Prevention Strategies to Address Behavioral Health Disparities

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About Me

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Objectives

- Identify barriers to behavioral health treatment for people of diverse racial/cultural backgrounds
- Define equality, equity, structural racism and disparities
- Understand the impact of historical, cultural, environmental, and structural components on behavioral health services
- Explore current professional practices to identify how to engage individuals equitably
- Learn several evidenced-informed approaches to serve people of diverse racial/cultural backgrounds
So Why Are We Here?

According to SAMHSA (2020):

50% of White Americans do not choose to access or do not have access to behavioral health services

69.4% of Black and Brown Americans do not choose to access or have access to behavioral health services

Only 1 out of 3 African Americans with behavioral health conditions will receive services
Definitions for a Common Language

**Equality**
Each individual/group is given the same resources or opportunities

**Equity**
The condition where one’s racial identity no longer determines how one fares in society

**Structural Racism**
Laws, rules, or policies that support unfair advantage to some and harmful treatment of others based on race

**Disparities**
One group is systematically faring worse than another for reasons not due to their needs, eligibility or preferences
A HISTORICAL PERSPECTIVE TIMELINE ON STRUCTURAL RACISM
IN THE BEHAVIORAL HEALTH SYSTEM

1773
The first Public Hospital of Insane and Disordered Minds in Williamsburg, Va. (accepted enslaved people as payment for mental health treatment of Whites).

1797
Benjamin Rush (Father of Psychiatry) coined the term "negritude" (Blacks have leprosy-like skin disease that can only be cured by turning Blacks into Whites.)

1840
The 1840 US Census created a symbolic oppression between slavery and mental health issues with a category on insane and idiotic.

1844
Association of Medical Superintendents of American Institutions (now called APA) for the Insane begins addressing segregation. Believe in "moral treatment," that patients of higher social status should not feel distress associating with people of lower status.

1845-1849
Dr. J. Marion Sims conducted surgical experiments on un-anesthetized female African American enslaved people and infants, many of whom died during experiments.

1847
The largest Psychiatric hospital, Georgia Lunatic Asylum, documented as operating exclusively by enslaved peoples labor.

1851
Dr. Samuel Cartwright created mental health diagnoses based on the constructs of race (Drapetomania: escaping behavior of enslaved people, treated by whipping); Dyssæthesia Aethiopica: laziness and lack of work ethic among enslaved people, treatment was whipping [should be noted that one of the symptoms was also body lesions)].

1854-1856
Black Codes designed to restrict the freedom of free enslaved people, resulting in arrests and psychiatric hospitalizations

1855
Dr. T.O. Powell documents increase in African American insanity due to freedom.

1862
Emancipation Proclamation liberates enslaved people with the adoption of the 13th Amendment

1870
Godfrey Goffney admitted to Central State Hospital in Virginia for "homicidal mania", cause of illness listed as freedom and threat to "kill every White man."

1870-1970+
Eugenics (sterilization of people unfit to reproduce) disproportionally performed on African American women; In North Carolina over 85% of women legally sterilized were African American.

1911
Negro Insane of Maryland used African American patients to construct its building and housed them on straw.

1932-1947
Tuskegee Study of Untreated Syphilis in the Negro Male Research study failed to disclose or offer curative treatment to participants, resulting in widespread mistrust of the healthcare system among African Americans.

1963
Community Mental Health Centers Construction Act denationalizes the mentally ill. Causes African Americans to get discharged without proper planning and no access to culturally sensitive community-based services.

1964
Civil Rights Act outlaws discrimination based on race, color, religion, sex, and national origin

1965

1967
National Institute of Mental Health funds a study on how psychosurgery (lobotomy) on African Americans could address street violence and political unrest. The research helped recognize that African Americans were being tried as a reaction to systematic oppression. Some surgeries were performed on African American adults and children with mental health conditions.

1981
Omnibus Budget Reconciliation Act displaces funding from federal oversight to state block grants creating a lack of oversight for services, data collection, and outcomes for publicly funded mental health treatment disproportionately impacting African Americans.

1968
Diagnostic and Statistical Manual of Mental Disorders II introduces new criteria for schizophrenia diagnosis that includes language on hostility/aggression, resulting in a 65% increase of diagnosis of schizophrenia in African Americans.

1968
Civil Rights Movement

2021
American Psychiatric Association issues an apology letter to the African American community for acts of racism and its commitment to developing anti-racist policies that promote equity in mental health for all.

By: Dr. Julie Radauer-Doerfler
Racism Shows Up Today

Flexner Report

• 1910- Federal Government closed 5 of 7 HBCU
• In the absence of Structural Racism:
  ○ There would have been 27,773 additional doctors between 1910-2020
  ○ In 2019 alone there would have been 355 Black medical school graduates (29% increase)
• 100% of Black participants reported that they would prefer to work with a Black professional

Sullivan & Suez Mittman (2010)
Video: Equality Vs Equity

https://youtu.be/X0N22PMdF1U
Inequities (Disparities)

Racial Disparities in Mental Health Treatment

31% of white children with mental health problems receive mental health services.

Only 13% of children from diverse racial and ethnic backgrounds with mental health problems receive mental health services.

Source: National Center for Children in Poverty
What are Social Determinants of Health and how do they impact society?
• Socio-economic status, exposure to childhood adversity (ACES), Neighborhood level factors

• Lack of insurance or underinsurance 37% uninsured are Hispanic, 13% Black (KFF, 2021)

• Need for culturally competent providers

• Lack of providers from diverse racial/ethnic backgrounds as less than 2% of mental health providers are Black or Brown. (APA, 2017)

• Distrust of the health care system due to Historical trauma related to research/treatment. (Lindsey, 2010)

• Stigma associated with mental illness -63% of African Americans believe that a mental health condition is a personal sign of weakness. (SAMHSA, 2017)
Behavioral Health and African Americans

• African Americans over-represented in prisons, 60% of the prison population, 37% of drug arrests, but only 14% of drug users (KFF, 2021)

• In 2017 suicide was the second leading cause of death for African American youth (SAMHSA, 2017)

• Rate of mental illness in African Americans same as general population however, disparities exist in quality of care, access to care and access to culturally competent care (SAMHSA, 2017)

• African Americans make up 13% of the population but are overrepresented in high-risk populations (KFF, 2021)
  ◦ 40% homeless population
  ◦ 60% of the prison population
  ◦ 45% of the child welfare population
How Do We Need To Show Up Differently for the People We Work With?
Understanding Bias and Unconscious Bias
The Cultural Iceberg

Easy to see

Language  Folklore
Fine arts  Dress
Holidays and festivals  Literature
Food

Difficult to see

Family roles  Beliefs and assumptions
Core values  Self-concept
Relation to authority
Manners  Biases
Body language
What is Implicit Bias?

- Implicit biases are the product of learned associations and social conditioning.
- They often begin at a young age, and most people are unaware that they hold them. Importantly, these biases do not necessarily align with personal identity.
- It's possible to unconsciously associate positive or negative traits with one’s own race, gender, or background.

Shandra Summerville, CLC Coordinator, Champaign, Illinois
How Do You Refer to These Items?

Remember BIAS is:

Our automatic and un/conscious preferences, that influence our choices and decisions based on our learned experiences.

These are similar but are more societally influenced based on where you may live geographically.

- Water fountain or bubbler?
- Soda or Pop?
- Bratwurst or Brat?
- Ice cream or custard?
- Diabetes or sugar?
- Doctor or Physician?
- Urban or city?
- Neighborhood or hood?

Gina Green-Harris, MBA, Director University of Wisconsin School of Medicine and Public Health, Center for Community Engagement and Health Partnerships
Video: Our Hidden Bias
How it Shows up

https://youtu.be/ZWgVs4qj1ho
Time for Reflection...

- How do you see yourself in this video?
- What role do/did you play?
- What was the most difficult part about watching this video?
- What would you hope was different?
- What biases did you see in this video?
- What would you have done differently if you were in this situation?
A Response to Structural Racism in the Behavioral Health Delivery System:

Exploring social support and social capital to create equity
Professional Education and Social Support

 Behavorial Health practitioners should be trained with an anti-racist component that includes the rhythm and cadence of Black life”

(Subject Matter Expert, 6)

Training for work with all people of diverse racial/cultural backgrounds

Radlauer, 2021
Why is Engagement Important?

Uptake of services is directly related to engagement

- 60% of children in need of mental health care do not receive services
- For both adults and children, drop out often occurs after the second or third session
- For both adults and children, drop-out rates for mental health services range from 35% to 70%

(SAMHSA, 2016)
Show of Hands

• When working, do you eat or drink in a family home?
• When working, have you shared information about your personal life?
• Are you comfortable when someone you are working with gives you a welcome hug?
• Would you take your shoes off in a family home if they asked you to?
• Do you share how you celebrate holidays with a family you are working with?
• Do you talk about current events and share your views with a family you are working with?
Common Barriers to Engagement

- Social Determinants of Health: poverty, single parent status and stress
- Concrete obstacles: time, transportation, childcare, homelessness, loss of employment
- Attitude about mental health, stigma
- Previous negative experiences with providers
- Fear of “Mental Health” system surveillance
- Concerns about confidentiality
- Isolation
- Waitlist times
Showing up with a Cultural Lens

Culturally competent practitioners:

- Are aware of their own cultural groups and of their values, assumptions, and biases regarding other cultural groups.
- Strive to understand how these factors affect the ability to provide culturally effective services.
Practitioners that are aware of their own personal Cultural Background

- Are more likely to acknowledge and explore how culture affects their relationships.
- Examine how their own beliefs, experiences, and biases affect their definitions of normal and abnormal behavior.
- Are more likely to take the time to understand an individual’s cultural groups and relationships and how this influences engagement in services and recovery.
Addressing Culture

• Invest the time to know individuals and their cultures.
• Be mindful that we do not know everything - be curious.
• Attend to an individual’s cultural attributes.
• Not make assumptions about clients’ race/ethnicity.
• Explore cultural identity or identities with individuals.
• Discuss what cultural identity means to individuals and how it influences behaviors and services.
• Examine obstacles to engaging in support.
• Discuss how cultural groups/identities can serve as guideposts in prevention and treatment planning.
Cultural Knowledge of Behavioral Health

• Patterns of treatment-seeking behavior specific to people of diverse racial and cultural backgrounds

• Beliefs and traditions, including cultural norms, surrounding behavioral health

• Beliefs about treatment, including expectations and attitudes toward counseling

• Community perceptions of behavioral health treatment

• Obstacles encountered by specific populations that make it difficult to access treatment

• Patterns of co-occurring disorders specific to people of diverse racial/cultural backgrounds
Cultural Knowledge of Behavioral Health

• Prevention messaging and prevention services or programs

• Assessment including culturally appropriate screening and assessment

• Diagnosis and awareness of common diagnostic biases associated with symptom presentation

• Therapy approaches that hold promise in addressing cultural backgrounds of diverse clients

• Culturally appropriate peer support, mutual-help, and other support groups

• Traditional healing and complementary methods (e.g., use of spiritual leaders, herbs, and rituals)

• Treatment engagement/retention patterns
What Can You Do?

• Use simple gestures as culturally appropriate—handshakes, facial expressions, greetings, and small talk—to help establish rapport.
• Involve one’s whole being in a greeting—thought, body, attitude, and spirit.
• Ensure the individual leaves the meeting feeling hopeful.
• Establish rapport before launching into questions.
• Draw attention to the presenting issue or subject matter without probing.
• Ensure that the individual feels engaged with any interpreter.
• Use culturally responsive interview behaviors.
You had me at Hello...

• The first step in engagement and setting tone for services relies on an understanding of child, family, community and system level barriers to behavioral health care

• Goals:
  ○ Clarify the need for and benefit of behavioral health services
  ○ Increase caregiving investment and efficacy
  ○ Identify attitudes about previous experiences with behavioral health care professionals and institutions
  ○ Problem solve with the family regarding any concerns they might have
The Art of Engaging Individuals and Families

- Speak so everyone understands what is being said
- Recognizing that everyone has strengths
- Family members are a valued resource
- Individuals and families are often doing the best they can
- Providers and systems agents need to balance “acceptance with change”
- Authenticity, warmth, and flexibility
- Be open minded and ask open-ended questions
- Imagine how you would feel if you were in their situation
- Offer hope
Trust and Power (Role and Status)

Depending on the cultural context, individuals may perceive practitioners as:

• All-knowing professionals
• Representatives of an unjust system

Show of Hands - How many recognize that the professional relationship has a power dynamic?
What You Can Do...

• Consider whether individual perceptions inhibit or facilitate the interaction and how perceptions affect the level of trust in the relationship.
• Identify and address these issues of trust and power early in the process.
• Provide individuals with opportunities to talk about and process their perceptions, past experiences, and current needs.
Boundaries – A Set of Guidelines

• They set expectations for ethical and technical standards in behavioral health.
• Derived from law, government, and professional code of ethics.
• Driven by health and safety, prevention or therapeutic process, intervention, practical considerations, funding and individual/worker safety.
What you should know about boundaries...

- Not setting boundaries leads to poor engagement with the family.
- Having strict boundaries may also lead to poor engagement with the family.
- Boundaries set the tone for a professional relationship.
- Professionals believe that many boundaries are “mandatory” when they are not.
- Maintaining boundaries is sometime challenging.
- Talk with your supervisor about boundaries and limits.
Cultural humility involves an ongoing process of self-exploration and self-critique combined with a willingness to learn from others. It means entering a relationship with another person with the intention of honoring their beliefs, customs, and values.
Cultural Humility Principles

• Lifelong commitment to learning and critical self-reflection
• Desire to fix power imbalances within provider-individual dynamic
• Institutional accountability and mutual respectful partnership based on trust
What is Social Support?

Social Support is the perception and actuality that one is cared for, has assistance available from other people, and that one is part of a supportive social network.
The Benefits of Social Support

According to the American Psychological Association:

- Research documents a direct, positive association between social relationships and mental and physical health (including lower mortality)
- Social relationships have been found to have the following stress-buffering effects on mental health including:
  - Promoting lifelong good mental health
  - Enhancing self-esteem
  - Improving health choices
  - Improving motivation
The Components of Social Support

• Quality of social relationships
• Network ties to relationships
• Emotional caring and concern
• Social influence including norms and behaviors
• Social control includes how social network members monitor, encourage, persuade and pressure adherence to positive practices
• Behavioral guidance, purpose and meaning (mattering)
• Includes emotional support, instrumental support and informational support
Potential Sources of Social Supports

- Family, Faith and Friends
- Co-workers
- Clubs and social organizations/civic and professional organizations
- Recreation centers (sports and hobbies)
- Volunteer opportunities
- Education opportunities
- Transportation resources
- Online communities
- Political parties and organizations
- Other parents at events (school, sports, etc.)
Video: How to Develop an Awesome Social Support System

https://youtu.be/e1jyVpc_41U
Ecogram/
Family Tree
Activity: Find My 5

Who are the 5 people you could count on when you need support?

Favorites

1
2
3
4
5
A Family in need of support looks a lot more like a family in need of treatment than a family that has support.
What is your commitment?

**Personal**
What will I change based on what I learned in this training event?

**Self-Care**
How will I practice self-care so I can show up for the families I work with?

**Professional**
What will I do differently to better meet the needs of families?

**Community**
What will I do to support the communities where families live, work, play and pray?


Slide 9: Video: Equality vs Equity; https://youtu.be/XON22PMdF1U


Slide 17: What is Implicit Bias; Shandra Summerville, CLC Coordinator, Champaign, IL.

Slide 18: Gina Green-Harris, MBA, Director University of Wisconsin School of Medicine and Public Health, Center for Community Engagement and Health Partnerships

Slide 19: Video- Our Hidden Bias, https://youtu.be/ZWgVs4qj1ho


Slide 44: Video: How to Develop an Awesome Social Support System; https://youtu.be/e1jtVFc_i1U

Slide 46: My 5 Activity- Julie Radlauer (2021)

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Thank you!