Strategies and Considerations for Providing a More Equitable Crisis Continuum for People of Color in the United States
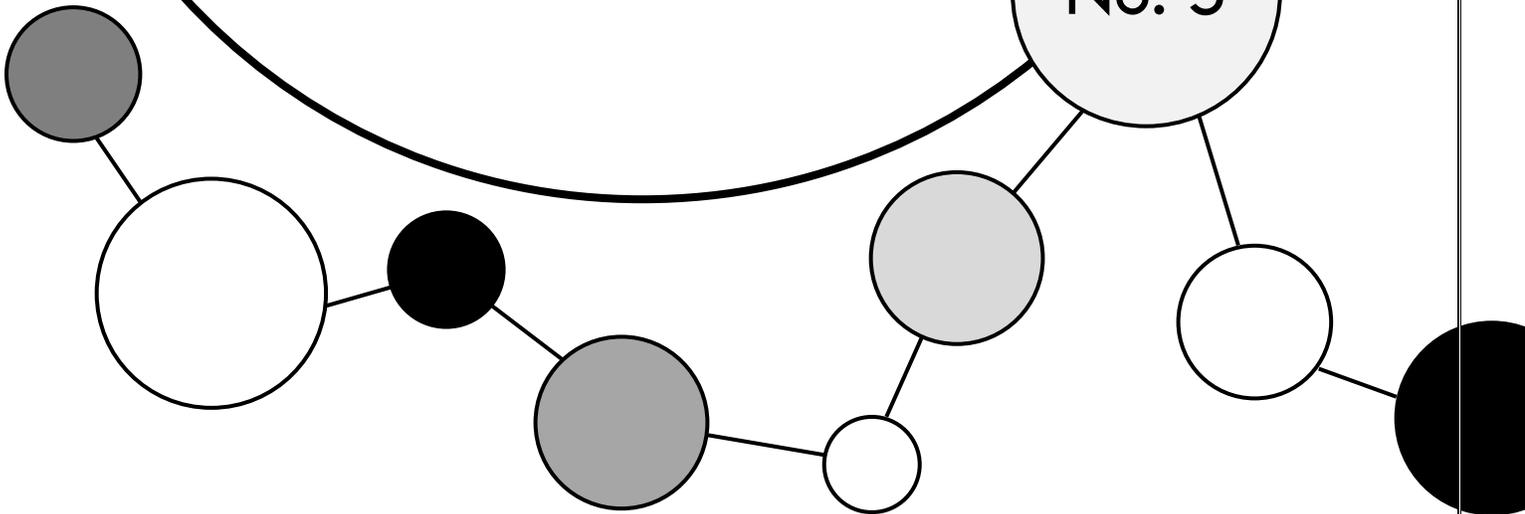
No. 5

NASMHPD

September 2021

Strategies and Considerations for Providing a More Equitable Crisis Continuum for People of Color in the United States

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Cover Art by Malkah Pinals

Fifth in the 2021 Ready to Respond Series of Ten Technical Assistance Briefs focused on Beyond Beds, Reimagining a Sustainable and Robust Continuum of Psychiatric Care

NASMHPD

National Association of State Mental Health Program Directors
www.nasmhpd.org/content/tac-assessment-papers

September 2021

Acknowledgements:

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Recommended Citation:

Neylon, K.A. (2021). *Strategies and considerations for providing a more equitable crisis continuum for people of color in the United States.* Technical Assistance Collaborative Paper No. 5. Alexandria, VA: National Association of State Mental Health Program Director

Abstract:

In the U.S., racism affects all people of color and is an enduring, primary social determinant of racial inequities in population health and mental health.[1] The goal of this paper is to improve understanding about the roles race and racism play in an individual's social determinants of health, in particular the social determinants of healthcare access and quality, and social and community context, and how these affect the availability, accessibility, and quality of mental health crisis services. Based on a review of the literature and a series of interviews with leaders from SBHAs and providers, multiple strategies were identified to help SBHAs and providers create an equitable crisis continuum. Historic, structural racism and implicit bias have led to a lack of trust among people of color of systems that involve law enforcement and institutionalization, including the mental health crisis system. This distrust also contributes to increased stigma among communities of color. To begin to overcome these barriers and to create a more equitable and accessible crisis system, it is critical that SBHAs and providers partner with trusted community leaders (e.g., clergy in local churches) to both offer supportive services that improve social determinants of health and spread the word to build trust and engage more people of color into crisis care. To further build trust, SBHAs and providers can improve data collection and reporting processes to be more transparent and embark on quality improvement initiatives to identify strengths and weaknesses in the crisis system. While it is ideal for law enforcement to be removed from crisis response, it is often not feasible to eliminate their role completely, especially in areas with limited resources. Therefore, it is critical that law enforcement be trained in how to effectively respond to crises without the use of force, and how to divert individuals to appropriate levels of care. These strategies will help build trust with communities of color to reach out for help when they are most vulnerable. To make these changes and overcome decades, or centuries of institutional bias, it is critical to have leadership from the SBHA to self-reflect and identify opportunities for equity.

Highlights:

- Racism contributes to barriers to health and mental healthcare access and quality, which in turn affect the availability, accessibility, and quality of crisis services for People of Color.
- The police killings of unarmed Black men, the subsequent Black Lives Matter movement, and the alarming racial disparities brought to light by the COVID-19 pandemic have placed a spotlight on inequities and injustices toward People of Color in the U.S.
- Recent funding and programmatic opportunities, including American Rescue Plan funds and increases to SAMHSA's Community Services Mental Health Block Grant, as well as the upcoming implementation of 988 provide a unique chance for SBHAs and mental health crisis providers to address structural racism in their behavioral health crisis services systems.

Recommendations for the Post-COVID-19 Future:

1. Build trust with communities of color through transparent data collection and reporting; and meaningful engagement and relationship building with trusted community leaders; and the improved/reduced use of law enforcement in crisis response.
2. Address disparities by allowing providers to incorporate supportive services (e.g., housing and hygiene), and through a more representative and culturally competent workforce.
3. Provide leadership at SBHA through organizational priorities and contract language modifications that support equity.

I n February 2020, the Substance Abuse and Mental Health Services Administration (SAMHSA) released the *National Guidelines for Behavioral Health Crisis Care* (referred to from here on as the "*National Guidelines*"), which outline the necessary services and best practices to deliver an effective crisis continuum. According to the *National Guidelines,* a comprehensive crisis service array includes three essential services: 1) centralized crisis lines that assess a caller's needs and dispatch support, 2) mobile crisis teams dispatched as needed in the community, and 3) crisis receiving and stabilization facilities that are available to "anyone, anywhere, anytime."[1] Ensuring each of these three components is available to "anyone, anywhere, anytime" is an admirable goal; however, as with many other system in the U.S. there is room for improvement in the public behavioral health system, and specifically the behavioral health crisis continuum, to address racial disparities to create a more equitable system for people of color. Current events and new funding and programmatic opportunities are aligning for state behavioral health authorities (SBHAs) and providers to make meaningful improvements to create a more equitable crisis service continuum for people of all races and ethnicities.

The goal of this paper is to improve understanding about the role race plays in an individual's social determinants of health, in particular the social determinants of healthcare access and quality, and social and community context. Given that these social determinants also interplay with the availability, accessibility, and quality of behavioral health crisis services, it is critical to unpack various issues, including race and structural barriers to improving care for all people. By fostering improved understanding of these issues, this paper aims to help SBHAs, policy makers, and providers identify strategies to overcome these barriers to provide a more equitable crisis continuum, and ultimately a more equitable behavioral health service system that better meets the needs of people of color in the U.S.

Methodology

A review of the literature was conducted to understand how race affects the availability, accessibility, and quality of behavioral health crisis systems. To ensure the most relevant and timely information is included, peer-reviewed journal articles, along with publications from national associations and news articles published within the last five years are referenced; however, several relevant studies and articles older than five years are included. Because this is such a timely and important topic, and news and research about racism in U.S. is updated daily, it is likely, though not the author's intent, that important research and news are excluded from this study.

In addition to a review of the literature, the author and colleagues from the National Association of State Mental Health Program Directors Research Institute (NRI) conducted a series of interviews during the summer of 2021 with a variety of behavioral health stakeholders, including representatives from SBHAs, state Medicaid agencies, universities, behavioral health providers, and African American/Black Christian clergy.

Key Terms: Defining Race, Ethnicity, Racism, Equality, Equity, and Intersectionality
It is important to note that race and ethnicity are two separate but related social constructs. **Race** refers to an individual's physical characteristics (e.g., skin color, facial type), while **ethnicity** refers to common national, tribal, religious, linguistic, or cultural origins or backgrounds.[2]

There is consensus among scientists and researchers that race is a social, rather than biological, construct.[3] Racism is defined as "a belief that race is a fundamental determinant of human traits and

capacity, and that racial differences produce an inherent superiority of a particular race".[4] While many dimensions of racism exist, the author considered three types of racism that affect social determinants of health, which in turn affect the availability, accessibility, and quality of behavioral health crisis services in the U.S.:

- **Structural Racism**: "social, economic, or political systems featuring public policies and practices, cultural representations, and other norms that perpetuate inequities." [5]
- **Institutional**: "the policies and practices within and across institutions (e.g., schools) that put certain racial groups at a disadvantage," often to the benefit of another. [6]
- **Individual/Implicit Bias**: "face-to-face or covert actions toward a person that express racial prejudice, hate, or bias," whether realized or not by the individual. [7]

In the U.S. racism affects all people of color and is an enduring, primary social determinant of racial inequities in population health and mental health.[8] However, it is also critical to understand that not all people of color experience racism the same way, as all individuals have multiple identities, and those identities afford individuals different levels of societal privilege that can affect their health outcomes. This concept is referred to as **intersectionality.** For instance, people of color who identify as LGBTQIA+, are members of an underrepresented religious group, and/or have fewer socioeconomic means may be "more susceptible to negative experiences and decreased mental health... due to chronic stress stemming from the marginalized social status they have in U.S. society," which can result in higher rates of depression and suicide risk, and a greater need for behavioral health crisis services.[9] Therefore, it is critical for policy makers, researchers, providers, and other behavioral health stakeholders to understand and consider how these different identities affect the unique experiences of people of color so they can help improve the availability, accessibility, and quality of services for all underrepresented populations.

Understanding the difference between equity and equality is also critical. **Equality** means that "each individual or group of people is given the same resources or opportunities," whereas **equity** "recognizes that each person has different circumstances and allocates the exact resources and opportunities needed to reach an equal outcome."[10]

Limitations
Most data sets separate out race and ethnicity, recognizing them as two distinct but intersecting groups (e.g., that individuals may identify as both a race and an ethnicity); however, some data sets count ethnicities (e.g., Hispanic/Latino) as a distinct race. When this occurs, it is difficult to make comparisons and draw conclusions across two distinct data sets. This paper's author makes every attempt to only include data sets that distinguish race from ethnicity, although this is not always possible. Additionally, many datasets only include data on White, Black, and Hispanic individuals, eliminating the ability to identify trends among smaller population groups (e.g., American Indian/Alaska Native, Asian, and Native Hawaiian or Other Pacific Islander).

Federal government agencies are required to adhere to the 1997 Office of Management and Budget (OMB) standards on race and ethnicity. The OMB recognizes the following races[11]

- **White:** a person having origins in any of the original peoples of Europe, the Middle East, or North Africa.
- **Black or African American:** a person having origins in any of the Black racial groups of Africa.

- **American Indian or Alaska Native:** a person having origins in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment.
- **Asian:** a person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent.
- **Native Hawaiian or Other Pacific Islander:** a person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

At the writing of this paper, the OMB standards only include "Hispanic or Latino Origin," and "Not Hispanic or Latino Origin" for ethnicities. **Hispanic or Latino Origin** refers to a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race. [12] There is a push for OMB to expand ethnicities to include a dedicated **Middle Eastern or North African** response category, but that has not yet been adopted.[13]

While the author made a conscious effort to be objective and unbiased in her writing, it is important to note that she is a white woman who has never personally experienced racism, thereby eliminating the rich context and nuance that a first-person perspective would provide to this report. In an effort to reduce bias in the language of this report, the author relied on the definitions and terms outlined by the National Institutes of Health and style from the Racial and Ethnic Identity Style Guide developed by the American Psychological Association (APA).

Understanding and Addressing Social Determinants of Health and Mental Health to Improve the Availability, Accessibility, and Quality of Crisis Services

A history of cruelty and oppression toward racial minorities in the U.S. persists through laws, policies, and attitudes that disadvantage people of color.[14] The disparities resulting from structural and institutional racism, and implicit bias affect everyone's social determinants of health, usually benefitting White communities while continuing to disadvantage communities of color.

The Centers for Disease Control and Prevention (CDC) defines social determinants of health as "conditions in the places where people live, learn, work, and play that affect a wide range of health and quality of life risks and outcomes."[15] The five domains of social determinants of health include: 1) healthcare access and quality, 2) education access and quality, 3) social and community context, 4) economic stability, and 5) neighborhood and built environment. Each of these five domains is interconnected and influences one another, making the distinction

Figure 1: Social Determinants of Health

between each domain somewhat arbitrary. Social determinants of health have profound effects on an individual's health and well-being[16]

Individuals with certain social determinants of health are at an increased risk of poor physical health and developing a mental illness, including depression and anxiety, which may result in an increased need for crisis services. [17] The World Health Organization recognizes that an individual's social determinants of health are "shaped by the distribution of money, power, and resources at global, local, and national levels," and that they are "mostly responsible for health inequities – the unfair and unavoidable differences in health status seen within and between countries."[18]

In the U.S., people of color are at a significant disadvantage compared to White individuals in each of these five domains.[19] The COVID-19 pandemic further highlights the racial inequities and disparities in the health and behavioral healthcare systems for people of color. Understanding and addressing the factors that contribute to poor social determinants of health and mental health is critical to providing high-quality services, including crisis services, and improving behavioral health outcomes for people of color.

Although all five domains of social determinants of health have implications for crisis services, this paper focuses specifically the two domains that have the most significant effects: healthcare access and quality and social and community context. Although the other domains, economic stability, neighborhood and built environment, and education access and quality are not specifically discussed in detail, all domains are so interconnected that factors related to these domains are included in the discussion.

Social Determinant of Health: Healthcare Access and Quality
Healthcare access and quality refers to the connection between an individual's ability to access health and behavioral health care services, as well as their level of literacy related to their own health and the health and behavioral health care systems.[20] Issues addressed in this domain include proximity to and availability of healthcare services, health literacy, and financing.[21]

People of color face significant disadvantages in healthcare access and quality compared to white individuals in the U.S. However, states and providers can take steps to improve healthcare access and quality for people of color to create a more equitable crisis continuum, including:

1. Enhance the crisis continuum so that is available to "anyone, anytime, anywhere," regardless of an individual's race or ethnicity.
2. Partner with community organizations and respected leaders to establish and increase engagement
3. Reduce financial barriers to care
4. Establish trust by improving the role and effectiveness of law enforcement in crisis response
5. Strategically market the availability of crisis services to diverse populations
6. Recruit and retain a representative, culturally and linguistically competent workforce that is adept at providing trauma-informed care
7. Improve diagnostic and level-of-care determination processes
8. Improve transparency and quality in crisis services through data collection and outcomes monitoring

HAQ Strategy 1: Enhance the Crisis Continuum so that it is Available to Anyone, Anywhere, Anytime

Behavioral health crisis services take many forms and look different in different communities across the U.S. While SAMHSA recommends three specific services for best practices, including centralized call lines, mobile crisis teams, and "no wrong door" crisis receiving and stabilization facilities, individuals in crisis have traditionally relied on emergency response and safety net services, including 911, the response of emergency support and first responders (including law enforcement, fire, or ambulance), and drop-offs or admissions to general hospital emergency departments (EDs). While these services are available to "anyone, anywhere, anytime," they are often not the most appropriate response for behavioral health crises, for either the individual experiencing the crisis or for the person or emergency team responding, which can lead to traumatic and devastating outcomes for individuals in crisis.

When someone calls 911 for mental health crisis response, assistance often "arrives in the form of a team of police officers, many of whom do not have the information or skills they need to provide support."[22] A detailed review of law enforcement and crisis services is provided in the 2020 technical assistance paper, *Cops or Clinicians,* as well as in the 2021 technical assistance paper, *Law Enforcement and Crisis Services: Past Lessons for New Partnerships and the Future of 988.*[23,24] Without these skills, law enforcement may not be able to effectively deescalate a crisis situation, resulting in traumatic transport to an inappropriate setting, a jail or an ED, where individuals may languish for days without addressing their mental health crisis, or worse. Carson, et al. found that "African American men in psychiatric crisis care are less likely to be given a psychiatric evaluation for hospitalization than individuals with similar symptoms who are white… and [are] more likely to be sent to jail."[25] There are also too many examples of tragedy when police respond to crisis calls, especially for people of color.

According to the Washington Post's Police Shooting Database, 23% of all people killed by police were identified as having a mental illness.[26] Another study estimates that "76% of individuals killed in police encounters have had previous mental health treatment."[27] One study by the Treatment Advocacy Center estimates that "people with untreated serious mental illness are 16 times more likely to be killed during an encounter with [law enforcement] than other civilians."[28] Furthermore, the rate at which Black Americans are killed by police is more than twice as high as the rate for White Americans (see figure at right[29]), so even though the data on killings by police on race and mental illness are unavailable, it stands to reason that African

Figure 2: Number of People Killed by Police by Race, Washington Post Police Shooting Database

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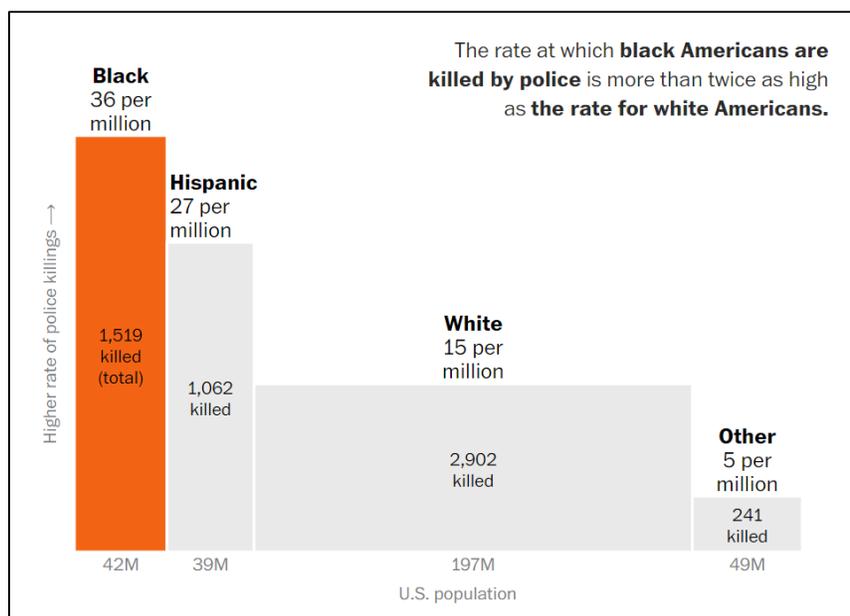
Americans/Blacks with mental illness are killed at significantly higher rates than Whites.[30] The death of Daniel Prude and Patrick Warren, Sr. are two examples of law enforcement response to a person of color experiencing a mental health crisis.

In March 2020, Daniel Prude, a 41-year-old Black man, experienced a mental health crisis. "Shoeless and shirtless," Mr. Prude wandered the cold streets of Rochester, New York shouting fears about the coronavirus.[31] In an effort to help, Mr. Prude's family called 911 twice. The first call resulted in a response from EMS (emergency medical services), who discharged Mr. Prude without effectively triaging his crisis. The second call later the same day resulted in a law enforcement response, which left Mr. Prude naked, restrained, handcuffed, hooded, and pinned face-down to the ground; after more than two minutes, he stopped breathing. Efforts to revive him only extended his life by one week, as he later died of "complications from asphyxia" in a Rochester hospital.[32]

In January 2021, just 10 months following the death of Mr. Prude, Pastor Patrick Warren, Sr. was experiencing a mental health crisis after the poor economy associated with the COVID-19 pandemic caused him to lose his job. Mr. Warren's family noticed behavioral changes that had them concerned enough to reach out for help. A mental health resource officer responded and escorted Mr. Warren to a local hospital for a mental health evaluation, from which he returned home later that day. The following day, his family was still concerned for his mental well-being and again sought help from the Killeen Police Department; unfortunately, no mental health resource officer was available to respond, and law enforcement officers "not prepared to handle a mental health crisis" responded instead.[33] This encounter proved fatal for Mr. Warren, as officers tased and shot him three times.

A robust crisis continuum, consisting of a centralized hotline, mobile crisis teams, and no-wrong-door crisis receiving and stabilization facilities that ensures proper response and follow-up care for all individuals can help provide a more equitable system for people of color, avoid tragic outcomes faced by Mr. Prude, Mr. Warren, and countless others, and begin to break the cycle of poor health and mental health.

Crisis Hotlines, 988, and Lessons from 911
Crisis hotlines are clinical call centers that operate 24-hours-per-day, seven-days-per-week. They are staffed with clinicians who provide risk assessments to individuals in crisis and engage people at imminent risk of suicide. SAMHSA's *National Guidelines* recommends that crisis hotlines be available through phone, text, and chat methodologies to be available to as many individuals as possible. The *National Guidelines* also recommend that crisis hotlines be centrally located within a region and "offer [GPS-capable] air traffic control quality coordination of crisis care in real time." With the Federal Communications Commission (FCC) voting in July 2020 to adopt 988 as the new three-digit dialing code to "increase the effectiveness of suicide prevention efforts,"[34, 35] there are new opportunities for states to create a more equitable crisis continuum for people of all races and avoid the pitfalls of 911.

However, people of color may fear calling a crisis hotline or the Lifeline if they expect a similar law enforcement response as calling 911; the racist history of 911 and the deaths of Mr. Prude and Mr. Warren highlight this very real possibility. Each year, nearly 100,000 trained 911 dispatch workers across the country handle 240 million 911 calls.[36] While the 911 crisis service system has helped to save a number of lives and de-escalate crisis situations, "the impact could well be negative,"

especially for people of color.[37] In fact, 911 was developed in the 1960s as a way to quickly suppress protests by Black communities against segregation and police brutality.[38] Simultaneously, the commission charged with the development of the 911 system also "encouraged the militarization of local law enforcement."[39] A 2019 article by Shaun King published by the Associated Press recognized the death of Osaze Osagie, a 29-year-old Black man who was killed in State College, Pennsylvania after his family called 911 to help address his mental health crisis. Mr. King notes that "Black families remain skeptical of calling the police for help under any circumstance – and fatal encounters like the one experienced by the Osagie family confirm those doubts." [40]

Because of this fear, it is critical that crisis hotlines, and the Lifeline/988 have qualified, culturally competent crisis counselors who are effective at de-escalating crises over the phone, and that states have an effective crisis infrastructure in place so that when necessary, crisis call operators can connect individuals in crisis to care through mobile crisis response or crisis receiving and stabilization facilities. SMHAs and local providers also need to engage with their local communities to ensure that the hotline services meet the diverse needs of the community, and that individuals understand what to expect when calling the local crisis hotline or the Lifeline/988. To ensure that 988 does not cultivate the same racist response as 911, several states are ensuring that the implementation of 988 be guided by diverse advisory groups, and be available to underserved populations, including ensuring that Native American Tribes, who do not have access to 911 services, have access to 988.

Colorado Crisis Services is relying on a cultural competency advisory council to guide its activities related to the implementation of 988. Megan Lee, L.P.C., Program Manager with Colorado Crisis Services notes that "988 is multi-faceted and has a cascade of implications for the rest of the crisis system."[41] Ms. Lee anticipates an increase in crisis call volume to 988, which will result in a greater need for mobile crisis response teams who are culturally and linguistically competent.

Washington State recently introduced $1 million in legislation "to develop and operate [a 988 tribal behavioral health and suicide prevention] line and a tribal 988 subcommittee."[42] The process will be guided by a subcommittee that includes representation from the American Indian Health Commission (AIHC) of Washington State. Vicki Lowe, Executive Director of AIHC indicates that the COVID-19 pandemic fueled this decision as leaders in the state began addressing service gaps to provide a more equitable system. In addition to the 988 Lifeline for tribes, the AIHC is working to develop the Washington Indian Behavioral Health Hub, which is a coordinating center that serves as a bridge between the sovereign tribes and the services offered by the statewide crisis system, including community services, crisis beds, and post-crisis follow-up services. Ms. Lowe's advice for others as they plan for 988 is that "states need to think about the populations they serve so they don't repeat the same mistakes; this is a chance to do something different."[43]

New York's Office of Diversity and Inclusion is helping to launch 988 while ensuring that the service will be culturally competent. It is reviewing all 988 contracts to ensure that the *National Standards for Culturally and Linguistically Appropriate Services (CLAS) for Health and Health Care* are addressed, and that mechanisms to support multiple languages are included. Mr. Canuteson notes that "we have to set up 988 so seamlessly that a person doesn't become so frustrated they call 911. This is how disparities and bad outcomes occur."[44]

Mobile Crisis Response Teams

Mobile crisis response teams are groups of two or more crisis counselors that are centrally "available to reach any person in their service areas in their home, workplace, or any other community-based location of the individual."[45] As described in the *National Guidelines,* mobile crisis response teams serve a broader range of individuals in less-acute crisis situations, but are capable of referring individuals to crisis receiving and stabilization facilities should they need a higher level of care. A survey of mobile crisis response teams shows that they are able to stabilize approximately 70% of all crisis calls in the community and make referrals to facility-based care for the remaining 30%.[46] There are several benefits to the use of mobile crisis response teams. One benefit is that they meet people in the community, ideally where people feel more comfortable, and try to address the crisis where the crisis is occurring without use of force. Another benefit of mobile crisis response is that it eliminates the need for law enforcement response when appropriate.

Colorado Crisis Services provides mobile crisis response in a diverse neighborhood of the City of Aurora. Aurora, while predominantly White, is significantly more diverse when compared to the rest of the state. As of 2016, 84.2% of Colorado residents are White, whereas only 61.1% of City of Aurora are White.[47] The remaining 39% of the population is composed of Black/African Americans (16%), Asians (6%), individuals who identify as having two or more races (5%), Native Hawaiian or Other Pacific Islander (>1%), and American Indian/Alaska Native (>1%).[48] Colorado Crisis Services was struggling to serve this marginalized community. They received feedback from a resident, who stated, "you're failing my community; we will not reach out for services because we don't trust you." After a series of conversations, it was determined that the staffing composition of the mobile crisis response team led to distrust in the community because the people responding were masters-led clinicians who "did not look like them," and were not members of the community. Many behavioral health providers, and crisis services providers in particular, in the State of Colorado "are well-meaning white women in their 30s" who may have trouble engaging with communities of color.

Colorado Crisis Services' mobile crisis teams are required to have a masters-level clinician respond to calls for service, who will sometimes bring along another person. Learning from this, to gain the trust of the community leadership at Colorado Crisis Services initiated planning for a pilot program with the mobile crisis provider in Aurora, allowing for the masters-trained clinician to bring known community leaders with them to respond to calls. As part of this pilot, the crisis encounter with the mobile crisis team was to be led by the familiar community leader, with the masters-trained clinician conducting the assessment. This approach helps the mobile crisis team to gain respect in the community, allowing them to better engage people into care. The pilot is now being explored by the City of Aurora. While the pilot is potentially no longer with Colorado Crisis Services, it did "open the door to thinking about the things that inadvertently get in the way of an effective community response."[49]

Following this pilot with the crisis team in the City of Aurora, Colorado Crisis Services began modifying its contract language to allow CMHCs to create a pilot program to "eliminate any contract requirement that gets in the way of making a program work the way it is supposed to."[50] The contract language specifically states:

> *Pilot Programs. The Office of Behavioral Health (OBH) or contractor may propose pilot programs to evaluate potential solutions or enhancements to Administrative Service Organization services. Pilots must be time-bound. OBH may waive conflicting contract terms for the duration of the*

pilot period as needed to allow for services to proceed according to the pilot proposal terms. If a pilot program is deemed successful at the conclusion of the pilot period, the parties may negotiate an amendment to this Contract to the extent necessary to accommodate the pilot activities.[51]

Feedback from several of the states interviewed for this paper addresses changing contract language to ensure that "services are reaching individuals of different identities and intersections, and to focus on priority populations from areas that have been historically excluded from services."[52] The changes that Colorado has made to its contracting language allowing flexibility in provider response and the prioritizing of specific groups helps to achieve equity among underrepresented populations; however, beyond changes to contract language, SBHAs and providers also need to consider how the contracts are awarded, and strive to improve the culture and expand the array of the organizations in which they work.

To create more equitable contracts and policies related to crisis services, understanding the needs of diverse communities is critical. One step to ensuring equity and inclusion is to create an advisory group that guides the development of new policies and contracts. Stephanie Sundberg, M.S.W., Manager of the Transition-Age Youth and Healthy Transition at the Colorado Office of Behavioral Health, recommends that advisory groups be representative of the communities a provider organization or SBHA serves, and not just by including one or two representatives from an underrepresented group, which is harmful and tokenizes individuals in a symbolic gesture with no substance, purpose, or power in their participation. In addition to meaningful representation, SBHAs can implement a variety of feedback mechanisms, allowing advisory group members to share their ideas for discussion, and open them up for feedback and implementation, ultimately creating intentional space for shared decision making to make substantial change. It is also important that these community engagement efforts are upheld through the allocation of resources, including funding, to make change happen. The programs an SBHA funds clearly identify the agency's priorities.

Crisis Receiving and Stabilization Facilities

Crisis receiving and stabilization facilities provide short-term (usually less-than 24 hours) observation and crisis stabilization services to individuals in a home-like, non-hospital environment. Best practices for crisis receiving and stabilization facilities outlined in the *National Guidelines* recommend that they have a dedicated first responder drop-off area that allows law enforcement to quickly return to their patrol; include beds within a "real-time regional bed registry system" that is accessible by the crisis call center and mobile crisis teams "to support efficient connection" to needed resources; and coordinate connections to follow-up services.[53] The "no wrong door" approach allowing law enforcement to easily drop individuals in crisis off reduces the likelihood that people experiencing a crisis will be brought to jails or other inappropriate inpatient settings.

Incorporating bed registries into the model also allows SBHAs to monitor the utilization of crisis services, including demographic information about who uses the services, to ensure that services are accessible and available to all communities. Ensuring that crisis services are working as intended (i.e., diverting people away from inappropriate settings of jails and hospitals, reducing law enforcement involvement, and connecting to follow-up care), bed registries in 20 states are monitoring the following data points[54]:

- Diversion: 12 states
- Connection to treatment: 8 states

- Volume of service usage: 8 states
- Connections to law enforcement: 5 states
- Outcomes: 5 states
- Public perception of the system: 1 state

Crisis Follow-Up Care

Regardless of how an individual interacts with the crisis system, it is critical that they be provided with follow-up care that meets their mental health and cultural needs. Colorado Crisis Services found that individuals in diverse communities tended to not follow through with care post-crisis intervention, "because the clinical services were not something they would ever engage in."[55] The feedback Colorado Crisis Services received from the marginalized communities was that follow-up would be more effective if it included non-traditional treatment that supports the individual. The change to the contract language allowing CMHCs to pilot programs that modify their approach gives the crisis provider flexibility to ask the community, "where do you feel supported," and "how can we get you connected with those supports?"[56] The revised contract language also allows CMHCs to refer to non-traditional providers, including community organizations like the Boys and Girls Club, and local churches. Megan Lee, L.P.C., Crisis Program Manager with the Colorado Office of Behavioral Health's Colorado Crisis Services, notes that "just because a person doesn't want to access clinical services, it doesn't mean that we (Colorado Crisis Services) can't support them." Changing the crisis model to serve the whole person can help to stabilize or improve an individual's economic station, encourage future engagement with behavioral health services, and potentially reduce the need for crisis services in the future.

HAQ Strategy 2: Partner with Community Organizations and Leaders to Establish Trust and Increase Engagement

Individuals of different races have different help-seeking behaviors that are formed by their cultures and experiences living in a White-dominated society that fails to recognize their differences and expects them to be the same as the dominant community. Understanding the differences between and within cultures will help providers identify community partners who can help to better engage with people of color. Rev. Joel Bowman Sr., L.C.S.W., and Founding Pastor at the Temple of Faith Baptist Church in Louisville, Kentucky notes that "help-seeking behaviors of African Americans are different than the general population. African American communities tend to be more communal than White communities, and when Black families are having issues, either they will deal with those issues within the family system, including fictive kin, or they may go to their faith tradition."[57] An avenue for outreach includes partnerships between SBHAs, health care providers, and others with traditionally Black churches. To gain respect and trust in the African American/Black communities, it is critical that SBHAs and crisis providers first gain trust with the senior pastors of the churches. According to Rev. Bowman, "the dynamic with Black churches is different from White churches; without the buy-in of the senior pastor of the church, it will be difficult to gain the trust and respect needed to engage the community." Brian Sims, M.D., Medical Director at NASMHPD reiterated the importance of engaging the faith community improve mental health outcomes, noting that "the Black pastor is such a pivotal person in the Black community, if we're going to make significant inroads, it has to start with clergy."[58]

Reinforcing Rev. Bowman's comments, Bryan Carter, Ph.D., Service Chief of the Pediatric Consultation-Liaison Service at Norton Children's Hospital in Louisville, Kentucky notes that immigrant communities

and communities of color tend to place more value in the family unit. Engaging family members in crisis care can help to establish trust in the system and increase participation in follow-up services. And, as discussed above, Colorado Crisis Services has found similar barriers to engagement with its racially diverse communities, and has allowed providers to engage community partners, including churches and local Boys and Girls Club chapters to provide non-clinical, supportive services. Sometimes, according to Gwendolyn Green, L.M.H.C., M.C.A.P., Executive Director with Tampa Crossroads, the simplest thing that a provider can do to increase engagement with a given community is to "simply ask people, instead of making assumptions, about what their barriers are and to see if we can correct those."[59]

In addition to partnerships with community organizations and churches, SBHAs and providers "should not be afraid to reach out to foundations or through the state college systems." Mr. Canuteson indicates that "foundations are hot on equity right now," and provide an opportunity for SBHAs and providers to enhance their crisis continuum and ensure equity at the state and provider levels.[60] Providers can also partner with historically Black colleges and universities (HBCUs) to ensure that crisis services are available to their diverse student populations.[61]

HAQ Strategy 3: Reduce Financial Barriers to Care

The cost of accessing mental health crisis services, whether real or perceived, is a barrier to people of color. People of color experience poverty at higher rates than White people in the U.S. According to 2018 Census Data, 25.4% of Native Americans, 20.8% of Black/African Americans, and 17.6% of Hispanics (of any race) are impoverished, compared to 10.1% of Whites and Asians.[62] Similarly, African Americans, Hispanics, and Native Americans are uninsured at higher rates than Whites and Asians (Figure 3).[63] A lack of reliable income and financial resources can prevent people from seeking help, and when they do seek help, the quality of services available is often inconsistent or inadequate.

Figure 3: Percentage of Individuals Under Age 65 Who are Uninsured by Race, 2014-2018[64]
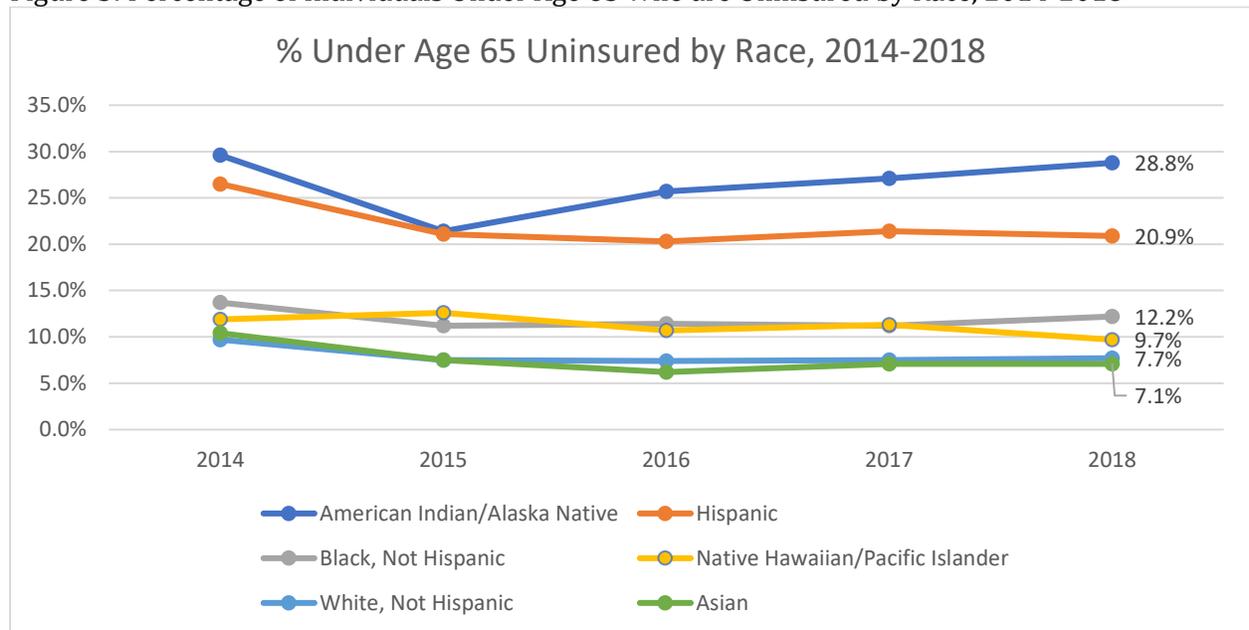
In 2019, an estimated 75 million individuals were enrolled in Medicaid in the U.S.[65] Medicaid provides coverage to low-income individuals, pregnant women and children, and individuals with disabilities.

Since 2014, Medicaid coverage is available to individuals up to 133% of the federal poverty level in the 39 states that elected to expand Medicaid (as of August 2021). Medicaid is the third largest payer in the U.S. healthcare system behind private insurance and Medicare, representing 16% of national healthcare spending in 2019. [66] People of color are more likely to be covered by Medicaid than White individuals. (See Figure 4 on the following page.) However, even with Medicaid coverage, people of color face barriers to care as many mental health providers do not participate in Medicaid plans; certified peer support specialists who can bring representation to the behavioral health crisis workforce are often not paid a living wage, reducing their utilization; and supportive services, such as housing and other social services may not be fully covered to promote equitable social determinants of health.

Figure 4: Percent of Medicaid Coverage of the Non-Elderly Population by Race/Ethnicity, 2019[67]
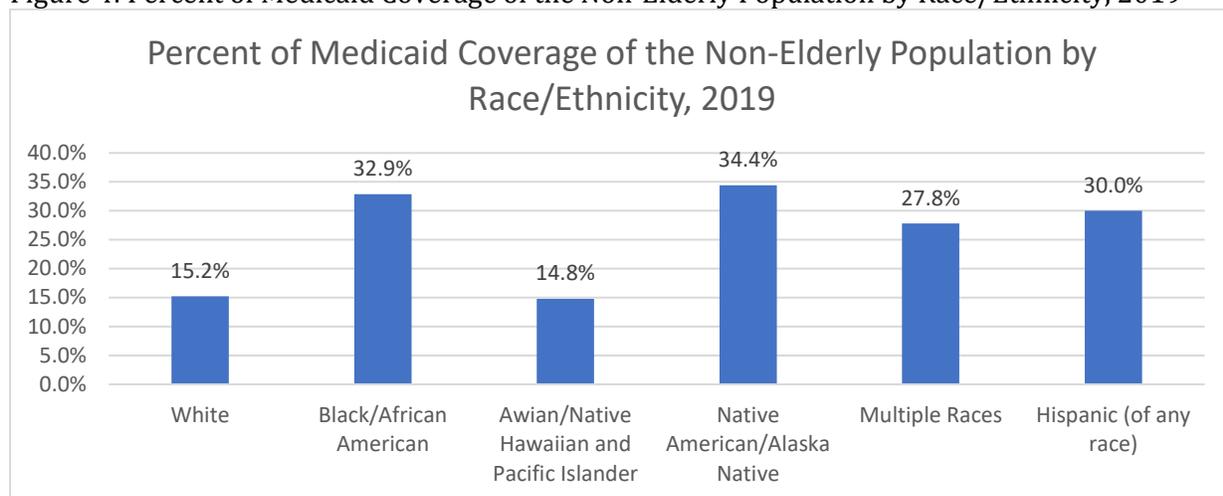
To overcome these barriers, the Oregon Health Authority is applying for an 1115 Medicaid Demonstration Waiver that creates "A Pathway to Health Equity."[68] Oregon's Waiver application for the five-year period between 2022 and 2027 strives to achieve equity by:

- Ensuring access to coverage for all people in Oregon, by "ensuring enrollment of people who are eligible and expanding eligibility for those at risk for becoming uninsured."[69] According to the Oregon Health Authority, an estimated 6% of people in the state do not have health insurance, with some communities of color, including Hispanics, Native Americans, and African Americans/Blacks less likely to be uninsured than Whites or individuals who identify as two or more races.[70] To do this, Oregon Health Authority proposes ensuring people who are newly enrolled in the Oregon Health Program during the COVID-19 pandemic maintain appropriate coverage; ensure that people who are eligible for Oregon Health Program are aware of the program and become enrolled; and enhance coverage continuity for both children and adults and expand coverage to low-income individuals who are not currently eligible for the Oregon Health Program.[71]
- Creating an equity-centered system of health that requires coordination and collaboration with systems beyond healthcare. To achieve this goal, the Oregon Health Authority will improve transitions across systems, close gaps in coverage and care, and provide "defined packages of services and supports for health-related social needs related to this transition."[72] Transitions from incarceration and institutional settings are especially challenging when an individual does

not have stable housing or is going through a tumultuous life event. Often, individuals "are left to navigate multiple complex systems independently because [Oregon's] state health care system is not designed to align and coordinate with other social systems and providers in a way that allows everyone to come together to support people in accessing systems more seamlessly."[73] The Oregon Health Authority notes that "these challenges are exacerbated for tribal members, communities of color, and people with disabilities as systems often lack the infrastructure and resources to provide culturally and linguistically appropriate care…[that] do not meet people where they are."[74] To achieve this goal, the Oregon Health Authority proposes enhancing care coordination and non-clinical supports to support transitions across outcomes; remove barriers to culturally and linguistically competent health services; and prioritizing marginalized communities to promote health equity across the system.[75]

- Encourage flexibility in spending on "upstream drivers of health" while prioritizing meaningful, equitable improvements in healthcare.[76] Through this action, the Oregon Health Authority plans to create a global budget, which entails flexible, service-integrated payments for the state's Coordinated Care Organizations (CCOs). This model enables CCOs to coordinate care across multiple sectors of health (physical, mental, and oral), and affords them the flexibility to provide individuals with housing and food supports which promotes equity in the communities the CCOs serve. To achieve this goal, the Oregon Health Authority will hold the CCOs accountable to a sustainable cost growth target, and incentivize CCOs "to focus on health equity, prevention, and high-quality services that… reduce costs."[77] In addition, the Oregon Health Authority will "use innovative rate methods to set global budgets that encourage efficiency and upstream investments" that address health-related social needs," and will hold CCOs accountable to meeting these needs.[78]

- Reinvest government savings across systems "to address larger or statewide problems that no single community can fix on its own."[79] The Oregon Health Authority will prioritize these savings on funding initiatives that address large-scale barriers related to health and health equity. Savings will be directed toward individual communities "to improve the social, economic, and physical environment."[80] To achieve the most effective and efficient progress, the Oregon Health Authority and the CCOs will "partner with community leaders to identify and operationalize strategies to eliminate health inequities."[81]

To ensure these goals and processes are meeting the needs of the diverse communities the Oregon Health Authority services, it will enhance and expand its feedback mechanisms to collect and understand the concerns and needs of providers, advocates, and community members.[82] In conversations with representatives from the Oregon Health Authority, there is excitement that this 1115 Demonstration Waiver will allow the state to "smooth out the edges of coverage" to ensure that people are receiving high-quality, culturally and linguistically competent services that meet the specific needs of each community.[83] The state emphasized the value of data, both quantitative and qualitative, in ensuring that this new waiver works for everyone. Using data, gathering and meaningfully considering input from the communities, and collaborating with respected community leaders will help the Oregon Health Authority gain trust within marginalized communities. This will be especially helpful in the delivery of crisis services in the state, so that when people are the most vulnerable, they will feel comfortable reaching out for the help they need and will receive linguistically and culturally competent care in return.

HAQ Strategy 4: Establish Trust by Improving the Role and Effectiveness of Law Enforcement in Crisis Response

Some communities of color have a mistrust of law enforcement and those who engage with them. This is particularly acute for African American/Black communities, due to the legacy of slavery and Jim Crow laws. Although it is ideal to remove law enforcement from all crisis response, and many advocacy organizations are encouraging just that, it is not always practical or safe to do so. Rev. Bowman underscores the need for law enforcement reform. Although there are calls to "defund the police," Rev. Bowman suggests that this call to action does not adequately describe the intent or the need behind the movement and can create excessive divisiveness which halts progress. Rev. Bowman indicates a need for "a paradigm shift. 'Defund the police' has become a sensitive issue, when what it really means is the reallocation of funds for improved services and police reform." He suggests that reform needs to happen at the local level, where if police need to be involved mental health practitioners work alongside them to respond to calls for service, and for police to receive appropriate, thorough, culturally competent training on how to de-escalate crisis situations.

Equipping law enforcement with the literal and figurative tools they need to safely and effectively respond to crises in the community, especially those serving remote areas where crisis infrastructure (e.g., workforce, mobile crisis response teams, and crisis receiving and stabilization facilities) may be lacking, is critical. Technology can be used by law enforcement responding to crisis to connect individuals directly to a mental health crisis counselor. Training in cultural competence and Crisis Intervention Team (CIT) education can provide law enforcement with the skills necessary to safely and effectively de-escalate crises in the field, which can help lead to more trust among people of color that law enforcement response, when it is the only option, can meet their needs.

Technology can be used to allow law enforcement instant access to a behavioral health crisis counselor while responding to crisis situations. Having ready access to a behavioral health crisis counselor can help the officer feel more confident knowing they have the tools to de-escalate crisis situations without force. Grand Lake Mental Health Center (GLMHC) in Oklahoma equips all officers with iPads within its catchment area. The iPads allow officers to immediately connect with health providers to help triage crisis situations in the field, reducing the need for transport. In addition, the tablets offer an application for officers to immediately connect to behavioral health providers that specialize in providing crisis services to law enforcement. Now, law enforcement officers have a way to reach out for help if they need to speak with someone after witnessing a traumatic event, and to deal with any personal and professional challenges that have an impact on their own mental health. Beyond officers, GLMHC also offers iPads to each recipient of their crisis services upon discharge, allowing individuals to immediately connect to qualified staff, 24/7. In 2015, prior to the launch of this program, more than 1,100 individuals were admitted to inpatient beds in the region, and almost all were brought in by police. After GLMHC opened new crisis facilities, allowing officers to utilize the tablets and facilitate quick drop offs, the number of patients admitted to an inpatient crisis bed in 2020 plummeted to one person. The program was funded through an incentive program by the SBHA. In 2016, Oklahoma's SBHA incentivized providers to develop alternatives to inpatient care to reduce hospitalization rates and allowed the CMHCs to use funds that would normally support inpatient services on community-based services instead. [84]

CIT was developed in Memphis, Tennessee to train police to respond more effectively and safely to mental health crisis encounters. Officers trained in CIT are equipped with skills to calm individuals

experiencing a mental health crisis and divert them to mental health services instead of jail. The objectives of CIT are to reduce injuries to officers and the individuals in crisis, promote decriminalizing individuals with a mental illness, and reduce the stigma associated with the experience of a mental health crisis. Training officers in CIT, especially in areas with limited mental health resources, results in more effective crisis services when the services recommended in the *National Guidelines* may be unavailable. In order to integrate CIT into the culture of law enforcement, Karl Rosston, M.S.W., suicide prevention coordinator with the State of Montana recommends training all new recruits during their training at the Academy. To ensure that the CIT model works for all people, it is imperative that the cities and counties that implement the program fully integrate it "into the wider behavioral mental health care system and route calls away from police."[85] Ron Bruno, a 25-year police veteran and current Executive Director of Crisis Team International notes that "if you keep throwing money at training officers, and that's all you do, and not address the system around mental health care, you'll continue to have nothing but problems."[86] Enhancing the mental health crisis continuum, and training officers in de-escalation techniques and how to recognize implicit bias will help create a more equitable response to mental health crises by law enforcement.

Another approach to diversion during or after a crisis is the implementation of the Sequential Intercept Model. SAMHSA's GAINS Center developed the five-point Sequential Intercept Model, which identifies five opportunities along the criminal justice continuum to divert individuals with mental illness from the criminal justice system and prevent further involvement in the system. The original five "intercepts" include: 1) Law Enforcement (including calls to 911); 2) Initial Court Hearings/Initial Detention; 3) Jails and Courts; 4) Re-entry; and 5) Community-based criminal justice supervision with behavioral health supports.[87] Recently, a new intercept, Intercept Zero, has gained support, encouraging system alignment to connect individuals with care before a behavioral health crisis emerges.[88] Intercept Zero includes the use of community services, peer warm lines, and crisis lines. The Sequential Intercept Model can help to reduce racial disparities across systems, to reduce the higher arrest rates and disparities in referrals to diversion programs among people of color, to reduce the disproportionate prevalence of pretrial incarceration and higher bail amounts for people of color, and to improve the chance that people of color are more likely to receive restorative mental health services rather than punitive consequences.[89]

CIT and the Sequential Intercept Model can help to reduce rates of incarceration among individuals experiencing a mental health crisis, including persons of color, which can contribute to higher rates of incarceration – a factor within the social and community context determinant of health.

Another way to reduce law enforcement involvement in crisis response and to reduce the potential for force, which is disproportionately used against people of color, is to embed crisis counselors within the 911 system.[90] While several models are in operation today, the first to implement this model is The Harris Center in Houston. The Crisis Call Diversion (CCD) program embeds behavioral health specialists in the City of Houston 911 Dispatch Center. It is a partnership between the Houston Police Department (HPD), the Houston Fire Department (HFD), and The Harris Center for Mental Health and Intellectual and Developmental Disabilities. When a person calls into 911 experiencing a crisis, the 911 dispatcher identifies and redirects mental health related, emergent, non-life-threatening calls for service to bachelor's trained crisis counselors and away from first responders. Since its launch in 2016, the CCD program as successfully diverted individuals away from law enforcement and fire department response and saved more than $2 million in resources for the HPD, and nearly $4.5 million for HFD. Recently, in March 2021, the CCD program began working with The Harris Center's Mobile Crisis Outreach Rapid

Response to dispatch teams in the community to respond to calls for service that could not be de-escalated over the phone.

To reduce the unnecessary reliance on law enforcement, which can lead to unnecessary incarceration or use of force which disproportionately affects people of color, New York City recently launched a similar program where crisis counselors are embedded within precincts in the Harlem and Harlem East neighborhoods of the city.[91] In November of 2020, Mayor Bill de Blasio announced plans to have mental health workers replace police officers in response to some 911 calls, beginning in 2021. The program is being piloted in three neighborhoods in the Burrough of Harlem, which is nearly 62% Black.[92] The neighborhoods participating in the pilot accounted for the most 911 calls in the city in 2019. The primary goal of the program is to "avoid bad outcomes from police interactions with individuals experiencing a mental health crisis."[93] When a person in crisis calls 911 from one of these neighborhoods, rather than police response, two Fire Department EMTs and one social worker will respond. The program is available 16 hours per day. It has been so successful that Mayor de Blasio anticipates extending the project city-wide.

HAQ Strategy 5: Market the Availability of Crisis Services to Diverse Populations

One of the most common barriers identified during the interviews for this paper is that "many people [of color] don't know what crisis services are, or what they can do."[94] This lack of knowledge can help spur fears among marginalized communities that by calling for help in a crisis, law enforcement or child protective services will respond to the call, and instead of receiving help for a behavioral health crisis, they may be arrested (or worse, as in the cases of Mr. Prude, Mr. Warren, and Mr. Osagie and countless others) or have their children removed from their home. Niambi Shakir, a crisis team lead with the Minnesota Department of Human Services, noted that "there is often a misconception of what crisis can do among under-represented communities," with some people expecting a SWAT-style response.[95] One way to overcome this uncertainty and mistrust is by marketing the availability of crisis services specifically to these diverse populations, by addressing what crisis services are, how they can help, and what to expect.

A variety of platforms exist to advertise the availability of behavioral health crisis services, including television, radio, and mobile applications ("apps," including social media). Marketing efforts can be targeted based on the population an SBHA or provider is trying to reach. The overall reach of each platform differs and varies by age and race. According to a 2017 study by Nielsen, "radio reaches more Americans each week than any

Figure 5: Weekly Reach of Radio, TV, Smartphone by Age, 2017

Weekly Reach of Radio, TV, Smartphone by Age, 2017

	All Adults	18-34	35-49	50+
Radio	93%	92%	95%	92%
TV	89%	79%	91%	94%
Smartphone	83%	91%	96%	70%

other platform," although this may have shifted since fewer people are commuting during the current
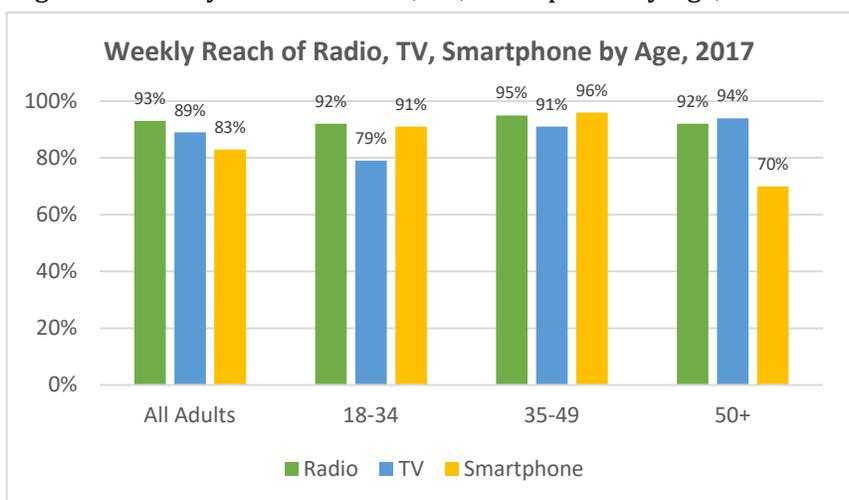
COVID-19 pandemic.[96] The figure to the right[97] shows the weekly reach by age group as a percentage of the U.S. population for each radio, TV, and smartphone apps.

Looking beyond the age categorizations, Nielsen also found that "African-American and Hispanic listening audience[s] now accounts for one-third of the [traditional radio] listening audience, and that number continues to grow."[98] Traditional radio reaches 93 percent of African American/Black consumers, and 98% of Hispanic consumers. African American/Black and Hispanic consumers also frequently consume radio through smartphones and other streaming devices. African American/Black listeners tend to listen between 3:00pm and 7:00pm, while Hispanic listeners are more likely to listen to the radio between 10:00am and 3:00pm.[99]

In addition to radio and TV, SBHAs can leverage social media to reach a wider, younger, and more diverse audiences to promote their services, including crisis services. YouTube, Facebook, and Instagram are the most widely used social media platforms in the U.S. Facebook has the widest reach across all adults ages 18 and over, while Instagram and SnapChat have the widest reach among youth ages 13 to 17. Non-Hispanic Black and Hispanic individuals are most likely to use YouTube (84% and 85%, respectively, of adults in each demographic group), and are least likely to use NextDoor (10% and 8%, respectively' see Figure below).

Figure 6: Use of Online Platforms by Race, 2021[100]
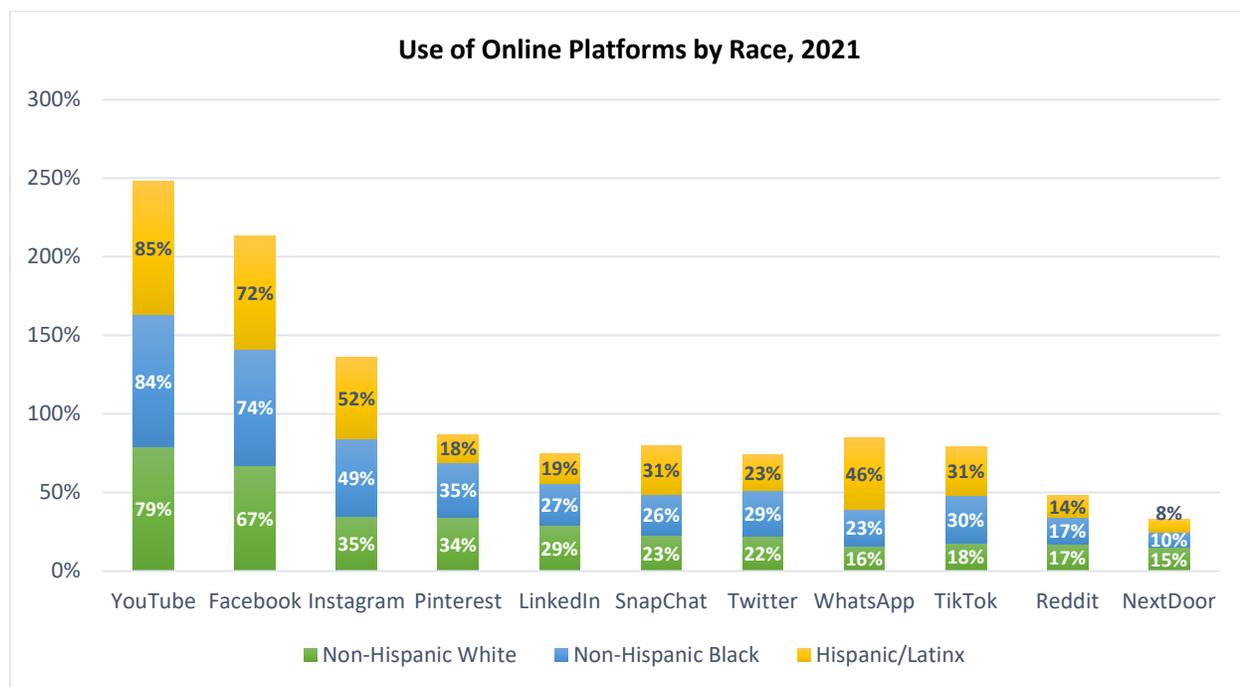
As discussed further on in the paper, behavioral health stigma among communities of color is a significant barrier to preventing individuals with behavioral health needs from seeking help, even in times of crisis.[101] social media has the added benefit of normalizing the conversation around the need for behavioral health services in racially and ethnically diverse communities. A 2018 study by the Pew Research Center found that 80% of Black social media users "value the platforms for magnifying issues that aren't usually discussed," and 60% of Hispanics and Whites felt the same.[102] Collaborating with

respected public figures, including athletes, to spread the word about behavioral health crisis services can help legitimize the value they offer, especially in diverse communities.

Regardless of which platform is used to promote the availability of behavioral health crisis services, the language used related to behavioral health also matters in overcoming stigma and increasing engagement. At least two states, Colorado and Minnesota, noted that instead of using the terms "mental health" or "behavioral health," their outreach efforts to diverse communities focuses instead on "mental wellness."

Lessons and Examples from Colorado Crisis Services
In 2019, Colorado Crisis Services began strategizing how to best promote its crisis services, especially to diverse, underserved communities (including rural communities and communities of color). During their market research, they also discovered, and were surprised to find that radio had a broad reach, especially among the Hispanic communities within the state. Based on these findings, Colorado Crisis Services began marketing its services on the radio specifically to Hispanic communities. While it took a while to see gains, the efforts to promote crisis services on the radio became "fruitful, especially with Spanish-speaking audiences."[103]

In addition to the targeted radio ads, Colorado Crisis Services has also tailored its social media and print materials for diverse populations, including Hispanic and Black communities. To promote its messages and services on social media, Colorado Crisis Services collaborates with local leaders, and recruits a more diverse group of social media influencers in Colorado to make its messaging more representative. One lesson learned in using social media influencers is that SBHAs and providers should provide guidance on what the messages should cover, while allow the social media influencers to craft their own messages, using language that resonates within their own communities.

Figure 7: Colorado Crisis Services Twitter Campaign Example

Recommended Text: *When you feel overwhelmed, you don't have to go it alone. Colorado Crisis Services can help if you don't know where to start. Our trained counselors and peer specialists will listen to your story, suggest next steps, and even connect you to resources in your community. Call 1-844-493-TALK, or text TALK to 38255. Coloradocrisisservices.org*

A comprehensive list of marketing campaigns used by Colorado Crisis Services, including examples designed to better engage people from Black and Hispanic communities, as well as reaching rural and

LGBTQIA+ communities can be found online (https://coloradocrisisservices.org/toolkit/general-campaign/). An example of a Twitter post developed by Colorado Crisis Services is provided above.[104]

HAQ Strategy 6: Recruit and Retain a Representative, Culturally and Linguistically Competent Workforce that is Adept at Providing Trauma-Informed Care

A culturally responsive and diverse workforce in mental health services overall, and in crisis services, can help restore faith in the system by people of color, and lead to better outcomes for all consumers. A 2020 technical assistance paper, *Crisis Services: Addressing Unique Needs of Diverse Populations*, provides an overview of the considerations, challenges, and implications for the workforce in various crisis settings.[105] Investing in efforts to recruit and retain a representative workforce, training providers in the National CLAS Standards and trauma-informed care, and recruiting a diverse workforce from local institutes of higher education, including historically Black colleges and universities (HBCUs) will help to engage marginalized communities.

Recruitment and Retention

A lack of diversity in the behavioral health crisis workforce, and behavioral health workforce overall "contributes to poor quality of care, including higher rates of misdiagnoses among racial minorities." Research supports Rev. Bowman's assertion that there is a lack of representation among people of color, and there are a relative few who he would consider to be culturally competent in terms of engaging African American clients and patients."[106]

Data from 2016 show that the behavioral health workforce is predominantly white for psychologists, although for early career psychologists there is some improvement in diversity. See Figure 8.

Figure 8: Diversity of the Psychology Workforce[107]
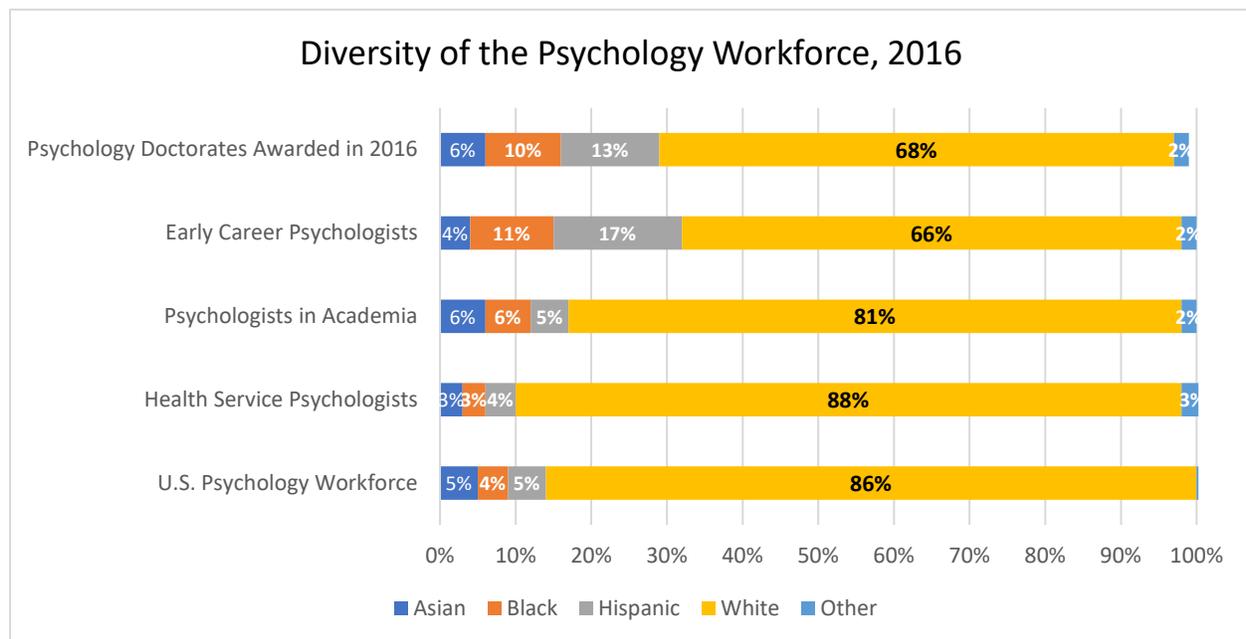
Oregon is taking steps to bolster and diversify its behavioral health workforce through significant investments from the legislature. In June of 2021, the Oregon Legislature passed a $474.4 million behavioral health package that addresses a wide variety of social determinants, including "housing and

residential services to community programs to incentives that attract people to the workforce and developing mobile crisis units."[108] $80 million of these funds will go toward two incentive programs to increase Oregon's behavioral health workforce, including scholarships, and grants for providers to offer clinical supervision for licensure.[109] Language in [HB2949](#) specifically charges the Oregon Health Authority to increase the behavioral health workforce to improve access culturally responsive behavioral health services, and to help transition individuals from incarceration back into the community, which will have profound effects on improving social determinants of health for people of color in Oregon, as Oregon's jail population is disproportionately represented by people of color.[110]

> "To improve access to culturally responsive behavioral health services by tribal members, people of color, lesbian, gay, bisexual and transgender youth, veterans, persons with disabilities, individuals with intellectual and developmental disabilities, individuals with limited English proficiency, individuals working in correctional facilities, residents of rural areas and other underserved communities. [The bill also] directs [the Oregon Health Authority] to provide funding to counties, community mental health programs and organizations to support individuals to transition from incarceration back into [the] community."

In addition to strengthening the clinical workforce, Shelley White, a Peer Policy Representative with the Minnesota Department of Human Services, recommends integrating peers into crisis response teams to improve diversity and representation.[111] She notes that peers can be incredibly helpful in crisis situations when they meet an individual experiencing a crisis in the community and wait with them until a clinician arrives. On the substance use side in Minnesota, they have been successful recruiting African American/Black peers, Muslim peers, and individuals from the large Somali community.

Recruiting from Local Institutes of Higher Education, Including Historically Black Colleges and Universities

Local universities and colleges, including HBCUs, are an excellent resource for SBHAs and providers to develop and recruit a diverse, representative, and culturally and linguistically competent crisis workforce. Providing scholarships to people of color to pursue degrees in mental health and covering the costs of licensure upon graduation help reduce the barriers many people of color face when entering the behavioral health workforce. SAMHSA sponsors an [Historically Black Colleges and Universities Center of Excellence in Behavioral Health](#), which provides up to $500,000 in funding to states to "recruit students to careers in the behavioral health field to address mental and substance use disorders, provide training that can lead to careers in the behavioral health field."[112]

National Standards for Culturally and Linguistically Appropriate Services (CLAS)

In 2013, the Department of Health and Human Services' Office of Minority Health (OMH) published the final, enhanced National CLAS Standards. According to OMH, "cultural and linguistic competency strives to improve the quality of care received and to reduce disparities experienced by racial and ethnic minorities and other underserved populations."[113] Research suggests that through the implementation of CLAS initiatives at the provider level, "there are substantial increases in provider knowledge and skill acquisition, and improvements in provider attitudes toward culturally and linguistically diverse populations."[114] In addition to more competent care, that implement the CLAS Standards also show an increase in patient satisfaction, higher levels of patient-reported quality of care, and increased levels of trust in the organization.[115] The CLAS Standards are made up of one Principle Standard, and 14 standards within three themes:

- Principle Standard 1: Provide effective, equitable, understandable, respectful, and quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.
- Theme 1: Governance, Leadership, and Workforce
  - Standard 2: Advance and sustain governance and leadership that promotes CLAS and health equity
  - Standard 3: Recruit, promote, and support a diverse governance, leadership, and workforce
  - Standard 4: Educate and train governance, leadership, and workforce in CLAS
- Theme 2: Communication and Language Assistance
  - Standard 5: Offer communication and language assistance
  - Standard 6: Inform individuals of the availability of language assistance
  - Standard 7: Ensure the competence of individuals providing language assistance
  - Standard 8: Provide easy-to-understand materials and signage
- Theme 3: Engagement, Continuous Improvement, and Accountability
  - Standard 9: Infuse CLAS goals, policies, and management accountability throughout the organization's planning and operations
  - Standard 10: Conduct organizational assessments
  - Standard 11: Collect and maintain demographic data
  - Standard 12: Conduct assessments of community health assets and needs
  - Standard 13: Partner with the community
  - Standard 14: Create conflict and grievance resolution processes
  - Standard 15: Communicate the organization's progress in implementing and sustaining CLAS

OMH has made available a series of tools and educational courses for behavioral health providers to improve their knowledge and understanding of the CLAS standards:

- An Implementation Checklist for the National CLAS Standards with a CLAS Action Worksheet and CLAS Testimonials to evaluate whether ad how well an organization is currently implementing the CLAS Standards.[116]
- Think Cultural Health is a free training for behavioral health providers. This 5.5-hour program contains four courses and is approved for up to 5.5 contact hours for counselors, nurses, psychologists, psychiatrists, and social workers; other professionals can earn a Statement of Participation. After completing these courses, participants will be able to describe how culture, cultural identity, and intersectionality are related to behavioral health and behavioral health care; describe the principles of cultural competency and humility; discuss how our bias, power, and privilege can affect the therapeutic relationship; discuss ways to learn more about a client's cultural identity; describe how stereotypes and microaggressions can affect the therapeutic relationship; explain how culture and stigma can influence help-seeking behaviors; describe how communication styles can differ across cultures; identify strategies to reduce bias during assessment and diagnosis; and explain how to elicit a client's explanatory model.[117]

Training Providers in Trauma-Informed Care

Training providers in trauma-informed care and providing trauma-informed services can help to engage people of color into treatment, including crisis services, and ensure their continued involvement in services.

Trauma is "the result of an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting, adverse effects on [an] individual's functioning and mental, physical, social, emotional, or spiritual well-being."[118] People of color are at higher risks for exposure to collective and individual trauma, due to racial trauma that has been passed through generations.[119] "People who experience extreme events of racial discrimination can develop racial trauma, which can lead to [post-traumatic stress disorder] and worsen symptoms of anxiety or depression.[120] Trauma "affects self-esteem and self-worth, especially when your skin color is weaponized against you."[121] Understanding the effects of trauma and minimizing future trauma are key components to trauma-informed care.

Trauma-informed care "views trauma through an ecological and cultural lens and recognizes that context plays a significant role in how individuals perceive and process traumatic events."[122] Trauma-informed care requires that providers anticipate and avoid institutional processes and individual practices that may retraumatize individuals with a history of trauma. Trauma-informed care values consumer participation in the development, delivery, and evaluation of services.[123]

HAQ Strategy 7: Improve Diagnostic and Level-of-Care Determination Processes

A 2014 review of the literature by Schwartz and Blankenship spanning a 24-year period found that African American/Black individuals are diagnosed with psychotic disorders at a rate three-to-four times higher than White individuals. Relatedly, African Americans/Blacks are almost five times more likely to be diagnosed with schizophrenia when compared to Whites admitted to state psychiatric hospitals. A similar trend was found among Hispanic, who were "disproportionately diagnosed at a rate more than three times higher than [White] Euro-Americans with a schizophrenia diagnosis.[124] Additionally, African Americans/Blacks discharged from state hospitals were "discharged more often with an unspecified diagnosis, such as psychosis not otherwise specified," compared to their White counterparts.[125] In a March 2021 Washington Post article, King Davis, Ph.D., former commissioner of the Virginia Department of Mental Health, indicated that one of the reasons for high rates of schizophrenia diagnoses is the perception that "Black people, Black men" in particular as "being on the cusp always of violence and danger."[126] In the same article, Arthur Whaley, Ph.D., M.P.H., notes that "when African Americans respond or react to oppression in an appropriate way, because those experiences are not shared by the mainstream they're seen as paranoid, and they're misdiagnosed."[127]

In his 30 years of service as a licensed social worker, Rev. Bowman has seen a lot of misdiagnoses among African American/Black youth, particularly for ADHD (attention-deficit, hyperactivity disorder) and oppositional defiant disorder (ODD). Contributing to this problem, notes Dr. Carter, is that diagnostic instruments and guides, including the Diagnostic and Statistical Manual of Mental Disorders (DSM) and Intelligent Quotient (IQ) tests were developed based on the experiences of White, Euro-centric populations. Inappropriate diagnostic tools and guides that are not culturally sensitive can categorize individuals with different cultural backgrounds as being lower functioning, "which is a whole other form of discrimination," as the clinical conclusion is usually that they are not able to be remediated, and therefore not given the same opportunities as White youth.[128] Dr. Carter also notes that, "if we're going

to be equitable in terms of diagnosing, the mental health community will have to look at a different diagnostic tool or significantly overhaul what we have because generally White males are the population upon which those instruments are based."[129]

SAMHSA's *National Guidelines* recommend that crisis providers use the LOCUS (Level of Care Utilization System), which "is a tool designed to assess level of care needs of individuals experiencing psychiatric and addiction challenges… [it] provides a single, easy-to-use instrument that can be used in a multitude of settings to clarify an individual's needs and identify services appropriate to address those needs."[130] By using a standardized tool, it can help providers overcome their implicit bias and reduce unnecessary institutionalization among people of color. However, more research may need to be done to ensure that these standardized instruments are equitable in their evaluations.

Dr. Carter also recommends that, "rather than starting with pathology, providers should take a strengths-based approach during evaluation," to avoid inappropriate diagnoses and level-of-care placements.[131] A strengths-based approach to mental health "moves the focus away from deficits of people with mental illnesses and focuses on [their] strengths and resources."[132]

Investing in a representative workforce that is culturally and linguistically competent can help reduce inherent bias among providers. According to Schwartz and Blankenship (2014), "the inclusion of cultural information within a diagnostic formulation is critical because a diagnostic judgement leading to a potential misdiagnosis can have several lasting negative effects for consumers, ranging from having an inaccurate healthcare record and complications related to insurance coverage, to being prescribed antipsychotropic medications and potential death resulting from self-stigma-induced suicide… Diagnoses can greatly influence the future of a consumer's healthcare, including participation in and trust of the healthcare system generally." If clinician biases can be overcome through cultural competence training, then the trend of misdiagnoses may begin to decrease.

Strategy 8: Improve Transparency and Equality in Crisis Services through Data Collection and Outcomes Monitoring

It is critical for states and providers to collect demographic data and monitor outcomes of crisis services so that racial inequities in crisis services can be understood and addressed. Data collection can also be useful to establishing trust among communities of color. Dr. Sims recommends that to overcome mistrust of the system, SBHAs and providers should be "flooding [the public] with transparency."

Many states and crisis providers do not collect demographic data about the people that use their crisis services. An internet search of SBHA data dashboards that display information about crisis services and race yields few results. However, Utah and Wisconsin both publish data about race and service access. These reports can serve to strengthen trust in the system through transparency, and enable the states to monitor the availability, accessibility, and quality of services for people of color.

Utah publishes reports for health status by race and ethnicity every five years. While not specific to crisis services or mental health, the 2015 report analyzes a wide array of health issues, including health care quality and accessibility, poverty, infant and maternal health, injuries and violence, and chronic disease.[133]

In February 2021, Wisconsin's Department of Health Services published the report, Differences in Crisis Services and Psychiatric Hospitalization across Race and Ethnicity.[134] The report provides information on

the types of unique individuals that receive crisis services in the states by race and ethnicity and identifies potential barriers to care. The report also reviews how crisis services and psychiatric hospitals are used by people of color.

By collecting, analyzing, and publishing these data, Utah's Department of Health and Wisconsin's Department of Health Services demonstrate their commitment to improving the quality of healthcare services and life for people of color in the state.

One reason that so few states publish data about who uses crisis services is that data collection in the midst of a crisis is inappropriate, as the first priority should be responding to the crisis. However, once a crisis is triaged, it is important for the crisis counselor, whether on the phone or in person, to schedule a follow-up for post-crisis care. At this point, data can be collected that helps states and providers better understand who is being served, the quality of services being offered, and the outcomes of the crisis interventions. Once an individual is in the system, it becomes easier to identify them and track their outcomes should any subsequent services be needed. SAMHSA's *National Guidelines* recommend that crisis call centers collect "data elements such as phone numbers of Medicaid-enrolled or privately insured individuals" so that they can be "combined with Caller-ID technology."[135]

Social Determinant of Health: Social and Community Context
Social and community context (SCC) refers to the "connection between characteristics of the contexts within which people live, learn, work, and play, and their health and wellbeing."[136] Factors within this domain that are pertinent to the delivery of crisis services include stigma and incarceration. Understanding and addressing the role stigma has on how people of color approach crisis services, and the effects of incarceration on communities of color are critical to providing a more equitable crisis continuum. Strategies that SBHAs and providers can use to address social and community context include:

1. Understand and address stigma in diverse communities
2. Reduce incarceration through diversion and improved law enforcement response

SCC Strategy 1: Understand and Address Stigma in Diverse Communities
In addition to reluctance to reaching out for crisis services due to mistrust, many communities of color attach stigma to seeking mental health services and see the need for care as taboo or controversial. For many African Americans/Blacks, their "story is one of perseverance and resilience," with the thought that "after all, we survived slavery; surely we can survive 'sadness' or 'anxiety.'"[137] Many Asian communities stigmatize mental health due to the emphasis on family honor and purity, whereas mental illness may be seen as shameful, untreatable, and weak.[138] According to Diana Lorenzo, M.D., a psychiatrist with the Cleveland Clinic's Center for Behavioral Health, "many Latinos would prefer to ignore [mental health] conditions over talking about them openly."[139] Understanding the stigma associated with mental illness among Native American/Alaska Natives is complex, as "the concept of mental illness has different meanings and is interpreted in various ways," as Native American and Alaska Natives are not one homogenous group. These attitudes cause some people of color "to believe they are exempt from mental health issues."[140] These beliefs can be dangerous because they cause individuals to avoid or delay critical treatment.

Ms. Green indicates that the first step in overcoming or reducing stigma is understanding how each culture perceives mental health treatment. Reframing the system from one that is punitive for people of

color to one that offers problem solving options, even if mandated treatment, would go a long way.[141] Other strategies to reduce stigma in communities of color to increase engagement with the system include reducing stigmatizing language (as Colorado Crisis Services did by changing "Mental Health" to "Mental Wellness) and engaging with community partners, as described above, to normalize the conversation around mental health and crisis services.

Focused marketing campaigns similar to what Colorado Crisis Services has implemented can also be effective at normalizing the conversation around mental health and wellness. By engaging community leaders and other respected individuals (e.g., athletes, celebrities, influencers) and allowing them to use their own voice to promote messages can help engage communities of color and destigmatize mental health crisis care.

Other strategies for overcoming stigma within communities of color include:[142]
- Removing the language barrier so that providers can fully understand the needs and desires of their clients. While interpreters can be helpful, a linguistically diverse workforce is most effective at interpreting cultural nuances and jargon.
- Due to stigma associated with mental health, people of color may be more likely to reach out to a primary care physician for help rather than a dedicated mental health or crisis provider. Ensuring that primary care providers have the right tools to help diverse populations identify a mental health crisis and normalize the need for mental health services can help to destigmatize the need for mental health services within diverse communities.
- Many communities of color emphasize the family unit more than White families in the U.S. Recognizing the value of the family unit and encouraging family involvement in care, including how to get someone the help they need in a crisis, can help normalize the need for mental health services in communities of color. By involving family members up front, it is also more likely that an individual will return for follow-up appointments post-crisis.

SCC Strategy 2: Reduce Incarceration through Diversion and Improved Law Enforcement Response

The U.S. jail census has nearly quadrupled since 1970, with admissions reaching 11 million annually.[143] Although people of color make up 20.8% of the U.S. population, they are significantly over-represented in prisons and jails, especially African Americans/Blacks. In 2019, African Americans/Blacks accounted for 26.6% of all arrests, even though they only make up 13.4% of the U.S. population. Similar trends exist for American Indians and Alaska Natives, where the percentage of arrests (2.4%) is nearly twice the percentage of their population (1.3%). Data also show that people of color are more likely to be arrested for minor offenses, including disorderly conduct and vagrancy. See Figures 9 and 10 on the following page.

Figure 9: Percentage of Arrests Compared to Overall Population by Race, 2019[144]
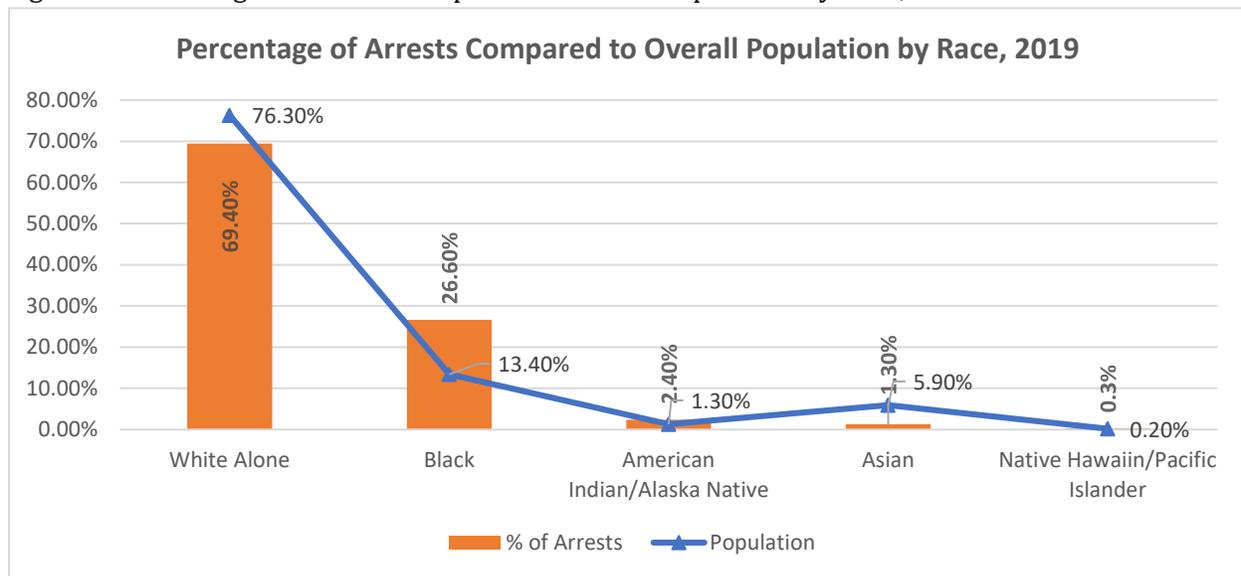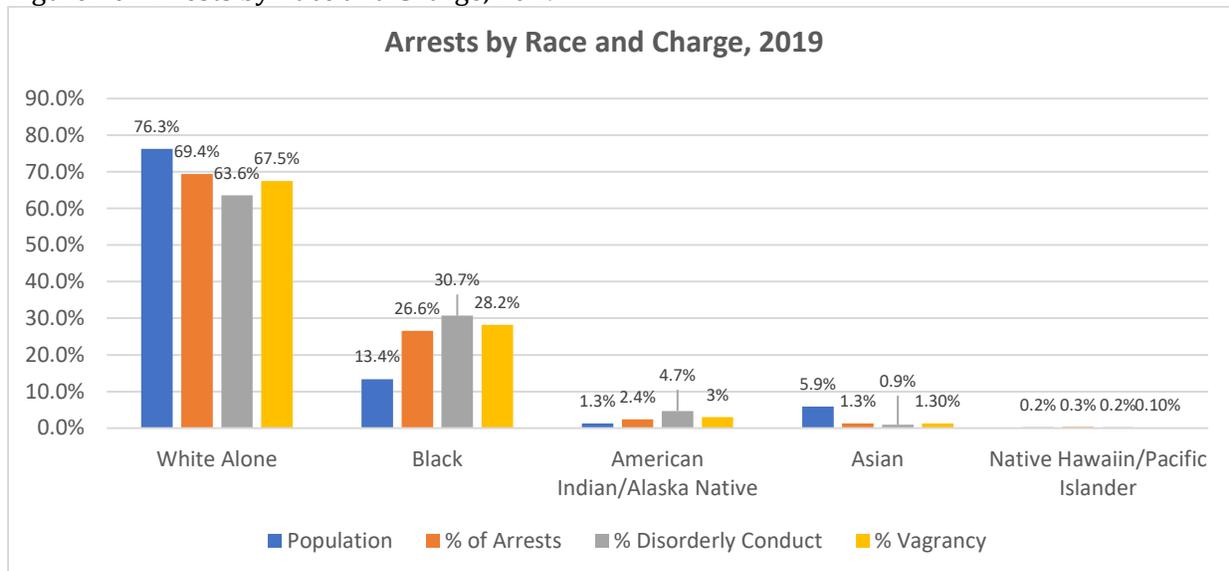

Figure 10: Arrests by Race and Charge, 2019[145]

Ms. Green observes that even though Tampa Crossroads operates in a predominantly diverse neighborhood, the majority of their clients are White. Even though the services provided by Tampa Crossroads are covered through a grant from the county, few people from the local area seek out their services. In addition to needing more outreach and education on how to access services, her theory for why her clientele are predominantly White is because "more people of color are sent to jail, and not given the option for treatment."[146] Research supports her theory. A study by Carson, et al. in 2014 found that African American/Black men experiencing a psychiatric crisis are less likely to be evaluated for hospitalization than White individuals with similar symptoms and are more likely to be sent to jail where they are less likely to receive behavioral health care than their White counterparts.[147]

Reducing law enforcement response to crisis services and enhancing training for the times when they need to respond will help reduce incarceration among people of color experiencing a crisis. Diverting individuals from jail will help to break the cycle of incarceration, and the trauma associated with incarceration by allowing parents to reunite with their children, return to work, and participate in their communities.

Making Change Happen: Leadership from the State Behavioral Health Authority

Meaningful change toward a more equitable system requires leadership from the SBHA. Several financial opportunities recently became available that SBHAs can leverage to bolster their crisis continuum, including the American Rescue Plan Act of 2021 (ARP), and an expansion of SAMHSA's Mental Health Community Services Block Grant (MHBG) Plan.

The ARP "establishes a new state option to provide community mobile crisis intervention services for a five-year period beginning April 2022."[148] To incentivize states to use these funds for the implementation of crisis services, "the law allows for an 85% enhanced federal matching rate for qualifying services for the first three years of state coverage." Additionally, the ARP also includes $15 million in state planning grants to support the development of a Medicaid state plan amendment or waiver request to take up the option. In addition, as part of the ARP, Congress added $1.4 billion to the MHBG with SAMHSA emphasizing to the SBHAs that these additional funds can be used to support crisis services.[149] The amount of funds each state receives through the ARP varies, ranging from $181,128 in Wyoming, to nearly $9.5 million in California. In addition, as part of the fiscal year 2021 MHBG appropriations to SAMHSA, Congress added a new 5% set aside (nearly $42.3 million) dedicated to supporting mental health crisis services.

Multiple SBHAs recognize the need for, and value of diversity and representation in behavioral health services. Some states, like New York, have gone beyond simply recognizing the value of diversity and representation to creating an Office of Diversity and Inclusion to manage the cultural shift required to create a more equitable system.

For many decades, New York's Office of Mental Health (OMH) has convened a stakeholder advisory group to focus on special populations. The stakeholder group consists of representatives from marginalized populations in the state, including people of color, residents from rural areas, veterans, and individuals whose native language is something other than English. This stakeholder group advocated that there be staff within OMH to work with the commissioner and other state leadership to focus on diversity and inclusion. At first, the office consisted of a secretary and "maybe one other person," and was not very high up in the SBHA. Around two years ago, priorities began to focus on diversity and inclusion within the SBHA and the office was elevated officially to the Office of Diversity and Inclusion, complete with senior staff and an executive team. Following the murder of George Floyd in May of 2020, the Office of Diversity and Inclusion was elevated further to report directly to the commissioner, and now has five staff. Funding for this Office comes directly from the SBHA through State General Funds.

The Office of Diversity and Inclusion is tasked with ensuring that all OMH requests for proposals address the CLAS Standards and address equity in a strong way, including diversifying and training the workforce to be more culturally competent. The Office of Diversity and Inclusion is also responsible for promoting

the message of inclusion and providing guidance on best practices for a culturally competent workplace. When working with providers, Matthew Canuteson, M.A., Director of the Bureau of Cultural Competence recommends "giving people information in concrete, tangible bites" that can be used incrementally to improve their programs.[150] Messaging should be "consistent and clear. It's important that people aren't getting 18 separate ideas on what they should be doing!"[151]

Mr. Canuteson acknowledged that the current political climate is creating opportunities to move the conversation around race and ethnicity forward; however, there is some fear that once the world settles and COVID is over, that some focus and attention on these important issues will be lost. Because of this risk, and the potential for changing priorities, it is important that structural changes to the organization of the SBHA be made to sustain the SBHAs leadership in diversity and inclusion. The Office of Diversity and Inclusion is also trying to show providers how to make lasting changes within their own organizations that support equity.

When asked what the biggest barrier to change is? Mr. Canuteson simply stated, "racism." He notes that racism is the number one issue that his office deals with. To overcome these challenges, they train from a model that everyone has bias. It takes leadership for an agency, a provider, and an individual to self-reflect and find ways to improve. Leadership from the SBHA can create avenues for communication to openly discuss bias, and it helps if there is leadership from other agencies, too.

Oregon's Health Authority is an example of state leadership in equity. In 2020, as part of its response to the COVID-19 pandemic, the Oregon Health Authority established a goal to eliminate health inequities by 2030. The Oregon Health Authority's Policy Board developed the following definition of equity that highlights its values in achieving the strategic goal:

> "Oregon will have established a health   system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances. Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments, to address:
> - The equitable distribution or redistribution of resources and power; and
> - Recognizing, reconciling, and rectifying historical and contemporary injustices."[152]

This goal is the driving force behind its 2022-2027 1115 Medicaid waiver application, its COVID-19 vaccine distribution campaign, and all other activities within the state's health system. By establishing this overarching goal, it has allowed the Oregon Health Authority, and the state legislature, to focus on one thing to make change. In order to achieve this goal, the Oregon Health Authority realizes that it "must meaningfully engage with communities most impacted and often left out of the decisions that affect their lives."[153]

To meaningfully gather input from marginalized communities and guide efforts related to equity, the Oregon Health Authority's Division of Equity and Inclusion went out to communities around the state. State representatives gave presentations in these communities to gain interest in the input process, and then offered space for the community to meet in the evenings outside of work hours, at times that would be most convenient to the community. To ensure candidness during these sessions, state representatives were not present; however, facilitators from the community were on hand to guide the

discussion and take notes. From these community engagement sessions, the Oregon Health Authority had analysts review the notes and categorize recommendations by themes. Some of the feedback the Oregon Health Authority received is that peer support specialists need to be utilized more to create a more representative workforce, and that both quantitative and qualitative data should be used to guide decision making and quality improvement efforts. This feedback is guiding the state's equity efforts moving forward. According to the state, "this was the most effective community engagement process."[154]

Conclusion

In the U.S., racism affects all people of color and is an enduring, primary social determinant of racial inequities in population health and mental health.[155] Historic, structural racism and implicit bias have led to a lack of trust among people of color of systems that involve law enforcement and institutionalization, including the mental health crisis system. This distrust also contributes to increased stigma among communities of color. To begin to overcome these barriers and to create a more equitable and accessible crisis system, it is critical that SBHAs and providers partner with trusted community leaders (e.g., clergy in local churches) to both offer supportive services that improve social determinants of health and spread the word to build trust and engage more people of color into crisis care. To further build trust, SBHAs and providers can improve data collection and reporting processes to be more transparent and embark on quality improvement initiatives to identify strengths and weaknesses in the crisis system. While it is ideal for law enforcement to be removed from crisis response, it is often not feasible to eliminate their role completely, especially in areas with limited resources. Therefore, it is critical that law enforcement be trained in how to effectively respond to crises without the use of force, and how to divert individuals to appropriate levels of care. These strategies will help build trust with communities of color to reach out for help when they are most vulnerable. Within any system, there will be resistance to change, particularly if the organization or system has amassed a lot of influence, and is part of a large, bureaucratic system. This resistance can lead to an oppressive culture; however, looking to SBHA leadership to make a commitment to equity and inclusivity helps move the efforts forward.

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