WEBINAR VIDEO TRANSCRIPT

Minority Fellowship Program

Health Disparities Overview Webinar, Part 1

Disparities in Mental Health and Addiction Services

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GRETCHEN VAUGHN: Greetings, everyone. My name is Gretchen Vaughn. And I'd like to welcome you to Part 1 of the Disparities in Mental Health and Addiction Service's Health Disparities Overview Webinar. This webinar is brought to you by SAMHSA, the SAMHSA Minority Fellowship Program Coordinator Center.

We'd like to draw your attention to this disclaimer. The views, opinions, and content expressed in this presentation do not necessarily reflect the views, opinions, or policies of the Center for Mental Health Services, the Substance Abuse and Mental Health Services Administration SAMHSA, or the US Department of Health and Human Services.

So this is the third part of our MFP Curriculum Series which provides a broad overview of cultural competency and health disparities. Today, Dr. Alegria Greer and Dr. Chapa will present Part 1 of the Health Disparities Overview. And they'll return with us again next week to present Part 2 on August 7.

We are so pleased to welcome again today's presenters Dr. Margarita Alegria and Dr. Teresa Chapa, both distinguished experts in this field. Margarita Alegria, PhD is the Chief of Disparities Research Unit at Massachusetts General Hospital and a professor in the Department of Medicine and Psychiatry at Harvard Medical School. Her research generates knowledge to increase equity in health outcomes and health care services delivery for diverse racial and ethnic populations. Dr. Alegria obtained her BA in psychology from Georgetown University in 1978 and her PhD from Temple University in 1989.

We also have Teresa Chapa, PhD, MPA who is the Regional Vice President of the Southern California Fred Finch Youth Centers, a nonprofit social science organization dedicated to serving a diverse community of children, youth, and families experiencing a range of mental health, substance use, trauma, and developmental disabilities. She is responsible for leadership, development and oversight of clinical programs and policy. Dr. Chapa is a subject matter expert, author, and lifelong advocate for the mental health and wellness health equity and eliminating health and behavioral health disparities as well as promoting integrated behavioral health, cultural and linguistic competence, and workforce development. And she is recognized for excellence also in public service.

Dr. Alegria will be joining us from the East Coast and Dr. Chapa from the West Coast. The floor is yours. Thank you for coming.

MARGARITA ALEGRIA: Thank you, everyone, for being here. Both Teresa and myself are thrilled to have you today. We really hope you enjoy this presentation and sharing with you some of the work we have been doing or also the work of others that really serves to showcase the problem we have in this country on disparities in behavioral health.

I think we're going to be talking today about so many things. I think the first thing I wanted to cover is that this is a tragic event that we really perceived with disparities. But I think what is so optimistic is that we can change this narrative. As Martin Luther King said, of all the forms of inequity, injustice in health care is the most shocking and inhumane. Because you think all of us to be invested in reducing disparities.

But the fact that today, even today, 85% of patients that have private insurance can get an appointment in comparison to only 58% of Medicaid patients shows us that these inequities are as palpable as when Dr. King was alive. I think that there are several things we want to talk in the introduction, really discuss today why, after decades of disparity research, these disparities in mental health care and substance abuse persist. We want to talk about health care reform and how it can and hopefully can make a change in the expansion of improved access. But we still have not achieved that.

We want to talk about disparities reduction initiatives. Because one of the things we are worried about is some of these initiatives at federal, state, and local level don't really consider who the patient is and how the population that needs services has changed dramatically over the last two decades. In this agenda, Teresa and I are hoping to talk to you about defining mental health service disparities for the underserved.

We're really looking at what are the numbers that we see. We want to talk about findings from key national reports and research looking at those reports. We want to touch upon the social determinants and how they're really so central in terms of mental health and addiction services, and also discuss what is the evidence.

We will talk about cultural competence, cultural humility, and the importance of responsiveness. We would do a brief discussion of certain practices and policies that we think are important for reducing disparities. And then we want to talk to you, presenting several frameworks about how we should think about reducing mental health disparities.

I think one of the most important things in this presentation is that partly when we talk about health care disparities, it's those differences in access to or availability of facilities and services. And you will see that these health care disparities differ from health disparities.

So one is differences in determinants of health that have to do with either social economic or environmental disadvantage. Because I think one of the things that we have changed

dramatically over the last years is the importance of determinants of health that indirectly affect health disparities, but are not necessarily the only mechanisms of disparities.

And then I think the other thing is health equity. I think more and more, there is an emphasis on making sure that everyone has the same opportunities to maintain their mental health and their well being. And that it's not only to try to think about service delivery, but what other areas we have to impact to make sure that people have the same opportunities for health.

For example, issues of poverty, discrimination, and racism have been really important in characterizing a decrease in mental health and increase in substance abuse. So that's important to take into account when we think about health equity.

I want to start with this very basic model. Because this model is quite important in trying to talk about what is acceptable differences in services. And those acceptable differences, if you look at this slide and this figure, are those that have to do with differences because one group has higher clinical need than another, because it's more appropriate to do this type of intervention with certain groups than others, and patient preferences. If people, certain groups, want for example more pharmacological treatments and others want less, that would be included under patient preferences.

But there's a lot of differences that are unacceptable, differences that have to do with the health care system and legal implications. A good example of this might be issues that we're seeing with immigrant populations that could not access our health care system. The same would be for regulatory or system differences that have to do with, for example, insurance or income or geography. Those are unacceptable differences that are not differences. They become part of the disparity. So insurance, income, geography, all of those are unacceptable mechanisms for which to show a disparity.

And then there's very important differences that are due to how we operate in the system, how we as active players in the system show bias, stereotyping, and uncertainty, and how that can lead to differences between minority and non-minority groups in terms of their health service delivery. One of the things that I think we have learned in doing a lot of the epidemiological work on mental health disparities has been that actually it's really interesting that we don't see differences with regards to mental health in terms of ethnic, racial minorities.

In fact, when you aggregate people of color, almost all groups have increased mental health as compared to white population. Where we see the biggest difference in terms of mental health disparities is in the persistence of the mental health conditions. So we see, for example, higher mortality, worse outcomes due to poor mental health when compared to white populations. But we'd actually, if you look at the prevalence of mental health conditions, actually populations of color do better than white populations.

However, in terms of when you need care, there is a lot of evidence of unequal access. There's a lot of evidence that this varies not only by race and ethnicity, but it also varies by sexual

identity. We know LGBT populations have less access. We know that age really matters. For example, we see a huge drop in access for people that are in the 20, 25 age group.

We see that people with disability have less access to actual services. And obviously, you're going to see a lot of data that we're going to present on poverty and geographic location as having differences in terms of behavioral health disparities with rural populations having less and poorer populations having worse access and worse quality.

I think overall, people have defined disparities not only as disparities in ethnicity and race, but disparities that affect people that have systematically experienced greater obstacles. And these are people that are either marginalized or people that are displaced or people that have less status or power in our systems.

I do want us to cover, make sure that we cover the importance of this disparity definition. Because one, I hear a lot of people talking about insurance as being an acceptable mechanism of disparity or really thinking about preference as being a problem in disparities. So we really need to make sure that we create a framework for understanding, what are the disparities, in which groups do we see service disparities, where are the possible interventions. And then that we do interventions that try to reduce disparities, increase equity, and that design approaches that are really measurable and have metrics to see, are we really eliminating disparities.

I think one of the areas that has been somewhat difficult is finding interventions that actually reduce disparities, showing how you're increasing health services for some populations to make sure that they're at an affordable level.

TERESA CHAPA: Yes. This is Teresa. Thank you. Maggie just reviewed the most common definitions on disparities, kind of giving us that overview and a little bit of a taste of a framework, and why having a common language is not only useful but important. Likewise, understanding the populations most impacted by disparities is essential in developing that framework in order for us to conduct meaningful research and interventions.

So let's start with what we look like today in the US and in the near future. We'll be looking at a series of slides that show us that. We're looking here to see a tremendous growth in the population overall. But mostly, we see that the non-Hispanic white population remains the largest, even though there is a projection of a decline and falling birthrates. So we see the other end of it, that racial and ethnic minority populations continue to grow and becoming more than 50% of the total population.

So racial and ethnic minority populations continue to grow and will outgrow the non-Hispanic white population, particularly over the next four decades. This growth includes immigrants as well as birth rates. And in fact, we will be coming to a majority-minority population. We already are there in five states. And in the next slide, I'll go over it in a sec.

But as you see here, this gives you a good idea of what Maggie was saying earlier about our population. You see the non-Hispanic white is 61%. And then the rest that are considered minority, racial and ethnic minority populations, at about 40% but really growing.

Let's consider who those folks are. They're refugees from certain countries as the Dominican Republic, Congo, Syria, Burma, kind of contrary to what you hear on the news, because we don't hear much about those populations. Also the black immigrant population has increased fivefold. Look at the numbers from 1980 to 2016, from in the 800,000s to 4.2 million.

And this is a 2016 and a 2018 and a 2017 figure. So we're continuously looking at this growth. And also, recognizing that the Asian-American population grew quite a bit, 72%, in just a 15-year period, and the fastest growth rate of any other major racial or ethnic group.

So here, it's a bit of what we just saw. But I wanted to tell you that as of 2016, the majority-minority population states include Hawaii—which never had a white majority population—New Mexico, California, Texas, and Nevada. And that the District of Columbia reached a majority black status during the later stages of the Great Migration. And that Great Migration period was between 1916 and 1970s. Just to give people a flavor of who we really are today but what we might look like also tomorrow.

And here is a little bit of what Maggie was talking about. Because we will be talking about health insurance in our populations. But this slide or this graph shows us that ethnic and racial minorities continue to be disproportionately impacted by health and mental health disparities in the insurance capacity. So this shows the differences. If you take a good look, you'll see that minority populations are underinsured, overall. Although we do have private insurance with some of the populations to work, the government programs or Medicaid and Medicare are much lower.

So in conclusion, it's really important for us to know our numbers and their underpinnings that will help us understand how to come to a better plan to reduce and ultimately eliminate health and mental health disparities. We both think that it's extremely important for you to understand the health care system, but also some of the elements surrounding racial and ethnic minority populations' lives. And we will be touching upon that a little bit later, and also looking at how we're growing.

Every year, our numbers and what impact will that have for us to be able to address some of these questions since, in fact, we do have the more persistent conditions and the worse outcomes and the higher mortality rates. And also, what we could do to create our programs and policies that are more culturally responsive, collaborative, integrative, patient centered to be able to understand better those patient preferences. Maggie.

MARGARITA ALEGRIA: Yes. I wanted to touch upon the changing narrative that we have now. This is an opportunity for people to decide enough's enough. We need to have system change. We can't have a system, health care system and behavioral health care system, that's stagnant

to the changing lives of people, especially people of color. That is really different, the lives that we have today, the work schedules that we have, the limited opportunities to go to health care I think are really central in thinking, how can we change the system.

It's true that health care reform and the Mental Health Parity Act really we're trying to make sure that people not only got access but got parity in mental health and substance abuse health care. But that's really, although it has improved access and quality, it has not done it for everyone. Definitely there is an increase in people in terms of access to behavioral care. But the benefit has not trickled to everyone. So I think this is where we have to think about the policies, initiatives, and programs to be really thinking about that growing population of people of color.

Like Teresa was showing, the Asian population growing 72%. But yet, if you look at the investment that National Institute of Health has done in sort of doing interventions for not only Asians, but Pacific Islanders, for our American tribes, none of that. It's such a small tiny percentage that we really are not really changing the needle in terms of making sure we have the programs and innovative models that can treat and offer services to those populations.

I think one of the things we have learned from a lot of the evidence that has come is, for example, the importance to monitor progress. There was a report that I was part of that actually was on 2009 that actually looked at the importance of collecting race, ethnicity, language data. This report, one of the most important findings it had, for example, is that if you look at the evidence in terms of treatment outcomes, it showed that for people to be able to be treated in English, they needed to speak the language very well. So even well was not enough to get good outcomes in care. This means that for a lot of people, we have to make sure that we can treat them in their primary language.

We also saw in that report how we have to try to get granular data about where people are born. Because when we aggregate some types into big, big categories, we're actually masking where disparities take place, especially for behavioral health. So for example, blacks born in the US seem to show different patterns than Caribbean blacks. So we would want to really make those distinctions to make sure that we address and target our interventions differently and customize to the differences in the populations of color.

I think there has also been a lot of disparities reports. I invite you to look at all of these reports that have been produced, really talking about how there is a quality chasm, how there is a need to focus on culture, race, and ethnicity in terms of treatment, how there's unequal treatment that really reduces the opportunities for so many people to alleviate poverty, for people to have good consequences in treatment.

And so here, we need to be thinking, why have these reports not led to the outcomes that we expected. We need to do a concerted effort to not only get these reports off the ground, but to really take a leadership position. And you, as providers and people working on the ground, can really make a difference in making sure that we enact policies and programs to reduce disparities and increase equity.

I think one of the biggest problems we have, and this has been shown, is part of the disparities problem is a quality problem. Some of the data that you will see and I'll present in a little while shows that we have an access problem. But we do have a really serious problem in terms of quality of care and what people are actually getting.

And part of the problem in quality performance measures has to do that we are really not asking accountability for what should be minimum adequate care. What should people be getting that really is at least acceptable behavioral health care, both in mental health and substance abuse. And then we should stratify this quality measure by race and ethnicity and socioeconomic position to really see who's really not getting the necessary services and quality of care that they deserve.

I want to say that in terms of thinking about disparities, like I said, we have to really distinguish between acceptable and unacceptable sources of difference. And this requires for us to think both normative in terms of what we should be expecting as good outcome and then statistical principles to make sure that, one, we could tie causality for adverse health inequities to these service system.

It means that we need to do a really good job in being able to quantify both responsibility and causality for the health inequities. And that's where we are short. Sometimes some of our research is not as causal to show that, yes, this is really leading to disparities in health outcomes.

I think what really has happened, however, is that we're seeing such horrible tragedies in terms of who gets health care, and who gets it early, and who gets it late, delayed treatment. For example, I think the public health crisis that we're confronting with the opioid epidemic has been one of the things showing us how so many people are dying today of opiate-related drug overdoses. 130 million people really die from opioid-related overdoses. This is the estimate that we have.

But part of what we have seen, and it's a really important point to make in terms of the area, people have said, well, this started as a white people epidemic. We are seeing that now it's an epidemic that is covering everyone. And people are dying from opioid overdoses partly in poor areas that have disadvantaged conditions, that have limited investment in substance abuse treatment. So this is where we need to make sure that we try to move resources to where the needs are.

So I wanted to ask the group if people could do a quick poll. And I want to see where do you think we are in terms of disparities in mental health and substance use services for the poor. Have disparities worsened? Have disparities stayed the same? Have they improved? Or you have no idea of the trend. And I would love to see how you vote and give you the outcomes of what people think. Can people please vote?

So I think 70% of people think that they worsened. 11% think that they stayed the same. 11% think they've improved. And 7% have no idea. And the right answer is the worsened. You will see some data that we will present. And it's actually, they have dramatically worsened for poor populations, even with everything we have talked about.

So there is a great report that the National Health Care Quality and Disparities Report that's done by AHRQ. And one of the things that we find in that report is there is definitely a movement towards better care. There is a movement to smarter spending and to healthier people. But unfortunately, disparities in that report have not really improved as much as we expected.

The access has improved for 43% of the measures. But for 14% of the measures, it's actually worsening. And let me show you that, in this report, what's really troubling is that although access improved for the aggregate population in 43% of the measures, you actually see that disparities is an area where we have not been so successful. And you'll see that this is especially for the poor and uninsured populations in all priority areas.

Let me show you the next slide. So as you see here in this slide, these are access measures. And it's comparing the results from 2015 to the results of 2017. And it's asking whether selected groups have experienced better, same, or worse access to care compared with that reference group of 2015. And for 20 indicators of access, we see that for 18 they're worse and for two they are the same.

If you look at black and white, it's only better for one indicator of access. But actually it's 11 are worse. And Latinos versus whites, you see 14 indicators where they're worse. Asians is actually one of the few groups where you see that for seven, there seems to be better access. And for American Indians, they're actually showing worse care or the same care.

I also want to show you that disparities, really in terms if you look at the quality of care for blacks, Hispanics, and Asians compared to whites by state, you can see where the disparities is the lowest in terms of best quality of care. And you can see that, for example, this is the average differences in quality of care for blacks, Hispanics, and Asians compared to whites.

And if you look, for example, I'm from Massachusetts. And Massachusetts has one of the worst disparities although it's one of the places that has the best care. We're actually getting some of the best comments in terms of having excellent quality of care. Yes, we have some of the worst disparities in terms of the care blacks, Hispanics, Asians receive compared to whites.

If you look, Alaska is one of the places that actually is in the second quartile. That means that Alaska, for example, in terms of worse is right in the middle in terms of disparities. So you can have a place that has low quality but everyone receives low quality. Or you can have a place like Massachusetts where people have good quality, but there's huge disparities in what people of color receive.

This is an example of the quality that I was telling you. And if you look here, Massachusetts is the blue, meaning it has some of the best quality of care. But again, in the previous slide that I showed you, Massachusetts had some of the worst disparities. But here, I can show you that it is one of the places that has the best quality of care.

So one of the things I really want to get through to this group is the importance that not necessarily because a state has good quality, it will have reduced disparities. The other important message by this slide is how where you live really matters in terms of the quality of care that you're going to be able to receive. As I told you before, for example, if you look in Alaska or Arizona or even California, you can see there that that's one of the places that has some of the worst quality of care compared to other places that actually have very good care.

I think the other thing that I wanted to cover with you is the importance of the roadmap for promoting health equity and eliminating disparities. I really, really recommend people get a chance to look at this. Because it's really talking about the importance of identifying and prioritizing at this state. But at the local and neighborhood level, how can we reduce health disparities, particularly behavioral health disparities?

What shall we try to do to identify? Is it make our governments accountable for trying to identify where are the areas that have higher problems of disparities? Second, I think it's the implementation component. How do we make sure that we implement evidence based interventions that can reduce disparities? There's a lot of interventions that are put into place. But there's no evidence that they really reduce disparities, either in access or in equity.

And then, one of the things I have been mentioning over and over is the importance of investing in developing and using equity performance measures to keep people accountable of who's not getting what. And not only who's not getting what, but who's responsible for making sure that people get access and quality behavioral health.

I think lastly, we need to incentivize the reduction of disparities. There's a lot of bonuses that are being put into place. But they're really, many of them, at the system level and are not showing necessarily that they make a big difference in terms of changing the pattern of disparities.

I guess I wanted to end this piece of the first hour talking about the importance that we really need to do better in understanding, reducing, and eliminating behavioral health disparities. We really need to think about what is being done and whether this is sufficient. There has been a lot of development in terms of creating centers and institutes to eliminate health disparities.

There has been a lot of knowledge and awareness that has been generated. There has been a lot of attempts to understand the contributors of disparities and setting goals for achieving health equity. But for some reason, we have not been as successful as we should.

And this is an area we're hoping to open it and hear from the people in the audience, why do they think that we have not done as well as we should in terms of reducing behavioral health disparities. So I'm going to open it to questions. And we're open, both Teresa and myself, for questions about and opinions about why are we where we are in terms of disparities.

And people can write in their chat and give us comments. Because we would love to hear from you. And I don't, Gretchen, if people can read comments people have or opinions people have.

GRETCHEN VAUGHN: Yep. Please type any comments or questions that you have into the chat box. We do have one comment. Someone said, it has a lot to do with issues like racism and discrimination that are swept under the rug.

MARGARITA ALEGRIA: Absolutely. I think the issues of racism and discrimination, all the way from at the institutional level. I think more and more, we are willing to acknowledge that structural racism and discrimination is very rampant in our institutions. I think what hasn't happened is making sure that we make people accountable, that we play a bigger role in civic action and civic leadership to really move the needle in terms of disparities.

But I also think as providers, we also have to reflect on how do we bring that structural racism and institutional problems to our interactions with our patients and our users of services. Because I think we are part of the problem. And although there's a lot of institutional racism, I think that we are part of the problem.

TERESA CHAPA: I agree. This is Teresa. And I was also, just before we go any further, just to corroborate what Maggie is saying and what the comment was all about, if we take a good look at those states that were showing the poorest quality, many of them are the minority-majority states. And so it's going to really take us to look not only at those broad sweeping policies that we have in place, but like as Maggie said, how do we filter that down in our delivery systems and building our workforce and taking patient preferences into consideration.

GRETCHEN VAUGHN: Thanks. We've got a couple more comments and questions coming in. Shelly said, disparities remain because it's wrongly viewed as a niche concern, not a priority for the field of mental health generally.

MARGARITA ALEGRIA: I completely agree that the people from the Mental Health Gap—it's interesting that this is not only a problem of the US, but actually we see this problem across many, many countries. The Mental Health Gap is a group that has been actually energized to try to look at mental health issues across many countries, both developed and middle and low income countries.

And what they found, the number one recommendation they had was changing the will of policymakers to invest in mental health and substance abuse services, that this has not been like the person said, this has been just talk and giving lip service. But really not making it a priority. And a will of these policy makers to really move the needle and invest.

For example, we're cutting on prevention services in the schools for mental health. We are cutting on investing in outreach for populations to make sure that we get people early into behavioral health care. So if you look at the budgets and how those budgets are dwindling in terms of increasing, even with all the opiate epidemic, suicide epidemic, depression epidemic, I mean you would think people would be saying, let's run and try to invest more funds in these resources to make sure that we allocate service. Go ahead, Teresa.

TERESA CHAPA: Yes. I'm in total agreement with you, Maggie, that we shy away and we've pulled away from the front end services. But if we take that all into consideration, just under the umbrella of mental health and substance use services, when we're starting to talk about our racial and ethnic minority populations, it even becomes a smaller amount of service that's brought to those communities and to those families.

So it really is incumbent upon us to push the agenda in the other direction. It's going to take a lot of voices and a lot of effort to switch that and not to become complacent with what we see. Because it's painful. And it's a lot of work.

And a lot of you, and us, have been working in this arena for a long time. And you kind of say, we've had this fair, that, the centers, the institutes, the investments, now what? So I think that's what makes this discussion so vital. Thank you.

GRETCHEN VAUGHN: Thank you. We do have a few more questions. I guess we can take a couple more minutes. Two of them are kind of related. One question from Bernadette was how does the current administration affect these numbers and what can we do individually to impact them. And then Maria asked, did the Affordable Care Act help reduce disparities at all? It sounding like it didn't, which is disheartening. I think they are similar questions about how government impacts these issues.

MARGARITA ALEGRIA: So there is some change going on. I'm going to start with the second one. The Affordable Care Act did improve, for example, access to insurance. So people did have more insurance. It did improve quality of services. The problem is not everyone has benefited equally. So I want to try to distinguish that one of the problems is not everyone has benefited equally from this different—for example, the expansions in Medicaid are one of the things that has shown—Ben Sommers here at Harvard has done a lot of work showing how the Medicaid expansions really have improved care and health care.

The problem that you do have is in behavioral health, there has not been as much investment as you would expect. There is more. But there needs to be way, way more. This is an area where we have not invested.

With regard to the current administration, I wouldn't have the numbers exactly to compare this administration with previous administrations. I have to say, overall, we haven't done a great job in many administrations to really invest in behavioral health. It's just, there have been programs

that have been called upon. But I don't really think we have done our job of putting behavioral health right up as a big priority. I don't know what you think, Teresa.

TERESA CHAPA: Well, I agree with you. But I would say that if we're looking at the Affordable Care Act, we need to keep in mind that the Medicaid expansion benefits did not reach the entire country because many states did not accept them. So that's something that I think we need to look at. What does it look like for those states who did uptake and uptick services through Medicaid expansion versus those that didn't. I think we already know that those states, those populations within those states, show greater numbers of disparities across the board. But so it's important for us to kind of take that look.

As far as this administration, I agree with Maggie. I haven't seen anything new. I haven't seen any new movement. And we are going to be the ones that need to make that happen, regardless of who's sitting in the leadership in Washington. So it's going to really be about the public stepping up.

MARGARITA ALEGRIA: Yeah. And I think the one area that we have seen a change, and I want to mention two things that are important. One that was due to the Affordable Care Act, which had to do with increasing what are essential benefits, and behavioral health, both mental health and substance abuse, were then put under essential benefits. So that was a huge change that we are studying to see whether it had a big impact. But that is something that previously had not happened.

And the same thing for including children until 26 years of age to make sure that they have access to their parent's. And the third one that was really important is pre-existing conditions. So people that have previously, for example, let's say, diagnosis of schizophrenia or a diagnosis of chronic depression had a horrible time getting insurance. So these are three changes that were done as part of the Affordable Care Act.

The change that has been done by this administration, they have put like $500 million in trying to deal with the opioid epidemic. And that is something that I hope they are testing different models. So I think there is now a movement to understanding the importance of behavioral health. But again, I don't think any administration has done enough to raise the issue to the highest level—other people.

GRETCHEN VAUGHN: OK. You have time for a few more? Or do you want to wait for the next question?

MARGARITA ALEGRIA: Yeah. I would love to hear the question.

TERESA CHAPA: Let's do one more.

GRETCHEN VAUGHN: So we have someone saying, although we have many evidence-based interventions that have been shown to be effective with a variety of groups, many of these programs are too expensive or not continuing after the initial research funding runs out.

MARGARITA ALEGRIA: Teresa, do you want to start?

TERESA CHAPA: With evidence-based, we basically, even where I'm at and for my workforce, we select evidence-based methodologies and approaches to work with our consumers, our clients as much as possible. And to make it not just—it's not the money thing. It's really about have those practices been tested and well utilized and show good outcomes with racial and ethnic minority populations, whether it be for trauma or suicide prevention or any particular need at the clinical level. What do you think, Maggie?

MARGARITA ALEGRIA: I actually agree. I very much agree with the person that said that. Because it is true. I think we have generated a lot of evidence on actually treatments that work for behavioral health. I think we have now a real great portfolio of treatments that at least have shown either efficacy or effectiveness. And I think there is also great evidence that these programs seemed to work fairly well for communities of color. So I think that that's very reassuring and optimistic.

I think the biggest problems that we're having is that those programs are not necessarily easily adoptable by states and local governments, partly because there's a lot of other logistical aspects that have to come in play. One is training. Another one is supervision. Another one is making sure that the programs are adapted for the populations and customized for the context of where they are going to be given.

And then I think there's very little investment in really giving people time to make that implementation change. But I think we're moving in the right direction. You hear more and more how people are trying to learn. We are doing a lot of work with community health workers. And we're going to talk about it more.

But I think there are ways of really training people effectively in ways that are not necessarily so costly to governments and especially do some task-shifting to make sure that the programs are not costly. But thanks for that question.

GRETCHEN VAUGHN: We have another comment that says, I'm also aware that many providers, especially in the MFT field, are unaware of the extent of the issues. Medical social work and public health have done much more research than we have in MFT. Have you seen differences between the various disciplines, I guess, in the research that's being done?

MARGARITA ALEGRIA: Teresa?

TERESA CHAPA: Yeah. I haven't seen a lot in MFT either. But they usually do go under the umbrella of mental health provider. So they would actually be able to reap the benefits of the

work that's done in other domains, whether it be psychology or social work, whatever. And typically, they would be a part of those community trainings, organizational trainings, or trainings within their university.

Now, if they need to add that to their curriculum, add some specific categories, that's really a guilt issue. And I would encourage them to be inclusive of this. I think that they really have been a part of delivering the services and talking a lot about quality cultural competence or sensitivity and readiness and humility. So they've been a part of the general discussion, in fact probably including social determinants of health, but the benefits from that being wrapped up a little bit differently.

MARGARITA ALEGRIA: I think there's a lot that could be done to do better training. If you look at a recent paper that was done by Green, he shows even medical students talk about really having problems in managing disparities, and knowing what to do to reduce them, and having difficulty in really getting good training on cultural humility and cultural competence. So I think there's a lot more that could be done, specially things that are interactive that can help people not only learn about it and become aware, but actually integrate it in their own practice.

GRETCHEN VAUGHN: Thank you. Let's go with one more, maybe. Manual asked, what is the role of acculturation for immigrant minorities.

MARGARITA ALEGRIA: Actually this is an area I love to talk about because I am so—this is an area that we're learning so much. And basically the evidence is pretty repetitive that acculturation is mostly when you're defining as people, for example, staying more in the US, acquiring more of the norms, values, and routines typical of the US environments have shown that their mental health decreases.

And when we study the issue of acculturation, we find several things. One of the issues that seems to be, at least in work that we recently are doing, is parent-family relationships start eroding. And we don't really know why. It might be less time, less opportunities, less incentives. But family relationships seem to go down.

We also see that people have a greater exposure to obviously discrimination and violence. And that might be because of residential segregation. We also see differences in terms of how people start thinking about their social position in their communities, that they start thinking less about themselves and their status in their communities. And that this has repercussions in terms of our mental health. How we feel about our place in society definitely has a big impact in our mental health.

GRETCHEN VAUGHN: OK. Thank you. We have more comments and questions. But I will let both of you continue. And we'll try to get to some more of them at the end. So please, go ahead and thank you for those stimulating questions.

TERESA CHAPA: Thank you so much. You know, I said a little bit earlier about racial and ethnic population figures and why they matter. This slide really highlights the actual mental health needs of racial and—some of them—ethnic minorities and immigrants, and examples of potential consequences. And it's so interesting that we just really talked about that in our Q&A.

But children and adults do experience higher rates of trauma, have fewer resources to access care, chronic stressors, as were mentioned earlier. The only exception would be isolation, food insecurity that we haven't really talked about a lot and we don't talk about a lot, socioeconomic disadvantage, what was mentioned earlier, some elements of acculturative stress, and language barriers.

And I wanted to give you an example of some of the work that I've done in the past in meeting families in their own environment and bringing foods. Because they had limited access to food. I was meeting with children and they had basically close to nothing to eat. And bringing in a bag of groceries, I saw all of these people in like a two bedroom apartment.

All of a sudden, I put a bag of groceries on the table and about six people ran out of these respective rooms and grabbed the food. And that's how desperate some of the situations are for people. And I think that clinicians oftentimes were unaware of that, and medical professionals, by the way. And I know that folks are starting to look at these elements. But they are really, really right on the surface.

And being in this situation, in a new environment, also not necessarily even knowing about what services might be available because you might be coming from an environment that you may not have spoken a lot about it or learned a lot about it or don't have a language for it. It's not just a language barrier in the provider and the recipient of care. But it's also not really knowing what's available and how to access it.

And of course, the consequences could be chronic depression, increased anxiety for our immigrant community. We're learning more and more about post-traumatic stress disorder and just trauma itself in the coming to this country, substance use, delinquency, et cetera.

So this gives us another example of how to look at barriers in access to utilization. We talked about it a little bit earlier. This could have gone in the last section. It can go in this section. But it's really about deferred or delayed care. And if we see here, at the different populations, we'll look and see that Latinos in particular—I'll just take it because it's the largest graph—don't see doctors because of cost. They believe or our community believes that cost is a huge barrier.

And then if you look at delayed need of care for reasons other than cost, you'll see that Asian-American Alaskan natives have the higher bar. And so we've got to really—I know there's research on this. But we've got to really see what can be done, particularly when people do have insurance or Medicaid expansion regardless of what kind of insurance, even if it's an FQHC, a Federally Qualified Health Clinic. Whatever it might be, we need to look at this a little deeper because the newest research is showing that oftentimes people just don't know that

they can access care and that it could be a sliding scale or extremely reduced cost or even no copays.

And here I'd like to focus our attention on the utilization of any mental health service or prescription medication by racial and ethnic minorities. And once again, Maggie you did talk about this a little bit earlier, talking about people's preferences. And here we see Asians, blacks, and Hispanics appeared to utilize services far less than their non-Hispanic white counterparts.

So these data, if we look at them carefully, allow us to visually see a difference and begin to hypothesize why there is such a gap. Maggie, did you want to add something to this?

MARGARITA ALEGRIA: Yeah. I mean, I think this is really important in terms of making sure always that we looked at why are we having such low numbers of people receiving care and really trying to—especially mental health service use—one of the patterns we see a lot is that people don't return to care. And that's where we need to find out what is the missed opportunity that we're not getting them to care.

TERESA CHAPA: Right. Thank you. And coming back to care or missing the second or third or just pulling out is such a common phenomenon for mental health services. It's really worthy of taking, as Maggie said, that deeper dive look into it, not just about adherence or engagement but taking a little bit deeper look at what that might be, particularly for our racial and ethnic minority populations that aren't coming to the door to begin with.

So here, once again, we're going to ask you—we're going to start looking at social determinants of health. And we want to ask you what you think. Are social determinants of health like poverty, racism, access to healthy foods risk factors for poor mental health outcomes? Please vote. I made this one a little bit easy for folks. Because we're going to come into a new area of discussion.

And the answer is yes, 100%. We have brilliant people. Thank you. Let's take a look at the next slide because we're going to start moving into this particular discussion. We're going to start looking at what might be contributing to poor health and mental health outcomes and disparities. In this particular section, we see that premature mortality among adults, I'm just going to take that right now—in the US is particularly noteworthy.

And I know, Maggie, you talked about it a little bit before. Aside from poor health behaviors, many individuals never received adequate medical care versus psychiatric care. And this is also an issue in our mental health system and substance use. Because sometimes we see them for their presenting diagnosis when they come in the door. And then they're in the treatment program. And we have failed over time to look at other intersections like even medical care or having an annual health checkup or checking for substance use and abuse.

We also know that many received first and second generation antipsychotics, leaving patients with adverse conditions such as neurological symptoms, tardive dyskinesia, extrapyramidal

symptoms, stiffening of the muscles, and second generation medications that had tremendous metabolic side effects including diabetes, weight gain, and high cholesterol. I'm saying this because it really points to a glaring need for us to look at people from a holistic perspective or an integrated perspective or integrative perspective, whichever way we want to do it.

But we need to come at this with more intersection and also be able to recognize that so much of what we see in our clients are really treatable conditions and we can prevent the early death, we can prevent the chronic disease if we can really address poor diet, lack of exercise, smoking, substance use, and the depression, inadequate access, et cetera.

So although health behaviors have an impact on health outcomes, as we've discussed, health behaviors are smoking, not walking enough, exercise, et cetera. Policies and programs are also important to help shape health factors that determine the outcome.

And here, this graph shows the relationship between health, behavior health, and social determinants. So it's not just are people exercising, are they following a program, are they receiving care, are they getting access to care. But it's also we're learning a lot more about level of education, are people employed, their income, their family and social support network. Community safety is essential, trauma, violence, and air quality, housing, et cetera. So the physical environment, socioeconomic factors, clinical care, and health behaviors.

No wonder so many practitioners feel overwhelmed, because it's a lot to take in when we're looking at a person coming in the door. It's not just presenting complaint of depression or anxiety. It's all of these different factors and elements that we keep in front of us and in the back of our minds. And so here are more examples of social determinants of health and breaking it down so you can see how it contributes to health outcomes.

Once again, you'll see economic stability, neighborhoods, education, food, community, and the health care system. And we've talked more in this particular element about social determinants and its impact with health and health outcomes, but also the health system, which was touched upon pretty clearly. What we also talked about was additional social determinants and comorbidities as risk factors. So we did talk about it in our discussion and a little bit earlier, but let's keep in mind that racism and discrimination has a tremendous impact.

And we'll talk about that a little bit later when we look at suicidality, anxiety, and trauma, trauma and violent crime, but also let's look at who some of our folks are. It could be children in out-of-home placement, foster care, persons with developmental disabilities, substance abuse, abuse disorders, addiction, persistent, and serious mental illness, those individuals that are incarcerated and receiving mental health treatment within jails and prisons, and also looking at health conditions, chronic health conditions, persons who suffer from obesity, diabetes, cardiovascular, hepatitis B, C, sickle cell, HIV, and looking at mental health and how it weaves in together. All of these, it's really our responsibility, I believe, to take a good look at it deeply and see how it can impact our treatment as well as positive mental health outcomes, not just poor mental health outcomes.

Suicide is one of the leading causes of death for older children and adolescents in the US. And although it's rare among young children, the latest findings are showing an increase among black boys, reinforcing the need for better research into racial disparities. I don't know if you're familiar with Jef Bridge's work, but I will refer you to his work.

And some suggestions include prevention efforts that address increased suicide risk, looking at mental illness in particular, anxiety that will significantly increase suicide risk among black teens and adults, acknowledge those social stressors that we've talked about such as racism that could exacerbate the suicide risk, and reduce access to guns everywhere. That could potentially be—I mean, I think we know it leads to—if you have a gun in front of you and you're at risk of suicide, it's not a good combination.

It's important for us to recognize that some barriers to care, they are due to stigma, shame, and fear and that it's critical in seeking care and staying engaged. As professionals, I really think it's important that we work hard to demystify and destigmatize seeking care for health, mental health, substance use, and abuse.

And that means going that extra mile. And I know people on this particular webinar are committed to that, but that's really a great part of what it will take to help people to the table. It's information, it's knowledge, it's early knowledge, it's getting to care early, it's knowing that care is available and that people are available to help you, no matter what your language is, or where you come from, or your racial or ethnic minority status.

We're going to shift a little bit to talk about migrants' health—and I'm going to ask Maggie to chime in as well—and look at barriers and service gaps among migrants that lead to chronic and disabling mental health conditions and addictions. This becomes more complex with migrant populations. And cultural considerations must become part of the treatment plan. So here, we've outlined some of the issues, really what we've learned through the research.

And most recent research over the past five years is really that our migrant populations often have a lack of understanding about mental health and addiction itself. And as I've talked about a little bit earlier, they're often unaware of the services that exist and where to receive them. They most likely have no insurance coverage.

And there are issues of stigma, shame, not understanding what these symptoms that their children might be exhibiting, or they might be exhibiting mean or signify, and, of course, potential language barriers and having a provider that speaks the language good enough that they are fully understood, and cultural considerations in that treatment, who would you bring in, who do they want, who they might have seen.

In the Mexican culture, and in many Latino cultures, and even in Asian cultures, people in the African American culture, people go to a church, or they go to a healer, or they go to a trusted member in the community. And later, you're going to hear about the role of community health workers, or promotores, as being those natural connectors for this particular cultural

consideration. But these are components that are really important for us to consider in serving this community.

So as we've discussed, there are numerous barriers and service gaps to seeking and receiving care. It becomes more complex, as I said before, but let's look at this. Migrants are more likely to experience emotional and physical vulnerabilities. They've left their homes, they've left their families, they've left what's known to them, what's a known social network. And this could cause a lot of instability. It depends. We see a lot of people coming alone or their families are separated. There's been a fracture, and it puts them at risk of possibly substance use or abuse and sexual abuse and risky behaviors.

We also see that there's a tremendous high rate of stress related to fear of deportation for those who don't have legal papers to be here, and it impacts labor and housing conditions. So it could mean that people are sharing places with other people, staying on their couches, staying on a park bench. There's lots going on out there that has to be looked at as a tremendous stressor for these particular individuals, as well as being exposed to increased amounts of drugs, drug use, and disconnection as stated before from the regular normal, everyday social network that they were experiencing.

This is a little bit of the same that we said before, except that, let's say, that migrants are more—and Maggie's talked about this a little bit earlier, but migrants are more likely to develop significant mental health problems. When we looked at Mexican, migrants who came versus those who stayed, they started showing more mental health problems over time. Particularly, those between 18 and 25 seem to have been at the greatest risk of experiencing a depressive disorder, and nearly 4 and 1/2 times greater than their same age peers who didn't migrate.

So it's really important for us to consider, number one, the age of the individual that we're working with, as well as what those special circumstances might have been through the journey to crossing the border. What support networks did they have? Did they have somebody on the other side? Were they able to come to a job right away? Did they fit into a community? Or were they isolated? Were they at loss? Did that connection not—was that connection not made? Are they fearful? So it's important for us to look at all of those components.

So what is cultural competence, responsiveness, and humility? We're dipping into Maggie's expertise. And I'm going to ask you to join me a little bit in this. But actually, the nomenclature is in flux. As you see, people use different words. The Fed uses cultural and linguistic competence. Many providers use cultural humility. And responsiveness is how we behave. But keep in mind that we're in a growth period of looking at this and examining what it means and how we could be effective as practitioners and what term best describes what we do and our competencies.

But overall, it's important for us to realize that we must relate effectively to people, to individuals, to families and communities from various groups and backgrounds. Our services must be tailored and created to be welcoming, to be inclusive, to have members of that

community in the workforce, to have even leadership and include components of the population that might be more attractive for children, families, schools, et cetera.

We have to be sensitive to ways in which persons with disabilities also experience the world and understand what that might look like in the behavioral health system. Whether it be a physical disability, a mental disability, a developmental disability, it's important for us to be able to take that into deep consideration when we're designing an intervention or even how people get into the door or if we meet them at their door or use any part of where they're being served. We must use cultural competence as a guiding principle so that our services are culturally sensitive and that we provide appropriate prevention outreach assessments and interventions within that cultural context. Because at the end of the day, cultural linguistic empathy must be embedded into all aspects of our work.

The National CLAS Standards are a part of a national effort. You'll see here that there are 15 action steps. And it's intended to advance health equity, improve quality, help eliminate health disparities by providing a blueprint. But basically, it was an effort to provide a framework for enhancing cultural and linguistic competence for practitioners and organizations.

CLAS is a way to improve the quality of services provided to all individuals, which will ultimately help reduce health disparities and achieve health equity. It's about respect and responsiveness, respect for the whole person and responsiveness to the individual's health needs and preferences. And I would suggest that everybody take a look at that website. It's with the Office of Minority Health. And that link is provided to you. But it's also at thinkculturalhealth.hhs.gov. If you want to look at their training, health pods, and so forth, that's all available for people.

But when we're talking about our immigrant communities, all of those things matter, but they're in a super high need for receiving information and communication about health, about mental health, about addiction, about alcohol, about all of the elements that would fall into what we called before behavioral health care, and all of the corresponding services, what they are and how to access them. And here are some of those suggestions.

Be familiar with how to relay that information—we, at the clinical level, need to hire and support persons who are bilingual and bicultural to be able to convey that information, collaborate with providers, infuse traditional health and healing practices, and use psycho-education and home visits as a way to increase knowledge and participation and trust. Here are some of the challenges. I can't stress enough the need to acknowledge and ameliorate barriers to care. A part of that is really understanding those social determinants of health and that care providers are increasingly more involved in addressing these issues. But here we are once again.

As a review, limited access to meaningful and quality of care, meaningful care is a place where people are going to get what they need that is in the language that they utilize that has cultural humility and sensitivity and competence, et cetera. And we look at what some of those challenges are—long wait list, little consideration. We'll lose people in that moment. As we said

before, people may come in once and not return. And that first visit is going to be enormously important in relating to the client and educating the person in that door about what the services might be, what might be at hand, and how to effectively address all of these barriers that are presented including stigma.

So this basically gives you tips on how to actually look at building that culturally and linguistically competent workforce and some strategies, build, attract, retain. With what we're doing, we work very closely with our HR in how do we best reach people, when we get people like potential providers, how do we then test them for their bilingual capabilities, how do we then identify and engage individual health care workers early in their studies. Earlier, we talked about MST. How do we incorporate elements of this knowledge of disparities and cultural competence into their curriculum? How can we partner, provide in-language and in-culture internships and supervision? And I don't know if a lot of people have had this opportunity, but it's where you have knowledge of a—maybe you speak Mandarin and you're able to get supervision with somebody who is working with you in Mandarin and be able to touch upon some key cultural elements that would have a positive impact on the intervention that you will be utilizing with potential clients or patients.

But this type of internship and supervision is growing across the country and really needed to help build competencies for our providers and also build and support that diverse and empowered leadership. If we don't have leaders that are from diverse backgrounds contributing to the dialogue, then we don't typically have the dialogue brought to the table until a complaint has come to the table. So we want to be able to consider all of these components when looking at building that cultural and linguistically competent workforce.

As far as building standards for behavior health training programs, once again, start looking at accreditation. We are looking at that a little bit when it comes to community health workers. In particular, I know that our respective fields have components of what is cultural competence, what about credentialing, what about advanced competencies and certification programs, and not just for working within cultural humility and cultural competence, but also with populations with limited English proficiency.

And I think that we want to be able to enhance language as much as culture, because it's just one and the same connected in so many ways. We want to be able to look at standardizing potentially, a national licensure. How can we make it easier for us to be mobile?

At the moment, if Maggie wanted to come and practice in California, she'd have to get a California license. If somebody wanted to go to Mississippi, the same, versus some of the other professions like nursing that may have an interstate compact or an agreement. Now, it's not 100%, but I think it's something worthy of taking a look at when we're looking at such small numbers of racial and ethnic minority providers or those who have cultural and linguistic competence to be able to be more flexible in their work experiences.

And also, as was mentioned earlier, revamp that accreditation process for institutions of higher learning. We must include required coursework. And sometimes, it's not just you have that one class and cultural competence or cultural humility, but that it's become part of so much of our other work. And I know, Maggie, you talked about this a little bit when you were speaking about med students and how they felt when you were maybe talking about a case or a particular individual presenting with an illness, and then incorporating those cultural components into that case study. Would you like to add anything to this?

MARGARITA ALGERIA: Yeah, I think one of the things we're learning more and more is what people are calling the science of engagement, Teresa. And I think I think it's not only really making sure that we implement linguistic standards, but actually that we really are sharing and engaging our populations of color to be willing to engage in care and doing investment, investing today in behavioral health care. It's a huge, huge investment, partly because our communities of color have limited time to spend going to health in general, as you can see from the slides that Teresa showed.

So asking people to make all of those sacrifices to come to care, you really have to be getting something that they think it's worth it. And I'm very worried that we are not customizing the service delivery and the organization of what we're offering in care to make sure that it fulfills what people are coming for. Sometimes, people are so much willing to go to psychics, because they're more responsive to what people want, than sometimes what we have to do as a behavioral health providers.

TERESA CHAPA: Absolutely, absolutely.

MARGARITA ALGERIA: So really making sure that we are more consumer-driven rather than having only our agenda is going to be central.

TERESA CHAPA: Thank you. I'm just showing you some of the reports that have been done in an effort to actually improve and advance best practices. And so I'm just going to move quickly through them and let you know that this was put together a couple of years back, actually led by the Office the Minority Health, but also with the deans and directors of the Schools of Social Work. So I ask people to take a look at that as a means to get the global picture of how to address behavioral health disparities and social work.

And this also is a taste of some of the work that had been done earlier. And although it was developed in 2012, it's a still relevant document with many suggestions for looking at, examining, and eliminating mental health disparities that really came together from individuals from throughout the country and different domains coming together and stating what their primary concerns were, but also avenues to achieve success. And finally, this is just another mental health plan. And although it's coming to 2020, it's almost incredible to think that we're approaching 2020.

But as Maggie said earlier, it's really a world effort to look at mental health and to create action plans. And what I've seen in the WHO's plan really impacts us even here in the US. And it's really about these four main objectives. And it's said this a little bit. But it's leadership and governance and how we're going to invest and provide integrated, comprehensive, and responsive mental health treatment that people feel related to, as was just mentioned, and implementing strategies for promotion and prevention in mental health—so education, giving the signs and signals. Where do you go? What do I do? Just health information, and making it a part of our overall knowledge base and strengthen those information systems and evidence and research for mental health.

It's imperative that we're knowledgeable, that we understand the intersections of mental health, mental illness, social determinants, impacts. Not only do we need to understand that, but what do we do with it? How do we create services that are culturally and linguistically competent, sensitive, and provide appropriate type of prevention outreach assessment and intervention? And what can we learn and implement about approaches to care that are meaningful to our consumers, our populations and communities that we serve? Thank you.

MARGARITA ALGERIA: Yeah, I want to just—we have a few more slides, and then we want to help to open it to people. But I did want to talk about starting with us and where really everything needs to start. And I wanted to emphasize how I think that we cannot change others, but we have to change ourselves. That's the starting point

I think in disparities, one of the things I really thought through—I mean, I did a lot of work on describing disparities and decided I can be blaming and blaming, but if I don't take action, I am as complicit as the people that I complain about. So I think that that really moved me from doing just descriptions of disparities to then deciding no, no, no, I'm going to really try to work on how we can change, how we can change patient provider interactions so that disparities are reduced, how we change clinical care so people are retained in treatment, especially for ethnic, racial, and linguistic minorities. And immigrant populations, how can we serve them in a more equitable and effective way?

I decided we needed to do policy change. So I started writing journals that are written by policy makers. And so I just want to really encourage you to think about yourselves as leaders of action in this disparities reduction scenario, and that we all have to change ourselves if we really want to make a different future.

I guess I wanted to just very briefly talk about our role as provider bias, and particularly because there's a lot of evidence in systematic reviews that have been done that most providers still have a bias in favor of white patients, that we really, even in our small spaces, really take more information, really treat differently our white patients compared to our patients of color. And this is troubling, because that means that we are also part of the problem, as I said before.

I think one of the issues why we're not doing such a great job is that sometimes people think if people are here, that's good enough in terms of health care access. But we know that it's access

and quality that is going to make a difference. So if we really lose those participants or patients, people that are in care in the second or third visit, I always think of that as our failure not the patient's failure. What did we do that we didn't engage that patient? So really, thinking about our role in terms of retention of our patients in behavioral health care, I think it's a way to really monitor and make ourselves accountable.

I think the other thing is, how do we do service planning to make sure that we address patient's preferences? What are the things we could do from that first interview, including making sure that when you do agenda setting for that visit we make sure that we are asking the patient, what is their main goal for that visit, and making sure that we advance that goal in some way? And then I think it's hard for providers that don't have evidence-based practice really readily available to use them, either because they haven't been trained, because the evidence-based interventions have not been translated and adapted to the populations they serve, or because they have no supervision to really know how to do it the best. But even under those conditions, I think there's tons that we could do to make sure that we really connect, particularly connect with our patients.

I think one of the issues also is this issue about making sure we learn of alternative ways of offering services. For example, I think many people live in racially segregated neighborhoods that, because of the lower reimbursement rates of Medicaid, don't have access to good care. And if that's the case and a higher proportion of both African Americans and Latinos are covered by Medicaid or are some way uninsured, we need to look for alternative ways of servicing that population. And some of the things we have done have to do with really trying to see, can we offer some of the behavioral health services through social services so that people get access to behavioral health care?

We also have to think about whether we have the population of providers that looks, talks, and feels like it's someone that's going to understand your circumstances. Right now, we know that, for example, only—if you think about psychology, only 5% of psychologists are Asians, only 4% of psychologists are black psychologists, and only 5% of psychologists are Hispanic psychologists.

So if you think about it, the numbers are dramatically lower. And many people—particularly, we know that, for example, both black and Asian patients, and even Latino patients, prefer to have someone that is concordant in terms of race, ethnicity, if possible. However, it's important to know that outcomes don't seem to matter, but it does seem to matter for retention in care.

I wanted to also talk about that even we have to think about making sure that policy levers that are there to improve health care delivery are really aligned not only to increasing access and increasing quality, but are also aligned with decreasing disparities. And that's an area where we see that some of the policy is geared towards the whole population, but it's not really addressing or targeting communities of color.

And then as I said, I mean, I think there is an incredibly disproportionate shortage of providers in certain communities. And this is an opportunity, because there are funds for professional health shortage areas, so areas that are really where health professionals are still in demand. And it's important to find out if your area is one of them, because there are special funds that have been allocated for training and for actually making sure that you increase the health care providers in those areas. So there might be ways of augmenting the workforce.

TERESA CHAPA: And loan reimbursement. [CHUCKLES]

MARGARITA ALGERIA: Right. Absolutely. I think the issue about what matters to people in care varies so dramatically. I mean, one of the things we have learned in our clinical trials is how important it is to ask people for why they would want to stay in care or come to care, and then what would incentivize them to make that incredible investment and effort to come to sessions, and if there are ways in which we can make their sessions a better investment for them, so talking about how people want care, what's important for them, what are time schedules that work for them.

Can you do tailored counseling? Is there a way where you can really accommodate to their needs? Many, many times neither clinicians nor policy makers really focus on what are people's preference. But I think more and more we're seeing that that's a big, big mistake, because we are losing a big proportion of the population that needs to be treated.

I also wanted to talk about how we need to, ourselves as providers, think about what really people want. Listening is a topic that everyone talks about, really being listened to. But how do you feel your listen might vary by the race, ethnicity, even age and gender of the patient you have in front of you? So I think it's really important that you think about how people want to be listened to. What would be good examples of being listened? When have they had good experiences of being listened? Because what we found in some qualitative work that we did is that, when people talk about being listened, they mean many different things. And we need to make sure that we are listening in a way the patient feels like they really are not only acknowledged, but we're paying attention and making them feel comfortable to self express.

I think the other thing I wanted to say is there are enormous gaps in terms of having interventions that have been tested in many populations of color. Although, the evidence seems to suggest that, at least the ones that have been tested in populations, in communities of color, have been quite successful.

There are two papers by Huey that seem to suggest that the outcomes are not that different. However, I do think customizing interventions to make sure that they work for diverse populations—we currently work on several trials where we are addressing the needs of black, Latino, and Asian populations. And our finding is that we do have to tweak how we provide the same interventions to make it respond to the needs of different groups.

I think there's also evidence that we need to do more in really making sure that we develop interventions for racial and ethnic minority populations, or at least adapt them to make sure that they are culturally tailored to treat this population. It's very hard to improvise if you have not really customized the intervention. And that takes practice and good coaching and supervision.

I want to end with this, the important role of providers, because I think that, as I said, the role of providers is more and more being questioned about how we are still maintaining differences when we see populations that have the same insurance, the same severity, and yet treat them very differently. And trying to see why we're doing those distinctions in care, why are we offering services that are different is something we're trying to understand.

I think that as physicians and providers, we can make a difference in how we operate to make sure that carries equitable, that everyone is getting good, quality care and they feel we respect them and are treating them with the same importance no matter their income, no matter their education, no matter where they're coming from. As leaders in this field and really as the people in the front lines that is doing this care, you are really the ambassadors that can change how we deliver care, that we can really advocate to make changes in laws and regulation, that we can make sure that we are making change within our organization, so that structural racism is taken out, and that we can promote what works to promote strategies and approaches that will likely work for our populations.

And finally, I think we know that there is an institute that has been funded to try to do more of this work. We actually wrote one of the papers, but there is a really nice group of papers that has been funded by the Institute of Minority Health and Health Disparities on new perspectives to advance minority health and health disparities. I really recommend that you do the e-learning program, too, to see what's there and that you are aware of all the potential things that could be done. There are so many resources coming out that are dealing with disparities. But the most important action is for you to take it seriously and tackle eliminating disparities.

We want to thank you for spending the time with us. And we have some minutes to answer questions.

TERESA CHAPA: Thank you so much.

GRETCHEN VAUGHN: Thank you so much, Dr. Alegria and Dr. Chapa. We have probably about five minutes for additional questions. And please know that we will forward questions to our presenters that we didn't get to in the earlier Q&A. And they'll be back next week, so we can perhaps spend a little time if we don't get to it today.

One of the earlier comments was you have spoken to the need to make sure you consider the nuances in populations such as people of African descent born and raised in this country, and those of African descent from the Caribbean. For example, Bridge's work found that the range in black children's suicide attempts or completed suicides in the age range five to 11. Therefore,

the interventions need to be focused on this group. So there were really, as you were saying before, some really particular differences in both ethnic groups as well as age groups.

MARGARITA ALGERIA: Absolutely. I think this is so important that people are now focusing on intersectionality and how, for example, the gender issue is also a very important issue, because not everything will work the same. We're finding that some, for example, cognitive treatments—some of the work that we did on CBT, on cognitive behavioral therapy, some of the things work better with women, but not so well with men.

And so I think this is an area where we have to really try to learn about intersectionality and making sure that we see the intersection not only of race, ethnicity, language, but also issues that have to do with poverty, gender, where you live to take them more seriously. And I'm glad that we should not be aggregating groups. I mean, we talk here about Latinos, Asians, et cetera. But honestly, I'm a big believer in trying to desegregate as much as possible, and then aggregate if you need to explain in bigger terms. But I really think desegregating is important to trying to understand what's similar and what's different.

GRETCHEN VAUGHN: Thank you. Another one of the earlier question was, often there are communities with high access to resources situated right next to, in proximity, to communities where there is minimal access to resources. What are your thoughts on how to integrate resources across county lines so communities aren't so insulated while still allowing communities to have their own independence and treatment tailored to their unique needs?

TERESA CHAPA: I'll take it, if you want. I think that will require some tremendous footwork for us as community leaders or community providers to get out and meet those individuals or those persons from other counties, because my experience is that counties are very possessive with their resources. For example, we have San Diego County, which is huge, and we have Imperial County next door, which is geographically huge but very rural and with much fewer resources.

And even when it comes to doing assessments, some folks—particularly for developmental disorders, some folks from Imperial have reached out or across to those in San Diego County to be able to get those assessments and those services needed. But my experience is that counties they're quite possessive with their budgets. And it's going to require a bigger effort to talk about those things.

The other thing is that sometimes it's not across counties it's within a county. San Diego County has higher income areas and lower income areas and persons who are homeless and persons along the border, people who are binational. It's a very diverse community. So it's really about getting that county to work cohesively as well. So that could be in the next presentation. It's a huge question and something that's really needed. Thank you for bringing that up.

GRETCHEN VAUGHN: Thank you. Let's go to one more question. There is research to suggest that medical providers have more implicit bias than is found in the general population. What are

educational institutions doing about this? Then you have mental health and behavioral health that are also stigmatized in the health care profession. You talked a little about this earlier, but do you want to talk a little bit more.

MARGARITA ALGERIA: Sure. I think they're—I mean, I think actually it's interesting that we're getting more push—I mean, the institutions are getting more push to actually do a better job at training is actually from the younger generation of providers that are going to the field and feeling this is really, really important. And the other push that's coming out—and I see it very distinctively now—is this push of patients saying I dropped from this provider because he really didn't get it, doesn't seem to get me and is either coming with microaggressions or really is presenting the problem from a very different view than the one I have.

So I think more and more providers are becoming pushed to really be coached and trained. I think the institutions are not reacting sufficiently fast. I think, for example, in some of my institutions that I've worked with, they're starting to give some trainings. But I honestly think that it's more superficial. I think we need to do coaching. We did an intervention to try to change the implicit bias component. And we found, yes, we can change this issue with providers, but it's not a one-shot deal. It really requires coaching and it requires coaching for quite a bit of time, at least six times to actually get people to really integrate and understand how they're doing that attribution error, how they're doing things that are going to give a message to the patient that they don't get it.

GRETCHEN VAUGHN: Thank you so much. I think we're going to try to wrap up. We'd just like to thank our presenters for this fabulous presentation on part one and also to our audience for your fabulous comments and questions. So this concludes the webinar. Thank you, Dr. Algeria and Dr. Chapa. And we look forward to hearing from you next week.

TERESA CHAPA: Thank you so much.

MARGARITA ALGERIA: Fantastic. Thank you, everyone.