# Rhode Island Behavioral Health System of Care Foundational Component #1 Detailed Plan: Ensuring Equity

The Ensuring Equity Work Group identified eleven equity categories for which they created goals. Each goal has specific objectives, which the Work Group color coded throughout the document.

We have not included Outcome Metrics or Data Sources here, but will include them when the final activities for the Goal are chosen.

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| **GOAL 1: Ensuring Equity For Children And Youth Across Races and Ethnicities** |
| **Objective 1.1: Destigmatize mental health within communities of color and address the historical injustices of criminalization of behavioral health disorders** |
| **Objective 1.2: Address racism and teach principles of equity to healthcare providers within the children's behavioral health system of care** |
| **Objective 1.3: Engage the immigrant community in behavioral health planning conversations** |
| **Objective 1.4: Work to change the inequities among Autism Spectrum Disorder populations** |
| **Objective 1.5: Increase the diversity of the provider population** |

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| **SYSTEM DESCRIPTION—FOR EXISTING STRENGTHS AND EVIDENCE-BASED OPPORTUNITIES –** |
| The right to access quality health care for all populations regardless of the individual's race, ethnicity, gender, socioeconomic status, sexual orientation, or geographical location. This includes access to prevention, treatment, and recovery services for mental and substance use disorders. In conjunction with quality services, this involves addressing social determinants, such as employment and housing stability, insurance status, proximity to services, culturally responsive care – all of which have an impact on behavioral health outcomes.<br><br>Up to 80 percent of our health is determined outside the doctor's office and inside our homes, schools, jobs, and communities – the places where people are born, grow, live, work, play, age, and pray. Conditions in these places – called the social, economic, and environmental determinants of health – have a greater influence on health than other factors, like genetics, individual choices, or access to healthcare. They are shaped by forces like structural racism, poverty, and the distribution of money, power, and resources at the global, national, and local levels.<br><br>Racial inequities persist in every system across our country, from healthcare to education, criminal justice, housing, and the economy. These inequities can't be explained by differences in socioeconomic status. Rather, they result from powerful forces in our systems and institutions. To improve health outcomes for everyone we serve, public health must make advancing racial equity a core part of its mission. Other Forms of Marginalization and Oppression include: Ageism; Classism and Colonialism; Sexism, Heterosexism, and Transphobia; Ableism; Saneism; and Sizeism.<br><br>**In fact, the health of a community is directly connected to its economic and educational ecosystem. And the disparities in health are due to structural racism and other inequities. Below are unfortunate examples that this still exists today:**<br><br>1. **Link between economic inequities and self-reported poor behavioral health:**<br>There are multiple factors that can increase or decrease risk of a mental health or substance use disorder, but according to a 2018 article in the journal *Nature,* there is a significant body of evidence linking "…social and economic inequality and poor mental health. There is a social gradient in mental health, and higher levels of income inequality are linked to higher prevalence of mental illness." 2018. The authors present a raft of growing evidence connecting "…economic inequality and poor mental health (Friedli, 2009; Pickett and Wilkinson, 2010; Platt et al., 2017). Experience of socioeconomic disadvantage, including unemployment, low income, poverty, debt and poor housing, is consistently associated with poorer mental health (Silva et al., 2016; Elliott, 2016; Platt et al., 2017; Friedli, 2009, Rogers and Pilgrim, 2010). Mental health problems are particularly prominent amongst marginalised groups experiencing social exclusion, discrimination and trauma, leading to compound vulnerability (Rafferty et al., 2015). Greater inequality within societies is associated with greater prevalence of mental illness (Wilkinson and Pickett, 2009; Pickett and Wilkinson, 2010), and economic |

recessions have had devastating impacts on population mental health (Platt et al., 2017; Wahlbeck and McDaid, 2012)."

2. **Links between structural racism, the economy, and behavioral health:**
Given the economic inequities as a result of race, Black, Indigenous, and People of Color (BIPOC) will be found in the groups at economic disadvantage to an analysis of Bureau of Labor Statistics Data by the Institute for Policy Studies Inequality.org project, Racial discrimination in many forms, including in education, hiring, and pay practices, contributes to persistent earnings gaps. As of the last quarter of 2020, the median White worker made 27 percent more than the typical Black worker and around 36 percent more than the median Latinx worker." And according to Rhode Island Kids Count, in 2019 Rhode Island's unemployment rate among White workers was 3.3%, compared to 4.6% for Black workers and 6.1% for Hispanic workers. Nationally, the unemployment rate for White workers in 2019 was 3.3%, compared to 6.1% for Black workers and 4.3% for Hispanic workers.

3. **LGBTQ+ Communities and Mental Health:[i]**
According to Mental Health America, in 2018 "4.5% of the U.S. Population identifies as lesbian, gay, bisexual. or transgender and of those, over 39% reported having a mental health illness in the past year." (Note, 2021 data show that LGBT identification rose to 5.6% of the U.S. population.)[ii]

Mental Health America also noted: "LGBTQ+ teens are six times more likely to experience symptoms of depression than non-LGBTQ+ identifying teens. LGBTQ+ youth are more than twice as likely to feel suicidal and over four times as likely to attempt suicide compared to heterosexual youth. And forty-eight percent of transgender adults report that they have considered suicide in the last year, compared to 4 percent of the overall US population. Regarding access to treatment, approximately 8 percent of LGBTQ+ individuals and nearly 27 percent of transgender individuals report being denied needed health care outright. In mental health care, stigma, lack of cultural sensitivity, and unconscious and conscious reluctance to address sexuality may hamper effectiveness of care. And evidence suggests that implicit preferences for heterosexual people versus lesbian and gay people are pervasive among heterosexual health care providers."

4. **People with Disabilities and Mental Health:**
According to the Centers for Disease Control and Prevention (CDC), 61 million people in the U.S. (or 26%) live with a disability. One in three adults with a disability do not have a usual healthcare providers and one in three adults also have an unmet healthcare need because of cost in the past year.[iii] In addition, the CDC reports that, "An estimated 17.4 million (32.9%) adults with disabilities experience frequent mental distress, defined as 14 or more reported mentally unhealthy days in the past 30 days. Frequent mental distress is associated with adverse health behaviors, increased health services utilization, mental disorders, chronic diseases, and functional limitations."[iv]

5. **Rhode Islanders with frequent mental distress and income:**
Specifically, America's Health Rankings reports that Rhode Islanders with Frequent Mental Distress (Percentage of adults who reported their mental health was not good 14 or more days in the past 30 days) was 7.2% for those making $75,000 a year or more, down to 14.5% for those making between $25,00 and $49,999 and 24.7% for those making less than $25,000.

6. **Inequities from COVID-19 have lasting impact:**
Finally, the impact of COVID on child poverty has been severe. According to Rhode Island Kids Count, since the onset of the COVID-19 pandemic, Rhode Island's unemployment rate has surged higher than the worst levels in the Great Recession, and revenue is expected to decline dramatically in FY 2021. Loss of employment in low-income households is expected to impact economic mobility and have devastating long-lasting effects on children in poverty. Black and Hispanic households are projected to face the greatest increase in poverty, and racial and ethnic disparities may be exacerbated if people of color face greater employment disadvantages. The impact of COVID includes the stress of the enforced isolation and economic upheaval, the grief that so

many Rhode Islanders feel upon losing loved ones, the way that the pandemic made evident and worsened structural racism, and the impact that it had on our overdose crisis.

These systems issues are more acute for communities of color, for whom **historical inequities and ongoing structural racism** have deprived them of equitable capital (recovery, financial, social), trust in institutions, and access to equitable services. As such, maintaining a focus on equity throughout the re-design of our children's behavioral health system of care in Rhode Island is critical.

**MAJOR ACTIVITIES AND PRIMARY AUDIENCE:**

**Potential Activities for Objective 1.1 (Target Audience = All)**
- Reducing the stigma and focusing on the benefits of utilizing behavioral healthcare.
- Marketing campaign explaining to people the importance of investing in behavioral healthcare.
- Develop a sense of community within the community

**Potential Activities for Objective 1.2 (Target Audience = Community/Patient Advocates)**
- Advisory boards from the community, patient advocates, and other diverse boards.
- What do people do? →What do they want? →Will it lead to them investing their time to get better?

**Potential Activities for Objective 1.3 (Target Audience = All)**
- Make members of the community stakeholders
- Offer school-based mental health services in different languages

**Potential Activities for Objective 1.4 (Target Audience = All)**
- https://autismpdc.fpg.unc.edu/evidence-based-practices

**Potential Activities for Objective 1.5 (Target Audience = All)**
- Create a pipeline from institutions to mental health organizations
- Hire members that resemble the community

**EQUITY CATEGORY:** This section lays out all of the different equity categories described in this detailed section of the plan. In subsequent categories, we list just the category for that section rather than this whole list.

**1: Race and Ethnicity**
2: Language Spoken
3: Sexual Orientation and Gender Identity
4: Ability Diverse
5: Culture and Beliefs
6: Socioeconomic and Environmental Determinants of Health
7: Geographical Location
8: Life Course Approach
9: Criminal Justice Involvement
10: Foster Care and/or Adoption Status

**BARRIERS AND CHALLENGES:** These Barriers and Challenges apply to the entire document.
- Stigma
- Lack of focus on social determinants
- Institutional and structural racism
- Lack of education and awareness
- Data collection gaps and limitations
- Need for culturally-sensitive integrated care practices

**TIMELINE CONSIDERATIONS:** See objectives for all timeline considerations for the entire document.

See objectives for all timeline considerations.

| RECOMMENDED ALIGNMENTS – These are relevant for all Equity objectives. |
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| • CLAS Standards for Behavioral Healthcare<br>• Race Equity Toolkit |

| GOAL 2: ENSURING EQUITY FOR CHILDREN AND YOUTH ACROSS LANGUAGES SPOKEN |
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| **Objective 2.1: Ensure engagement of the Commission for the Deaf and Hard of Hearing community as it relates to behavioral health planning**<br><br>**Objective 2.2: Increase the linguistic diversity of the provider population**<br><br>**Objective 2.3: Ask and document patients' preferred language within behavioral health records and ensure access to appropriate translation services**<br><br>**Objective 2.4: Implement Cultural and Linguistically Appropriate Services (CLAS) standards and assessments for providers**<br><br>**Objective 2.5: Avoid jargon terms and acronyms.** |

| MAJOR ACTIVITIES AND PRIMARY AUDIENCE: |
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| **Potential Activities for Objective 2.1 (Target Audience = All)**<br>• Provide certified and qualified medical & mental health interpreters to assist with behavior health planning.<br>• Ensuring providers understand the deaf community and culture.<br>• Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area. (Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.<br>• Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.<br><br>**Potential Activities for Objective 2.2 (Target Audience = All)**<br>• Expand recruiting initiatives. Be intentional about casting a wide net when recruiting. Although education requirements are a standard part of any job description, competitive companies are beginning to loosen the baseline requirements around college degrees. To recruiters who are focused on recruiting candidates with college experience: don't just focus on elite universities, make sure to include historically black colleges and universities, Hispanic-serving institutions, women's colleges, and public and community colleges.<br><br>**Potential Activities for Objective 2.3 (Target Audience = All)**<br>• Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.<br><br>**Potential Activities for Objective 2.4 (Target Audience = All)**<br>• https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/CLAS-Toolkit-12-7-16.pdf<br><br>**Potential Activities for Objective 2.5 (Target Audience = All)**<br>• Understand the population being served and meeting them where they're at. |

| EQUITY CATEGORY: |
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| 2: Language Spoken |

| GOAL 3: ENSURING EQUITY FOR CHILDREN AND YOUTH ACROSS SEXUAL ORIENTATION AND GENDER IDENTITIES |
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**Objective 3.1:** Ensure that 90% of pediatric healthcare, behavioral health, disability services, and mental health agencies meet the "Community Standards of Practice for the Provision of Quality Health Care Services to Lesbian, Gay, Bisexual, and Transgender Clients" a set of recommendations created by the LGBT Health Access Project, part of the Massachusetts Department of Public Health, and supported by the American Medical Association.
(**https://www.ama-assn.org/delivering-care/population-care/creating-lgbtq-friendly-practice; http://www.glbthealth.org/documents/SOP.pdf**)

**Objective 3.2:** Ensure that 90% of providers are trained on and follow evidence-based practices in health care for transgender and non-conforming people.
(**https://www.lambdalegal.org/sites/default/files/publications/downloads/fs_20160525_transgender-affirming-hospital-policies.pdf; https://www.lgbtqiahealtheducation.org/wp-content/uploads/2016/12/Affirmative-Care-for-Transgender-and-Gender-Non-conforming-People-Best-Practices-for-Front-line-Health-Care-Staff.pdf**)

**Objective 3.3:** Ensure that 90% of behavioral, mental health, disability services, and pediatric healthcare providers are effectively able to navigate and normalize conversations about diverse sexual and gender identities and expressions, including minors' rights to confidential gender and sexuality health care services without parent/ guardian consent.
**https://www.lambdalegal.org/sites/default/files/publications/downloads/fs_20160525_transgender-affirming-hospital-policies.pdf; https://www.lgbtqiahealtheducation.org/wp-content/uploads/2016/12/Affirmative-Care-for-Transgender-and-Gender-Non-conforming-People-Best-Practices-for-Front-line-Health-Care-Staff.pdf**)

**MAJOR ACTIVITIES AND PRIMARY AUDIENCE:**

- Ensure the provision of safe spaces within institutions, especially in health care provider offices
- Ensure that providers are trained and use trans-affirming practices to include:
  - Using patients preferred/correct pronouns and understand that intentionally not doing so is psychological abuse and directly harms patients
  - Not using the phrases "his or her" or "he or she" in a sentence. E.g., The child will take his or her checklist to the teacher.
  - Not dividing people into binary sex or gender groups. E.g., "Boys put on the blue shirts and girls put on the pink shirts" (binary view of sex) or "Males to the right and females to the left" (binary view of gender).
  - Not gendering colors, objects, activities, etc.
  - Include LGBT+ health related signage and materials in the office/department
  - Understanding families of choice
  - Using terms like partner or spouse rather than girl/boyfriend or husband/wife
  - Understanding the difference between the diagnosis Gender Dysphoria and that LGBT+ identities are not mental illnesses.
  - Recognizing family of choice
  - Recognizing when one's beliefs interferes with appropriate provision of care
- Assist behavioral health clinicians in navigating and normalizing gender expression conversations with youth and families

**Potential Activities for Objective 3.1 (Target Audience = All)**
- Host a mandatory training on SOGI affirming healthcare at agencies, hospitals, and health care offices using evidence based practices
(**https://www.lambdalegal.org/sites/default/files/publications/downloads/fs_20160525_transgender-affirming-hospital-policies.pdf; https://www.lgbtqiahealtheducation.org/wp-content/uploads/2016/12/Affirmative-Care-for-Transgender-and-Gender-Non-conforming-People-Best-Practices-for-Front-line-Health-Care-Staff.pdf**)
- Hold a discussion afterwards around how to improve the environment of your organization, distribute information on SOGI evidence-based practices, and discuss implementation of the best practices.
- Encourage staff to post the Best Practices Sheet near their work-station.
- Include LGBT+ health related signage and materials in the office/department

- Use a climate survey to assess the effectiveness of these interventions and how they can be improved.

**Potential Activities for Objective 3.2** (Target Audience = All)
- Include an evidence-based practices for SOGI in orientation packets for new hires. Provide a brief verbal introduction to the document and why it is included.
- Host a mandatory training on SOGI affirming healthcare at agencies, hospitals, and health care offices using evidence based practices (https://www.lambdalegal.org/sites/default/files/publications/downloads/fs_20160525_transgender-affirming-hospital-policies.pdf; https://www.lgbtqiahealtheducation.org/wp-content/uploads/2016/12/Affirmative-Care-for-Transgender-and-Gender-Non-conforming-People-Best-Practices-for-Front-line-Health-Care-Staff.pdf)
- Hold a discussion afterwards around how to improve the environment of your organization, distribute information on SOGI evidence-based practices, and discuss how you will implement the best practices.
- Encourage staff to post the Best Practices Sheet near their work-station.
- Use a climate survey to assess the effectiveness of the interventions and how they can be improved.

**Potential Activities for Objective 3.3** (Target Audience = All)
- Create an evidenced based workshop for providers educating them on how to have SOGI diversity conversations with youth and families and having them practice in role play scenarios to help them get comfortable.
- Incorporate the use of pre- post- surveys to determine if the workshop was effective and how it can be improved.

**EQUITY CATEGORY:**

3: Sexual Orientation and Gender Identity

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**GOAL 4:  ENSURING EQUITY FOR CHILDREN AND YOUTH ACROSS DIVERSE ABILITIES**

**Objective 4.1:** Educate the public and ensure that 90% of providers understand intellectual and developmental disabilities using a social model and incorporated with mental health, and apply this disability lens to all access, services, advocacy, and engagement conversations about behavioral health. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7918274/; https://www.independentliving.org/docs2/daa3.pdf; https://www.resourcesforintegratedcare.com/concepts/disability-competent-care ; https://fndusa.org/wp-content/uploads/2015/05/Approaches-to-Training-Healthcare-Providers.pdf)

**Objective 4.2:** Ensure that virtual services are still accessible to people and communities who need them.

**Objective 4.3:** Incorporate Universal Design for Learning models in 90% of educational environments.

**MAJOR ACTIVITIES AND PRIMARY AUDIENCE:**
- Provide more education statewide to the public and providers on understanding individuals with intellectual and developmental disabilities
- Ensure that when in a virtual environment, services are still accessible to various populations
- Apply a disability lens to all access, services, advocacy, and engagement conversations about behavioral health
- Develop methods to recruit (or train?) more interdisciplinary providers that understand both disability affairs and mental health
- Incorporate a Universal Design for Learning which incorporates a flexible variety of modalities to allow individuals across language and cognitive abilities to understand and demonstrate their knowledge.

**Potential Activities for Objective 4.1** (Target Audience = All)

- Public
    - Develop awareness weeks or days; public awards to communities for access to transport, education, employment, housing, leisure, etc.; public readings/signings of statements, concerts/plays/exhibitions of pictures, poems, art, music, etc. by disabled people about their lives; Training days that promote integration at parents' group meetings; advertising/leaflets that inform people of local progress; Conferences for health and education professionals; Integrated sports events; Meetings between mainstream school or college governing bodies and the governors of special schools and colleges to discuss integration and ways of reducing segregation, including the employment of disabled teachers. https://www.independentliving.org/docs2/daa3.pdf;
- Providers
    - Develop a mandatory training for all providers that incorporates the Biopsychosocial Model and the Disability Competent Care Model of care and discuss how you will implement the practices in the training. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7918274/; https://www.resourcesforintegratedcare.com/concepts/disability-competent-care ; https://fndusa.org/wp-content/uploads/2015/05/Approaches-to-Training-Healthcare-Providers.pdf)
    - Assessment for effectiveness of the training and areas for improvement. EBP desired outcomes: (https://fndusa.org/wp-content/uploads/2015/05/Approaches-to-Training-Healthcare-Providers.pdf)
        - Be familiar with disabling conditions and their associated / secondary medical conditions
        - Acknowledge "narrow margins of health"
        - Be familiar with assistive technology (including augmentative communication devices) and associated prescriptions
        - Recognize the patient as an important source of information
        - Understand legal and consent issues when patients have cognitive disabilities
        - Be aware of appropriate and preferred language (e.g., "person first")
        - Understand alternative positioning needs during physical examinations
        - Recognize accessibility issues in the clinical environment
        - Be familiar with social service and health care financing systems and issues
        - Understand the complex interplay between disability and health
        - Acknowledge interdisciplinary team approaches to address the complex interplay between disability and health
        - Accept that some people with disabilities might approach the encounter with mistrust because of previous negative experiences with health care providers
        - Recognize sexuality and reproductive health of people with disabilities
        - Recognize one's own attitudes toward persons with disabilities, including one's own cultural influences
        - Support partnerships with patients and respect their autonomy (e.g., avoid "infantilization")
        - Appreciate the importance that persons with disabilities place on preserving function and maintaining their lifestyles
    - Two Surgeon General reports (2002, 2005), one Institute of Medicine Report (2007), the National Council on Disability Report (2009), and the WHO World Report on Disability (2011) recommended several key actions to improve the health of people with disabilities:
        - 1. Improve public recognition that people with disabilities can live long, healthy and productive lives and reduce stigma and discrimination;
        - 2. Improve knowledge, skills and attitudes of health care providers to improve care;
        - 3. Improve accessibility of health care, including insurance, facilities, equipment, transportation;
        - 4. Improve opportunities for health promotion, safety and wellbeing;
        - 5. Improve data on disability populations, and research on disability-related health disparities and interventions.

## Potential Activities for Objective 4.2 (Target Audience = All)

- https://www.ama-assn.org/practice-management/digital/adopting-telehealth-your-physician-practice-follow-playbook

**Potential Activities for Objective 4.3 (Target Audience = All)**
- https://www.learntechlib.org/primary/p/181969/
- Universal Design with Culturally responsive teaching hyperlink

**EQUITY CATEGORY:**

4: Ability

**GOAL 5: ENSURING EQUITY FOR CHILDREN AND YOUTH ACROSS VARIOUS CULTURES AND BELIEFS**

**Objective 5.1: Hold community focus groups to understand what behavioral health means to various population groups and their cultural norms/preferences**

**Objective 5.2: Engage the youth voice in planning, education, and communications activities through student associations and parent groups**

**Objective 5.3: Develop cultural competencies for providers in behavioral healthcare that underscore cultural norms of diverse populations, address both explicit and implicit biases, and include holistic approaches**

**Objective 5.4: Honor patient choice, as much as possible, when determining facility or home-based services**

**Objective 5.5: Create partnerships with non-traditional behavioral health support systems, such as places of worship**

**Objective 5.6: Develop a culturally responsive lens universally within clinical assessments**

**Objective 5.7: Develop methods to recruit more culturally diverse providers**

**MAJOR ACTIVITIES AND PRIMARY AUDIENCE:**

**Potential Activities for Objective 5.1 (Target Audience = All)**
- Coordinate with members in the community to hold focus groups
- Build a rapport with the community by being present and reachable

**Potential Activities for Objective 5.2 (Target Audience = All)**
- Working with schools to identify youth looking to get involved
- https://www.childwelfare.gov/topics/systemwide/youth/engagingyouth/

**Potential Activities for Objective 5.3 (Target Audience = All)**
- https://www.nsvrc.org/sites/default/files/2017-06/cultural-competence-guide.pdf

**Potential Activities for Objective 5.4 (Target Audience = All)**
- https://www.reliasmedia.com/articles/142787-facility-leakage-and-the-delicate-matter-of-patient-choice

**Potential Activities for Objective 5.5 (Target Audience = All)**
- https://nccc.georgetown.edu/documents/faith.pdf

**Potential Activities for Objective 5.6 (Target Audience = All)**
- https://www.ncbi.nlm.nih.gov/books/NBK248423/
- Ask questions if unsure oppose to assuming

**Potential Activities for Objective 5.7 (Target Audience = All)**

- Improve culture from the ground up. Create or improve your company mission and vision to reflect your organization's dedication to diversity, equity, and inclusion.
- Understand unconscious bias. Remove unconscious bias from sabotaging the recruiting and interviewing process. A company might create a plan for improving diversity and inclusion, but if it doesn't address implicit biases, it won't make much of an impact. These types of biases include affinity, confirmation, effective heuristic, halo effect, groupthink, and perception bias.
- Create a diversity, equity, and inclusion committee. This committee should include the participation of the CEO and executive team leadership to help oversee and approve the creation and management of comprehensive DEI initiatives. Even though the presence of C-level and upper management is crucial, they should not have complete veto power. It's also worth noting that any committee that engages all employees will inevitably result in new perspectives and unexplored avenues of thought and consideration.
- Implement diversity-driven recruiting technology. Of course, technology alone won't fix diversity problems, but it can certainly help. Businesses, HR professionals, recruiters, and hiring managers can use diversity recruiting software to design recruiting initiatives that drive diversity and inclusion. Each tool provides a unique variety of features that help remove unconscious bias during the recruiting and interviewing process.
  - Use job description management software to create unbiased job descriptions; optimize job ads so that they reach the most candidates.
  - Rely on diversity technology to redact personal candidate information from resumes (name, age, ethnicity, university name); removing these details help recruiters focus on what really matters.
  - Post on job boards that promote minority and underrepresented talent (i.e. people of color, candidates over a certain age, veterans, etc.).

| EQUITY CATEGORY: |
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| 5: Culture and Beliefs |

| GOAL 6: ENSURING EQUITY FOR CHILDREN AND YOUTH ACROSS SOCIOECONOMIC STATUS AND ENVIRONMENTAL DETERMINANTS |
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| **Objective 6.1:** Ensure people in communities of color gain increased access to affordable, quality healthcare, including behavioral healthcare services.<br><br>**Objective 6.2:** Engage in the prevention of adverse childhood experiences and their effects through parental supports, social connectedness, and efforts more globally<br><br>**Objective 6.3:** Reduce stigma about receiving services and increase protective factors teaching children's awareness.<br><br>**Objective 6.4:** Ensure safe spaces in health care offices for immigrants |
| **MAJOR ACTIVITIES AND PRIMARY AUDIENCE:** |
| - Ensure communities of color gain increased access to affordable, quality healthcare, including behavioral healthcare services. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5027758/; https://www.ama-assn.org/delivering-care/population-care/7-ways-improve-black-health-mind-and-body<br>- Engage in the prevention of adverse childhood experiences and their effects through parental supports, social connectedness, and efforts more globally<br>- Reduce stigma about receiving services (like seeing the school nurse for meds, having a TA, going to resources class, etc.) and increase protective factors teaching children's awareness.<br>- Engage with more non-traditional partners to reach children by building relationships with community organizations, especially those that work with youth of color and LGBT+ youth.<br>- Ensure safe spaces in health care centers for immigrants |

- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5027758/:
  - Mobile clinics that target hard-to-reach populations such as the homeless and the uninsured and have behavioral health screening, outreach, and brief interventions would enable confidential, language-specific treatment that eliminated some of the stigma associated with clinic-based treatment (for alternative treatment models, see Appendix 3). Mobile clinics reduce the numbers of emergency department visits and save money. Challenges to this approach include the limited space in mobile vans for confidential discussions and regular treatment visits.
  - Using mobile technology can help patients who are not proficient in English conduct confidential self-assessments of symptoms and that can refer them to linguistically compatible clinicians. Linguistically and culturally appropriate technology that utilizes culturally normative concepts, imagery, and recommendations could increase awareness of symptoms and available providers for diverse racial/ethnic groups.
  - To provide direct language-matched treatment even when geographic distance might preclude face-to-face sessions, we recommend telephone- and video-based treatments (see Appendix 3). Such treatments—including assessments, care management, referral services, medication consultation and management, and therapy—facilitate care continuity and scheduling flexibility. Paying for these services would require a change for most insurers.
  - Integrate behavioral health services into programs that provide housing, employment, or other social services, such as Housing First and Recovery College (see Appendix 3). Low-income patients are more likely to adhere to behavioral interventions when these are combined with community resources that attend to basic social needs.
  - Widespread social marketing and culturally relevant campaigns developed with input from minority groups are needed to promote access to behavioral health care. Such strategies can address issues of stigma and mistrust. Examples include Minnesota's "Make It OK" and "El Silencio Duele" campaigns, which destigmatize treatment and encourage minorities to seek behavioral health care. SAMHSA has disseminated multifaceted strategies that combine social marketing with community outreach to inform racial/ethnic minorities about their insurance eligibility and enrollment. We recommend that these strategies be used not only to provide general information but also to offer information on locally accessible treatment options such as behavioral health screening, multilingual services, or mobile interventions.
  - We recommend that health care providers collect data on patient preferences in terms of behavioral health care needs, treatment options, and barriers to care. We also suggest that providers use this information to inform administrators of reimbursement programs and state policy-makers about the needs of minority behavioral health consumers. This would help Medicaid agencies and state minority health offices to collaborate in creating behavioral health services that address the preferences of minority patients.
  - We recommend that patient activation interventions—such as those that were part of the Effectiveness of DECIDE In Patient-Provider Communication Therapeutic Alliance, and the Care Continuation trial (see Appendix 6)—and decision aids in multiple languages (that is, tools to improve decision quality and personalize health care options) be built into Medicaid contracts with integrated provider organizations. Examples of decision aids include the Agency for Healthcare Research and Quality's Effective Health Care Program, the Ottawa Hospital Research Institute's Patient Decision Aids, and the Shared Decision-Making National Resource Center's Depression Medication Choice tool.
  - Expanded use of patient and family advisory boards, which are already required in federally qualified health centers and hospital systems, may also help increase the engagement of minority patients. We recommend that boards with a diverse membership of patients and community advocates provide feedback on disparities reduction initiatives, suggest ways for staff to recognize minority patient concerns, and help design strategies to reach new behavioral health care consumers.
  - Payers should hold provider groups financially accountable for addressing disparities. The Centers for Medicare and Medicaid Services (CMS) currently requires health care organizations to address ethnic/racial disparities when they draft quality improvement goals. However, in the case of accountable care organizations, only one quality measure required by CMS relates to behavioral health.

- We recommend that CMS as well as Medicaid payers expand disparities reduction initiatives while concurrently expanding the use of behavioral health quality measures that can be stratified by racial/ethnic groups. CMS reimbursements should be contingent upon providers' demonstrating acceptable levels of racial/ethnic minority engagement by reporting the demographic breakdown of patients who began and continued treatment, and through a similar breakdown of outcomes and patient satisfaction measures organized by patient demographics. This approach would help integrated care organizations become vehicles for disparities reduction and could prevent them from avoiding at-risk or low-income patients, practices that would exacerbate disparities.[53]
- We recommend adapting these practices to the target communities through partnerships among researchers, clinicians, and community leaders. Adapting evidence-based practices requires familiarity with the target population and an understanding of the opportunities and barriers to behavioral health service engagement in that population. These partnerships are also vital to the sustainability of behavioral interventions. Indeed, engaging community agencies in planning the delivery of behavioral health interventions is more predictive of positive health outcomes than is providing evidence-based practices at the individual program level alone.[54] The primary challenges in these collaborations are finding available funding and staff time to develop and sustain the partnerships.
- We also recommend expanding the behavioral health care workforce to treat patients newly eligible for Medicaid. In part, this can be done by providing behavioral health training to some of the more than 120,000 community health workers now employed in clinics and community-based organizations (see Appendix 3).[11] (Community health workers are lay public health workers who often come from the communities they serve and are more typically trained in physical instead of behavioral health services.) Equipping them to provide quality assessments and behavioral health care would require rigorous training and supervision by experienced behavioral health professionals. Minimizing turnover among community health workers would involve careful hiring practices, ongoing support, rewards for optimal performance, and efforts to foster a sense of empowerment.
- Ensuring appropriate training and supervision could be accomplished through implementation of comprehensive certification standards. Currently, qualifications for community health worker training and certification vary across states, with only seventeen states having any certification standards, training programs, or Medicaid payment provisions for community health workers.
- New federal and state funding to support behavioral health service employers and community partners will also be needed. An effective model with greater fidelity to evidence-based practices can be found in a multistate implementation of Assertive Community Treatment in which state health authorities provided financial support, quality monitoring, technical assistance, and human resource support to implementing agencies.

## Potential Activities for Objective 6.2

- Examples of Evidence-Based ACEs Primary Prevention Strategies: https://www.astho.org/ASTHOBriefs/Adverse-Childhood-Experiences-Primary-Prevention/
  - Early Head Start Programs - Early Head Start (EHS) is a program focusing on child development and parent education. A recent longitudinal study examined the long-term benefits of EHS on child maltreatment and short-term child, parent, and family outcomes that are linked to child maltreatment. The study found that participating in EHS led to a long-term reduction in the number of children involved in the child welfare system. Family outcomes include an increase in parental emotional response, lower levels of parental stress, and less family conflict. EHS is currently federally funded to serve a small percentage of families. Broadening the criteria of EHS could be beneficial to addressing CAN at the population level.
  - Dual Generational Approaches to Address the Needs of Children and Their Caretakers - Dual generational approaches focus on creating opportunities and addressing the needs of both children and their caretakers. Two examples include substance misuse treatment with a parenting component and rooming-in for newborns with neonatal abstinence syndrome (NAS). A systematic review of the outcomes of dual treatment for substance misuse and parenting found an overall positive outcome for dual treatment programs compared to programs without a parenting component. Rooming-in, the practice of keeping the newborn with the mother after birth, is associated with immediate and long-

term health benefits for both the mother and newborn, and is an emerging promising practice to address NAS.

- o Strengthening Economic Supports for Families - Economic supports for families are key to helping lift working families out of poverty and reducing parental stress, which are risk factors for CAN. Two promising practices include enhancing the state and federal Earned Income Tax Credit (EITC) and increasing the minimum wage. The EITC raises more than 6 million people—half of them children—above the poverty line each year. Economic support from EITC is associated with favorable socioeconomic effects, such as improved school performance for children. Regarding minimum wage, a study found that increases in the federal baseline minimum wage of $7.25 per hour led to a decline in overall child maltreatment reports for states. In the study's analysis, a $1 increase in the minimum wage led to a statistically significant 9.6 percent decline in child neglect reports.

- CDC recommendations for Preventing ACES: https://www.cdc.gov/violenceprevention/pdf/preventingACES.pdf
- Creating gigh-capacity community networks reduces ACEs: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3483862/
- Recommend pediatricians screen parents for ACEs as well: https://acestoohigh.com/2014/07/29/to-prevent-childhood-trauma-pediatricians-screen-children-and-their-parentsand-sometimes-just-parents/
- Multigenerational trauma and ACES - https://www.centerforchildcounseling.org/aces-and-intergenerational-trauma/

**Potential Activities for Objective 6.3 (Target Audience = All)**

- https://pediatrics.aappublications.org/content/145/6/e20190780 Eliminating stigma of Differences Curriculum for Schools

**Potential Activities for Objective 6.4**

- https://aapcho.org/wp-content/uploads/2017/09/Creating-a-Safe-Space-at-your-Health-Center_091817.pdf

| EQUITY CATEGORY: |
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| 6: Socioeconomic and Environmental Determinants of Health |

| **GOAL 7: ENSURING EQUITY FOR CHILDREN AND YOUTH ACROSS GEOGRAPHIC LOCATIONS** |
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| **Objective 7.1:** Meet youth where they are for engagement in the System of Care Planning and Implementation. |

| MAJOR ACTIVITIES AND PRIMARY AUDIENCE: |
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| <ul><li>Work to ensure care is provided at a time and place that is convenient and in close proximity for individuals who need care but may have other barriers to be considered</li><li>Develop mechanisms for the coordination of care for those children who receive services or residential care out of state</li><li>Provide behavioral health services within the community (e.g., schools)</li><li>Understand where those who need services but are not getting them frequently—may not be a doctor's office at all</li><li>Develop community-based health care navigators that can support families, meet people where they are at, and reflect diversity as assets.</li></ul> |

| EQUITY CATEGORY: |
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| 7: Geographical Location |

| GOAL 8: ENSURING EQUITY FOR CHILDREN AND YOUTH ACROSS THE LIFE COURSE |
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Objective 8.1 Ensure families are provided care as a unit, as applicable

Objective 8.2 Ensure transitions of care as folks age, grow, change, and develop over time (youth to adult, prenatal and pregnancy, etc.), Incorporate the trauma-related needs of veterans into behavioral health promotion and service delivery, and Ensure that youth transitioning into adult care have access to behavioral health services

Objective 8.3 Develop a system of Parent Partners who have lived experiences with children who can help other parents

Objective 8.4 - Develop a comprehensive system to support families with substance exposed newborns, Universal screenings for pregnant women for both illicit and prescription drug use,

In addition: Apply considerations for multigenerational trauma or connectedness (ACEs work**) (addressed in objective 6.2)**

| MAJOR ACTIVITIES AND PRIMARY AUDIENCE: |
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**Potential Activities for Objective 8.1**
- https://journalofethics.ama-assn.org/article/evidence-based-design-structuring-patient-and-family-centered-icu-care/2016-01
- https://journalofethics.ama-assn.org/article/creating-value-patient-and-family-centered-care-methodology-and-practice-what-trainees-need-know-why/2016-01

**Potential Activities for Objective 8.2**
- https://jacksoncountycares.org/wp-content/uploads/2014/02/Transition-to-Adulthood-Program-Models-and-Evidenced-Based-Practice-Summary.pdf
    o also has recommendations related to criminal justice involvement and foster care, and incorporating families and communities into care.
- https://ohioemploymentfirst.org/up_doc/evidence_based_practices_for_transition_youth_-_accessible.pdf
    o focused on preparing youth for employment and adult life tasks including accessing community resources.
- https://mackcenter.berkeley.edu/sites/default/files/chi-2016-05-06/CHI/TOC-CHI-114.pdf
    o "San Mateo County's model helps transition older youth to become self-sufficient adults through a focus on job skills, career development, educational planning, life skills, and independent living. By utilizing the evidence-based practices of mentoring and case management in the areas of education and employment services, and incorporating a subsidized employment program to meet regulations for youth to continue to remain in foster care until 21 years old, we can continue to support and foster connections for youth.
- https://www.hospitalmedicine.org/clinical-topics/care-transitions/
    o Hospital transitions of care emphasizing the importance of a "patient-centered" approach, incorporating input and engagement from patients and their families/caregivers about the care transition process and providing recommendations for pediatric hospitals and minority-serving institutions.
- https://transitionalcare.org/home/
    o Bridge model reduces patient readmission and focuses on psychological, community, and social determinants of health.
- https://www.healthystartepic.org/resources/evidence-based-practices/
    o List of evidence-based programs for before, during, and after pregnancy, for mothers and infants up to two years
- https://www.cdc.gov/mmwr/volumes/69/wr/mm6934a2.htm
    o Transitional care for adolescents with mental illnesses
- https://policylab.chop.edu/sites/default/files/pdf/publications/Transitions_Of_Care.pdf

- o  Transitional care for adolescents with intellectual and developmental disabilities
- https://humanim.org/what-we-do/youth-services/mental-health/
  - o  Transition care program for youth up to 25.
- Service-connected children in our state have some programs but there are many gaps. Challenges are that children move a lot and have difficulty with socialization as a result, having a parent or both who are deployed, having to grieve the loss of a parent at a young age (any age), and children and families with a loved one who is struggling with a service-connected disability might need support in addition to caregiver support.

## Potential Activities for Objective 8.3 (Target Audience = all)

- https://ripin.org/about/ - RIPIN is a 501(c)(3), charitable, nonprofit organization established in 1991 by a passionate group of parents of children with special needs. These parents recognized that together they could provide support through sharing essential information and helping to find the resources they needed for their loved ones. This peer model continues to be at the heart of our work and has lead RIPIN's network to expand statewide. Today we have over 100 employees, most of whom have personal experience caring for a loved one with special health care or educational needs.
  - o  Can broaden and add to it

## Potential Activities for Objective 8.4

- https://www.firstthingsfirst.org/2020/04/helping-home-visitors-serve-substance-exposed-newborns-and-their-families/
  - o  Home visitation system in Arizona - DCS implements a comprehensive Substance Exposed Safe Environment (SENSE) program that provides wrap-around services to ensure newborns who are born substance-exposed are safe and their needs are being met while remaining in the home with their family. These families receive up to five in-home visits per week for the first four months by DCS and service providers…Although home visitation is designed to serve all types of families, these one-on-one visits with trained providers have been shown to be an effective way to support and empower families and children experiencing various high-risk challenges, such as opioid addiction, as well as to support the bonding and relationship between the parents and child.
- https://www.aacc.org/cln/articles/2016/march/as-substance-abuse-rises-hospitals-drug-test-mothers-newborns - Ohio's implementation of Universal Drug Screening
  - o  "American Congress of Obstetrics and Gynecology recommends universal drug screening during prenatal care using a validated screening tool, such as the widely used 4P'sPlus." The tool uses five questions to determine risk for substance abuse during pregnancy. A urine drug test is recommended, with patient consent, if the screen points to drug abuse…it is important that there be appropriate consent processes in place, as well as confirmatory results,' explained Young. The American Academy of Pediatrics also advocates a similar position".
  - o  In Cincinnati's universal screening program, participating hospitals encourage mothers to consent to testing. If mothers do not consent, their babies are tested instead. When possible, pregnant women identified with substance abuse problems are referred to addiction services. Opioid-exposed newborns may need longer stays in the hospital, especially if they are suffering from withdrawal and need pharmacologic care. Cincinnati hospitals use urine immunoassays for initial screening, followed by mass spectrometry to validate results
- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6120972/
  - o  Screening Pregnant Women and Their Neonates for Illicit Drug Use: Consideration of the Integrated Technical, Medical, Ethical, Legal, and Social Issues. – Concern about a pregnant women's drug use which, "cannot be treated as a medical issue and becomes increasingly politicized, legalized and stigmatized in these pregnant women and for their children", resulting in negative healthcare outcomes for the mother and baby.

| EQUITY CATEGORY: |
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| 8: Life Course Approach |

| GOAL 9: ENSURING EQUITY FOR CHILDREN AND YOUTH ACROSS LEVELS OF INVOLVEMENT WITH JUVENILE JUSTICE |
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| **Objective 9.1: Work to reduce bias against people youth and family members with a criminal background – Not letting the behavior define the person** |
| **Objective 9.2: Develop a juvenile hearing board or court system that considers trauma and mental health** |
| **Objective 9.3: Ensure that providers are training on and use affirmative language surrounding criminal justice involvement** |
| **Objective 9.4: Work to reduce inappropriate criminalization of behaviors and social groups by ensuring that providers understand and are self-aware of racial, ethnic, sex/gender, religious and other biases in the labeling of behavior as criminal.** |
| **MAJOR ACTIVITIES AND PRIMARY AUDIENCE:** |
| **Potential Activities for Objective 9.1 (Target Audience = ?)**<br>• Focus on seeing people as individuals. Rather than focusing on stereotypes to define people, spend time considering them on a more personal, individual level.<br>• Work on consciously changing your stereotypes. If you do recognize that your response to a person might be rooted in biases or stereotypes, try to consciously adjust your response.<br>• Take time to pause and reflect. To reduce reflexive reactions, take time to reflect on potential biases and replace them with positive examples of the stereotyped group.<br>• Adjust your perspective. Try seeing things from another person's point of view. How would you respond if you were in the same position? What factors might contribute to how a person acts in a particular setting or situation?<br>• Increase your exposure. Spend more time with people of different racial backgrounds. Learn about their culture by attending community events or exhibits.<br><br>**Potential Activities for Objective 9.2**<br>• Look into other states that have implemented juvenile hearing board or court system<br>    ▪ https://www.texasattorneygeneral.gov/sites/default/files/files/divisions/juvenile-justice/JuvenileJusticeHandbook.pdf<br>• https://www.nap.edu/read/14685/chapter/5<br><br>**Activities for Objective 9.3 (Target Audience = All)**<br>• Policymakers, researchers, program managers, healthcare providers, criminal justice professionals, and custodial service commissioners should engage people who are currently or formerly incarcerated –and ask them about the language they prefer using to identify themselves.<br>• https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6240232/table/Tab1/?report=objectonly<br><br>**Potential Activities for Objective 9.3 (Target Audience = All)**<br>• https://www.unodc.org/documents/justice-and-prison-reform/18-02303_ebook.pdf |
| **EQUITY CATEGORY:** |
| 9: Criminal Justice Involvement |

| GOAL 10: ENSURING EQUITY FOR CHILDREN AND YOUTH ACROSS FOSTER CARE OR ADOPTION STATUS |
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| **Objective 10.1: -** Outline equity gaps in foster care/adoption that lead to loss of relationships, identity struggles, loss of culture/history, guilt for not feeling exclusively grateful, etc. |
| **Objective 10.2: -** Create education training support for caregivers that will equip then with resources to support children. |

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| **Objective 10.3:** Recruiting and retaining foster families of color. |
| **MAJOR ACTIVITIES AND PRIMARY AUDIENCE:** |
| **Potential Activities for Objective 10.1 (Target Audience = ?)** <br> • Child–Parent Psychotherapy (CPP): CPP is designed for children ages birth to 6. The treatment focuses on decreasing traumatic stress responses, learning difficulties, and relationship problems in infants and young children by improving the quality of parent–child relationships. <br><br> **Potential Activities for Objective 10.2 (Target Audience = ?)** <br> • Support for caregivers (adoptive parents, foster parents): training, education, etc. related to all the various types of foster/adoption – domestic, international, same race, interracial, kinship care – with a trauma-informed lens to navigating the child's experience and gaining an understanding of the psychological and physiological impacts of adoption and foster care. (This may look like courses provided by adoption agencies/DCYF? Additions to the vetting process?) <br> • Support for children: 1:1 therapy, family therapy/intervention, support/peer groups, etc. (this may occur in connection with the education sector… how to incorporate something like this into schools?) <br> • Educating the public: advocacy, campaigns, community interaction <br><br> **Potential Activities for Objective 10.3 (Target Audience = All)** <br> • Developing a website, to provide information to prospective foster parents about the children in need of care, as well as to provide realistic information about foster parenting. <br> • Hire program coordinators to lead community-based recruitment teams. <br> • Assign staff specifically to seek out family members and fictive kin who would be able and willing to foster. <br> • Work with private organizations like churches and other faith-based organizations, businesses, and universities. <br> • Developing culturally responsive practices. |
| **EQUITY CATEGORY:** |
| 10: Foster Care and/or Adoption Status |

[i] Mental Health America, Inc. "LGBTQ+ Communities and Mental Health." Mental Health America, 2021, https://www.mhanational.org/issues/lgbtq-communities-and-mental-health.

[ii] Jones, Jeffrey M. "LGBT Identification Rises to 5.6% in Latest U.S. Estimate." Gallup.com, Gallup, 13 Aug. 2021, https://news.gallup.com/poll/329708/lgbt-identification-rises-latest-estimate.aspx.

[iii] CDC. "Disability Impacts All of Us Infographic." Centers for Disease Control and Prevention, 16 Sept. 2020, https://www.cdc.gov/ncbddd/disabilityandhealth/infographic-disability-impacts-all.html.

[iv] CDC. "Many Adults with Disabilities Report Frequent Mental Distress." Centers for Disease Control and Prevention, 10 Sept. 2020, https://www.cdc.gov/ncbddd/disabilityandhealth/features/adults-with-disabilities-mental-distress.html.