Brief Introduction

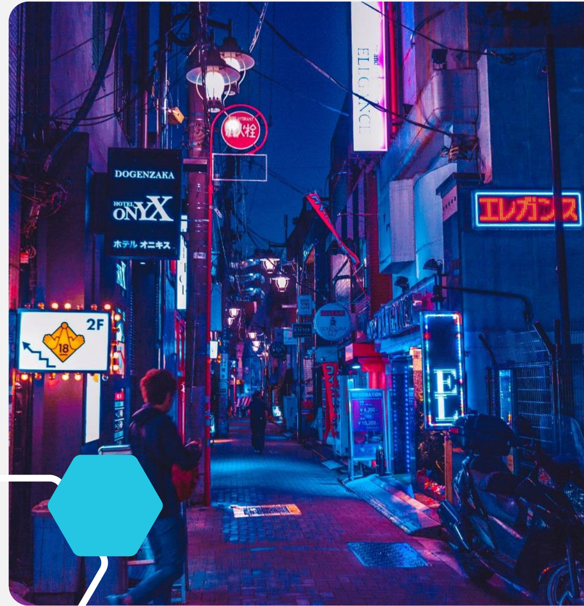
Rosalyn Davis, Ph.D.

I am a clinical associate professor of psychology at Indiana University Kokomo. I direct our MA in Mental Health Counseling program and serve in an administrative capacity as the Faculty Diversity Liaison. My training and background is in Counseling Psychology from Ball State University with a focus on diversity issues. Each of my professional roles has had a diversity component to it and this is one of my professional passions.

2

Learning Objectives for Today

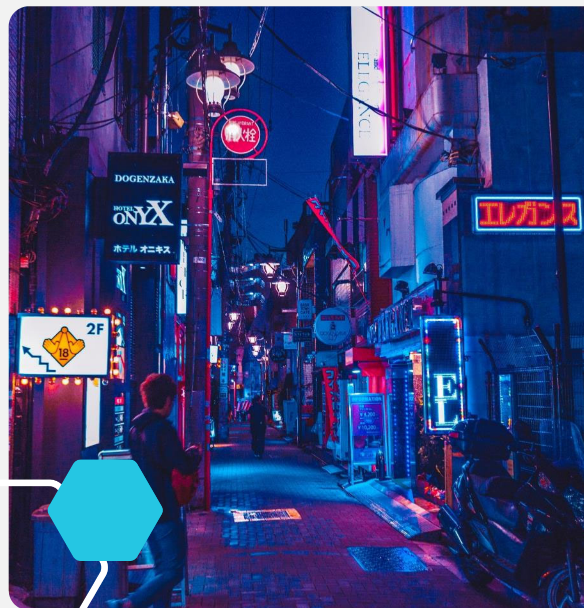
- Identify causes and conditions of health disparities in the United States.
- Describe the impact of those health disparities on our clients.
- Explain how health disparities continue to impact our treatment efforts.
- Describe ways to minimize the impact of health disparities on treatment efforts.



3

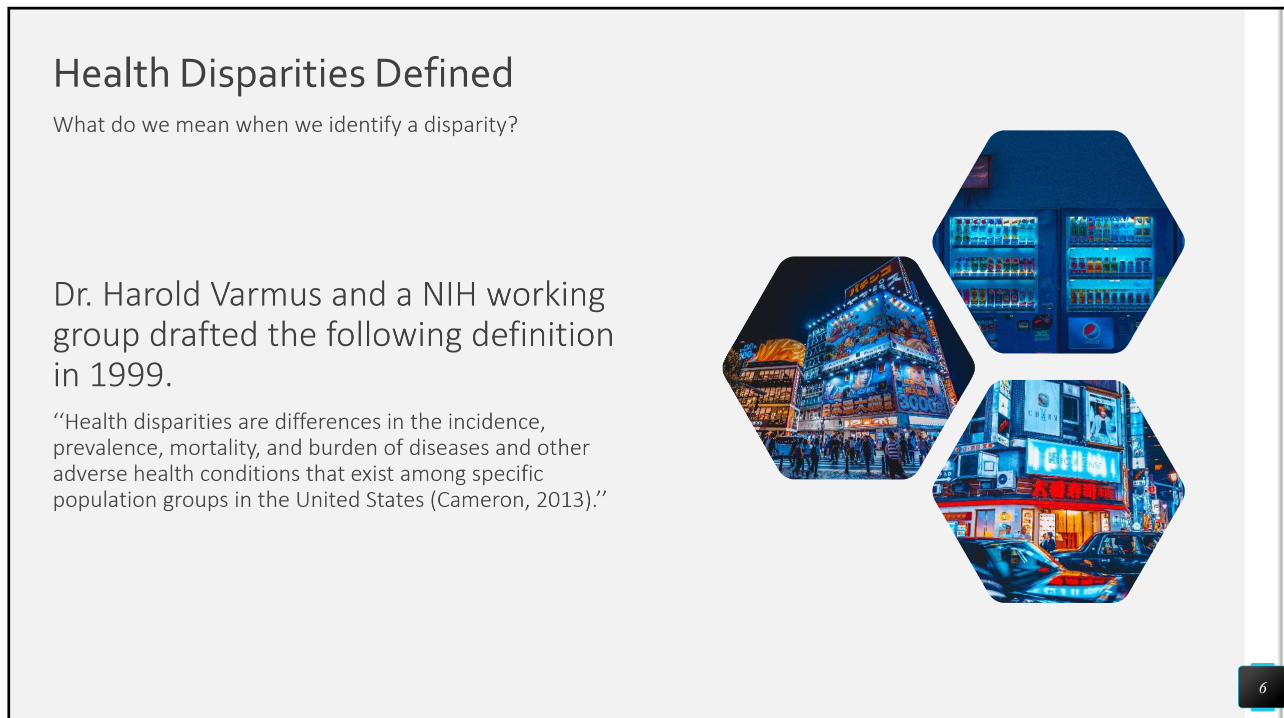
Plan for Today

- We'll cover those learning objectives in different sections and participate in small group activities as we go to tackle burning questions.
- Open to discussion at any point so please ask a question you may have when you feel inclined to do so.
- Will attempt to address what we need to do outside of our office space to help address health disparities from a training and advocacy standpoint.



4

Defining Health Disparities
What are they? Who is impacted?
5


Health Disparities Defined
What do we mean when we identify a disparity?
Dr. Harold Varmus and a NIH working group drafted the following definition in 1999.
''Health disparities are differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the United States (Cameron, 2013).''
6

Health Disparities Defined

What do we mean when we identify a disparity?

A legal definition of health disparities was drafted in 2000 by the ‘Minority Health and Health Disparities Research and Education Act’’

- ‘’A population is a health disparity population if, as determined by the Director of the Center after consultation with the Director of the Agency for Healthcare Research and Quality, 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. (p. 2498) (Cameron, 2013).”

7

Health Disparities Defined

What do we mean when we identify a disparity?

Braverman (2011) as cited in Bowen & Walton (2015) defines health disparities as:

- “systematic plausibly avoidable health differences that adversely affect socially disadvantaged groups”

8

How do the definitions help us

- In looking over what the previous two definitions provide we have the basis for several years of empirical research and our thoughts on what we need to tackle with clients
- The definitions provided a common framework for researchers to identify and process areas of further study.
  - They could readily identify what was lacking or problematic for underserved or underrepresented communities
  - They could readily make comparison between the underserved/underrepresented groups and dominant culture
  - They could readily reproduce the problems in various cities, age groups, populations and conditions
- The definitions also allowed treating professionals to not entirely pathologize their clients
  - Health disparities in the broadest sense could account for why clients may not improve at the rate one would expect from a dominant group member
  - Disparities could also account for why treatment may not be effective with some groups
  - Flexibility in terms of how clients might be viewed was provided through acknowledging health disparities without completely addressing what was causing those issues

9

How the definitions hurt us

- Overall, several researchers indicate the definitions and identifications of health disparities alone do not help us completely
  - We lack context for why the groups are not improving
  - The continued research does not address worldview of clients or their perspective enough to be effective in creating change
  - Treating professionals are becoming more culturally competent but not using the tools of the communities in which they work to alleviate the health disparities
  - The Joint Center for Political and Economic Studies reported that between 2003 and 2006"the cost of racial/ethnic disparities in direct medical costs and lost productivity in the U.S. exceeded $1.24 trillion" (Cameron, 2013)

10

Another perspective

- Recent literature has also begun to question the entire concept of health disparities (Macon, 2022)
  - Per the authors, health disparities ignores the very real situations in which the society at large has created circumstances that have generated the present disparities while also not doing anything to address them
  - There's a lack of knowledge about various communities so serving them properly is going to be a struggle (Martin & Johnson, 2023)
  - A better focus for them is to address the systems in place that keep the disparities in place and to not further stigmatize minoritized populations

11

Health Disparities & Gender

- Gender presents a unique set of challenges when we discuss health disparities
- Women can present with issues that are misdiagnosed or underdiagnosed if respect for the cultural variables that may be in play is missing
  - Women often face a myriad of issues that can be ignored if the client is not a strong advocate for themselves (Hoffman & Tarzian, 2001)
    - Recently a number of high profile, financially stable women have reported severe health scares or died as a result of their complaints not being taken seriously
      - Serena Williams had serious health complications after pregnancy that had she not demanded care could have resulted in her death. So did Alyson Felix who luckily survived as well as Tori Bowie who unfortunately did not.
      - Kim Porter died after going to her doctor for several weeks complaining of feeling ill and it was dismissed as stress and a cold. She had a massive heart attack.
      - A new research piece just revealed that the most dangerous place for women is their home
      - So if financial security and access to good health care is not enough to protect women and home is not safe there are layers of work to do to unpack for women in treatment settings

12

Health Disparities & Gender

- When we look at women in lower SES groups the aforementioned complications escalate
  - They may lack basic access to health care overall
    - Having insurance but being unable to cover a procedure
    - Having no insurance but not having access to affordable clinics in their area
    - Inability to take time off work to attend to their health care
    - Inability to travel to areas where more affordable care may be available
  - Additional issues may arise if violence enters the picture
    - There are limited public resources for women and children to escape violence easily and without fear for their safety
    - During a brief period of time, three women were shot at and/or murdered by abusive partners.
      - At least one of those women was forced to interact with her abuser because she couldn't afford to pay for mediators to handle custody exchanges

13

Health Disparities & Gender

- Even considering women who are gainfully employed in jobs that should keep them in a comfortable SES there are still issues of pay equity which limits women's options for employment, when or if they can afford to have children and end of life support
- When comparing the lives of women in the US to 135 other countries, we were 20th overall but 47th in workforce participation, 62nd for health and survival and 65th for the gender wage gap.
- We rank last for paid maternity leave and do not provide childcare as a society

(Takamuru, 2015)

- We have a shockingly high maternal mortality rate for the country and doctors are routinely ignoring the concerns of pregnant women that can result in their death or loss of pregnancy especially in minority women (Villarosa, 2018)
- Female college students are showing an increase in mental health diagnoses and suffer from lower self-esteem, male college students are showing lack of social support, diminished coping skills, and gender role stress (Prasath et al, 2023).

14

Health Disparities & Gender

- For those that are gender nonconforming they are struggling in different ways
  - Others refusing to use their preferred pronouns or being mocked for even requesting the use of preferred pronouns
  - Financial stress because of difficulty finding work when because of their physical presentation
  - Lack of community or acceptance by others which can lead to isolation
- Prasath (2023) and colleagues also noted that while across genders college students were reporting similar level of anxiety and depression, GNC respondents also indicated that they were experiencing insomnia, OCD and PTSD
  - They were more likely to seek service and utilize services as well
  - They were more likely to experience poor mental health outcomes and other disorders as well

15

Health Disparities & Sexuality

- While I think as a profession we are doing better with addressing health disparities with the LGBTQ population they still face significant issues
  - The LGBT population views their own health as worse than other groups for a variety of reasons
    - Lack of support from social networks
    - Doctors who represent higher status groups who purposely or inadvertently demean them
    - Institutional and societal constructs that invalidate their experiences or refuse to afford them full standing as members of the larger group
    - Feeling doubly stigmatized because of a perceived “blemish of character” that is solely their fault

(Ryan, Hunger & Major, 2017)

16

Health Disparities & Sexuality

- Researchers have also noted that there are other concerns for this population as well
  - They do not have a community that they are born into like other stigmatized groups so they can be lonely throughout critical development periods if they can find no support groups
  - Group members may develop self-stigma by internalizing the negative beliefs about their community
  - Increase rates of destructive coping mechanisms to combat the negative emotions they are experiencing
  - Dealing with social identity threat

(Ryan et al, 2017)

17

Health Disparities & Sexuality

- For those that transitioning financial and social concerns are present
  - Surgical procedures in the United States are often seen as elective and thus not covered by insurance
  - In order to get medication for transitioning or approval for surgery they have to be diagnosed by a mental health professional who agrees they have the gender dysphoria
    - This can be expensive and belittling for patients
  - Changing their birth certificate or identification can be a cumbersome process
    - Even if they manage to accomplish that, upon their death if there are not clear requests on behalf of the decedent the families can often come in and both deadname them as well as present them as their sex at birth
  - Difficulty finding work or losing previously held jobs
  - Social support can be minimal or limited
    - Often ostracized from family and friends when transition is announced
    - May lose social ties to church and other organizations

18

Health Disparities & Sexuality

19

Health Disparities & Race/Ethnicity

- There are a plethora of health disparities that have been identified by race over the last twenty years. Several research studies have been conducted but have shown mixed to no improvement across the board.
- Per Cameron (2013) "Between 1990 and 2005, disparities between non-Hispanic Black and non-Hispanic White populations at the national level narrowed significantly for seven of the 15 measured indicators. Yet even in these areas where improvement was seen, the overall progress was deemed to be ''generally slow'' (p. 352). For 6 of the 15 indicators, disparities widened (five significantly). The authors conclude that ''there was no significant trend toward overall improvement (*P*=.85)'' (p. 352). The authors also explored the same health status indicators among Black and White residents of Chicago, IL. They found that 11 of the 15 indicators showed a widening of disparities (five significantly), and only four indicators showed a narrowing of disparities (two significantly) (Orsi et al., 2010). Thus, even though some health status indicators are improving, and may be improving for multiple populations, improvement does not automatically equal a reduction in disparities."
- Consider life in Chicago for Black residents for a moment and how do these health disparities play into their daily lives?

20

Health Disparities & Race/Ethnicity

- Williams and Mohammed (2009) specifically identify the health disparities in their paper that have significant gaps between African American and Caucasians in the US
  - For most of the 15 leading causes of death including heart disease, cancer, stroke, diabetes, kidney disease, hypertension, liver cirrhosis and homicide, African Americans (or blacks) have higher death rates than whites
  - The elevated death rates were across the life course for African and Native Americans
  - 100k African Americans die prematurely every year that would not if the health disparity issues were properly addressed
  - Despite health gains, there's still a nearly six year gap in mortality rates between African Americans and Caucasians that has persisted since the 1960s
  - Consideration should also be given to the impact of discrimination, perceived and genuine, on health at a minimum but this could also impact educational performance and mental health as well

21

Health Disparities & Race/Ethnicity

- Takamuru (2015) notes that many of the strengths of minority populations are reduced by constant "discrimination, marginalization, trauma and abuse…"
  - That results in minority group members not feeling safe or welcome in many areas and to potential isolation as those group members age
  - Also noted was that foreign born members who were of Hispanic and African descent held a disability advantage over native born members of those groups but that the longer they resided in the US that advantage disappeared because of their own experiences of racism and discrimination.

22

Health Disparities & Race/Ethnicity

- Within the Asian/Asian American population researchers have identified the following issues as health disparities that need to be addressed
  - Heart disease (Cameron, 2013)
  - Lack of access to health care due to being underinsured (Blewett et al, 2018)
  - Mental health issues and increases of suicides among elders is also a concern (Takamuru, 2015)
  - Additionally, levels of acculturation could play into how this group seeks out or responds to treatment in traditional settings

23

Health Disparities & Race/Ethnicity

- For the Latino/a population a host of health disparities are present as well, some similar to and uniquely different from the Asian American population
  - Heart disease, Breast cancer, Colon cancer (Cameron, 2013)
  - Lack of access due to being underinsured as well as being undocumented in some cases so seeking care may result in other negative outcomes (Blewett et al, 2018)
  - When looking at Puerto Rico specifically, researchers found that across the board they were subject to significant health disparities in everything from infant mortality to cancer (Burgos et al, 2017)

24

Health Disparities & Race/Ethnicity

- For the African American population we can identify a number of health disparities that are persistent even though they have been consistently studied for the last few decades
  - General health concerns like obesity, heart disease, diabetes
  - Social concerns like discrimination which impacts their economic situations, housing, educational opportunities, policing issues, biased sentencing within the legal system
  - Mental health concerns that are made worse by the other two areas of concern, lack of access to therapists in some areas, lack of African American therapists, affordability of treatment, mistrust of treatment providers, stigma and poor or inadequate treatment
    - A survey of ministers conducted in 2007 indicated the following were seen in their congregations: depression, anxiety, stress, hostility, alcohol and drug abuse, bipolar disorder, schizophrenia, and oppositional/conduct disorders.

(Tillotson, Doswell, & Phillips, 2015)

25

Health Disparities & Race/Ethnicity

- Unfortunately, news has recently been brought to light that medical algorithms for different insurers have been treating sicker Black clients differently than less ill White clients
  - When both groups were in the same stage of illness White clients were given more and more intense treatment
  - When Black clients were more ill than White clients, they were treated in a less aggressive or intense fashion than was warranted
  - They are working on a fix but no one seems to know why it was in place initially and why no one caught it prior to now

(Johnson, 2019)

26

Health Disparities & Indigenous Populations

- Indigenous populations vary by country, culture, location, language and a variety of other concerns
- A Canadian study conducted by Hadjipavlou and colleagues (2018) found that
  - Indigenous mental health issues in Canada are linked to a host of political, social and economic inequities
  - Lower rates of utilization and higher acute admissions for mental health treatment and suicidality
  - Poverty, racism and inner-city living compound these issues
  - Indigenous elders may be sought out instead of traditional mental health providers
- Another study by Browne et al (2016) noted a variety of issues
  - Income inequality that was only second to the United States
  - Structural violence that continued to perpetuate lower standards of living
  - That mean health of Indigenous men and women are 10 and 6 years less than other Canadians respectively
  - Indigenous children have a higher than average mortality rate and representation in state care
  - Additionally there were high rates of HIV infection among Indigenous women along with the threat of violence

27

Health Disparities & Indigenous Populations

- Browne also looked at Indigenous groups outside of Canada
  - And found that in Australia there was an average 20 year age gap in life expectancy for Aboriginal groups. That there was still lack of cultural sensitivity to their care and treatment that contributed to public shaming and lower health outcomes
  - In South America there were extremely high infant mortality rates that were tied to poorer access to care, limited income and “public insecurity”
- Keys (2020) looked at the use of language in working with indigenous populations specifically within the Kikapoo tribe
  - This community, much like others with a native language that is not English, may express themselves more readily and clearly in their first language
  - This is likely true for other indigenous tribes as well

28

Mental Health Disparities & Race/Ethnicity

- When specifically looking at mental health issues one of the first major reports on this issue was released in 2001 by the Surgeon General: “Mental Health: Culture, Race and Ethnicity”
  - Specifically it identified that minorities received lower mental health care services than Caucasians did and there were still issues with accessing services for minority group members
- Further research also identified the financial barriers to accessing mental health treatment as well as the lack of recognition that formal mental health services may be needed at all
- Among many groups there is still massive stigma for seeking out mental health treatment as well

Holden et al, 2014

29

Mental Health Disparities & Race/Ethnicity

- Holden et al (2014) additionally indicated ethnic minorities are more likely to experience “higher degrees of functional limitation and chronicity” when compared to the dominant group
- They also address the methods in which ethnic minorities are likely to initially seek help for mental health concerns, early terminations and lack of trust in mental health providers due to long-standing cultural mistreatment
  - Seeking treatment through emergency rooms leads to lower quality care
  - Seeking care later in the disorder progression may lead to power outcomes
  - Additional issues present with overdiagnosis with psychiatric disorders and underdiagnosis with disorders like depression
    - Those diagnostic biases remain present even when cultural competence training has addressed reasons to consider better diagnostic procedures with racial and ethnic minorities

30

Mental Health Disparities & Diverse Populations

Psychiatry.org has a detailed collection of information about mental health and disparities across groups. Key findings across groups:

- Minority groups more often receive a lower standard of care
- Are more likely to be hospitalized instead of treated in outpatient settings depending on the disorder
- Have similar or lower rates of mental health diagnoses as the larger population but have more chronic conditions
- Have a higher level of distrust of mental health providers because of historical interactions.
- Long-term environmental and social stressors increase suicide rates and mental health diagnoses in some populations (LGBTQ and Appalachian)
- There is still societal and structural stigma in treatment of diverse groups.

31

Intersections of these disparities

- It would remiss to not consider that these separate disparities can be compounded by the individual identities our clients possess
  - While one identity may be more pressing in session at a given moment, we still have to consider how being a black transwoman may be more complicated than being a black cisgender woman
  - That intersection could influence everything from our eventual diagnosis, to help seeking behaviors, to overall treatment outcomes

32

Intersections of these disparities

- African American college educated women have a higher rate of infant mortality than nearly every other group of women that only have high school diplomas (Williams & Mohammed, 2009)
- African American women in the United States are 243% more likely to die in or shortly after childbirth than other groups of women
- LGBTQ+ and GNC individuals are more likely than their straight cisgender colleagues to experience mental health concerns and more likely to have limited access to treatment
- Asian American clients may be experiencing more stress and anxiety in related to COVID and the uptick of violence that has accompanied it
- Other religious minorities and minoritized communities may be experiencing this as well without research to support that distress currently

33

Limitations to what we know

- There are limited to no studies that specifically focus on just SES.
  - While we know that intersectionality matters, looking at access issues based on income or resources could inform us of what interventions may need to be made
- We have not been able to do a large-scale study that does pull in multiple factors of identity in a robust fashion
- The data for health and mental health disparities and men is not always informative outside of the increase in stress, anger, alcohol use and other established challenges

34

Given what we know of health disparities what happens with treatment?

- The question is not one that can be easily answered because so much depends on our willingness to acknowledge that the disparities exist and how to work around them in terms of what we are able to do as treating professionals
  - Are there easy ways to adjust traditional treatment platforms to meet the needs of our clients most likely to have health disparities?
  - Do we need to take an inventory of what is working and what is not in our community before we begin making adjustments?
  - In terms of community mental health and integrated care how can we make those systems work together more efficiently in order to help our clients?
  - Are we creating extra barriers or roadblocks to the communities in questions accessing our services?

36

Research Leading to Practice Implications

- Thankfully most of the research that is focused on health disparities are providing some new theoretical and/or empirical evidence to address the health disparities that are present in a variety of our racial and ethnic minority as well as other underserved and underrepresented groups
- An additional question is posed by Krieger (2017) in their paper which asks if trying to identify the causes of diseases really serves health disparity work as it assumes there is a way to explain 100 percent of what is causing a disorder instead of the myriad of variation in an individual
- Additional focus has been more in a training and advocacy piece which will be interspersed throughout the rest of the talk

37

Addressing Health Disparities in General

- Almost all of the researchers included in this talk indicate two necessary areas to address when trying to reduce health disparities regardless of group
  - Access to insurance
  - Access to services
- They also discuss the need for increase cultural competence of the treating professionals throughout integrated care models
  - The most frequent way of achieving this goal was looking through the context of the population to be treated

38

Addressing Health Disparities in General

- Blewett et al (2018) noted that when the state of Kentucky expanded its Medicare, Medicaid and ACA related insurance requirements that they saw significant drops in residents being underinsured or uninsured
  - African Americans dropped from 16.7 percent to 5.5 percent compared to whites who dropped from 13.1 percent to 5.3 percent.
  - The uninsured rates dropped for the African American nonelderly group by 9 percentage points and 12 percentage points for the Hispanic nonelderly group within two years of implementation of the ACA.
  - Improved access to insurance meant improved access to health care and less cost barriers to treatment
- While it is just data from one state we know that at least having the opportunity to access care can increase utilization provided there are adequate service providers in the area
- The drop in uninsured for African American residents was also due partially to a significant portion of that group being able to qualify for Medicaid due to their limited income levels which addresses other health disparity issues that still need to be resolved

39

Addressing Health Disparities in General

- Kaye (2019) found similar results when looking at those with some ability level impairment.
  - The ACA overall reduced the number of people without coverage
  - Those that needed ADL help were the least impacted by the coverage gap reduction
  - Family income level was directly tied to the ability of the differently abled to access insurance or health care
    - Mental health impairment also increased the likelihood of not having access
- The US will continue to struggle with addressing some of these disparities as long as we continue to bicker about what the minimum wage is for and should do as well as refuse to engage with basic minimum income for citizens

40

Addressing Health Disparities in General

- The access issue is more difficult to address even when one does have insurance.
  - As we know Indiana is still a resource poor state so individuals may have to travel long distances to access specialty medical care
    - Community mental health and integrated care centers are expanding to help address the mental health need but opportunities for long-term treatment or hospitalization can still be limited
- Co-pays can still be a barrier to receiving care if an individual cannot cover those and other financial responsibilities
- Finding a good fit for your needs can also be an issue given your demographics and requirements
  - E.g. if I wanted to find an African American female therapist to see within a short distance I would likely be unable to do so as I either work with or socially network with most of them

41

Addressing Health Disparities Related to Gender

- Cameron (2013) discussed reframing the discussions about the more physical aspects of health disparities for women to put it into a context that would resonate more with the target groups
  - They recommended creating more personalized educational plans or pamphlets for Latina women to help increase their likelihood of being screened for breast cancer
  - They also made the same recommendations for African Americans and Latinos to help with screening for colon cancer
  - These kinds of programming shifts were made after testing currently available materials and then focus grouping why those were not effective
    - After doing so new material was drafted that did result in increased utilization in the targeted groups and others were still under study

42

Addressing Health Disparities Related to Sexuality

- Ryan et al (2017) suggest a number of strategies to help alleviate the health disparities present for this group
  - Have structural affirmative policies in place that provide both material and psychological benefit to LGBTQ populations, i.e. marriage equality
  - Have continued positive and affirming messages of LGBTQ individuals for both them and to potentially reduce negative messaging among heterosexual individuals
  - Providing education about a variety of LGBTQ issues may be helpful in boosting self-esteem and social support which should help provide a protective barrier for LGBTQ group members
  - Create interventions aimed at targeting stigma related stress and social identity threat

43

Addressing Health Disparities Related to Race/Ethnicity

- In this area much like the work that you will see in Indigenous populations, researchers indicated a need to see the work that needs to be done with racial/ethnic minorities from a different lens
- They highly encourage clinicians to look at their clients with
  - Increased cultural sensitivity
  - A new cultural worldview that more readily aligns with the worldview of that group
  - More cultural competence

44

Addressing Health Disparities Related to Race/Ethnicity

- The table below is from Tillotson et al(2015)

Table 1 Selected Healthy People 2020 health goals

Healthy People 2020 goals	Measures of progress
Create social and physical environments that promote good health for all	Determinants
	Social and economic factors
	Natural and built environments
	Policies and programs
Promote quality of life, healthy development, and healthy behaviors across all life stages	Well-being/satisfaction
	Physical, mental, and social health-related quality of life
	Participation in common activities

Addressing Health Disparities Related to Race/Ethnicity

- The researchers stress that had worldview been taken into consideration that the last 20 years worth of mixed results may have been different
- They discuss both the ways in which worldview could change the discussion around health disparities but also what has been lost by specifically African American individuals who lost contact with their traditional ways of knowing upon being forced into slavery
- They primarily address five aspects of what they call the traditional African Worldview:
  - Peace with nature
  - Communalism
  - Spirituality
  - Respect for elders
  - WEUSI.
- They also encourage working in a more integrated model so that gaps in the referral chain from medical settings to mental health centers are reduced or eliminated

Addressing Health Disparities Related to Race/Ethnicity

- The table below is from Tillotson et al (2015)

Table 2 Structural changes

Indigenous beliefs lost	Resultant health risks
Departure from indigenous beliefs of country of origin	Increase in palliative behavior
Loss of historical memory, knowledge, and wisdom	Presentation of maladaptive self-destructive behaviors
Lessened connections between elders and youth	Hyperconsumerism/therapeutic consumerism and materialism
Loss of communal ideological orientation	Unhealed historical and intergenerational wounds
Loss of love/respect for one another as a priority	Increased interpersonal conflict, violence, and perpetration of crimes against one another

47

Addressing Health Disparities Related to Race/Ethnicity

- Miconi (2021) and her colleagues conducted a timely study regarding mental health needs in relation to the pandemic and racism
  - They found that members of visible minoritized groups and those of lower SES endorsed being more exposed to COVID 19 and experienced more stigma related discrimination during COVID
  - Those who were Black as well as white endorsed more symptomology than before COVID.
  - Those who were of Arab descent reported the worst overall mental health functioning versus those who were East Asian reporting the best.
  - The researchers note however that East Asians may be unlikely to report such distress in research and that some of their overall positions are lacking local support because Canada has not disaggregated mortality and morbidity rates by race/ethnicity as other countries have

48

Addressing Health Disparities Involving Indigenous Populations

- Different sets (Browne et al, 2016; Hadjipavlou et al, 2018) of researchers focusing on the Canadian Indigenous Peoples found that working to establish more robust integrated care models helped improve the conditions for their clients
  - They maintained traditional counseling practices but:
    - Included opportunities for the Indigenous clients to work with community Elders in the integrated care model
    - Allowed for group work to be led by community Elders
    - Highly encouraged the mental health practitioners to learn about and engage with traditional Indigenous ways of knowing and communicating to connect with their clients
  - Stanley (2020) and her colleagues work supports this position and encourages us to make sure that future research actively involve minoritized populations and the way they understand illness and healing
  - Keys (2020) encourages practitioners to allow tribal members to use their native language to discuss their concerns initially before having it translated to English either by the client or a translator

49

Addressing Health Disparities Involving Indigenous Populations

- Hadjipavlou et al (2018) found that clients who worked in that model endorsed more positive beliefs about that future with almost no exceptions. The one client that did not endorse that belief said it just had not been long enough for them to know but that they were hopeful.
- They were also able to identify five themes that the clients embraced from this experience which were:
    - Finding a place of healing after a prolonged period of seeking and desperation
    - Strengthening cultural identity and belonging
    - Developing trust and opening up
    - Coping with losses
    - Engaging in ceremony and spiritual dimensions of care as a resource for hope
- Meeting with the Elders allowed for an unmet need to be found outside of the traditional counseling space

50

Addressing Health Disparities Involving Indigenous Populations

- Similar findings were discovered in the Browne et al (2016) study that encouraged practitioners to focus on the following themes to best serve Indigenous clients:
  - Culturally Safe Care
  - Trauma and Violence Informed Care
  - Contextually Tailored Care
- They also proposed four general approaches and ten strategies to achieve better outcomes within this population

51

Addressing Health Disparities Involving Indigenous Populations

Key Dimensions of Equity-Oriented Services

4 General Approaches:
- Partnerships with Indigenous peoples
- Action at all levels (patient-provider; organizations; systems)
- Attention to local and global histories
- Attention to unintended and potentially harmful impacts of each strategy

10 Strategies to Guide Equity-Oriented Services with Indigenous Peoples:
- Explicitly commit to fostering health equity
- Develop supportive organizational structures, policies, and processes
- Optimize use of place and space
- Re-vision the use of time
- Attend to power differentials
- Tailor care, programs and services to local Indigenous contexts
- Actively counter racism and discrimination
- Ensure meaningful engagement of patients and community leaders
- Tailor care to address inter-related forms of violence
- Tailor care to address the social determinants of health

Fig. 1 Essential Elements of Equity-Oriented Primary Health Care with Indigenous Peoples

52

Addressing Mental Health Disparities

- Here is where we get stuck unfortunately. The suggestions are not born out of sound research that has proven that the strategies below work but are more best practices
  - Provide more training to reduce provider bias (McGuire and Miranda, 2008)
  - Look at culturally sensitive practices to provide the best care (Safran et al, 2009, Sanchez et al, 2016)
  - Use integrated health practices to increase treatment compliance (Sanchez et al, 2016)
  - Reducing barriers to seeking treatment and reduce stigma about help seeking (Le Cook et al, 2019)
  - Arevian (2019) and colleagues encourage us to use the burgeoning telehealth industry to reach out to minoritized and stigmatized populations, potentially working with them to co create mobile apps that could be more easily accessed

53

Addressing Mental Health Disparities

- Here is where we get stuck unfortunately. The suggestions are not born out of sound research that has proven that the strategies below work but are more best practices
  - Shim et al (2018) recommend tackling both what we consider to be social norms and public policy simultaneously while also noting that access continues to remain an issue for minoritized and marginalized communities
  - Yoo et al (2018) encouraged us to work with increasing engagement of caregivers when it comes to treating mental health issues in youth and to also involve youth in decision making about their treatment
- Nearly all of the researches encouraged continued research on diverse groups and disparities to develop more profound and evidence based strategies

54

In what ways are health disparities impacting your work with clients?

- Let's discuss what you are currently seeing as part of an integrated care team in clinical practice
- Let's discuss private practice issues.
- Let's revisit the handouts.

55

What does this mean in terms of true integrated care?

- If our true focus is to address "the management and delivery of health services so that clients receive a continuum of preventive and curative services, according to their needs over time and across different levels of the health system." (WHO, 2008 as cited in de Saxe Zerden et al, 2017) then there are a vast array of changes we have to make at least at the critical thinking level if not fully implemented in the organizational structure
  - It may be difficult to find Indigenous Elders to speak in Kokomo or Tipton but how can that experience be replicated here
  - In what ways can our organizations better meet the wide ranging needs of those who are severely below the poverty level

56

What does this mean in terms of true integrated care?

- de Saxe Zerden and colleagues (2017) also spoke to using government funding to expand training opportunities for mental health workers to be better prepared to work in integrated health settings.
- Their focus was on social work programs but that funding could be potentially sought by others to help bring in those committed to integrated care as well as possibly defray some costs of shoring up cultural competence of the work force.
- Additionally, this work does highly tout the need for cultural competence to dispel certain health beliefs about other groups it does not expressly address health disparity concerns and assumes to some degree that healthy will look the same for most clients

57

Resources to help expand our knowledge base

- Black Mental Health—journal that is/was published quarterly, waiting for it to restart
  - Previous issues are available on Issuu
- Setting up journal alerts through our journal subscriptions to send emails or other messages to address topics of interest
- Attend trainings when possible
- Speaking with minoritized populations and those in underserved areas

58

Where can we do the most beneficial work outside of our clinical roles?

- Researchers are consistently pointing to one area for us to address outside of our clinical setting (Abrishami, 2018; Bruisin, 2012; Matthews & Van Wyk, 2018)
  - Educating future providers to be more culturally competent
    - Regardless of role or setting they believe that cultural competence can help alleviate some of the health disparities we may be seeing
    - They believe that improving cultural competence will enhance knowledge of different groups to help create better treatment plans and educational offerings for those with health disparities
    - Both in the United States and abroad this is being pushed forward as a possible solution

60

Is cultural competence enough?

- Cultural competence has been a focus of mental health programs for a prolonged period of time
  - Has it alone influenced how you believe most clinicians interact with groups different from themselves?
  - Would cultural humility be a better model to work from?
  - What are the short falls with this being a push from a training perspective?

61

Suggestions from a Mental Health Adovocate

- Advocate for yourself. As Blackman said, you can't be an advocate for others if you don't first advocate for yourself. For instance, she recently talked to her therapist and psychiatrist about discontinuing her medication. They collaborated on a specific plan, which includes continuing to attend weekly therapy sessions and calling her doctor and returning to medication if she notices any negative changes. According to Blackman, advocating for yourself means getting educated, understanding your triggers, developing coping skills and stating your needs.
- Share your story. Start with family and friends, which also will reveal whether you're ready for a wider audience, Borchard said. Love said if you're comfortable, consider sharing your story on social media. "The beginning of ending stigma is being able to put it out there and talk about it."
- Educate your immediate circle. "There is a tremendous amount of power in reflecting on how you think and talk about mental health, and how you can help others in your life to take a more positive and accepting stance on mental health and mental illness," Kennedy said. For instance, you can correct misinformation, such as using person-first language ("person with schizophrenia"), instead of "schizophrenic," she said. Blackman also noted that you can text family, friends, and colleagues articles about mental health. In fact, she started by sharing articles and videos with loved ones to help them understand what she was going through.
- https://psychcentral.com/blog/what-it-means-to-be-a-mental-health-advocate-and-how-to-become-one/

62

Suggestions from MHA continued

- **Volunteer.** Many of the advocates suggested joining local mental health organizations and assisting with their programs and events.
- **Get a mentor.** "Like most things, getting the right mentor is about building relationships," Spencer-Thomas said. She suggested noticing people you'd like to be like, reading their posts, leaving comments, and asking questions. "Volunteer for events or at meetings where [this person] is present…Ask them directly about being a mentor and set realistic expectations."
- **Get trained in legislative advocacy**. Spencer-Thomas noted that one way to do that is to become a field ambassador for the American Foundation for Suicide Prevention.
- **Find your niche**. "[F]ind the thing that you are better at than most and that inspires you," Howard said. This might be anything from public speaking to writing to fundraising to managing volunteers, he said

63

Advocacy Issues

- Where can integrated care providers do better advocacy in terms of addressing health disparities?
- What can they potentially do better than other groups now that can address health disparities?
- What training would one need to be useful as an advocate?
- When would it fit into an already busy schedule?
- Who would be the targets of such advocacy work?

64

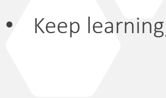
Advocacy Issues

- Wilkinson et al (2017) note several ways in which the mental health profession should be advocating for our clients including the following:
  - defending health care reform in the political arena
  - promoting direct investment in primary prevention by health care providers
  - helping to build power for patients and communities through a combination of organizing, advocacy and multisector partnerships
  - engaging in campaigns to promote affordable housing, economic development, safe neighborhoods, food security, environmental quality, and other issues that help de-termine health.

65

What can you do now to become a better advocate for clients?

- Join a professional organization in the field. There is usually at least on branch that stays on top of mental health initiatives and bills that are up in federal, state and local government.
- Use services or tools that allows you contact your elected officials about issues that are important to you regarding mental health
- Get to know other providers in the area outside of our area of expertise, both to expand your referral base but also to help facilitate treatment
  - Talk with them about how they treat clients in general but in particular diverse clients
  - Talk with them about ways in which you may be able to help educate each other to better treat clients
  - Talk with them about the benefits of integrated care even when you aren't in the same offices
- Get to know about the local community and what stressors are present as well as the leaders trying to combat those stressors
- Do a more thorough "identity check" with clients to make sure that you aren't ignoring critical pieces of their identity that could be contributing to their overall issues (could be mental or written but think about issues surrounding identity acceptance, resources and support)
- Keep learning, go to the trainings, listen to the new issue being raised, be okay being told you're wrong



66

What can you do to be a better advocate for yourself?

- The professional societies are still beneficial especially as you wrap up training
  - EPPP 2 perhaps
- Speak with mentors or trusted advisors about how to advance your training or career
- Speak with colleagues about what has worked in being successful in their careers to date advice they would give you now
- Try, and potentially fail, at new techniques or opportunities to increase your knowledge base and marketability
- Make a flexible plan and then figure out what supports you may be lacking to achieve it

67

Contact Information

If you have questions or would like a copy of the electronic materials please reach out to me at the information listed below:

Rosalyn Davis, Ph.D.

- Email: rosddavi@iuk.edu
- Phone: (765) 455-9456
- Address:
  Indiana University Kokomo,
  2300 S Washington St.
  Main Building KO211D
  Kokomo, IN 46904

69

References

- Abrishami, D. (2018). The need for cultural competency in health care. *Radiologic Technology, 89*(5), 441-448.
- Arevian, A., Jones, F., & Chung, B. (2019). Mental health disparities and technology: New risks and opportunities. *Psychiatric Annals, 49*(5), 215-219.
- Blewett, L. A., Planalp, C., and Alarcon, G. (2018). Affordable Care Act impact in Kentucky: Increasing access, reducing disparities. *AJPH, 108*(7), 924-929.
- Bowen, E. A. and Walton Q. L. (2015). Disparities and the social determinants of mental health and addictions: Opportunities for a multifaceted social work response. *Health and Social Work, 40*(3), e59-e64.
- Browne, A. J., Varcoe, C., Lavoie, J., Smye, V., Wong, S. T., Krause, M., …Fridkin, A. (2016). Enhancing health care equity with Indigenous populations: evidence-based strategies from an ethnographic study. *BMC Health Services Research,* 16:544.
- Bruisin, J. H. (2012). How cultural competency can help reduce health disparities. *Radiologic Technology, 84*(2), 129-147.
- Burgos, G., Rivera, F. I., and Garcia, M. A. (2017). Contextualizing the relationship between culture and Puerto Rican Health: Towards a place-based framework of minority health disparities. *Centro Journal, 29*(3), 36-73.
- Cameron, K. A. (2013). Advancing equity in clinical preventative services: The role of health communication. *Journal of Communication, 63*, 31-50.
- Hadjipavlou, G., Varcoe, C., Tu, D., Dehoney, J., Price, R., and Browne, A. J. (2018). "All my relations": Experiences and perceptions of Indigenous patients connecting with Indigenous Elders in an inner city primary care partnership for mental health and well-being. *CMAJ, 190*(20), E608-15.

70

References

- Hoffman, D. E. & Tarzian, A. J. (2001). The girl who cried pain: A bias against women in the treatment of pain. *Journal of Law, Medicine and Ethics, 29*, 13-27.
- Holden, K., McGregor, B., Thandi, P., Fresh, E., Sheats, K., Belton, A., …Satcher, D. (2014). Toward culturally centered integrative care for addressing mental health disparities among ethnic minorities. *Psychological Services, 11*(4), 357-368.
- Kaye, H. S. (2019). Disability-related disparities in access to HealthCare before (2008–2010) and after (2015–2017)the Affordable Care Act. *AJPH Policy, 109*(7), 1015-1021.
- Johnson, C. Y. (2019, October 24). Racial bias in a medical algorithm favors white patients over sicker black patients. *The Washington Post.*
- Keys, C. M. (2020). *Exploring Indigenous language and psychological health among the Kikapoo tribe bilinguals.*
- Krieger, N. (2017). Health equity and the fallacy of treating causes of population health as if they sum to 100%. *AJPH, 107*(4), 541-549.
- Le Cook, B., Hou, S. SY., Lee-Touler, S. Y., Progrovac, A. M., Samson, F., & Sanchez, M. J. (2019). A review of mental health and mental health care disparities research: 2011-2014. *Medical Care Review and Research, 76*(6), 683-710.
- Macon, T. M. (2022). Language matters: Why we need to stop talking about eliminating health inequities. *Health Affairs.*
- Martin, K. J. and Johnson, K. L. (2023). You can't dismantle what you don't recognize: The effect of learning critical Black history in healthcare on perspective-taking. *Journal of Experimental Psychology: General.*
- Matthews, M. and Van Wyk, J. (2018). Towards a culturally competent health professional: a South African case study. BMC Medical Education, 18:112.

71

References

- Miconi, D., Li, Z.Y., Frounfelker, R.L., Santavicca, T., Cenat, J.M., Venkatesh, V. & Rousseau, C. (2021). Ethno-cultural disparities in mental health during the COVID-19 pandemic: a cross-sectional study on the impact of exposure to the virus andCOVID-19-related discrimination and stigma on mental health across ethno-cultural groups in Quebec (Canada). *BJPsych Open, 7*(4), 1-10.
- McGuire, T. G. & Miranda, J. (2008). Racial and ethnic disparities in mental health care: Evidence and policy implications. *Health Affinity, 27*(2), 393-402.
- Prasath, P. R., Lohmar, S., Rich, W. Z., Dalan, E. E., & James, J. K. (2023). Mental health disparities among cisgender, transgender and gender nonconforming college students in the United States. *Journal of Mental Health, 45*(2), 129-146.
- Ryan, W. S., Hunger, J. M., and Major, B. (2017). Applying intergroup relations research to understanding LGB health disparities. *Journal of Social Issues, 73*(3), 477-492.
- Safran, M. A., Mays Jr., R.A., Huang, L. N., McCuan, R., Pham, P. K., Fisher, S.K., …. Trachtenberg, A. (2009). Mental Health Disparities. *American Journal of Public Health, 99,* 1962-1966.
- Sanchez, K., Ybarra, R., Chapa, T., & Martinez, O. N. (2016). Eliminating behavioral health disparities and improving outcomes for racial and ethnic minority populations. *Psychiatric Services, 67*(1), 13-15.
- de Saxe Zerden, L., Jones, A., Brigham, R., Kanfer, M., & Zomorodi, M. (2017). Infusing integrated behavioral health in an MSW program: Curricula, field, and interprofessional educational activities. *Journal of Social Work Education, 53*(s1), s59-s71.

72

References

- Shim, R.S., Kho, C.E. & Murray-Carcia, J. (2018). Inequities in mental health and mental health care: A review and future directions. *Psychiatric Annals, 48*(3), 138-142.
- Stanley, L.R., Swaim, R.C., Kaholokula, J.K., Kelly, K.J., Belcourt, A., & Allen, J. (2020). The imperative for research to promote health equity in Indigenous Communities. *Prevention Science, 21,* 13–21.
- Takamuru, J. (2015). Closing the disparity gap requires an integrated response from policy, research, and programs. *Journal of the American Society on Aging, 38*(4), 119-126.
- Tillotson, M., Doswell, W. M., and Phillips, C. M. (2015). Finding a voice: An Allocentric worldview to guide effective reduction of behavioral health disparities in African Americans. *Journal of African American Studies, 19*, 65-78.
- Villarosa, L. (2018, April 11). Why America's Black mothers and babies are in a life-or-death crisis. *New York Times.*
- Wilkinson, G. W., Sager, A., Selig, S., Antonelli, R., Morton, S., Hirsch, G., …Wachman, M. (2017). No equity, no triple aim: Strategic proposals to advance health equity in a volatile policy environment. *AJPH, 107*(s3), s223-s228.
- Williams, D. R. and Mohammed, S. A. (2009). Discrimination and racial disparities in health: evidence and needed research. *Journal of Behavioral Medicine, 32*, 20-47.
- Yoo, A., Kim, M., Ross, M.R., Vaughn-Lee, A., Butler, B., & dosReis, S. (2018). Engaging caregivers in the treatment of youth with complex developmental and mental health needs. *The Journal of Behavioral Health Services & Research, 45*(3), 440-453.