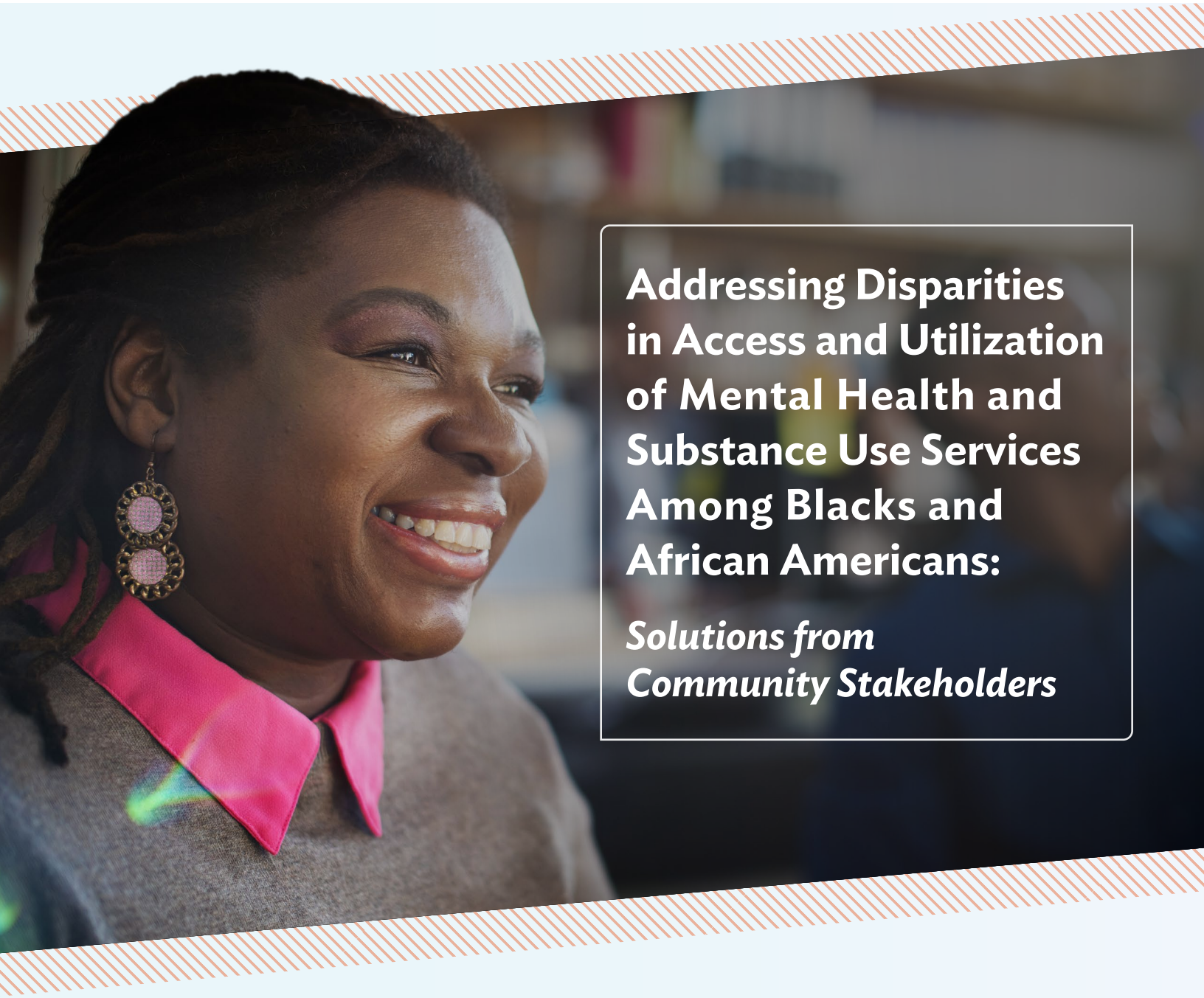
African American Behavioral Health
CENTER OF EXCELLENCE



Addressing Disparities in Access and Utilization of Mental Health and Substance Use Services Among Blacks and African Americans:

Solutions from Community Stakeholders

NATIONAL COUNCIL
for Mental Wellbeing

February 2022

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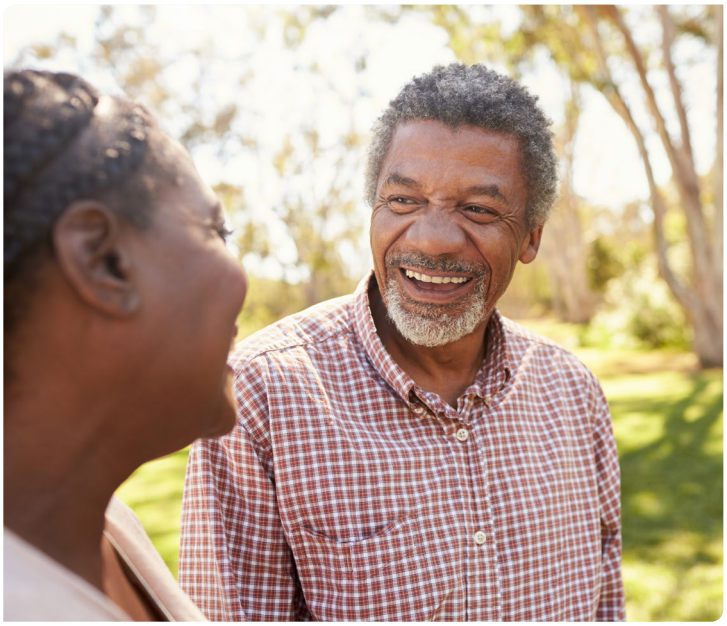
Introduction

Overall, the rates of mental health conditions and substance use in Black/African American (B/AA) people are similar to those of the general population, yet outcomes for B/AAs are poor relative to the general population. According to a 2018 study by the Substance Abuse and Mental Health Services Administration (SAMSHA), 16% of B/AAs reported having a mental illness, and serious mental illness rose with 22.4% of B/AAs reporting a serious mental illness that year.[1] Furthermore, substantial increases in drug overdose deaths have been reported. The rate of increase in drug overdose deaths in 2016 for B/AAs exceeded other racial groups (40% compared to 21% for the overall population).[2] Non-Hispanic B/AAs, compared to all other races, had the highest death rates attributed to synthetic opioids, represented by an increase of 818%. [3]

To address the need for health equity in this large and critically affected population, SAMHSA has established the African American Behavioral Health Center of Excellence (AABHCOE) at Morehouse School of Medicine. Tasked with providing training and technical assistance to organizations and practitioners, the new AABHCOE is determined to direct its resources toward central and critical aspects of this large and multifaceted problem.

Located within the Morehouse School of Medicine's National Center for Primary Care, this five-year grant will use innovative, evidence-based, culturally aligned systems-change, workforce development, technology transfer and collaborative national partnerships to eliminate disparities and promote mental health and substance use treatment and health equity for African Americans. The center of excellence proposes to meet the following goals:



- ***Goal 1:*** Increase the capacity of mental health and substance use treatment systems to provide outreach, engage, retain, and effectively care for B/AA people.
- ***Goal 2:*** Improve dissemination of up-to-date information and culturally appropriate evidence-based practices/approaches for B/AA people.
- ***Goal 3:*** Increase workforce development opportunities focused on implicit bias, social determinants of health, structural racism and other factors that impede high-quality care for B/AA people.
- ***Goal 4:*** Increase collaboration between the AABHCOE and SAMHSA Technical and Training Assistance (TTA organizations, to infuse culturally appropriate information on B/AA people in all SAMHSA-funded TTA Centers.

Purpose of the Paper

As one of the AABHCOE's national partners, the National Council for Mental Wellbeing has developed the following white paper to assist the public in better understanding the health disparities that exist in the access, engagement, utilization and outcomes for B/AAs seeking specialty mental health and substance use treatment services. Additionally, this report will highlight solutions and promising practices derived from mental health and substance use treatment providers to effectively meet the needs of B/AAs seeking mental health and substance use treatment services.

METHODOLOGY

This paper provides a brief literature review of recent research related to disparities in access, delivery and outcomes for B/AA in need of mental health and substance use treatment services. The National Council conducted searches of relevant medical, psychological and public health databases, including PubMed, EBSCOhost and PsycInfo as well as recent editorials and other supplemental materials from key mental health and substance use agencies and associations (e.g., SAMHSA, APA, etc.). This is not an exhaustive review but rather seeks to help the reader understand the current range of issues and concerns that affect access, outcomes and utilization of mental health and substance use services.

To supplement findings from the literature review, the National Council conducted four key informant interviews and one focus group. Key informants provided perspectives related to clinical practice, advocacy, funding, leadership, service delivery and receipt of mental health/substance use services. The focus group participants were a convenient sample of providers who have significant experience working with the population and providing services. These conversations offered context for understanding the literature as well as providing solutions from the field to better address gaps in service and improve outcomes. The discussions were guided by a set of questions (see appendix) that centered on various themes such as engagement strategies, finance, trauma, workforce, access and utilization of services.

BACKGROUND

Although, the overall rates of mental health and substance use conditions in B/AAs are similar to those of the general population, a myriad of inequities exists in regard to the outcome and provision of these services. B/AAs often receive poorer care. They have lower rates of utilization of any mental health service including medications and outpatient services compared to Whites but greater use of inpatient services and emergency rooms rather than mental health services. [4] B/AAs are less likely to be given evidence-based treatment or psychotherapy compared with the general population. [5] The literature cites a myriad of possible factors for these differences; chief among them are stigma, funding/accessibility, lack of treatment knowledge, cultural competence and provider diversity, and racial bias-stereotyping.

STIGMA

According to a study by Ward, Wiltshire, Detry, and Brown in 2013, B/AAs have beliefs which are associated with help-seeking, stigma and psychological openness which in turn affects their coping behaviors and how they seek mental health and substance use services. For example, surveys of their attitudes and beliefs suggest they view mental health problems as stigmatizing or as a weakness and are not very open to acknowledging such problems. They also believe that mental health problems can improve on their own as a coping strategy and also tend to prefer religious-based coping strategies. [6] Historically, there has been a mistrust of the mental health service systems within the black community as they have been known to misinterpret and criminalize the behaviors of B/AAs, which has sometimes led to involuntary hospitalization, incarceration and potential loss of benefits such as employment or housing. [7,8]

This stigma within minority communities or family networks may decrease the utilization of medical and community-based mental health services. Stigma related to the use of mental health services may lead to a preference for using primary care clinics to receive necessary treatment for mental health challenges. However, services provided in primary care clinics have been shown to underdiagnose and undertreat mental health disorders. [9] Thus, the potential efficacy of these services may be limited and thereby contribute to existing disparities. Additionally, there are negative attitudes and stigma towards Opioid Agonist Treatment which persist as a barrier to the receipt of care among B/AAs. Injection drug use continues to be a major public health issue and evidence suggests that the burden falls disproportionately on minority individuals. Methadone maintenance therapy (MMT) has been shown to reduce opiate use and general mortality, but minorities are less likely to access MMT compared to Whites. [10] The findings suggest that potential barriers to treatment include negative perceptions that methadone is detrimental to health, the cost of MMT, a belief that a person on MMT is not abstinent from drugs and the difficulty of attending a methadone clinic regularly.

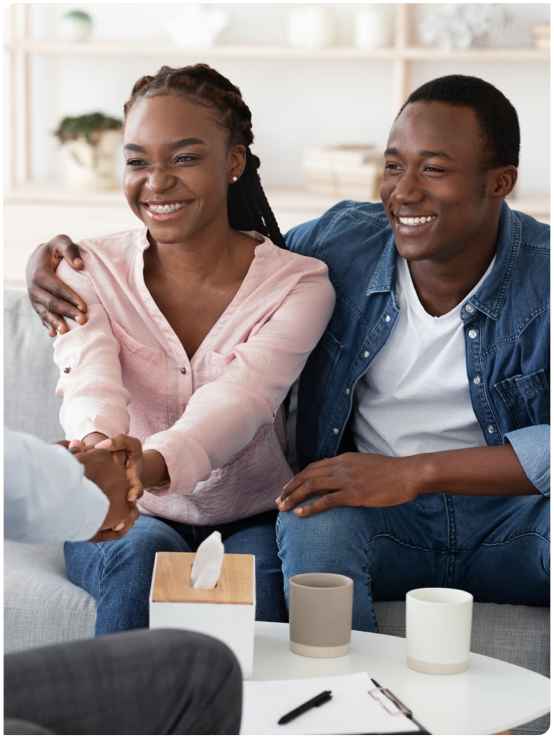
FUNDING/ACCESSIBILITY

One major reason disparities in access or utilization of services for B/AA people exist is the lack of health insurance and other financial resources to pay for services. In 2018, the number of uninsured B/AAs was 11.5% compared to 7.5% of Whites. [11] In 2018, 50% of B/AA adults with a serious mental illness and 90% with a substance use disorder did not obtain the needed treatment. [12] In 2016, 12% of B/AAs compared to 7% of Whites had difficulty obtaining the necessary care, tests or treatment. [12]

With increasing rates of opioid overdoses among B/AA, it is important that research and policy efforts particularly address racial and economic differences in the availability of treatment options.

Disparity in access to buprenorphine and methadone exist, and buprenorphine is considered to be a less stigmatizing office-based treatment. Yet, it can be difficult to find a buprenorphine waivered provider in many organizations serving uninsured or low-income B/AAs due to limited reimbursement rates and lack of resources and training to properly administer buprenorphine.[13] Thus, methadone is accessed by low-income individuals, people of color and the publicly insured while buprenorphine is accessed by high-income individuals, Whites and the privately insured. Despite the expansion of Medicaid and enactment of mental health and substance use parity legislation, the number of self-pay buprenorphine visits has remained relatively steady. A recent study showed that 50% of the physicians who prescribed buprenorphine in Ohio accepted only cash, and this practice may be widespread in other areas which created additional financial barriers for low-income populations limiting options for care. [14]

Moving forward, an examination of patient, clinician and system characteristics with a discussion of inequities in treatment access and utilization will be imperative to reducing these disparities.



Emphasizing upstream factors by addressing barriers in access to mental health services which are linked to racially inequitable distribution of resources is imperative for minimizing unmet need among B/AAs.

Research has also shown that racial disparities exist in the use of medications that treat opioid disorders among pregnant women where B/AA women were less likely to use medications and were less likely to receive buprenorphine compared to White women. [14,15] This is possible as B/AAs compared to Whites are more likely to access medication from publicly funded treatment programs and the majority of these programs dispense only methadone.

LACK OF TREATMENT KNOWLEDGE AND OPTIONS

Furthermore, according to the study by Kiechle and Gonzalez (2020), B/AAs are not aware or knowledgeable of standard treatment options for substance use disorders which decreases the chance that they will seek evidence-based treatments. [16] Disparities in treatment options is prevalent among many B/AA communities and access to treatment depends on income, race, geography and insurance rather than individual preferences or medical indicators. [17] Also, research shows that B/AAs with opioid use disorders have less access to the complete range of medication-assisted treatment compared to Whites.[12]

Additionally, according to a study, B/AAs who resided in non-metro areas were more likely to report accessibility barriers such as the lack of transportation, knowledge on where to go for care and the inconvenient location of providers compared to their peers in large urban areas. They were also more likely to believe that mental health treatment will not work. [8] One possibility for this point of view is that accessibility barriers are preventing individuals from seeking care and therefore limiting opportunities to experience positive outcomes of care.

CULTURAL COMPETENCE AND DIVERSITY AMONG SERVICE PROVIDERS

A disproportionably low supply of providers in diverse communities also promotes service disparities in access. There is a shortage of culturally responsive B/AA providers and physicians who can prescribe medications and treat substance use disorders making it difficult for B/AAs to engage in treatment. [18] Racial/ethnic concordance between physicians and patients could result in improved trust, utilization and adherence to medical treatment, yet less than 2% of American Psychological Association members are B/AA. [19] Communities with high proportions of B/AA and Latino residents are four times as likely as White communities to have a shortage of healthcare providers, regardless of community income. [20] Minority physicians are most likely to practice in communities that have a high proportion of minority patients. Thus, the recruitment and retention of minority practitioners can help improve access for this vulnerable population.

The recruitment and retention of B/AA faculty in academic medicine and psychiatry remains a challenge. Major changes in the demographic landscape of the nation over the past decade highlight the need for the health care system to be better aligned with the cultural and social needs of individuals seeking care. In an editorial by Dr. Altha Stewart, former president of the American Psychiatric Association (APA), indicates that significant changes need to be made in institutional practices to address racism.[21] Leaders should be willing and able to recognize the unintentional but institutionalized limitations in their systems to create equitable and welcoming environments for all professionals entering the field.

Other recent personal accounts bolster concerns about racism hurting the recruitment and retention of people of color in the mental health and substance use field. One of the nation's preeminent B/AA psychiatrists, Dr. Ruth Shim, described her reasons for leaving the APA to include structural racism, lack of prioritization and inattention to the needs of B/AAs. She emphasized the need for financial commitment and accountability in order to eradicate structural racism in organized psychiatry. [22]

RACIAL BIAS/STEREOTYPING

Data suggests that racial bias and stereotyping may also play a significant role in these disparities. False notions of biological differences continue to shape the way B/AAs are perceived or treated in healthcare. In a study that assessed racial attitudes, 50% of White medical students and residents had non-scientific beliefs regarding fundamental biologic differences between B/AA and White individuals.[23] Several factors may also contribute to disparities in B/AA pain management. A review of the literature to explore the interaction between race/ethnicity, cultural influences; pain perception and communication suggests that B/AAs are more likely to experience miscommunication regarding their pain with medical providers [24] A meta-analysis showed that B/AAs were 29% less likely to be prescribed opioids for pain symptoms compared to Whites. [25] The false beliefs regarding the disparities between B/AA and White individuals' pain thresholds results in less appropriate treatment options for B/AAs. Further research indicates that the physician-patient communication varies by races as well. One study suggested that with B/AAs, 23% of physicians were more verbally dominant and 33% of physicians were engaged in less patient-centered communication.[26]

Another study described how structural racism affects patients and staff in the hospitals as well as the communities they serve and the importance of staff training to create a more informed health care workforce to address discrimination and unconscious bias. The study found that implicit bias was significantly related to patient-provider interactions, outcomes, treatment decisions and adherence. [27] Thus, individual racism affects how patients are treated through implicit bias or subconscious prejudices.

> ***"Tell me your story for African Americans really translates into 'tell me what has happened to you.' There's a big difference from our typical clinical assessment of trying to determine what's wrong to truly being interested in what's happened to you, again particularly for people of color."***

Focus Groups and Key Informant Interviews

Described below are some of the key findings and possible solutions that emerged from the focus group and interviews regarding access and utilization of mental health and substance use treatment program services within the B/AA population.

> ***"You can't be just the mental health agency; you have to be part of the community. You have to be there at the table and start to build credibility and respect and those doors become [wide open]."***

Lack of Resources/Social Determinants of Health:

The B/AA community is disproportionately impacted by issues such as poverty, incarceration, transportation, underserved schools, environmental exposures, insurance coverage, adequate housing and other social determinants of health. This lack of resources can make accessing and maintaining mental health and substance use services more difficult and lead to poorer outcomes. These effects can be exacerbated in rural areas.

SOLUTIONS

Prioritize building infrastructure and securing additional grant funding from a variety of sources.

Our standard funding models for providing mental health and substance use services may not be adequate to address the needs of people in diverse communities. Given that, organizations need to prioritize building the internal infrastructure (e.g. grant writers) to compete for non-traditional funding sources. Having resources beyond the traditional insurance and fee for service model will provide flexibility that many organizations will need to sustain work in diverse communities.

Providing a broad array of services at existing mental health and substance use organizations.

It is essential that organizations located in B/AA communities provide a broad array of services beyond mental health and substance use services. As discussed, B/AAs are disproportionally impacted by many by social determinants of health and will require access to mental health and substance use service providers that are able to address issues related to housing, criminal justice, general health care and education as well as other social determinants.

Increasing use and capacity for telehealth services.

To improve access and address issues such as lack of transportation and lack of availability of providers in B/AA communities', further expansion of telehealth options could be a viable solution. Investments would need to be made to ensure that community members had the physical infrastructure (e.g., internet/broadband services) and hardware (e.g., smart phones and computers) resources available. These short-term investments could go a long way in addressing some of the access inequities cited by key informants.

Working with and embedding mental health and substance use providers in existing community organizations such as local faith-based institutions.

In many communities it may not be possible to build stand-alone mental health or substance use programs; however, the potential may exist to embed mental health and substance use professionals within existing community organizations to offer services. This can expand the array of available options to receive services and build credibility as they are linked to existing community partners with established credibility in the community.

System /Financial Barriers:

Structural barriers exist both in the financing of mental health and substance use services and the location of services which can have significant effects on access to care. Key informants cite concerns that provider availability can be affected by whether the population being served has higher rates of public versus private insurance or no insurance. Public insurers tend to reimburse for services at lower rates than private insurers. Because of this, some providers find that providing services within communities with high rates of public insurance or no insurance is less financially viable, which could lead to reductions in services or even discontinuing services altogether.

Another key informant noted that although insurance is a major issue, it may not be an equalizer and doesn't remove race and provider preferences from the equation when examining issues around access. There is data which showed that even when one controls for public insurance (Medicaid) in populations, there is still segregation among racial lines. A study by Lee, et al. (2021) examined whether Medicaid expansion by the Affordable Care Act (ACA) mitigated racial/ethnic disparities in access and utilization of health care for persons below the federal poverty level. The study showed that after the expansion of Medicaid, the majority of access outcomes improved for disadvantaged persons, but for others as well, with the findings showing that disparities were not significantly decreased. [28] Other studies suggested that insurance did not remove the disparities in mental health and substance use treatment services between B/AAs and Whites. [29]

> ***The "onus [should not be on the individual but] on the system to do a better job to serve them."***

SOLUTIONS

Greater incentives for the provision of care in under-resourced communities

To address these concerns, some participants suggested working with policymakers and other payers to enhance financial incentives for providing services in B/AA and other traditionally underserved communities. Creating specific funding set asides over and above standard reimbursement rates for providing mental health and substance use services in underserved communities could address provider concerns about sustaining services in diverse communities.

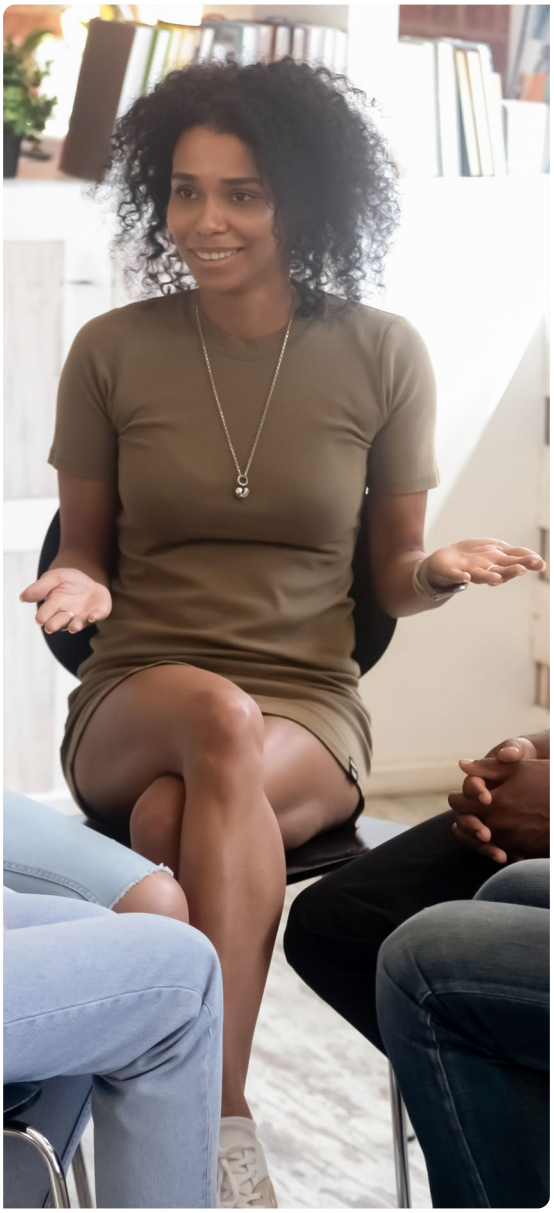
Expansion of substance use and mental health services in non-traditional settings

Providing mental health and substance use services in other health care and social service settings such as health centers, emergency rooms and departments of health may help mitigate some of the concerns around the financial viability of stand-alone mental health and addiction services. Pairing these services with other revenue-generating services may also help expand the availability of services in communities that have traditionally been underserved.

"A lot of the challenge is who owns the problem(s) because it can't be owned by black and brown communities that don't have resources to fix it."

Lack of Focus on Prevention and Education:

The importance of prevention and early intervention before the exacerbation of symptoms was emphasized by all participants. Several key informants noted that despite the lack of treatment resources, particularly treatment resources tailored to the needs of B/AAs, there seemed to also be a lack of focus on prevention of mental health and substance use challenges. This lack of prevention and early intervention services can lead to B/AAs accessing care in in the most expensive and trauma inducing ways such as emergency rooms, hospitals and criminal justice settings.



SOLUTIONS

Prioritize Prevention and Education efforts

Providing more culturally relevant prevention and educational resources is critical to reducing stigma related to substance use and mental health challenges and improving outcomes by helping people recognize the need for services much earlier and improving trust in the health care system. Having these resources available in places that Blacks/African Americans frequent and trust can be useful as well as using trusted community members to convey messages of prevention early intervention. The more we can utilize these trusted spaces and community members to normalize conversations about mental health and substance use challenges, the more likely we are to reduce stigma and improve outcomes.

Prioritize screening for mental and substance use challenges in non-traditional settings.

To help improve outcomes, we must identify substance use and mental health challenges much earlier. One of the most effective ways to do this is by screening and assessing for mental health and substance use challenges in non-traditional healthcare settings, such as schools, community centers, faith-based organizations and other trusted organizations within communities. The more we can normalize screening for mental health and substance use challenges within the normal context of health, the more likely we are to create an environment conducive to seeking care earlier.

"We don't see enough of Black psychiatrists, psychologists, therapists – there are case managers, but they are so burnt out because they have too many in their caseload."

Lack of staffing:

The workforce shortage of practitioners and researchers in B/AA communities has also been described as a major concern. The importance of creating a diversified and sufficient workforce as described by a key informant cannot be "overstated... it's going to take a while to build up a workforce of black and brown psychiatrists, psychologists, social workers." Staff turnover was also mentioned as a barrier in the provision of services. The need for culturally competent staff was stated by all participants. The failure of service providers to bridge this cultural divide can contribute to discontinuation of treatment among B/AAs. Engagement of patients during treatment can be a difficult task and the lack of well- trained professionals skilled in working with diverse populations certainly contributes to this problem.

SOLUTIONS

Increase investments in recruiting and retaining B/AA providers in the mental health and substance use field.

While some investments have already been made to recruit and maintain providers of color in the mental health and substance use field such as SAMHSA's minority fellowship program, more must be done. Developing relationships with colleges and universities specifically to bolster interest in the field could go a long way in increasing interest from communities of color to enter the mental health or substance use treatment workforce.

Additionally, more needs to be done to retain B/AAs in the existing mental health and substance use workforce. While incentives such as promotions, pay increases and bonuses can be helpful in retaining staff, other incentives such as prioritizing wellness activities and improving workplace culture could also be helpful in retaining B/AAs.

Greater use of Peer support specialists

Peer coaches or peer support specialists can play a critical role in engaging people in services and building community trust and by-in for mental health and substance use services. Trained peers have a unique way of incorporating their lived experiences to help patients understand the treatment process and reduce stigma., yet peers are often underutilized in these roles. Expanding the role of peers, particularly those who reflect the cultural orientation of the population being served, can be helpful in increasing access to services and improving outcomes.

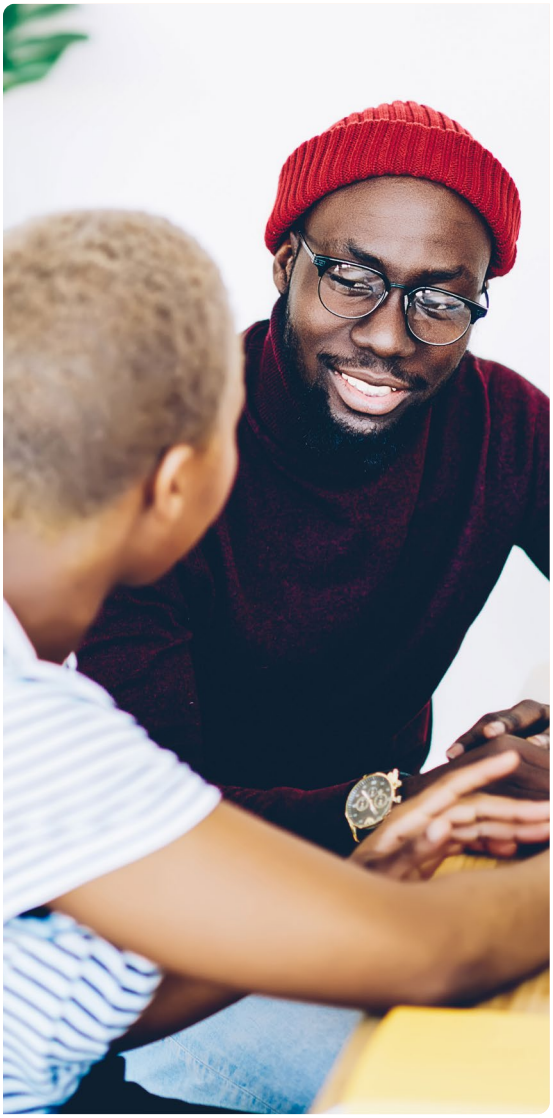
Better Supervision around cultural competencies

Ensuring staff are culturally competent and have the requisite knowledge and skills to work with diverse populations has always been important within the substance use and mental health field, but as society becomes more diverse this has become an even greater priority. When working with the B/AA community or any community that may have experienced historical racial trauma, this concern becomes of paramount importance. To improve engagement and treatment outcomes, organizations need to double down on ensuring that all staff are culturally competent and that there are supervisory mechanisms in place to periodically assess staffs' level of cultural competence.

"The data on intergenerational trauma is focused on holocaust survivors, and we choose not to look at or publish intergenerational trauma on indigenous/Black people."

Trauma:

One of the most significant issues pertaining to mental health and substance use treatment within the Black community is trauma. Historical trauma and current-day injustice can affect perceived psychological safety in treatment and impact long-term recovery. Addressing historical trauma was a solution mentioned during the interviews as many cited examples of racial trauma having detrimental psychological effects on people and their communities. Yet, many psychologists and health care professionals struggle to understand intergenerational trauma and its impact.



SOLUTIONS

More training on trauma-informed approaches to care

Most of our key informants agreed that it is critical that clinicians and health care workers serving these individuals develop the necessary knowledge, skills and empathy to successfully work in communities with significant histories of trauma. It is important for the workforce to become more knowledgeable and better trained on intergenerational trauma and trauma-informed approaches to care and engagement. Better training on trauma can result in more effective engagement of clients in care and help facilitate long term recovery.

Utilizing family-centered treatment models

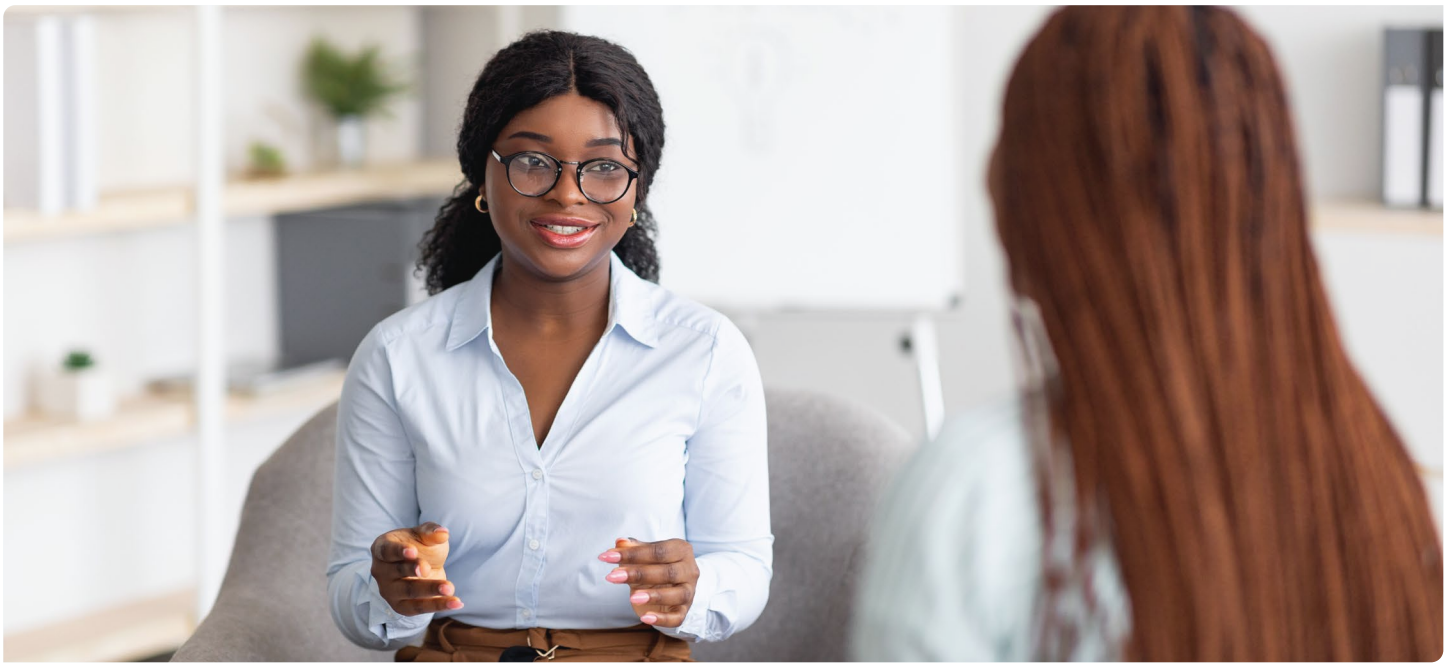
Using family-centered treatment approaches, which are comprehensive and evidence-based and address the problems faced by patients and other family members was recommended as a strategy for engaging individuals that should be incorporated into integrated treatment programs. Treatment models that support patients within the context of their family members have been shown to improve health outcomes.[30]

Discussion

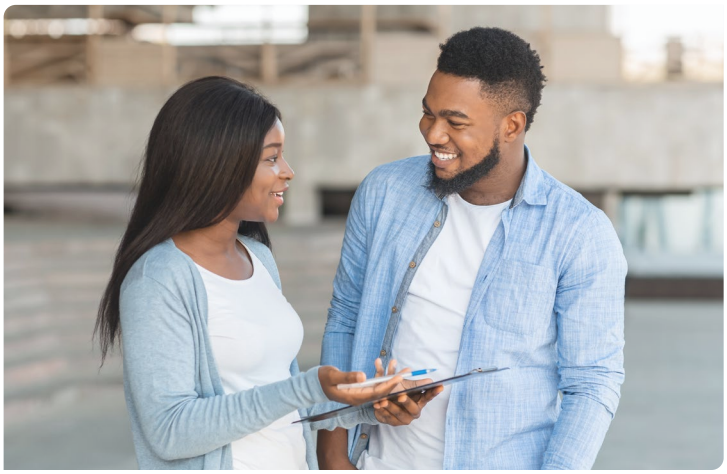
The literature review and key informant information presented here while not exhaustive, does contribute to the growing body of work needed for understanding the health disparities related to mental health and substance use services among B/AAs. These findings might decrease the stigma towards mental health and substance use challenges and emphasize the scope of the problem by illuminating systematic barriers to care instead of individual barriers to care. It also provides more information on barriers to clinicians and the public alike, which can enable them to understand the problems of managing mental health and substance use challenges among B/AAs within our current system.

While the perspectives provided in this paper were from providers, advocates and high-level staff, some of whom have "lived "experience, we acknowledge that these staff are part of the system and thus do not provide an exhaustive view of the experiences and systemic barriers that individuals may face. Therefore, it is recommended that further research examining this topic involve more B/AAs with lived experiences. Greater understanding of the perspective of those seeking and receiving services could help provide further context for the challenges they face in accessing services and meaningful input on possible solutions. Projects like this could also be replicated to include more voices from different regions of the county to examine if any regional nuances play a role in the findings. As the key informants who participated in this project were a convenience sample, a broader set of voices could bolster the generalizability of this work.

Another suggestion for future research would be to focus on the shortage of B/AA mental health and substance use providers that has been highlighted by this research. Further projects could examine the reasons behind this shortage and provide more possible solutions to increase such staff. Education was also mentioned as a possible solution to reduce barriers, and this can be another potential area for more research. Programs that provide education should examine which methods are most effective methods. The education of families and communities regarding mental health and substance use challenges should be emphasized to provide more understanding about these challenges and their impact.



Other Considerations for Further Research



FINANCE

The improvement of funding mechanisms for mental health and substance use services also needs to be addressed. While expanding insurance is an integral part of decreasing financial barriers, some studies have shown that the disparities in mental health and substance use treatment have not been eliminated. Since disparities were not significantly decreased despite the ACA Medicaid expansion, this implies the importance of continuous monitoring of the effect of policy as well as further research into ways that insurance affects access to services and reduces disparities among racial groups.

CULTURAL COMPETENCE

The provision of cultural competence training will not suffice. Although a majority of mental health and substance use providers may perceive themselves as culturally competent, additional studies that utilize observer ratings are needed to ascertain the prevalence and efficacy of the behaviors of culturally competent clinicians. Also, mental health care organizations could benefit from better infrastructure and systems that support cultural competence. Interpersonal characteristics within the provider-patient relationship are important, specifically shared understanding, familiarity with the cultural preferences of the patient and whether or not the provider relates to the patient in unprejudiced terms.[31] Further study should examine the preferences of B/AAs while receiving mental health and substance use services .

EVIDENCE-BASED PRACTICES

Although focusing on evidence-based practices has been theoretically compatible with the provision of high-quality care, these practices have been criticized for comparing effectiveness with meticulously screened patients within research settings to effectiveness with complex patients within real world conditions. [32] Documenting racial inequities in mental health status, access to services and utilization of care requires comparing findings between marginalized and dominant racial groups. Therefore, the majority of the research examining inequities utilizes race comparative methods. However, determining and addressing mechanisms that underlie inequities necessitate further in-depth analyses of the contexts in which Blacks experience poor health outcomes. Therefore, examining the impact of social determinants of health is necessary to fully understanding poor behavioral health outcomes among B/AA.

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Appendix A. Key Informant/Focus group Interview Questions

General/Background

- In your experience, have you heard anything from clients or colleagues regarding hesitancy from clients around receiving care? If so, what are some of the reasons you have heard for that hesitation?
  - » *If you have, what steps have you taken to address this?*
- We know SDOH more adversely impact minority communities, and things like access to quality, local health care services, lack of transportation, etc., play a role in whether or not these patients will seek treatment. Can you share any thoughts about resources offered beyond the treatment process? Are there assistance programs or resources you offer related to SDOH for patients in need?
  - » *If so, has this assistance been seen as beneficial? (e.g., Housing resources, transportation passes, other resources related to getting patients in the door, but not necessarily directly related to their treatment)*
- What are some of the factors that would make someone currently coming into care discontinue services?

Outreach/Engagement Strategy

- What have outreach efforts looked like for you and your agencies related to getting African Americans into services?
- What challenges have you experienced in getting more African Americans to participate in services?
- In your opinion, what would you say are some of the solutions?

Finance

- When it comes to patient payments and finances, do you think this is a barrier for patients coming in to receive care?
  - » *Any resources or strategies to combat this?*

DEI/Workforce

- Do you feel that there's a lack of diversity or shortage of Black or POC providers?
- Do you see any benefit to having POC working with clients or a need for more POC clinical staff and providers?
- Are there any strategies or solutions to this shortage of Black or POC providers? How have you address this provider shortage?
- Can you share some of your thoughts of cultural competencies for providers and the value of this?

Closing Questions

- Are there any other considerations we should be thinking about related to African Americans seeking treatment, access to quality care, social determinants of health, or BIPOC providers, etc.?
- Is there anyone else you think is doing great work in this space that you would recommend we speak to or any resources we should check out to include in our final write up?

Appendix B. List of Key Informants and Focus Group Interviewees

Sarah Vinson

Morehouse School of Medicine
Atlanta, Ga.

Victor Armstrong

NC Division of Mental Health, Developmental Disabilities, Substance Abuse Service
Raleigh, N.C.

Jewell Gooding

Silence the Shame
Atlanta, Ga.

Joseph Yancey

Places for People
St. Louis, Mo.

FOCUS GROUP PARTICIPANTS

Otis Lattimer

Swope Health Group
Kansas City, Mo.

Nallu Reddy

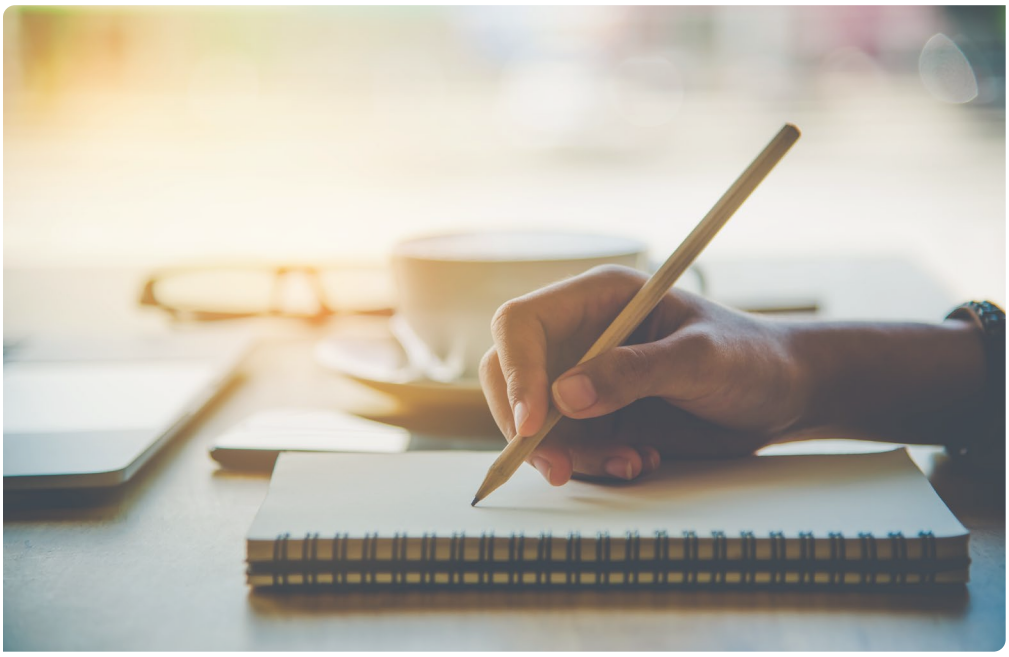
Swope Health Group
Kansas City, Mo.

Cheryl Reed

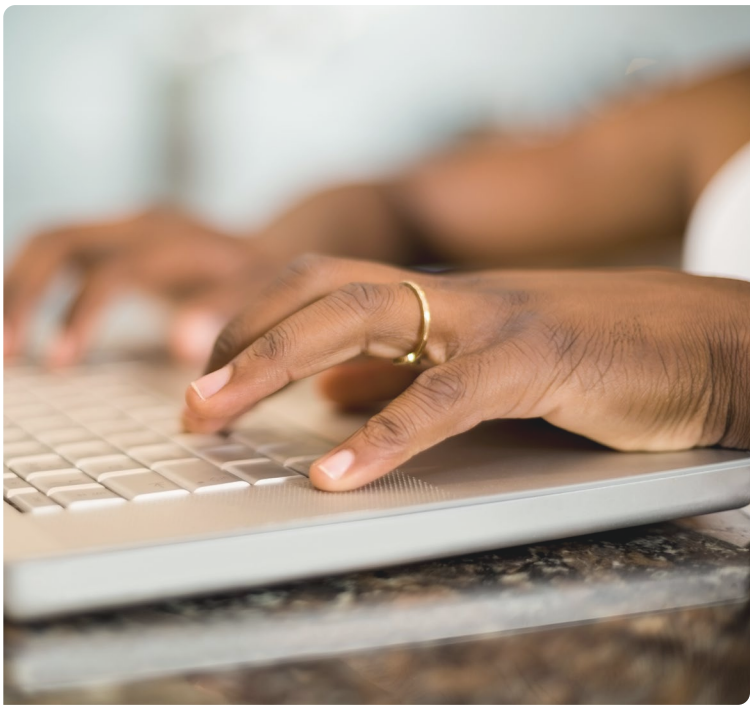
Swope Health Group
Kansas City, Mo.

Jennifer Munroe,

Swope Health Group
Kansas City, Mo.



Staff Contributors



Aaron Williams, MA

Senior Advisor
Practice Improvement & Consulting
National Council for Mental Wellbeing

Glory Okwori, DrPH

Former Graduate Intern
Practice Improvement and Consulting
National Council for Mental Wellbeing

Tiffany Francis, MJ

Sr. Project Manager
Practice Improvement & Consulting
National Council for Mental Wellbeing

Ciara Hill, BS

Former Project Manager
Practice Improvement & Consulting
National Council for Mental Wellbeing

Funding for this initiative was made possible by grant no. 1H79FG000591 from SAMHSA. The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official policies of the Department of Health and Human Services; nor does mention of trade names, commercial practices or organizations imply endorsement by the U.S. Government.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