps.

An additional affordability issue relates to the ability of providers who have familiarity and relationship with specific cultural communities to provide or continue to provide services. Historically culture-specific and community-based providers have had challenges in addressing the infrastructure requirements to participate as a Medicaid or managed care provider. In general, providers are challenged to maintain their financial viability based on the dollar value of and administrative requirements attached to grants, contracts, case rate, capitation rate and so forth. The risk is that cultural communities will lose effective providers due to the financial burdens to these providers. Assessment of the cultural and geographic diversity of provider pools and analysis of billing data by provider offer opportunities to identify potential challenges.

In both cases, communities will need to create structural and financing policies that remove the barrier of money from access and utilization of quality services.

- 5. Appropriateness**—*Is the right intervention being offered and implemented correctly?*  
Cultural groups have a variety of ways to express emotional distress. They have a variety of ways of labeling emotional distress. Approaches to assessment, diagnosis, and treatment offered may not be compatible with the family's cultural groups. Consider the following questions. Do screening and assessment tools and processes take cultural issues into consideration in their development, implementation and analysis? Are diagnoses accurate and appropriate within the client's cultural context? Was the *Cultural Formulation Interview* in DSM-V (American Psychiatric Association, 2013) used to inform the clinical assessment? Were psychopharmacological interventions informed by culture specific physiological considerations (Jackson,

Croghan, Melfi & Lewis-Hall, 1999)? Are interventions designed to achieve optimal outcomes for the context of the recipient of services (consider dosage, intensity of service, duration of services, frequency of intervention, level of restrictiveness of care, etc.)? Are services offered in the language that is preferred by the service recipient? Do treatment goals include both, relief from signs and symptoms of distress, and, promotion of function in culturally important roles?

The analysis of clinical and functional outcomes, and relapse and recidivism rates by cultural group will yield general clues regarding the appropriateness of services. Each of the specific elements noted above can be analyzed to discern population differences. For example, analysis of diagnoses in a given agency by race may surface disproportionately high numbers of diagnoses of African American male youth with Oppositional Defiant Disorder as compared to white male youth, and disproportionately low number of the African American male youth with affective disorders. This type of discovery signals the need for additional study to understand why these differences have emerged. Is there actually a difference in prevalence or is there provider bias in assignment of diagnoses? Another example would be to compare prescribing protocols with the prescribing guidance in the literature for specific cultural groups. The outcomes of the more detailed analyses will guide the development of corrective actions.

- 6. Acceptability**—*Is the intervention offered congruent with cultural beliefs, values and world view?*  
This question references the degree to which youth or families believe that the services are congruent with cultural beliefs, values, and worldview about the nature of emotional distress, causal factors, who should be making treatment decisions in the family, who should be providing help, what the nature of the help should be, and what the goals of intervention should be. These issues influence the quality of the helping relationship. Data that may help signal challenges in this domain include, premature termination rates, utilization rates, participation rates, and satisfaction rates. For some families, concordance between provider and family based on race, ethnicity, tribal affiliation, gender, sexual orientation,

faith community or other cultural marker may be a central factor. For others, the incorporation of indigenous or spiritual healers may be important. For others, culture-specific evidence-based treatments will successfully address their needs. The specific solutions will be determined through the creation of an organizational culture that authentically values difference, respects the family's and youth's voice, and is willing to be flexible. The respect that is offered will enable opportunity for creating plans for intervention that utilizes the culturally informed expertise of practitioners and the lived cultural experience of the youth and family. Cultural brokers—persons who possess knowledge of the community, knowledge of the service system, knowledge of beliefs and practices, and trusted by both—and representatives from relevant cultural groups need to be engaged in decisions regarding the planning, implementation, and evaluation of services to maximize the opportunity to offer acceptable services.

These six factors provide clues to the range of items that can be measured and analyzed to inform strategies for change. The *Matrix for Behavioral Health Disparities* (Table 1) provides an organizing framework to capture the discrete and overlapping issues.

### External Data Sources

Some data required to identify and analyze these questions can be found from existing sources, while other data must be generated by the system and/or organization. National, state, and sometimes local level data are available from the Census Bureau, SAMHSA –

National Surveys–Youth Risk Behavior Survey, Behavioral Risk Factor Surveillance System, Office of Immigration Statistics in the Department of Homeland Security, Office of Refugee Resettlement in the Administration for Children and Families, Migration Policy Institute, The Archives of Religious Data, Children's Defense Fund (Kids Count), Children with Special Health Needs Data, (see Appendix A for contact information and additional resources). At the state and local levels, school systems, office of city planning, public health departments, child welfare systems, juvenile justice systems, and Medicaid are resources for relevant data.

### Internal Data Systems

In addition to population profile information and assistance from other community systems, the behavioral health system and service entities need to capture internal data. Organizations must have or must develop the capacity to identify cultural characteristics from the point of first contact through the service experience to the conclusion of those services as incorporated in a thorough program evaluation and quality improvement system. To the extent possible, demographic data fields should include race, ethnicity, tribal affiliation, gender, gender identity, sexual orientation, faith identity (including "none"), preferred language and physical/developmental/or intellectual ability. Note that the Department of Health and Human Services is implementing data collection fields for race, ethnicity, sex, language and disability (USDDHS, 2011a) that are being used for national surveys and are recommended for use by SAMHSA grantees (SAMHSA, n.d.)

**Table 1. Matrix for Behavioral Healthcare Disparities**

	Availability	Awareness	Accessibility	Affordability	Appropriateness	Acceptability
<b>Data Sources</b>						
<b>Data</b>						
<b>Strategies</b>						
<b>Outcomes</b>						
<b>Next Steps</b>						

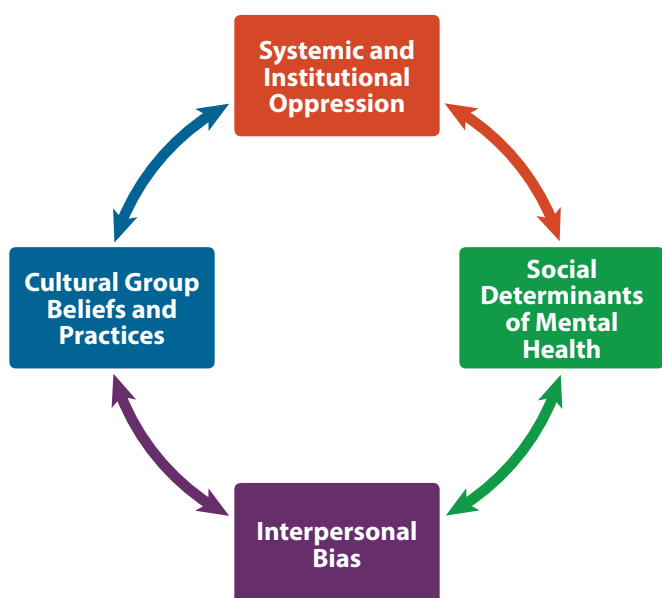
## Summary

Behavioral health disparities explore the difference in behavioral health status and behavioral health services based on cultural group identity. The existence and nature of disparities need to be described to be meaningfully understood and tracked to assess impact of interventions. Data collection and analysis are central components for this work. As noted in the preceding discussion, there are some types of interventions that contribute to the resolution of specific types of service disparities. However, there are overarching causal factors that should be considered in designing interventions in any given community. These causal factors will be discussed in the following section.

## Causal Factors for Disparities

Once there is clarity about the nature of the disparities, communities, systems, organizations have the opportunity to explore contributing factors. In general, there are at least four major interrelated factors that contribute to disparities in behavioral health services.

1. Systemic and Institutional Oppression
2. Social Determinants of Mental Health
3. Interpersonal Biases
4. Cultural Group Beliefs and Practices



## Systemic and Institutional Oppression

Throughout the history of the United States, policies and practices of society have generated advantages to some populations and disadvantages to other populations. In general, US society has functioned to provide advantages to white, Anglo-Saxon, Protestant, heterosexual, male, able-bodied, affluent persons. Some policies such as those related to tribal nations, slavery, segregation, immigration and sexual practices, deliberately and openly negated the value of specific populations. Other policies were more indirect in their impact. This includes practices such as poll taxes for voter registration, failure to include agricultural workers for Social Security retirement benefits, and convict-lease programs. On the surface, these policies may not have been developed with the publicly explicit goal of disadvantaging certain populations, but they had that effect and their legacies continue to this day. Systemic and institutional oppression means that certain populations continue to be disadvantaged without any individual having to declare him/herself as biased or prejudiced. Further, these populations tend to be blamed for their condition because “legalized discrimination is over”.

Systemic and institutional oppression has consequences related to behavioral health. Braveheart (1999, 2000, 2003) introduced the concept of “historical trauma” and DeGruy (2005) introduced “post-traumatic slave disorder”. Both describe the trauma experienced at the population level from systemic and institutional oppression that impacted the psychological wellbeing of its members and their social and parental functioning. This historical trauma is then expressed in subsequent generations and can be exacerbated by present time bias. There is even exploration of historical trauma as a factor for some Latino youth (Phipps & Degges-White, 2012). The mechanisms of transmission are multifold including—parental functioning, epigenetics, etc. (Denham, 2008, Yehuda, 2000 and 2007).

Historical and intergenerational trauma should be a consideration in the work to build relationships with marginalized communities and in the process of intervention planning and implementation. On a societal level, no one agency or system will be able to undo the impact of institutional and system oppression by itself.



However, there is a responsibility to explore the impact of current policies and practices and implement or advocate for corrective action. The *Racial Equity Toolkit an Opportunity to Operationalize Equity* (Nelson, 2015) and the Race Equity Impact Analysis (Annie E. Casey Foundation, 2006) offer two examples of tools to guide such an analysis. Secondly, there is opportunity for organizations to set the intention to reinvent themselves as anti-racist/oppression organizations. The *Local and Regional Government Alliance for Race and Equity* ([www.racialequityalliance.org](http://www.racialequityalliance.org)) is a network of jurisdictions that have set the intention for change. Similarly, agencies can organize towards change. In New York City, agency executives who had participated in *Undoing Racism* training organized the *First Monday Undoing Racism Collaborative*. This monthly discussion group provides opportunity for leaders to authentically address racism at the organizational and personal level, develop strategies, and share resources (Beitchman & Muid, MSW, 2011)

## Social Determinants of Mental Health

Place matters. The environment in which people live, work, and play influences their emotional well-being and the resources available for support. The World Health Organization defines the social determinants of health as the conditions in which people “are born, grow, live, work and age” influenced by the distribution of money, power, and resources (World Health Organization, 2008). Social determinants of discrimination, adverse early life experiences, poor education, unemployment, underemployment, job insecurity, economic inequality, neighborhood deprivation, food insecurity, poor housing quality, housing instability, poor access to health care, and adverse land use policies, zoning and community design, independently and interactively, negatively impact health and behavioral health. The same populations who are affected by disparities in behavioral health and behavioral healthcare are disproportionately located in community environments struggling with these social determinants (Adler University, Institute on Social Exclusion, n.d.; Compton & Shim, 2015).

Behavioral health systems, organizations and practitioners first need to acknowledge the interaction between these factors in the lives of youth and their families. These systems need to acknowledge the resilience and strengths in these families to have

been able to function as well as they do under these circumstances. Second, they need to take these issues into account in clinical practice using strategies as basic as using the *Cultural Formulation Interview* in the DSM-V, or screening for adverse childhood experiences during initial assessments. Third, they can expand their collaborations, advocacy and community education activities for policy and practice changes external to behavioral health services. Fourth, they can stimulate and participate in activities that promote population health approaches in communities. *Live Well San Diego* ([www.livewellsd.org](http://www.livewellsd.org)) represents one example of a county that is attempting to impact all of the community elements necessary for healthy life.

## Interpersonal Bias

The Institutes of Medicine’s ground breaking report, *Unequal Treatment: Confronting Racial and Ethnic Disparities* (Smedley, Stith & Nelson, 2002) concluded that “(al)though myriad sources contribute to these disparities, some evidence suggests that bias, prejudice, and stereotyping on the part of healthcare providers may contribute to differences in care” (Institute of Medicine, 2002). This conclusion is painfully disconcerting to well-meaning professionals, who commit themselves to conscientious, ethical and fair practice. Some even make a proactive, deliberate decision to serve marginalized cultural groups. And yet, they too may be contributing to disparities. Even members who share cultural identities with clients can be contributors to these disparities.

A bias is a preference for one thing, person or group over another. It is a natural human reaction. We all have biases. Bias becomes a concern when it becomes a prejudice against (e.g., anti-immigrant) or towards (e.g., model Asian) certain people or groups in ways that are unfair and lead to discrimination. Bias can be conscious and explicit, demonstrated through words and deeds without apology. Bias can also be unconscious or implicit.

Implicit bias is a function of cognitive processes—the attitudes, preferences, and beliefs—that often operate below conscious awareness and without intentional control. Oftentimes, persons with implicit bias will consciously espouse egalitarian values, but their negative feelings will emerge through a sense of anxiety or be justified by a reason other than the core issue.

“People with egalitarian values and beliefs, including health and behavioral health care professionals, often have a difficult time accepting that they harbor prejudicial attitudes or would do anything that would be negative toward another person. Yet, as well documented in the literature, it is the professional’s expression of bias that contributes to disparities.” — Goode, T. (2014)

For example, “Jane was not hired because she was not qualified, not because she was a woman.” Fortunately, cognitive psychology and neuroscience contribute to the understanding of implicit bias and points to actions to address it. The brain organizes multiple stimuli at any given point in time into conceptual buckets or labels to enable human comprehension (e.g., chair vs sofa, young person vs old person). The labels are learned from the social environment and constitute our vocabulary and associated meanings attached to the labels. Stereotypes constitute one type of label. Some stereotypes become associated with danger and trigger the stress response of “fight, flight or freeze.” This response takes place automatically and with much greater speed than the part of the brain that registers reasoned, planned thinking where action based on critical thinking and values would take place. Therefore, it is possible for well-meaning people to have conflicting internal responses to the same situation. (Bobula, 2011; Dovidio, Kawakami & Gaertner, 2002; Kang, 2009; Ridley & Hill, 1999; Staats, 2016)

In practice, practitioners may behave differently by assuming negative attributes, giving more credence to negative information than positive information, limiting the duration, depth and breadth of conversation, and failing to offer a full range of intervention or referral options. Each of these actions can lead to inaccurate assessments, inadequate interventions, less than optimal outcomes and increased disparities. Those in policy-making roles may take actions based on stereotypes, but rationalize decisions through the application of apparently neutral criteria such as budget considerations (Chapman, Kaatz, & Carnes, 2013; Johnson, Roter, Power & Cooper, 2004; Sabin, Rivara, Greenwald, 2008).

Biases are malleable. They do not need to be permanent. They can be addressed and modified. It

requires an acknowledgement and acceptance that unconscious bias exists. Further, individuals must assume responsibility for identifying their problematic biases and engaging in the work of change. This work includes self-reflection and self-assessment. The Implicit Association Test (see <https://implicit.harvard.edu>) is one resource to assist in identification of biases. Organizational data that exposes individual differential practices (e.g., referral for medication only for Latino clients and referral for medication and psychotherapy for white clients) and outcomes serve as another source of information for exploration. Once there is greater clarity regarding one’s personal issues, there is opportunity to engage in some of the techniques that are emerging from the research in neuroscience (Burgess, van Ryn, Dovidio & Saha, 2007; Blair, 2002; Blair, Ma & Lenton, 2001; Kang, 2009). For example, there are “stereotype negation training”, “counter stereotype strategies”, and application of “social and self-motivation” (Matthew, 2015).

The organizational contribution to an environment that provides “social motivation” includes safe spaces where staff can explore their biases, while concurrently enforcing an intolerance for prejudicial or discriminatory behavior. In addition to administrative and clinical supervision, organizations can include reflective supervision (Heffron & Murch, 2010). Organizations can also organize the work flow to allow time for staff to engage the executive functions of their brain that expresses egalitarian principles in contrast to a fast paced, high pressure environment that favors automatic actions based on stereotypes and biases (Burgess, et al., 2007).

Central to the success of any of these endeavors is the need to confront the resistance to address matters related to race, racism and other forms of oppression directly. *White privilege, white fragility, internalized oppression, micro-aggression* are concepts that tend to stimulate angst in many organizations (David & Derthick, 2014; DiAngelo, 2011; McIntosh, P.; Sue, Capodilupo, & Holder, 2008; Sue, Capodilupo, Torino, Bucceri, Holder, Nadal, & Esquilin, 2007). Even so, authentic change can emerge using reconciliation processes in which the truth about the negative history is acknowledged and apology is offered as preconditions of collaborative solution finding (Blackstock, Cross, George, Brown & Formsma, 2006).

## Cultural Group Beliefs and Practices

Cultural groups can contribute to disparities in their morbidity and service experience. Beliefs, values and practices about mental illness and substance use can impede utilization of services in a timely manner. For many cultural groups, stigma is a major issue that precludes early intervention and ongoing engagement with behavioral health services. In some circumstances, religious beliefs that equate mental illness with sin reinforce the stigma. On the other hand, some groups are very accepting of the person and his/her behaviors without consideration of the potential benefits of intervention (e.g., “Henry is just ‘crazy’, that’s just how he is.”) Here too, religious beliefs may identify the behavior as “special”, giving the person status within his/her group.

Certain cultural groups express their psychic distress in manners that are not familiar to Western oriented practitioners. For example, symptoms may be more somatic than emotional, or the threshold for distress is higher than for other cultural groups. At times, the issue is that there is not the vocabulary available to describe their experience with a practitioner either due to language barriers or mental health literacy barriers. For some groups, there is no concept of mental illness. For others, there are illnesses that are unique to their own culture.

Cultural beliefs and practices inform the labeling of when issues reach a stage for which intervention is necessary, who the appropriate interventionist should be (e.g., therapist, minister, teacher, medical doctor), what that person should do (e.g., medication, individual therapy, group therapy, prayer, or special teas and herbs), and towards what goals (e.g., adolescent independence or young adult remaining in household). Conflicts between cultural group members and behavioral health practitioners will influence the desire to access care, the utilization of services and the sense of satisfaction.

Finally, a history of prejudicial or biased experiences directed towards various cultural groups reinforces mistrust of service providers resulting in reluctance to seek help at the early stages of behavioral health challenges. This mistrust is exacerbated when neighbors, friends, relatives experience similar treatment in present time.

Clearly, practitioners need to expand their cultural knowledge through formal and informal processes. The transcultural psychiatry, sociology, history, and anthropology literature offers considerable background to help understand behavioral health beliefs and practices. However, informal processes through participating in the community life of cultural groups and listening carefully to the stories of families will provide valuable lessons for practitioners. Similarly, interaction with coworkers and colleagues of diverse cultural groups will enable useful perspectives on the life and experiences of youth and their families.

Engagement of representatives from culturally and linguistically diverse groups in the planning, implementation and evaluation of services and supports is a primary strategy for organizations and systems to engage in cultural learning and to build trusting relationships. Partnership provides opportunities to identify gaps and create services that actually matter. Cultural brokers can serve as crucial links to initiate and help maintain fruitful relationships. Change requires engagement of multiple stakeholders at the organizational, systemic and community levels. The resulting collaborations are essential to address the social determinants of mental health and to engage the impacted communities. (National Center for Cultural Competence, 2004).

## Summary

The causal factors and related intervention strategies do not exist in isolation from each other. Institutional and systemic oppression, social determinants of mental health, interpersonal bias and cultural group factors buttress each other. Interrupting the mutually reinforcing cycle at any point provides opportunity for meaningful change.

Strategies identified thus far include:

- Use external and internal data to create baseline disparities data and track progress
- Engage in racial equity policy analyses (use similar format to address impact on other specific marginalized groups)
- Strive to become an anti-racism/oppression organization
- Engage in a reconciliation process

- Establish a strong advocacy agenda and engage in stakeholder collaborations to address social determinants of mental health
- Participate in population health approach to community wellbeing and place-based initiatives
- Expand the cross-cultural knowledge base at the individual and organizational level
- Engage in partnership with culturally and linguistically diverse groups in advocacy, service planning, implementation, and evaluation
- Engage in partnership with cultural brokers and culture specific-organizations to support mutual relationship building and extend service array
- Take individual initiative to acknowledge and address explicit and implicit bias in relationship to both direct services and supports, and management and policy.

These strategies change the gestalt in which disparities work takes place. Clearly changes in policies, practices and behaviors must change to achieve changes in access, utilization and quality. However, a plan with good content will not be implemented unless the foundation for change is solid.

## Cultural and Linguistic Competence

Cultural and linguistic competence (CLC) is an important, but not exclusive, tool to address disparities. These are concepts that apply to individuals, organizations, and systems. Cultural and linguistic competence focus on the ability to provide services effectively cross-culturally. What are the policies, practices, structures, behaviors and attitudes that maximize the opportunity for positive outcomes within the context of the family's cultural context? In this sense cultural and linguistic competence represent quality improvement strategies. Unfortunately, quality alone is insufficient to eliminate all types of behavioral health disparities, but it does make a considerable contribution.

In the seminal work on cultural competence, *Towards a culturally competent system of care: A monograph on effective services for minority children who are severely emotionally disturbed*, Cross and colleagues (1989) indicate that organizations should have a clearly defined,

congruent, set of values and principles and demonstrate behaviors, attitudes, policies, structures, and practices that enable them to work effectively, cross-culturally. At the individual level, a person should acknowledge cultural differences, understand their own culture, engage in self-assessment, acquire cultural knowledge and skills, and view all behavior within a cultural context. At the organizational level, the organization should value diversity, conduct self-assessment, manage the dynamics of difference, institutionalize cultural knowledge and adapt to diversity in its values, policies, structures and services. This vantage point should be reflected at the policy making, administrative, practice and service delivery, child, youth and family and community levels.

Similarly, linguistic competence according to Goode and Jones (2009) is “the capacity of an organization and its personnel to communicate effectively, and convey information in a manner that is easily understood by diverse groups including persons of limited English proficiency, those who are not literate or have low literacy skills, individuals with disabilities, or those who are deaf or hard of hearing.” It requires organizational and provider capacity to respond effectively to the health literacy and mental health literacy needs of the populations served and ensures policy structures, practices, procedures and dedicated resources to support this capacity.

Frameworks for cultural competence described in helping disciplines such as psychology, counseling and social work, share the same basic concepts (American Psychological Association, n.d.; Multi-Racial/Ethnic Counseling Concerns Interest Network of the American Counseling Association Taskforce, 2015; National Association of Social Workers, 2015):

1. Knowing one's own cultural story
2. Identifying and addressing one's own biases
3. Developing a knowledge base about the diverse populations being served
4. Developing the capacity for effective communication—language, literacy, disability, deaf and hard of hearing
5. Developing cross-cultural skill sets for engagement
6. Establishing and maintaining a cultural and linguistically diverse workforce, governance,

- contractor and volunteer base at all levels of the organization
7. Engaging in organizational cultural and linguistic competence assessment
  8. Creating or modifying programming to align with cultural beliefs and practices
  9. Establishing partnerships with community being served for planning, implementation and evaluation of services
  10. Exercising formal and informal leadership to promote and advance CLC

## Cultural and Linguistic Competence in Action

The culturally and linguistically competent organization will use its data collecting capacity to identify the cultural and linguistic profile of the population it is designed to serve (e.g., state publicly funded behavioral health services, or local community based social services agency). It will identify the strengths and challenges of that population and with the support of the cultural community, it will develop and monitor appropriate services and supports.

The culturally and linguistically competent organization will establish human resources and professional development policies and practices which

will build a diverse workforce at all levels, facilitate training, coaching and mentoring to ensure cultural and linguistic competence of all staff, include cultural and linguistic competence as criteria in workforce recruitment, staff supervision, staff evaluation and awards.

The culturally and linguistically competent organization will allocate resources to support the financial and personnel requirements to do the work and support interpretation and translation expenses. It will use its resources to be a positive financial neighbor by purchasing goods and services from cultural communities.

The culturally and linguistically competent organization will engage in collaboration and partnership with leaders of cultural communities, with family and peer organizations, community based organizations and other key stakeholders. It will embody the principle of “nothing about us without us”, leading to more accuracy regarding needs and assets, facilitating better planning of resources and intervention modalities. The partnerships with cultural groups will assist in obtaining more knowledge of available resources and increase opportunity to diminish stereotypes and biases.

When a culturally and linguistically competent organization contracts work to other entities, it will hold those entities to the same standards for cultural and linguistic competence as it applies to itself. The contracts will include the parameters for monitoring

**Table 2. CLC and Disparities Interface—Practitioner Level Examples**

Disparity Doman	Level of Operation	CLC Components					
		Values	Policies	Structure	Practices	Behavior	Attitudes
Appropriateness	Practitioner	Families and youth are entitled to services that are effective for their cultural context	Organizational policy requires practitioners to become knowledgeable about the strengths and weaknesses of various intervention strategies relevant to the cultural groups the organization is serving	Clinical Team, CLC Committee, Community Advisory Group, Consumer Group to establish a plan for continuous learning	Assessment tools and intervention strategies are regularly reviewed by team members for relevance to population served. CQI team tracks interventions and provides feedback to this team for guidance	Practitioner research and seek consultation related to the effectiveness of any service options to be considered with the cultural group	Commitment to doing it right the FRIST time
Possible Disparities Outcomes	Practitioner offers services that are more likely to be appropriate, thereby increasing the likelihood of success measured by better clinical and functional outcomes. People get better.						

**Table 3. CLC and Disparities Interface—System Example**

Disparity Doman	Level of Operation	CLC Components					
		Values	Policy	Structure	Practice	Behavior	Attitudes
Availability	System	Serve the entire community no one should be left out	County Behavioral Health Department is required to conduct annual demographic analysis as a condition of continued state funding	Evaluation and Reports Office in collaboration with Program Managers	Annual review of census data, school enrollment data, immigration data and geo-mapping of services	Seeks out member of new and emerging population groups to assess strengths and challenges	Personnel want to know who is the community and are open to a variety of approaches to meet the needs and view the regular analysis as routine
Projected Disparities Outcome	<b>Potential disparities in care are averted by discovery of who is in the area and a process to facilitate early intervention is developed in collaboration with community leaders. Potentially less utilization of emergency care services, greater utilization of less intense, community based care (including culture-specific natural networks for healing).</b>						

and accountability. (National Center for Cultural Competence, 2004).

The subtlety and complexity of the intersection of cultural and linguistic competence and disparities in behavioral health are demonstrated in Tables 2, and 3. Each example uses one of the disparities domains on one axis and the elements of culturally competent organizations on the other axis. The examples propose the potential pathway regarding how cultural and linguistic competence might have an impact on behavioral healthcare disparities.

## Leadership for Organizational and Systemic Change

Creating culturally and linguistically competent organizations, mobilizing communities, stakeholders, clients, and cultural communities to tackle disparities, means thinking, feeling, and behaving differently from the ways of thinking, feeling, and behaving today. Because most institutions in US society were created based on the values and principles that were concordant with the white middle class dominant

*“People do not assimilate new ways of doing things unless they make emotional space in their current paradigms. So unless they can figure out how it’s relevant to them, they don’t do it with their clients.”* — Henry Gregory, Rafiki Consortium

cultural group, these institutions often require types of changes that take into consideration the values, principles and experiences of clients from other cultural groups. Facilitating that change requires effective leadership from formal leaders and those who share the passion and urgency for change (including informal leaders). Moving people to make a shift out of their current comfort zone, especially in matters related to race, ethnicity and other marginalized populations, requires leaders who are knowledgeable and skilled to orchestrate such a change.

The organizational and leadership literature offers a range of frameworks to reference for a change strategy. Rogers (2010) describes stages of diffusion of innovations --Knowledge, persuasion, decision, adoption, and sustaining. Each stage reflects movement in knowledge about and then commitment to the change. The rate of adoption of new innovations is predictably variable across the population from early adopters to laggards. Mayeno (2007) applies Prochaska’s (2000) transtheoretical stages of change to the process of creating multicultural organizations. These stages are pre-contemplation, contemplation, preparation, implementing, and sustaining. She offers a range of strategies that are tailored for each stage noting that the use of strategies that are inappropriate for the stage of change will not yield success. Heifetz (1994) introduces the concepts of technical and adaptive challenges. Technical challenges are those in which

there is alignment on what the issues are and what the tasks are. The leader's role is to provide sanction and resources. Adaptive challenges require change in attitudes, values, beliefs and habits of behavior. These are challenges for which there is no ready answer or process and for which the organization must learn its way to solutions. In most cases, the types of work required to successfully address disparities are in the category of adaptive challenge because issues related to race, culture, bias, prejudice, privilege, oppression and similar concepts are so emotionally charged. For example, the task of contracting for interpretation services may be considered a technical task. However, the decision to use interpretation services represent an adaptive challenge if most of the staff believe in English Only. The leader's task is to challenge the group to examine preconceived beliefs and create new solutions

The management of the change process is a necessary precondition for authentic change. The community as a whole must be able to address historic and current societal oppression, pursue reconciliation, invest monetary and personnel resources, authentically engage cultural communities as partners in the planning, implementation and evaluation of services. This adaptive work must take place to enhance the quality of essential, but more familiar planning processes (See Martinez, Francis, Poirier, Brown, & Wang, 2013).

## Summary

With this comprehensive perspective, communities have the opportunities to promote change in the service array, to ensure awareness of services (because the community helped plan the services), establish programming that accommodates the life style and life demands of culturally and linguistically diverse families, ensure effective communication, and engage the right people in the service planning, implementation and evaluation with full attention to informed decision making. Individuals and organizations must advocate and implement policies and practices that oppose present time oppression and rectify past oppression. They will be in a constant learning process to understand more about themselves as cultural beings and their own biases, and to develop the cultural knowledge and skills to engage in effective cross-cultural practice.

## References

- Adler University, Institute on Social Exclusion. (n.d.). What are the Social Determinants of Mental Health? Retrieved from <http://www.adler.edu/page/institutes/institute-on-social-exclusion/projects/mhia/social-determinants-of-mental-health>
- Albright, A. R., & Chung, H. (2002). Depression in Asian American children. *Western Journal of Medicine*, 176(4), 244-248.
- American Psychiatric Association. (2013). *The diagnostic and statistical manual of mental disorders. Fifth Edition (DSM-V)*. Arlington, VA: Author.
- American Psychological Association. (n.d.) *Guidelines for providers of psychological services to ethnic, linguistic, and culturally diverse populations*. Retrieved from <http://www.apa.org>.
- Annie E. Casey Foundation. (2006). *Race Matters: Racial Equity Impact Analysis: Assessing policies, programs and practices*. Baltimore, MD: Author. Retrieved from <http://www.aecf.org>.
- Beitchman, P. D., & Muid, O. (2011). Advancing Anti-Racism Work: The First Monday Collaborative. *Mental Health News*, 13(1), 4.
- Blair, I. V. (2002). The malleability of automatic stereotypes and prejudice. *Personality and Social Psychology Review*, 6(3), 242-261.
- Blair, I. V., Ma, J. E., & Lenton, A. P. (2001). Imagining stereotypes away: the moderation of implicit stereotypes through mental imagery. *Journal of Personality and Social Psychology*, 81(5), 828-841.
- Bobula, K. (2011). *This is your brain on bias... or, the neuroscience of bias*. Faculty Lecture Series—Clark College, Vancouver, Washington. Retrieved from [http://www.clark.edu/video/faculty\\_speaker/DrKathyBobula/presentation.pdf](http://www.clark.edu/video/faculty_speaker/DrKathyBobula/presentation.pdf).
- Brave Heart, M. Y. H. (1999). Gender differences in the historical trauma response among the Lakota. *Journal of Health and Social Policy*, 10(4), 1-21.
- Brave Heart, M. Y. H. (2000). Wakiksuyapi: Carrying the historical trauma of the Lakota. *Tulane Studies in Social Welfare*, 20, 245-266.
- Brave Heart, M. Y. H. (2003). The historical trauma response among Natives and its relationship with substance abuse: a Lakota illustration. *Journal of Psychoactive Drugs*, 35(1), 7-13.
- Burgess, D., van Ryn, M., Dovidio, J., & Saha, S. (2007). Reducing racial bias among health care providers: Lessons from social-cognitive psychology. *Society of General Internal Medicine*, 22(6), 882-887. doi: 10.1007/s11606-007-0160-1
- Center for Disease Control and Prevention. (2014). *LGBT Youth*. Retrieved from <http://www.cdc.gov/lgbthealth/youth.htm>.
- Chapman, E. N., Kaatz, A., & Carnes, M. (2013). Physicians and implicit bias: How doctors may unwittingly perpetuate health care disparities. *Journal of General Internal Medicine*, 28(11), 1504-10.
- Compton, M. T., & Shim, R. S. (Eds.). (2015). *The social determinants of mental health*. Washington, DC: American Psychiatric Publishing.
- Cross, T., Bazron, B., Dennis, K., & Isaacs, M. (1989). *Towards a culturally competent system of care: A monograph on effective services for minority children who are severely emotionally disturbed (Vol.1)*. Washington, DC: National Technical Assistance Center for Children's Mental Health, Georgetown University Child Development Center.

- David, E. J. R. (Ed.). (2014). *Internalized oppression: The psychology of marginalized groups*. New York: Springer Publishing Company.
- David, E. J. R., & Derthick, A. O. (2014). What is internalized oppression, and so what? In E. J. R. David (Ed.), *Internalized oppression: the psychology of marginalized groups* (pp. 1-30). New York: Springer Publishing Company.
- DeGruy, J. (2005). *Post Traumatic Slave Syndrome: America's legacy of enduring injury and healing*. Portland, OR: Uptone Press.
- Denham, A. R. (2008). Rethinking historical trauma: Narratives of resilience. *Transcultural Psychiatry*, 45(3), 391-414.
- DiAngelo, R. (2011). White fragility. *International Journal of Critical Pedagogy*, 3(3), 54-70.
- Disparity. (n.d.). In Merriam-Webster's online dictionary. Retrieved from <http://www.merriam-webster.com/thesaurus/disparity>.
- Dovidio, J., Kawakami, K., & Gaertner, S. (2002). Implicit and explicit prejudice and interracial interaction. *Journal of Personality and Social Psychology*, 82(1), 62-68.
- Goode, T. (2014). Overcoming Barriers that Sustain Disparities/ Creating Attitudes that Support Equity: Challenging our Biases. Presented at *Addressing Disparities: Achieving Equity in Children's Mental Health Care*, Pre-Institutes Training Program, Georgetown University 2014 Training Institutes, July 15, 2014, Washington, DC.
- Goode, T., & Jones, W. (2009). *Linguistic competence*. Washington, DC: Georgetown University Center for Child and Human Development. Retrieved from <https://nccc.georgetown.edu/documents/Definition%20of%20Linguistic%20Competence.pdf>.
- Heffron, M. C., & Murch, T. (2010). *Reflective supervision and leadership in infant and early childhood programs*. Washington, DC: Zero to Three.
- Hirsch, J. (2015). A review of the literature on rural suicide. *Crisis*, 27, 189-199.
- Huang, L. N. (2014). *Taking Action to Reduce Behavioral Health Disparities*. Presented at *Addressing Disparities: Achieving Equity in Children's Mental Health Care*, Pre-Institutes Training Program, Georgetown University 2014 Training Institutes, July 15, 2014, Washington, DC.
- Institute of Medicine. (2002). *Unequal Treatment: What healthcare providers need to know about racial and ethnic disparities in health care*. Retrieved from <http://www.iom.edu>.
- Jackson, M. P., Croghan, T. W., Melfi, C., & Lewis-Hall, F. C. (1999). Cultural competency and psychopharmacology. In V. Jackson & L. Lopez (Eds.). *Cultural competency in managed behavioral health care*. (187- 210). Providence, RI: Manisses Communications Group.
- Jackson, V., & Lopez, L. (1999). *Cultural competency in managed behavioral health care*. Providence, RI: Manisses Communications Group.
- Johnson, R. L., Roter, D., Power, N., & Cooper, L. A. (2004). Patient race/ ethnicity and quality of patient-physician communication during medical visits. *American Journal of Public Health*, 94(12), 2084-2090.
- Kang, J. (2009). *Implicit bias: A primer for courts*. Williamsburg, VA: National Center for State Courts.
- Lê Cook, B., Barry, C. L., & Busch, S. H. (2012). Racial/Ethnic disparity trends in children's mental health care access and expenditures from 2002 to 2007. *Health Services Research*, 48(1), 129-149.
- McIntosh, P. *White privilege: unpacking the invisible knapsack*. Retrieved from: <https://www.deanza.edu/faculty/lewisjulie/White%20Priviledge%20Unpacking%20the%20Invisible%20Knapsack.pdf>
- Martinez, K., Francis, K., Poirier, J., Brown, L., & Wang, M. (2013). A Blueprint for Using Data to Reduce Disparities/Disproportionalities in Human Services and Behavioral Health Care. Retrieved from <http://www.tapartnership.org/COP/CLC>.
- Multi-Racial/Ethnic Counseling Concerns Interest Network of the American Counseling Association Taskforce. (2015). *Competencies for counseling the multiracial populations*. Alexandria, VA: American Counseling Association.
- National Association of Social Workers, Committee on Racial and Ethnic Diversity. (2015). *NASW standards and indicators for cultural competence in social work practice*. Washington, DC: Author.
- National Center for Cultural Competence. (2004). *Planning for Cultural Competence in Systems of Care...for children and youth with social-emotional and behavioral disorders and their families*. Washington, DC: Georgetown University Center for Child and Human Development.
- Nelson, J. (2015). *Racial Equity Toolkit: An Opportunity to Operationalize Equity*. Local and Regional Government Alliance for Racial Equity Retrieved from [http://racialequityalliance.org/newsite/wp-content/uploads/2015/10/GARE-Racial\\_Equity\\_Toolkit.pdf](http://racialequityalliance.org/newsite/wp-content/uploads/2015/10/GARE-Racial_Equity_Toolkit.pdf)
- Office of the Surgeon General; Center for Mental Health Services; National Institute of Mental Health. (2001). *Mental health: Culture, race, and ethnicity: A supplement to mental health: A report of the Surgeon General*. Rockville, MD: Author.
- Phipps, R. M., & Degges-White, S. (2012). A new look at transgenerational trauma transmission: Second-generation Latino immigrant youth. *Journal of Multicultural Counseling and Development*, 42, 175-187.
- Ridley, C., & Hill, C. (1999). Categorization as primary-process cognition in racism: Implications for counseling. *The counseling psychologist*, 27(2), 245-255.
- Rogers, E. M. (2010). *Diffusion of innovations*. Simon and Schuster.
- Sabin, J., Rivara, F., Greenwald, A. (2008). Physician implicit attitudes and stereotypes about race and quality of medical care. *Medical Care*, 46(7), 678-685.
- Smalley, K. B., Yancey, C. T., Warren, J. C., Naufel, K., Ryan, R., & Pugh, J. L. (2010). Rural mental health and psychological treatment: A review for practitioners. *Journal of Clinical Psychology*, 66(5), 479-489.
- Smedley, B., Stith, A., & Nelson, A. (Eds.)/Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care, Board on Health Sciences Policy, Institute on Medicine (2002). *Unequal treatment: Confronting racial and ethnic disparities in health care*. Washington, DC: National Academy of Sciences.
- Staats, C., Capatosto, K., Wright, R. A., & Contractor, D. (2016). *State of the Science: Implicit Bias Review 2015*. Columbus, OH: Kirwan Institute for the study of race and ethnicity, Ohio State University.



- Substance Abuse and Mental Health Services Administration [SAMHSA]. (n.d.). *Disparities Impact Statement*. Retrieved at <http://www.samhsa.gov/grants/grants-management/disparity-impact-statement>.
- Substance Abuse and Mental Health Services Administration [SAMHSA]. (n.d.). *Racial and ethnic minority populations*. Retrieved from <http://www.samhsa.gov/specific-populations/racial-ethnic-minority>.
- Substance Abuse and Mental Health Services Administration [SAMHSA]. (2015a). *Behavioral Health Barometer, United States, 2015*. HHS Publication No. SMA-16-Baro-2015. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Substance Abuse and Mental Health Services Administration [SAMHSA]. (2015b). *Behavioral Health Equity Barometer: United States, 2014*. Publication No. SMA-15-4895EQ. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Substance Abuse and Mental Health Services Administration [SAMHSA]. (2015c). *Racial/Ethnic Differences in Mental Health Service Use among Adults*. HHS Publication No. SMA-15-4906. Rockville, MD: Substance and Mental Health Services Administration, 2015.
- Sue, D. W., Capodilupo, C. M., & Holder, A. M. B. (2008). Racial microaggressions in the life experience of Black Americans. *Professional Psychology: Research and Practice, 39*(3), 329-336. doi: 10.1037/0735-7028.39.3.329
- Sue, D. W., Capodilupo, C. M., Torino, G. C., Bucceri, J. M., Holder, A. M. B., Nadal, K. L., & Esquilin, M. (2007). Racial microaggressions in everyday life: Implications for clinical practice. *American Psychologist, 62*(4), pp 271-286. doi: 10.1037/0003-066X.62.4.271
- U.S. Department of Health and Human Services [USDHHS]. (2001). *Mental Health: Culture, Race, and Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.
- U.S. Department of Health And Human Services [USDHHS]. (2011a). *Implementation guidance on data collection standards for race, ethnicity, sex, primary language, and disability status*. Washington, DC: Author.
- U.S. Department of Health and Human Services [USDHHS]. (2011b). *HHS Action Plan to Reduce Racial and Ethnic Health Disparities*. Washington, DC: Author.
- U.S. Department of Health and Human Services [USDHHS]. *The Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2020. (2008). Phase I report: Recommendations for the framework and format of Healthy People 2020 Section IV: Advisory Committee findings and recommendations*. Washington, DC: Author.
- U.S. Department of Health and Human Services [USDHHS], Office of Minority Health. (2013). *National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care*. Retrieved from <https://www.thinkculturalhealth.hhs.gov/assets/pdfs/EnhancedNationalCLASstandards.pdf>.
- U.S. Department of Health and Human Services [USDHHS], The Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2020. (2008). *Phase I report: Recommendations for the framework and format of Healthy People 2020*. Washington, DC: US. Department of Health and Human Services.
- Whitehead, M. (1991). *The concepts and principles of equity and health*. World Health Organization, Regional Office for Europe, Copenhagen, Denmark.
- Willing, C. E., Salvador, M., & Kano, M. (2006a). Pragmatic help seeking: How sexual and gender minority groups access mental health care in a rural state. *Psychiatric Services, 57*(6), 871-874.
- Willing, C. E., Salvador, M., & Kano, M. (2006b). Unequal treatment: Mental health care for sexual and gender minority groups in a rural state. *Psychiatric Services, 57*(6), 867-870.
- World Health Organization. (2008). *Closing the gap in a generation: Health equity through action on the social determinants of health*. Geneva, Switzerland: World Health Organization, Commission on Social Determinants of Health.
- Yehuda, R., & Biere, L. M. (2007). Transgenerational transmission of cortisol and PTSD risk. *Progress in Brain Research, 167*, 121-35.
- Yehuda, R., Bierer, L., Schmeidler, J., & Aferiat, D. (2000). Low cortisol and risk for PTSD in adult offspring of Holocaust survivors. *The American Journal of Psychiatry, 157*(8), 1252-1259.

## Appendix A—Data Sources

### **Alliance for Equity in Child Welfare**

Disparities and Disproportionality in Child Welfare: <http://www.cssp.org>

### **Annie E. Casey Foundation**

Kids Count Data Center: <http://datacenter.kidscount.org>

### **The Association of Religion Data Archives**

[www.thearda.com](http://www.thearda.com)

### **Center for Disease Control (CDC)**

Behavioral Risk Factor Surveillance System (BRFSS): [www.cdc.gov/brfss/about/index.htm](http://www.cdc.gov/brfss/about/index.htm)

Youth Risk Behavior Surveillance System: [www.cdc.gov/healthyyouth/yrbs/index.htm](http://www.cdc.gov/healthyyouth/yrbs/index.htm)

Data Set Directory of Social Determinants of Health at the Local Level: [www.cdc.gov/dhdsp/docs/data\\_set\\_directory.pdf](http://www.cdc.gov/dhdsp/docs/data_set_directory.pdf)

### **Migration Policy Institute**

[www.migrationpolicy.org](http://www.migrationpolicy.org)

### **Office of Immigration Statistics**

[www.dhs.gov/office-immigration-statistics](http://www.dhs.gov/office-immigration-statistics)

### **Pew Research Center**

[www.pewresearch.org](http://www.pewresearch.org)

### **Pew Hispanic Trends Project**

[www.pewhispanic.org](http://www.pewhispanic.org)

### **Urban Institute**

[www.urban.org](http://www.urban.org)

### **United States Census Bureau**

[www.census.gov](http://www.census.gov)

### **U.S. Census Bureau**

American Community Survey: [www.census.gov/acs](http://www.census.gov/acs)

### **U.S. Department of Health and Human Services, Administration for Children and Families**

Children's Bureau Statistics and Research: [www.acf.hhs.gov/programs/cb/research-data-technology/statistics-research](http://www.acf.hhs.gov/programs/cb/research-data-technology/statistics-research)

### **U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention**

National Disproportionate Minority Contact Databook: [www.ojjdp.gov/ojstatbb/dmcsdb](http://www.ojjdp.gov/ojstatbb/dmcsdb)