Eliminating Structural Racism in Behavioral Healthcare Work Group Meeting Summary

10.5.2020 held via Zoom

Speakers: Rev. Benjamin F. Gohlstin, Board Chair and Scott Osiecki, CEO

Breakout Moderators: Tami Fischer, Kelli Perk, Allison Schaefer and Madison Greenspan

ADAMHS Board Staff Facilitating Work Group Meetings: Carole Ballard (ballard@adamhscc.org), Beth Zietlow-DeJesus (dejesus@adamhscc.org)

- **Introductions:** Scott Osiecki thanked all for attending and explained why the work group is important and reviewed the agenda.

- **Ice breaker activity:** Scott gave the opportunity for the group to share in the chat box, one word that comes to mind when you think of "racism". Some examples are "Inequity, inequality, silent, stereotypes, limiting, hurtful, unjust, fear, disrespect, harmful, discrimination, suffering, anger, current, trauma, burden, frustrating, disempowering, generational, etc. "(not inclusive list)

- Mr. Osiecki introduced 2 videos as a framing exercise:

    - Video 1 by CBS "Think". Video reviews racism as a public health crisis, just like Covid-19: https://www.nbcnews.com/think/video/racism-and-the-body-why-racism-is-a-public-health-crisis-for-black-americans-89669701906

    - Video 2 is "Health Equity Animated" a quick refresher video that reviews differences between equity and equality: https://www.youtube.com/watch?v=tZd4no4gZnc

- Rev. Gohlstin shared information about the economic impact of racism: "America has missed $16 trillion because of racism in America. The African American community has failed to grow $2 trillion dollars due to racism"

- Rev. Gohlstin explained why the ADAMHS Board was acting on work to address Racism as a Public Health Crisis now and reviewed the ADAMHS Board Resolution and recommendations with attendees.

- **Brainstorming Session:** Split into 4 breakout groups to:

  1. Define existing barriers for behavioral healthcare and consider the who, where, when, how these are impacted by racism.

  2. Identify Disparities in Behavioral Healthcare keeping in mind immediate, short-term and long-term goals?

  - Groups Reported Out: See report out notes by question below

  - Meeting Structure, dates and times, and next steps discussed:

  - Mr. Osiecki introduced a poll about meeting structures and to when and how we can best meet again.

    - Group preferred smaller subcommittees that meet monthly on the first Monday of the month during time frame 1 – 4 pm.

  - Mr. Osiecki talked about next steps - what will be happening at next meeting and that a consultant was hired to help move work forward.

  - One question asked: “Is this an open meeting for others to attend?”

    - Scott: “yes, anyone interested is welcome to attend”

  - Thanked all for attending and meeting ended at 2:04pm

Breakout Session Notes:
Eliminating Structural Racism in Behavioral Healthcare
Work Group Meeting, Monday, Oct. 5, 2020.

Q1. Define Existing Barriers for Behavioral Health Care Related to Racism

Group 1 (Samantha H.):

- Seeing therapists that look like you and understands experience.
- Making preferences available, as requested.
- Considering efforts and incentives to specifically target recruitment efforts to make your organization diverse on purpose.

Group 2 (Lori O.):

- Helpful to have more providers of color
- Hard to find staff
- Linguistic competency that clients need
- Lack of training / need for training around bias in working with clients in minority populations
- Ignorance/lack of experience – various populations don't understand each other and what may be construed as offensive. Creates issues amongst staff. Lack of knowledge about generational trauma and importance of verbiage. Words matter. Can be hurtful.
- Not an "equal opportunity" to get arrested in Cuy. Co.
- Lack of access – disproportionally impacts minorities
    - Numerous factors involved in lack of access –
    - Including homelessness
    - Disproportionally affects minorities
    - This can lead to barriers to access due to lack of verification of residency – Also it is very difficult to focus on or succeed in treatment when one does not have a safe place to sleep
- Stigma / cultural competence – need to remove so more people will come forward
- Policies often do not support people who are disenfranchised
- Marketing of services – many people do not have access to internet – lack of delivering the message in forms that people can receive it.
- Overall general assumptions that a group of people are all the same.
- Some cultures may not accept behavioral health services, and this results in smaller numbers. Don't want to be viewed differently in their own culture.
- System disproportionally impacts people of color/minorities. System is built on assumptions that people have certain resources. Assume people have a safe place to sleep, eat, transportation. Expect people to show up at certain day/time

without helping them to do so. These assumptions may not hold true to the most vulnerable.

- Access and image. The face of behavioral health is white – clinicians, etc. Minorities usually show up in lower level positions. People prefer to have people who have "like" experiences. That person can relate a little more. Assumptions: everyone we come into contact with is not in the same category. Access: majority of services are in 1-2 areas in Cleveland, leaving others with no access.

Group 3 (Christina B.):

- Insurance or lack thereof
- Many individuals are not eligible for Medicaid but do not make enough money to be able to pay for care out of pocket
- Workforce issues; racial and ethnic make-up does not reflect the communities we serve
- Unconscious bias – on both sides; clients reluctant to meet with someone that is of their race/ethnicity; and practitioners that make assumptions based upon an individual's race/ethnicity
- Messaging is practically non-existent in minority communities
- Stigma/labeling
- Historical impact of racism
- Not trusting of systems
- Keep family issues within the family
- Wary of law enforcement involvement
- Need for training on historical trauma
- Accountability: must be able to hold organizations and practitioners accountable for that which they've been trained
- Lack of community involvement; need more input, i.e., focus groups, and other opportunities for those we serve to have a voice in the process

Group 4 (Joe A.):

- Health literacy
- Financial barriers for both providers and clients
- Ability to access/use technology for telehealth
- Stigma
- Not having enough conversations about cultural differences and service delivery
- Trust

Q 2. Identifying Disparities in Behavioral Healthcare

Group 1 (Samantha H.):

- European model of care does not always consider the world view of all ethnicities.
- Training on how to assess for racial trauma, understanding on how to diagnose and treat racial trauma and BH needs.
- Encouraging legislation for repairing racial trauma/disparities
- Workforce development to focus on the needs of bilingual and diverse needs of the populations served
- Rabbi Gohlstin recommended a book... Ibrim Kendi- "Anti- Racism"

Group 2 (Lori O.):

- Education, requirements for licensure.
- How do we attract people of color?
- Transportation / access
- Access: Verification of residency (barrier for people with no ID), people with severe co-occurring disorders who need crisis care (can't be admitted for mental health needs if need detox and vice versa)
- Is there a difference re: coverage of insurance? Do minorities have more denials of coverage? Wondering.
- Referrals – Minority communities may have opportunities. May be arrested instead of being referred for service.
- Generational racism – minorities may learn to distrust systems over time.
- Perception that minorities don't want to be in treatment. Offered plea bargains instead. Affects numbers of minorities in treatment centers.
- A lot of people access care only through the criminal justice system. May see treatment as a punishment as a result.

Group 3 (Christina B.):

- The manner in which people of color come into the system
    - Often the result of system involvement, DCFS, criminal justice, etc.
- Lack of access to and/or awareness of community resources
- Those who have $ and those who do not
- Law enforcement and other system involvement
- Concrete data is needed around disparities; not sure what data is out there or how it should be tracked

Group 4 (Joe):

- Need to educate clinicians about different treatment modalities that are culturally specific – short-term

- Need to coordinate services more and work together more between providers – short-term
- Misdiagnosis of African American clients
- Not having information about what services are available
- Historical trauma