Strategies and Opportunities for Implementing Behavioral Health Disparities Impact Statements

Introduction

The recent system-wide policy and requirement for grantees of the Substance Abuse and Mental Health Services Administration (SAMHSA) to establish and develop a Behavioral Health Disparities Impact Statement (BHDIS) represents an important step to advance the quality of behavioral health and supportive care for children, youth, and families. The primary purpose of a BHDIS is to assess and strengthen the impact of policies, programs, processes, and resource decisions to eliminate behavioral health disparities and disproportionalities.

The terms *disparity* and *disproportionality* are key concepts for practitioners to use and clarify for others in their communities to address the needs of diverse populations of focus. A disparity is an inequality marked by a comparative difference. Unequal access to health and human services experienced by a racial or ethnic population in comparison to another racial or ethnic population is a prominent example of a disparity. Research has shown that racial and ethnic minorities are at much greater risk of experiencing negative health outcomes compared to their nonminority peers (Lurie & Dubowitz, 2007; Smedley, Stith, & Nelson, 2003). A disproportionality is skewed representation of a given population group. A local detention center that confines a higher number of African American and Latino youth compared to the racial and ethnic makeup of the surrounding geographic area is a prominent example of a disproportionality. Practitioners can mistakenly use the terms disparity and disproportionality interchangeably, or may default to labeling all inequalities a disparity, yet these terms are distinctive in terms of what is specifically compared (i.e., one group to another group versus disproportionate representation).

SAMHSA's BHDIS provides an important framework for practitioners to address gaps in behavioral health among vulnerable and marginalized populations. In 2013, SAMHSA began to require grantees/programs to achieve the following:

1. Outline their populations of focus by race, ethnicity, and sexual/gender minority identity;

2. Address issues regarding data collection, service implementation, and data reporting; and

3. Plan their policies and procedures in a way that aligns with the enhanced National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care.

For many communities and grantees, this is the first time they have ever been asked to collect and use these data, while others are more advanced with centers of excellence in various areas of the country. Documenting the core needs, challenges and opportunities, and lessons learned that can be shared across states, communities

and grantees will provide a local and national view of program achievements and successes.

This Resource Brief discusses core needs and rationales for grantees to develop their BHDIS, a summary of lessons learned from BHDIS technical assistance, and BHDIS resources that are available from the Cultural and Linguistic Competence (CLC) Hub Library.

Needs and Rationales

Since practitioners may find administrators, staff and community members do not buy-in to the importance of prioritizing disparities and disproportionalities, the following talking points can facilitate understanding and support:

Quality, model programs align with the cultural and linguistic needs of their communities.

The primary need for practitioners to outline their populations of focus by race, ethnicity, and sexual and gender minority status is that the increasingly diverse "face" of America is changing in terms of demographic trends and visibility. Without an understanding of these trends and how they impact behavioral health disparities and disproportionalities within their particular service area, programs will continually experience challenges with outreach and recruitment of potential enrollees from emerging and minority populations. They will also struggle with client engagement and service alignment, thereby making it difficult to meet their clients needs. In addition, a program will struggle to understand gaps that exist within and across service systems.

According to the 2000 and 2010 U.S. Census data, racial and ethnic minority populations are increasing within single racial categories and across multi-racial categories. The Southern region of the U.S. experienced the largest percentage change (49.1%) of individuals identifying as multi-racial during this period, followed by the Midwest (41.6%), West (24.3%), and Northeast (15.3%). Part of this change is due to changing social attitudes regarding multi-racial coupling. In 1980, nearly 13 years after the 1967 U.S. Supreme Court decision declared anti-miscegenation laws unconstitutional, the U.S.

"...System builders ...[need] to be thoughtful about the characteristics, strengths, and needs of subpopulations within the identified population of populations so that relevant strategies will be pursued and responsive structures built." (Pires, 2010, p. 268).

Census recorded 6.7% of marriages involving spouses of a different race or ethnicity from each other. Thirty years later in 2010, this percentage more than doubled to 15.1% (U.S. Census Bureau, 2012).

The Pew Research Center (2012) conducted surveys from 1987 to 2009 that showed a similar trend (48% to 83%) in the acceptance of Blacks and Whites dating each other. A further analysis of this perception by age group illustrates that youth ages 18-29 are driving the acceptance trend, and although there are large proportions of acceptance among the 30-49, 50-64, and 65+ age groups, the acceptance decreases among progressively older generations.

The Hispanic and Latino population has grown substantially in the U.S. From 2000 and 2010, the U.S. Census findings indicate that Hispanics comprised more than half of overall U.S. population growth. The Pew Research Center notes that while migration trends change due to economic and immigration policies, the Hispanic population is projected to grow by 86% between 2015 and 2050 (Krogstad, 2014; Gonzalez-Barrera, 2015).

Linguistic diversity and English proficiency in the U.S. are evolving in tandem with immigration, intergenerational use, and other socio-cultural influences (Rumbaut & Massey, 2013; Shin & Kominski, 2010). According to the U.S. Census Bureau (2015), the Limited English Proficient (LEP) population in the U.S. is approximately 8%. and at least 350 languages are spoken at home (Zong & Batalova, 2015).

National surveys are providing increasing sets of data that illustrate the visibility of the sexual/gender

minority population since the inclusion of same-sex households began with the 2010 U.S. Census. These data illustrate that same-sex households and same-sex couples raising children reside within every congressional district (Gates & Cooke, n.d.).

Addressing disparities and disproportionalities is increasingly tied to funding.

Health care reforms are accelerating a trend among service providers to provide behavioral health and support services that are responsive to the needs of diverse client populations. For example, the Patient Protection and Affordable Care Act (ACA) contains specific provisions for federal agencies and providers to address health disparities (RWJF, 2011). Healthy People 2020, which sets the 10-year national agenda and framework for the U.S. Department of Health and Human Services (HHS), upholds the importance of addressing ecological and social determinants of health to eliminate health disparities (HHS, 2015). HHS agencies are implementing this agenda by requiring grantees to document specific plans for improving access, service use, and outcomes. State agencies and municipalities, particularly with flow-through funding from federal sources, are aligning similar requirements.

SAMHSA's requirements for grantees to establish and develop BHDIS are within the Funding Opportunity Announcements, Notices of Grant Awards, and ongoing reporting requirements. The data collected for the BHDIS also extend beyond SAMHSA's requirements by providing a solid foundation for organizations to pursue other public and private funding opportunities, since disparities and disproportionalities frequently illustrate integrated service needs.

Cultural adaptation advances access, service use, and outcomes.

Additional rationales for programs to promote cultural adaptation with the use of a BHDIS are provided by evidence from population studies and large-scale federal initiatives (CDC, 2015; SAMHSA, 2015; SAMHSA-HRSA Center for Integrated Health Solutions, 2015). For example, addressing gaps in care (disparities and disproportionalities) can yield improvements in overall

quality and efficacy of care, health and well-being outcomes (quality of life), communication and trust between clients and providers, and client and provider satisfaction. Addressing these gaps can also yield declines in provider bias and discrimination, service system costs, and delays in seeking needed care and services (Goode, Dunne, & Bronheim, 2006; IOM, 2002; IOM, 2011).

Each of these talking points connect to foundational System of Care principles and values that ensure that services are family-driven and youth-guided, community-based, and reflective of cultural, racial, ethnic, and linguistic differences (Blau & Stroul, 2008; Cross, Bazron, Dennis, & Isaacs, 1989; Pires, 2002). Even within communities or programs where there may be challenges when addressing the needs of populations experiencing disparities and disproportionalities, practitioners can objectively point to state and regional maps, reports, and other resources that clearly demonstrate the context and plans for implementing strategies within a BHDIS.

Lessons Learned from BHDIS Technical Assistance

A BHDIS provides a framework for how a program will eliminate behavioral health disparities and disproportionalities. Since it is data-driven and contains a quality improvement plan, it can be used as an ongoing program planning tool with guidance from the Government Project Officer (GPO) and resources from the TA Network (Gamache & Lazear, 2014). The following section provides a cross-section of findings and lessons learned from an ongoing review of BHDIS documents submitted to SAMHSA:

Outlining populations of focus by race, ethnicity, and sexual/gender minority identity.

Beginning with the Fall 2013 SAMHSA request for applications cycle, grantees were asked to outline their populations of focus by race, ethnicity, and sexual/gender minority identity by using the following table containing the disaggregated estimate of unduplicated clients to be served:

Strategies and Opportunities

Direct Services # to be Served	FY 1	FY 2	FY 3	Total
By Race/Ethnicity				
» African American				
» American Indian/Alaska Native				
» Asian				
» White (non-Hispanic)				
» Hispanic or Latino				
» Native Hawaiian/Other Pacific Islander				
» Two or More Races				
By Gender				
» Female				
» Male				
» Transgender				
By Sexual Orientation/Identity				
» Gay				
» Lesbian				
» Bisexual				

This table illustrates plans for access and inclusive services for these populations. Due in part to a lack of data regarding their populations of focus, there are opportunities for practitioners to update these numbers so that there are no zeroes or "not applicable" entries for specific groups. Omissions such as these imply that the program is not inclusive when it fails to plan to serve individuals within these groups. For example, many practitioners expressed that they are able to estimate the race and ethnicity of their proposed populations of focus, in addition to males and females, but were uncertain how to estimate transgender or sexual orientation/identity. Their intake forms may not have traditionally had these fully inclusive identity options, there may be misperceptions that these populations do not exist within their service area, or they may not know where to find demographic statistics for their area.

The references provided within this Resource Brief – particularly the U.S. Census and other demographic reports – can be used to address these gaps in access. The National Training and Technical Assistance Center for Children's Behavioral Health (NTTAC) can also provide direct links and assistance.

Addressing issues regarding data collection, service implementation, and data reporting.

Data collection by race, ethnicity, gender, and sexual orientation/identity is critically important to examine disparities and disproportionalities. There is an opportunity for practitioners to actively use these data by sharing summary information with community advisory boards, youth and family steering committees, and other program partners to establish a feedback loop for how the program can make adjustments. For instance, an enrollment report that shows Latino youth are not engaging with the program (in comparison to White youth) is an example of identified disparity. Sharing this information with a youth advisory committee can yield strategies for changing outreach messaging and other efforts for Latino youth engagement.

Additional short-term strategies that can be used to improve practices, knowledge, and engagement include the following:

1. Update forms to collect race, ethnicity, and sexual/gender minority identity;

2. Conduct an anti-discrimination policy review to determine whether policies include race, ethnicity, and sexual/gender minority identity;

3. Expand integration zones/safe spaces for all youth, including racial, ethnic, and sexual/gender minority youth;

4. Identify training opportunities on selected topics related to disparities and disproportionalities (e.g., homelessness, suicide prevention, bullying);

5. Share learning content with service systems, programs, providers, and caregivers connected to the program (e.g., foster care families, schools, faith-based organizations);

6. Develop inclusive referrals for racial, ethnic, and sexual/gender minority youth and families;

7. Partner with racial, ethnic, and sexual/gender minority community alliances;

8. Identify local racial, ethnic, and sexual/gender minority inclusive success stories; and

9. Provide self-assessment tools for agency/program staff to evaluate their level of comfort, acceptance, or stigma for working with racial, ethnic, and sexual/gender minority youth and families.

Planning policies and procedures in a way that aligns with the enhanced CLAS Standards.

The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS) are intended to advance health equity, improve quality and help eliminate disparities and disproportionalities (OMH, 2013). The use of the CLAS Standards is part of a program's quality improvement plan. There is an opportunity for practitioners to describe how their programs will address diverse cultural health beliefs and practices, preferred languages, and health literacy and other communication needs of all populations of focus. Examples of alignment with the CLAS Standards include adjusting staff orientation, continuing education, materials, and other tools and resources to support the needs of racial, ethnic, and sexual/gender minority populations.

Each of these lessons learned provide a path for celebrating program achievements and forming centers of excellence. To gain more information about lessons learned, please join the TA Network's Peer-To-Peer Learning Sessions to share in ongoing discussions. The following section provides additional BHDIS resources.

BHDIS Resources

The following resources about BHDIS can be found at the Cultural and Linguistic Competence (CLC) Hub Library: http://cfs.cbcs.usf.edu/projects-research/CLChub_resourcelib.cfm

SAMHSA Disparity Impact Statement Examples

Generic examples for what minimally needs to be sent to the grantee's Government Project Officer

Program Example: BHDIS Fact Sheet

Resource tool to facilitate discussions about how disparities can be best addressed.

BHDIS 15 Item Assessment Tool

A 15 item tool to help grantees assess the degree to which their programs describe their populations in terms of disparity/disproportionalities, address data, and address the CLAS Standards

Racial Impact Statements: History and Applicability to Juvenile Justice Policies

Webinar/Slides. Presented by the Coalition for Juvenile Justice's Ethnic and Cultural Diversity Committee

Using Behavioral Health Disparities Impact Statements to Improve Services for Youth and Families
https://www.youtube.com/watch?v=JNKSjDWp3s0

Part 1: Learning Exchange Series – Moving Towards Cultural and Linguistic Competence: From Knowing to Doing. This webinar discusses a new federal requirement for grantees of the Substance Abuse and Mental Health Services Administration (SAMHSA) to create a Behavioral Health Disparities Impact Statement and the manner in which they are addressing the specification. Participants will gain practical examples of how to create organizational changes to address disparities, meet CLAS Standards, and improve behavioral health services to children, youth and families

How to Use Organizational Self-Assessment Tools and Climate Surveys
https://theinstitute.adobeconnect.com/p5r1xs8vavq/

Part 2: Learning Exchange Series – Moving Towards Cultural and Linguistic Competence: From Knowing to Doing. Webinar focused on operationalizing Behavioral Health Impact Statements and CLAS Standards

How to Develop and Enhance Employment Non-Discrimination Policies
https://theinstitute.adobeconnect.com/p9sdv8xytsa/

Part 3: Learning Exchange Series – Moving Towards Cultural and Linguistic Competence: From Knowing to Doing.

Strategies to Conduct Outreach to Diverse Populations
https://theinstitute.adobeconnect.com/p97489u3x09/

> *Part 4: Learning Exchange Series* – Moving Towards Cultural and Linguistic Competence: From Knowing to Doing.

Communication and Education on Gender and Orientation in System of Care: Engaging in Authentic and Open Discussions
https://theinstitute.adobeconnect.com/p8zobgongcx/

> *Part 5: Learning Exchange Series* – Moving Towards Cultural and Linguistic Competence: From Knowing to Doing.

In addition, Tip Sheets developed from these webinars and other resources are available at the CLC Library http://cfs.cbcs.usf.edu/projects-research/CLChub_resourcelib.cfm

Health Beliefs

> https://theinstitute.adobeconnect.com/p8n9ostw7te/

Language Access

> https://theinstitute.adobeconnect.com/p25o8mpd82t/

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