

Appendix G – Addressing Behavioral Health Disparities

In April 2011, the Department of Health and Human Services (HHS) released its *Action Plan to Reduce Racial and Ethnic Health Disparities*. This plan outlines goals and actions HHS agencies, including SAMHSA, will take to reduce health disparities among racial and ethnic minorities. Agencies are required to continuously assess the impact of their policies and programs on health disparities. The Action Plan is available at: http://minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf.

The number one Secretarial priority in the Action Plan is to: **“Assess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities.** HHS leadership will assure that: Program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits.” (See disparity impact statement examples at: <http://beta.samhsa.gov/grants/grants-management/disparity-impact-statement>)

To accomplish this, SAMHSA expects grantees to utilize their data to: (1) identify subpopulations (i.e., racial, ethnic, sexual/gender minority groups) vulnerable to health disparities; and (2) implement strategies to decrease the differences in **access, service use, and outcomes** among those subpopulations. A strategy for addressing health disparities is use of the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care.

Definition of Health Disparities:

Healthy People 2020 defines a health disparity as a “particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.”

- **Behavioral health status disparity:** “A population is a health disparity population if there is a significant disparity in the overall rate of disease incidence, prevalence, morbidity, mortality or survival rates in the population as compared to the health status of the general population.” (Minority Health and Health Disparities Research and Education Act, 2000)
- **Behavioral health care disparity:** “...Racial or ethnic differences in the quality of healthcare that are not due to access-related factors or clinical needs, preferences and appropriateness of interventions.” (Institute of Medicine, 2002)

Subpopulations

SAMHSA grant applicants are routinely asked to define the population they intend to serve given the focus of a particular grant program (e.g., adults with serious mental illness [SMI] at risk for chronic health conditions; young adults engaged in underage drinking; populations at risk for contracting HIV/AIDS, etc.). Within these populations of focus are *subpopulations* that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, Latino adults with SMI may be at heightened risk for metabolic disorder due to lack of appropriate in-language primary care services; Native American youth may have an increased incidence of underage drinking due to coping patterns related to historical trauma within the Native American community; and African American women may be at greater risk for contracting HIV/AIDS due to lack of access to education on risky sexual behaviors in urban low-income communities. While these factors might not be pervasive among the general population served by a grantee, they may be predominant among subpopulations or groups vulnerable to disparities. It is imperative that grantees understand who is being served within their community in order to provide care that will yield positive outcomes, per the focus of that grant. In order for organizations to attend to the potentially disparate impact of their grant efforts, applicants are asked to address access, use and outcomes for subpopulations, which can be defined by the following factors:

- By race
- By ethnicity
- By gender (including transgender), as appropriate
- By sexual orientation (i.e., lesbian, gay, bisexual), as appropriate

HHS published final standards for data collection on race, ethnicity, sex, primary language and disability status, as required by Section 4302 of the Affordable Care Act in October 2011,

<http://www.minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=208>.

The ability to address the quality of care provided to subpopulations served within SAMHSA's grant programs is enhanced by programmatic alignment with the federal CLAS standards.

National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care

The National CLAS standards were initially published in the Federal Register on December 22, 2000. Culturally and linguistically appropriate health care and services, broadly defined as care and services that are respectful of and responsive to the cultural and linguistic needs of all individuals, is increasingly seen as essential to reducing disparities and improving health care quality. The National CLAS Standards

have served as catalyst and conduit for the evolution of the field of cultural and linguistic competency over the course of the last 12 years. In recognition of these changes in the field, the HHS Office of Minority Health undertook the National CLAS Standards Enhancement Initiative from 2010 to 2012.

The enhanced National CLAS Standards seek to set a new bar in improving the quality of health to our nation's ever diversifying communities. Enhancements to the National CLAS Standards include the broadening of the definitions of health and culture, as well as an increased focus on institutional governance and leadership. The enhanced National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care are comprised of 15 Standards that provide a blueprint for health and health care organizations to implement culturally and linguistically appropriate services that will advance health equity, improve quality, and help eliminate health care disparities.

You can learn more about the CLAS mandates, guidelines, and recommendations at: <http://www.ThinkCulturalHealth.hhs.gov>.

Examples of a Behavioral Health Disparity Impact Statement are available on the SAMHSA website at <http://www.samhsa.gov/grants/grants-management/disparity-impact-statement>