Health Disparities in Utah's Public Mental Health and Substance Use Treatment Systems

NEEDS ASSESSMENT

Health Disparities Research Team

Utah Division of Substance Abuse & Mental Health

Authors' Notes

- This Needs Assessment was funded by the Youth Empowered Solutions to Succeed (YESS), which is a federal Substance Abuse & Mental Health Services Administration (SAMHSA) grant to help transition-age youth between the ages of 16 and 25 to successfully transition into adulthood by strengthening skills and increasing stability in housing, employment, education, and community living.
- We have no known conflict of interest.
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ACKNOWLEDGEMENTS

The health disparities research team appreciates the hard work and dedication of the following workgroup members, liaisons, steering committee members, consultants, and helpers who made this report possible.

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EXECUTIVE SUMMARY

Purpose

The purpose of this health disparities needs assessment was to identify needs and obstacles that contribute to health disparities of four target populations within Utah's public mental health and substance use treatment systems. Health disparities were defined as **avoidable** and **unjust** differences in mental health and substance abuse access and outcomes within these systems. The four target populations included in the study were:

- Transition-Age Youth & Young Adults, ages 14 through 26 years old;
- Black, Indigenous, and People of Color (BIPOC);
- LGBTQ+ folks; and
- People with Developmental Disabilities

Strategy

The overarching strategy employed during this needs assessment was to compare the ideal situations for reducing health disparities among target populations with the current situations observed among Utah's public mental health and substance use treatment agencies. Ideal situations were defined by workgroups comprised of target population community members and informed by a comprehensive literature review. Current situations were defined through wide-ranging data collection efforts and data analysis. The difference between the ideal and the current situations were defined as the needs.

Data collection efforts included surveys of workforce members, focus groups with leadership teams, focus groups with clients, public-facing document reviews, and walkthroughs at a majority of public mental health and substance use treatment facilities across the state.

Framework

The evaluation framework used in this study utilized three levels identified as affecting health disparities within agencies:

- Organizational—the organization's leadership, policies and workforce
- Structural—the organization's facilities, materials, assessments, programming, and services
- Treatment—the extent to which cultural awareness, attitudes, knowledge, and skills were demonstrated by treatment providers and incorporated into services

Findings

System Level[1]

Clinicians and other providers need more training in their educational programs, particularly with regard to substance use disorder treatment and culturally responsive approaches. Without these additions, clinicians enter the workforce poorly prepared to meet the needs of target populations. Furthermore, licensure exams must be made culturally responsive and adapted to the experiences of marginalized communities. Without adaptation clinicians from target populations are unfairly excluded from the workforce.

Assessments, evaluation tools, and evidence-based practices need to become culturally responsive. This would likely improve if target populations were included in the processes used to develop clinical instruments and establish best practices.

Organizational level

Agencies need the voices of target populations to inform policies, practices, and decisions. For this to happen, target populations need to be better represented in leadership and agencies need to make meaningful connections with community members and grass roots organizations. Workforce members from target populations need to feel at least as valued and included in the workplace as their peers do.

Structural Level

Public spaces, public-facing documents, programs, and services in Utah's mental health and substance use treatment systems need to reflect and address the diverse needs and values of the target populations. This would likely be achieved by better representation within organizations and stronger connections with the target communities.

Service Level

Service providers, for the most part, have positive attitudes toward people from the target populations and a desire to improve services. Providers, however, need more knowledge about the target populations and need specific skills in order to provide culturally sensitive and responsive services.

Recommendations

The health disparities research team has provided targeted recommendations to each agency based on data collected during this study. Key recommendations that apply to all stakeholders are related to representation and education. We recommend increased input on all policy and practice decisions from target population voices within the workforce and community. We also recommend inclusion of diverse voices in the development, delivery, and evaluation of all future trainings, guidelines and educational materials within the mental health and substance use systems.

[1] Although the system level was beyond the scope of this needs assessment, we would be remiss if we did not include the voices of agency leaders and practitioners that repeatedly brought systemic needs to our attention.

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Project Overview

In this health disparities needs assessment, health disparities are defined as **avoidable** and **unjust** differences in mental health and substance abuse treatment outcomes experienced by socially disadvantaged populations. The purpose of this project is to identify needs and obstacles faced by clients and providers in Utah's public mental health and substance use treatment systems. Addressing the identified needs may improve service delivery and reduce health disparities within four identified populations:

- Transition-Age Youth & Young Adults (ages 14-26)
- Black, Indigenous and People of Color (BIPOC)[2]
- LGBTQ+ folks
- People with Developmental Disabilities

The evaluation framework used in this study utilizes three levels identified as affecting health disparities within an organization:[3]

- Organizational—the organization's leadership, policies and workforce
- Structural—the organization's facilities, materials, assessments, programming and services
- Treatment—the extent to which cultural awareness, attitudes, knowledge and skills are demonstrated by treatment providers and incorporated into services

Within the evaluation framework, four factors commonly associated with culturally responsive services in social work and health care settings were selected to guide data collection and analysis:[4]

- Awareness—recognition of one's own cultural biases and an understanding that everyone has a unique cultural lens through which the world is seen
- Attitudes—tolerance or intolerance, respect or disrespect, and positive or negative regard for people from diverse cultures and communities
- Knowledge—factual information about different cultures and the impact of cultural differences on treatment access and outcomes
- Skills—techniques necessary to adapt communications, services and supports to effectively support staff and clients from different cultural backgrounds

[2] BIPOC stands for Black, Indigenous, and People of Color. This term highlights the different experiences that People of Color have. It should be noted that terminology for how Communities of Color identify themselves changes over time. While BIPOC is now the preferred term by many, this is subject to change as new language and acknowledgements come to the forefront of our social consciousness. For more information, please see the "resources" section.

[3] Betancourt JR, Green AR, Carrillo JE, Owusu A-FI. *Defining Cultural Competence: A Practical Framework for Addressing Racial/Ethnic Disparities in Health and Health Care.* Public Health Rep. 2003;118(4):293–302.

[4] Alizadeh S, Chavan M. Cultural competence dimensions and outcomes: a systematic review of the literature. *Health & social care in the community*. 2016;24(6):117–30.

Data from across the public mental health and substance use treatment systems[5] were collected to assess awareness, attitudes, knowledge, and skills in each of the identified levels within the organizations. Data were analyzed and used to answer each of 11 evaluation questions:

Organizational Level

Q1. If an employee identifies with one of the target populations, how likely are they to have an administrative role in Utah's public mental health or substance use treatment system?

Q2. To what extent does the workplace offer an inclusive atmosphere where members of the target populations feel valued and heard?

Q3. To what extent are employees safe from discrimination and microaggressions in the workplace?

Q4. To what extent did leadership focus group responses align with the culturally responsive responses that workgroup members had envisioned?

Structural Level

Q5. How welcoming, accessible and inclusive are the websites and social media platforms of the agencies that provide Utah's public mental health and substance use treatment services?

Q6. How welcoming, accessible and inclusive are the facilities where Utah's mental health and substance use treatment services are provided?

Treatment level

Q7. With regard to race and ethnicity, how well does the public mental health and substance use workforce align with the clientele?

Q8. To what extent do service providers demonstrate the awareness, attitudes, knowledge and skills necessary to provide responsive services to the target populations?

Q9. To what extent are workforce members and treatment providers aware of their own racial and ethnic biases?

Q10. To what extent are culturally responsive approaches integrated into the services delivered by mental health and substance use treatment providers in Utah?

Q11. To what extent are provider knowledge and attitude related?

[5] Public mental health and substance use treatment system agencies in this study included each of the 13 local mental health and substance use treatment authorities as well as the Division of Substance Abuse and Mental Health and the Utah State Hospital.

Summary of Research Findings about Target Group Health Disparities

Summary of Transition-Age Youth and Young Adults Health Disparities

Transition-age youth and young adults (TAY) range in age from 14 to 26 years old. This age group faces unique challenges that impact their need for mental health and substance use treatment, their ability to access this treatment, and their outcomes when they do access treatment. There are multiple factors that drive these disparities. Often the factors and disparities are intertwined and impact each other. Youth are also especially impacted by race/ethnic health disparities.

TAY have certain **risk factors** that impact their experiences around mental health and substance use. For example, TAY are more likely to experience:

- Facing suicide as a leading cause of death;[6]
- Having multiple chronic illnesses; [7] and
- Having at least one mental illness in their lifetime if in foster care. [8]

Many TAY are aging out of foster care or juvenile justice systems (JJS). Others are changing from pediatric to adult care systems and losing insurance from their parents. This leads to youth being ***less likely*** to:

- Receive care when transitioning to adulthood;[9, 10]
- Receive quality handoff to adult care;[11, 12, 13]
- Receive care outside of foster care or JJS;[14, 15] and
- Access non-emergency services. [16, 17]

Some factors that lead to youth not receiving treatment include:

- Parents not allowing TAY to get care;[18]

[6] Suicide. (2020, September). Retrieved December 18, 2020, from https://www.nimh.nih.gov/health/statistics/suicide.shtml
[7] Mcmanus, M., White, P., Schmidt, A., Barr, M., Langer, C., Barger, K., & Ware, A. (2020). Health care gap affects 20% of United States population: Transition from pediatric to adult health care. *Health Policy OPEN*, 1, 100007. doi:10.1016/j.hpopen.2020.100007
[8] Havlicek, J. R., Garcia, A. R., & Smith, D. C. (2013). Mental health and substance use disorders among foster youth transitioning to adulthood: Past research and future directions. *Children and Youth Services Review*, 35(1), 194–203. doi: 10.1016/j.childyouth.2012.10.003
[9] Mcmanus Health care gap
[10] Pottick, K. J., Warner, L. A., Stoep, A. V., Knight, N. M., & Vander Stoep, A. (2014). Clinical characteristics and outpatient mental health service use of transition-age youth in the USA. *Journal of Behavioral Health Services & Research*, 41(2), 230–243. https://doi.org/10.1007/s11414-013-9376-5
[11] Mcmanus Health care gap
[12] Paul, M., Ford, T., Kramer, T., Islam, Z., Harley, K., & Singh, S. P. (2013). Transfers and transitions between child and adult mental health services. *British Journal of Psychiatry*, 202(S54), 36-40. doi:10.1192/bjp.bp.112.119198
[13] Cleverley, K., Lenters, L., & McCann, E. (2020). "Objectively terrifying": a qualitative study of youth's experiences of transitions out of child and adolescent mental health services at age 18. *BMC Psychiatry*, 20(1), 1–11. https://doi.org/10.1186/s12888-020-02516-0
[14] Mcmanus Health care gap
[15] Havlicek Mental health and substance use disorders
[16] Battaglia, M., Detrick, S., & Fernandez, A. (2016). Multidisciplinary Treatment for Adults with Autism Spectrum Disorder and Co-Occurring Mental Health Disorders: Adapting Clinical Research Tools to Everyday Clinical Practice. *Journal of Mental Health Research in Intellectual Disabilities*, 9(4), 232–249. https://doi.org/10.1080/19315864.2016.1192708
[17] Tsang, Y. T., Franklin, M., Sala-Hamrick, K., Kohlberger, B., Simon, V. A., Partridge, T., & Barnett, D. (2020). Caregivers as gatekeepers: Professional mental health service use among urban minority adolescents. *American Journal of Orthopsychiatry*, 90(3), 328–339. https://doi.org/10.1037/ort0000432
[18] Tsang, Y. T., Franklin, M., Sala-Hamrick, K., Kohlberger, B., Simon, V. A., Partridge, T., & Barnett, D. (2020). Caregivers as gatekeepers: Professional mental health service use among urban minority adolescents. *American Journal of Orthopsychiatry*, 90(3), 328–339. https://doi.org/10.1037/ort0000432

- TAY facing fear of judgement from parents and doctors;[19, 20]
- Inability to pay for services;[21]
- TAY not knowing how to search for doctors;[22, 23, 24]and
- Services not being available outside of work hours.[25]

When TAY do access services, there are often **disparities in outcomes**. These disparities can be exacerbated by:

- TAY having a lack of autonomy in choosing level of treatment;[26, 27, 28]
- Stigma and bias from doctors;[29]
- Lack of continued provider education;[30]
- Lack of communication between providers;[31, 32, 33] and
- TAY being under-prescribed medications[34]
- Lack of collaboration between the children and adult systems to ensure seamless transitions of care[35]
- Care is not grounded in youth driven and youth empowerment approaches.[36]

Local Mental Health and Substance Abuse Authorities can help TAY by addressing the contributing factors. For example, by working to reduce stigma and improve communication between providers, TAY may face better health outcomes. In the clinical setting, local authorities can reduce disparities by providing meaningful trainings, increasing knowledge, and improving transition specific care through policy and practice.

[19] Battaglia Multidisciplinary Treatment for Adults
[20] Moskos, M. A., Olson, L., Halbern, S. R., & Gray, D. (2007). Utah Youth Suicide Study: Barriers to Mental Health Treatment for Adolescents. *Suicide and Life-Threatening Behavior*, 37(2), 179–186. doi: 10.1521/suli.2007.37.2.179
[21] Hower, H., Case, B. G., Hoeppner, B., Yen, S., Goldstein, T., Goldstein, B., … Keller, M. B. (2013). Use of Mental Health Services in Transition-age Youth with Bipolar Disorder. *Journal of Psychiatric Practice*, 19(6), 464–476. doi: 10.1097/01.pra.0000438185.81983.8b
[22] Havlicek Mental health and substance use disorders
[23] Battaglia Multidisciplinary Treatment for Adults
[24] Tsang Caregivers as gatekeepers
[25] Gibson, K., Cartwright, C., Kerrisk, K., Campbell, J., & Seymour, F. (2016). What Young People Want: A Qualitative Study of Adolescents' Priorities for Engagement Across Psychological Services. *Journal of Child & Family Studies*, 25(4), 1057–1065. https://doi.org/10.1007/s10826-015-0292-6
[26] Paul Transfers and transitions between child
[27] Cleverley "Objectively Terrifying"
[28] Ådnanes, M., & Steihaug, S. (2016). "You Never Know What Happens Next" - Young Adult Service Users' Experience with Mental Health Care and Treatment through One Year. *International journal of integrated care*, 16(3), 5. https://doi.org/10.5334/ijic.2435
[29] Moskos Utah Youth Suicide Study
[30] Gilmer, T. P., Ojeda, V. D., Fawley-King, K., Larson, B., & Garcia, P. (2012). Change in Mental Health Service Use After Offering Youth-Specific Versus Adult Programs to Transition-Age Youths. *Psychiatric Services*, 63(6), 592-596. doi:10.1176/appi.ps.201100226
[31] Havlicek Mental health and substance use disorders
[32] Pottick Clinical characteristics and outpatient
[33] Battaglia Multidisciplinary Treatment for Adults
[34] Hower Use of mental health services
[35] Davis, M., Sabella, K., Smith, L. M., & Costa, A. (2011). Becoming an Adult: Challenges for Those with Mental Health Conditions [English and Spanish versions]. *Psychiatry Information in Brief*, *8*(15), 1.
[36] ibid

Summary of BIPOC Health Disparities

BIPOC face unique challenges that impact their need for mental health and substance use treatment, their ability to access this treatment, and their outcomes when they do access treatment. There are multiple factors that drive these disparities. Often the factors and disparities are intertwined and impact each other.

BIPOC have an ***increased risk*** for mental illness and substance use disorder. For example, BIPOC are more likely to experience:

- Poverty;[37]
- Unemployment;[38]
- Stigma;[39]
- Discrimination;[40, 41]
- Adverse childhood experiences (ACEs);[42]
- Lack of social support;[43]
- Microaggressions;[44]
- Environmental racism;[45] and
- Targeted violence.[46]

Subsequently, BIPOC have ***increased rates*** of mental illness and substance use disorder including higher rates of:

- Depression;[47]
- Suicidal ideation;[48]
- Race-related stress;[49]
- Historical trauma and loss;[50, 51, 52]

[37]. Castanyer, P. (2019). Notes on Race and Gender in the USA: Poverty and Intersectionality. *Papeles De Europa*, 32(1), 1-12
[38] IBID
[39] Krill Williston, S., Martinez, J., & Abdullah, T. (2019). Mental health stigma among BIPOC: An examination of the impact of racial discrimination. *International Journal of Social Psychiatry*, 65(6), 458-467.
[40] IBID
[41] Held, M., & Lee, S. (2017). Discrimination and mental health among Latinos: Variation by place of origin. *Journal of Mental Health*, 26(5), 405-410.
[42] Brockie, T.N., Dana-Sacco, G., Wallen, G.R., Wilcox, H.C. and Campbell, J.C. (2015), The Relationship of Adverse Childhood Experiences to PTSD, Depression, Poly-Drug Use and Suicide Attempt in Reservation-Based Native American Adolescents and Young Adults. *American Journal of Community Psychology*, 55: 411-421. doi:10.1007/s10464-015-9721-3
[43] Davis, R. L., Vakalahi, H. F. O., & Smith, L. L. (2015). Pacific Islander Youth and Sources of Risk for Problem Behaviors (Research Note). Families in Society, 96(2), 99–107. https://doi.org/10.1606/1044-3894.2015.96.3
[44] Nadal, K. L., Wong, Y., Sriken, J., Griffin, K., & Fujii-Doe, W. (2015). Racial microaggressions and Asian Americans: An exploratory study on within-group differences and mental health. Asian American Journal of Psychology, 6(2), 136–144. https://doi.org/10.1037/a0038058
[45] Pulido, L. (2017). Geographies of race and ethnicity II: Environmental racism, racial capitalism and state-sanctioned violence. *Progress in Human Geography*, 41(4), 524–533. https://doi.org/10.1177/0309132516646495
[46] Hate Crime Statistics. (2020). Retrieved December 22, 2020, from https://www.justice.gov/hatecrimes/hate-crime-statistics
[47] Wyatt, L. C., Ung, T., Park, R., Kwon, S. C., & Trinh-Shevrin, C. (2015). Risk Factors of Suicide and Depression among Asian American, Native Hawaiian, and Pacific Islander Youth: A Systematic Literature Review. *Journal of health care for the poor and underserved*, 26(2 Suppl), 191–237. https://doi.org/10.1353/hpu.2015.0059
[48] Gloppen, K., McMorris, B., Gower, A., & Eisenberg, M. (2018). Associations between bullying involvement, protective factors, and mental health among American Indian youth. *American Journal of Orthopsychiatry*, 88(4), 413–421. https://doi.org/10.1037/ort0000284
[49] Krill Williston Mental health stigma
[50] Brockie The Relationship of Adverse Childhood Experiences
[51] Gloppen Associations between bullying involvement
[52] Goodkind, J., LaNoue, M., Lee, C., Freeland, L., & Freund, R. (2012). Feasibility, Acceptability, and Initial Findings from a Community-Based Cultural Mental Health Intervention for American Indian Youth and Their Families. *Journal of community psychology*, 40(4), 381–405. https://doi.org/10.1002/jcop.20517

- PTSD,[53] especially in immigrant populations;[54]
- Poly-substance use;[55] and
- Anxiety.[56]

Despite a higher need for care, BIPOC have ***reduced access*** to care. Reduced access has been shown to be affected by:

- BIPOC being less likely to receive care from providers even after care is requested from clients;[57]
- More discrimination in healthcare;[58]
- Underdiagnosis of mental health disorders such as depression[59] and autism;[60]
- Living in areas where psychiatrists are not as commonly found;[61]
- More often receive punishment than treatment;[62]
- Limited understanding of what services are available;[63]
- Termination and postponement of treatment;[64]
- Lack of provider education around stigma;[65] and
- Lack of providers who share identities with patients.[66]

Even when BIPOC do access services, there are often **disparities in outcomes**. These disparities can be exacerbated by:

- Lack of trust towards providers;[67]
- Overrepresentation in juvenile justice services;[68]
- Dissatisfaction with mental health services;[69, 70] and
- Feeling judged by providers.[71]

[53] Dixon, L. E., Ahles, E., & Marques, L. (2016). Treating Posttraumatic Stress Disorder in Diverse Settings: Recent Advances and Challenges for the Future. *Current Psychiatry Reports*, 18(12), 108.
[54] Norris, A. E., Aroian, K. J., & Nickerson, D. M. (2011). Premigration Persecution, Postmigration Stressors and Resources, and Postmigration Mental Health: A Study of Severely Traumatized U.S. Arab Immigrant Women. *Journal of the American Psychiatric Nurses Association*, 17(4), 283–293. https://doi.org/10.1177/1078390311408900
[55] Davis Pacific Islander Youth
[56] Pulido Geographies of race and ethnicity
[57] Alegría, M., Chatterji, P., Wells, K., Cao, Z., Chen, C. N., Takeuchi, D., ... & Meng, X. L. (2008). Disparity in depression treatment among racial and ethnic minority populations in the United States. *Psychiatric services*, 59(11), 1264-1272.
[58] Krill Williston Mental health stigma
[59] Lee, S. Y., Martins, S. S., Keyes, K. M., & Lee, H. B. (2011). Mental health service use by persons of Asian ancestry with DSM-IV mental disorders in the United States. *Psychiatric Services (Washington, D.C.)*, 62(10), 1180-1186.
[60] Son, E., Magaña, S., Pedraza, F. D. M., & Parish, S. L. (2020). Providers' guidance to parents and service use for Latino children with developmental disabilities. *American Journal on Intellectual and Developmental Disabilities*, 125(1), 64–75. https://doi.org/10.1352/1944-7558-125.1.64
[61] Brockie The Relationship of Adverse Childhood Experiences
[62] Marrast, L., Himmelstein, D. U., & Woolhandler, S. (2016). Racial and Ethnic Disparities in Mental Health Care for Children and Young Adults: A National Study. *International journal of health services : planning, administration, evaluation*, 46(4), 810–824. https://doi.org/10.1177/0020731416662736
[63] Fischer, E. H., Turner, J. L., Fripp, J. A., & Carlson, R. G. (2017). Exploring the Influence of Attitude and Stigma on Participation of African American and Latino Populations in Mental Health Services. *Journal of Multicultural Counseling and Development*, 45, 80–94.
[64] Moore, K., Lopez, L., Camacho, D., & Munson, M. (2020). A Qualitative Investigation of Engagement in Mental Health Services Among Black and Hispanic LGB Young Adults. *Psychiatric Services (Washington, D.C.),* 71(6), 555-561.
[65] Wyatt Risk Factors of Suicide and Depression
[66] Moore A Qualitative Investigation of Engagement in Mental Health
[67] Alegría Disparity in depression treatment
[68] Davis Pacific Islander Youth
[69] Son Providers' guidance
[70] Alegría, M., Carson, N. J., Goncalves, M., & Keefe, K. (2011). Disparities in treatment for substance use disorders and co-occurring disorders for ethnic/racial minority youth. *Journal of the American Academy of Child and Adolescent Psychiatry*, 50(1), 22–31. https://doi.org/10.1016/j.jaac.2010.10.005
[71] Moore A Qualitative Investigation of Engagement in Mental Health

Local Mental Health and Substance Abuse Authorities can help BIPOC by addressing the contributing factors. For example, by working to reduce discrimination and stigma in the community and by actively improving cultural humility of providers. In the clinical setting, local authorities can reduce disparities by providing meaningful trainings, increasing knowledge, and embracing community-based interventions through policy and practice.

Summary of LGBTQ+ Health Disparities

LGBTQ+ people face unique challenges that impact their need for mental health and substance use treatment, their ability to access this treatment, and their outcomes when they do access treatment. There are multiple factors that drive these disparities. Often the factors and disparities are intertwined and impact each other. It is important to note that all factors and disparities addressed here impact transgender people the most within the LGBTQ+ community.

People in the LGBTQ+ community have an ***increased risk*** for mental illness and substance use disorder. For example, LGBTQ+ people are more likely to experience:

- Poverty; [72, 73]
- Homelessness; [74, 75, 76]
- Domestic violence,[77] hate crimes,[78] and sexual violence;[79]
- Prejudice, stigmatization[80] and discrimination; [81]
- Minority stress;[82] and
- Lack of social support.[83]

Subsequently, people in the LGBTQ+ community have ***increased rates*** of mental illness and substance use disorder including higher rates of:

- Depression; [84]
- Anxiety; [85, 86]
- Suicidal ideation; [87]

[72] Rhoades, H., Rusow, J. A., Bond, D., Lanteigne, A., Fulginiti, A., & Goldbach, J. T. (2018). Homelessness, Mental Health and Suicidality Among LGBTQ Youth Accessing Crisis Services. *Child Psychiatry and Human Development*, 49(4), 643–651. https://doi.org/10.1007/s10578-018-0780-1

[73] Baams, L., Wilson, B. D., & Russell, S. T. (2019). LGBTQ Youth in Unstable Housing and Foster Care. *Pediatrics*, 143(3). doi: 10.1542/peds.2017-4211

[74] Rhoades Homelessness, Mental Health and Suicidality

[75] Baams LGBTQ Youth in Unstable Housing

[76] Gattis, M. N., & Larson, A. (2017). Perceived Microaggressions and Mental Health in a Sample of Black Youths Experiencing Homelessness. *Social Work Research*, 41(1), 7–17. https://doi.org/10.1093/swr/svw03

[77] Scheer, J. R., McConocha, E., Behari K., & Pachankis, J. E. (2019): Sexual violence as a mediator of sexual orientation disparities in alcohol use, suicidality, and sexual-risk behaviour among female youth, *Psychology & Sexuality*, DOI: 10.1080/19419899.2019.1690031

[78] Blondeel, K., De Vasconcelos, S., GarcÃ-a-Moreno, C., Stephenson, R., Temmerman, M., & Toskin, I. (2018). Violence motivated by perception of sexual orientation and gender identity: a systematic review. *World Health Organization*.

[79] Jenness, V., & Maxson, C. L. N., Matsuda, M. K., & Sumner, J. (2007). *Violence in California correctional facilities: An empirical examination of sexual assault*. Sacramento, CA: California Department of Corrections and Rehabilitation.

[807] Link, B.G., & Phelan, J.C. (2006). Stigma and its public health implications. *Lancet, 367,* 528-529.

[81] Romanelli, M., Lu, W., & Lindsey, M. A. (2018). Examining Mechanisms and Moderators of the Relationship Between Discriminatory Health Care Encounters and Attempted Suicide Among U.S. Transgender Help-Seekers. *Administration and policy in mental health*, 45(6), 831–849. https://doi.org/10.1007/s10488-018-0868-8

[82] Meyer I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: conceptual issues and research evidence. *Psychological bulletin*, 129(5), 674–697. https://doi.org/10.1037/0033-2909.129.5.674

[83] Bränström, R. (2017). Minority stress factors as mediators of sexual orientation disparities in mental health treatment: a longitudinal population-based study. *J Epidemiol Community Health*, 71(5), 446-452.

[84] Grant, J. E., Odlaug, B. L., Derbyshire, K., Schreiber, L. R. N., Lust, K., & Christenson, G. (2014). Mental health and clinical correlates in lesbian, gay, bisexual, and queer young adults. *Journal of American College Health*, 62(1), 75–78. https://doi.org/10.1080/07448481.2013.844697

[85] Klein, A. A., & Ross, B. L. (2014). Substance use and mental health severity among LGBTQ individuals attending Minnesota Model-based residential treatment. Journal of Gay & Lesbian Social Services: The Quarterly Journal of Community & Clinical Practice, 26(3), 303–317. https://doi.org/10.1080/10538720.2014.924459

[86] Ross, L. E., Salway, T., Tarasoff, L. A., MacKay, J. M., Hawkins, B. W., & Fehr, C. P. (2018). Prevalence of Depression and Anxiety Among Bisexual People Compared to Gay, Lesbian, and Heterosexual Individuals: A Systematic Review and Meta-Analysis. *Journal of Sex Research*, 55(4/5), 435. https://doi.org/10.1080/00224499.2017.1387755

[87] Peterson, C. M., Matthews, A., Copps-Smith, E., & Conard, L. A. (2016). Suicidality, Self-Harm, and Body Dissatisfaction in Transgender Adolescents and Emerging Adults with Gender Dysphoria. *Suicide and Life-Threatening Behavior,* 47(4), 475–482. doi: 10.1111/sltb.12289

- Alcohol misuse or abuse; [88, 89] and
- Polysubstance use.[90]

Despite a higher need for care, People in the LGBTQ+ community have ***reduced access*** to care. Reduced access has been shown to be affected by:

- Lack of health insurance;[91, 92]
- Avoidance and postponement of treatment;[93, 94]
- Denial of services;[95] and
- Higher costs of services.[96, 97]

Even when LGBTQ+ people do access services, there are often **disparities in outcomes**. These disparities can be exacerbated by:

- Lack of LGBTQ+ specific knowledge and skill among providers;[98, 99]
- Dissatisfaction with mental health services;[100]
- Perceptions of marginalization and discrimination;[101] and
- Inability to track outcomes (and thus disparities) of LGBTQ+ people.[102]

Local Mental Health and Substance Abuse Authorities can help LGBTQ+ people by addressing the contributing factors. For example, by working to reduce discrimination and stigma in the community and by actively welcoming the LGBTQ+ population to treatment, agencies can help improve care and care outcomes for LGBTQ+ people. In the clinical setting, local authorities can reduce disparities by providing meaningful trainings, increasing knowledge, and rejecting homophobia and transphobia through policy and practice.

[88] Grant Mental health and clinical correlates
[89] Mccrone, S. (2018). Lgbt Healthcare Disparities, Discrimination, And Societal Stigma: The Mental And Physical Health Risks Related To Sexual And/Or Gender Minority Status. *American Journal of Medical Research* (New York, N.Y.), 5(1), 91-96.
[90] Kashubeck-West, S., & Szymanski, D.M. (2008). Risky sexual behavior in gay and bisexual men: Internalized heterosexism, sensation seeking, and substance use. *Counseling Psychologist, 36,* 595-614.
[91] Peterson Suicidality, Self-Harm, and Body Dissatisfaction
[92] Stepleman, L. M., Yohannan, J., Scott, S. M., Titus, L. L., Walker, J., Lopez, E. J., Smith, L. W., Rossi, A. L., Toomey, T. M., & Eldridge, E. D. (2019) Health Needs and Experiences of a LGBT Population in Georgia and South Carolina, *Journal of Homosexuality*, 66:7, 989-1013, DOI: 10.1080/00918369.2018.1490573
[93] Moore, K., Lopez, L., Camacho, D., & Munson, M. (2020). A Qualitative Investigation of Engagement in Mental Health Services Among Black and Hispanic LGB Young Adults. *Psychiatric Services* (Washington, D.C.), 71(6), 555-561.
[94] Israel, T., Gorcheva, R., Burnes, T., & Walther, W. (2008). Helpful and unhelpful therapy experiences of LGBT clients. *Psychotherapy Research*, 18(3), 294–305. https://doi.org/10.1080/10503300701506920
[95] Romanelli Examining Mechanisms and
[96] Moore A Qualitative Investigation of Engagement
[97] Tran, L. D., Haiyong Xu, Azocar, F., Ettner, S. L., & Xu, H. (2018). Behavioral Health Treatment Patterns Among Employer-Insured Adults in Same- and Different-Gender Marriages and Domestic Partnerships. *Psychiatric Services*, 69(5), 572–579. https://doi.org/10.1176/appi.ps.201700331
[98] Peterson Suicidality, Self-Harm, and Body Dissatisfaction
[99] Vance, S. R., Halpern-Felsher, B. L., & Rosenthal, S. M. (2015). Health Care Providers Comfort With and Barriers to Care of Transgender Youth. Journal of Adolescent Health, 56(2), 251–253. doi: 10.1016/j.jadohealth.2014.11.002
[100] Avery AM, Hellman RE, Sudderth LK. Satisfaction with mental health services among sexual minorities with major mental illness. Am J Public Health 2001;91:990–991.
[101] Veltman, A., & Chaimowitz, G. (2014). Mental health care for people who identify as lesbian, gay, bisexual, transgender, and (or) queer. Canadian journal of psychiatry. Revue canadienne de psychiatrie, 59(11), 1.
[102] Cahill, S., & Makadon, H. (2014). Sexual orientation and gender identity data collection in clinical settings and in electronic health records: a key to ending LGBT health disparities. LGBT health, 1(1), 34-41.

Summary of Health Disparities for People with Developmental Disabilities

People with developmental disabilities face unique challenges that impact their need for mental health and substance use treatment, their ability to access this treatment, and their outcomes when they do access treatment. These challenges result in health disparities for people with developmental disabilities. Multiple factors drive these disparities and often the factors and disparities are intertwined and impact each other. It is important to note that the factors and disparities addressed here impact women with developmental disabilities more than men. Additionally, there is a known lack of research around health disparities for people with Developmental Disabilities.[103]

People with a developmental disability have an ***increased risk*** for mental illness and substance use disorder. For example, people with a developmental disability are more likely to experience:

- Poverty;[104, 105]
- Unemployment;[106]
- Domestic violence;[107, 108]
- Homelessness;[109]
- Lack of social support; [110] and
- Stigma[111] and discrimination.[112]

Subsequently, people with developmental disabilities have ***increased rates*** of mental illness including higher rates of:

- Anxiety;[113]
- Depression; [iv, 114]
- Obsessive Compulsive Disorder;[115]

[103] Anderson, L. L., Humphries, K., Mcdermott, S., Marks, B., Sisirak, J., & Larson, S. (2013). The State of the Science of Health and Wellness for Adults With Intellectual and Developmental Disabilities. *Intellectual and Developmental Disabilities*, 51(5), 385–398. doi: 10.1352/1934-9556-51.5.385

[104] ibid

[105] Berg, K. L., Shiu, C. S., Feinstein, R. T., Acharya, K., MeDrano, J., & Msall, M. E. (2019). Children with developmental disabilities experience higher levels of adversity. *Research in developmental disabilities*, 89, 105–113. https://doi.org/10.1016/j.ridd.2019.03.011

[106] Ragmar, J., Hijern, A., Vinnerljung, B., Strömland, K., Aronson, M., & Fahlke, C. (2014). Psychosocial Outcomes of Fetal Alcohol Syndrome in Adulthood. *Pediatrics*, 135(1), 52–58. doi: 10.1542/peds.2014-1915d

[107] Johnston-McCabe, P., Levi-Minzi, M., Van Hasselt, V. B., & Vanderbeek, A. (2011). Domestic violence and social support in a clinical sample of deaf and hard of hearing women. *Journal of Family Violence*, 26(1), 63+. https://link-gale-com.ezproxy.lib.utah.edu/apps/doc/A345457763/AONE?u=marriottlibrary&sid=AONE&xid=bc40e84b

[108] Hickson, L., Khemka, I., Golden, H. and Chatzistyli, A. (2013), Views and Values of Developmental Disabilities and Domestic Violence/Sexual Assault Support Professionals Regarding the Prevention and Handling of Situations of Abuse. *Journal of Policy and Practice in Intellectual Disabilities*, 10: 207-214. doi:10.1111/jppi.12040

[109] Anderson, The State of the Science

[110] Johnston-McCabe, Psychosocial Outcomes

[111] Aggarwal, R., Guanci, N., & Appareddy, V. L. (2013). Issues in treating patients with intellectual disabilities. *Psychiatric Times*, 30(8), 9.

[112] Raymaker, D. M., Mcdonald, K. E., Ashkenazy, E., Gerrity, M., Baggs, A. M., Kripke, C., . . . Nicolaidis, C. (2016). Barriers to healthcare: Instrument development and comparison between autistic adults and adults with and without other disabilities. *Autism*, 21(8), 972-984. doi:10.1177/1362361316661261

[113] Beck, Jonathan S, Lundwall, Rebecca A, Gabrielsen, Terisa, Cox, Jonathan C, & South, Mikle. (2020). Looking good but feeling bad: "Camouflaging" behaviors and mental health in women with autistic traits. *Autism: The International Journal of Research and Practice*, 24(4), 809-821.

[114] Chabrol, H., & Raynal, P. (2018). The co-occurrence of autistic traits and borderline personality disorder traits is associated to increased suicidal ideation in nonclinical young adults. *Comprehensive psychiatry*, 82, 141–143. https://doi.org/10.1016/j.comppsych.2018.02.006

[115] Spendelow, J. S. (2011). Assessment of mental health problems in people with Down syndrome: key considerations. *British Journal of Learning Disabilities*, 39(4), 306–313. https://doi.org/10.1111/j.1468-3156.2010.00670.x

- Suicidal ideation;[116, 117] and
- Adverse childhood experiences;[118]
- PTSD, especially with those treated with ABA;[119] and
- Coexisting mental illnesses.[120]

Despite a higher need for care, people with developmental disabilities have ***reduced access*** to care. Reduced access has been shown to be affected by:

- Lack of health insurance;[121]
- Lack of understanding of health care forms, such as intake forms;[122, 123]
- Difficulty finding providers;[124]
- Postponed treatment;[125] and
- Lack of understanding how appointment scheduling works.[126]

Even when this population does access services, there are often **disparities in outcomes**. These disparities can be exacerbated by:

- Not being able to process the information given;[127]
- Lack of knowledge about appropriate services among providers;[128, 129]
- Lack of funding for research and services;[130]

[116] Kirby, A.V., Bakian, A.V., Zhang, Y., Bilder, D.A., Keeshin, B.R. and Coon, H. (2019), A 20-year study of suicide death in a statewide autism population. *Autism Research*, 12: 658-666. doi:10.1002/aur.2076

[117] Hirvikoski, T., Boman, M., Chen, Q., D'Onofrio, B., Mittendorfer-Rutz, E., Lichtenstein, P., . . . Larsson, H. (2020). Individual risk and familial liability for suicide attempt and suicide in autism: A population-based study. *Psychological Medicine*, 50(9), 1463-1474. doi:10.1017/S0033291719001405

[118] Berg, K. L., Shiu, C. S., Feinstein, R. T., Acharya, K., MeDrano, J., & Msall, M. E. (2019). Children with developmental disabilities experience higher levels of adversity. *Research in developmental disabilities*, 89, 105–113. https://doi.org/10.1016/j.ridd.2019.03.011

[119] Kupferstein, H. (2018). Evidence of increased PTSD symptoms in autistics exposed to applied behavior analysis. *Advances in Autism*, 4(1), 19-29. doi:10.1108/AIA-08-2017-0016

[120] Anderson, L. L., Humphries, K., Mcdermott, S., Marks, B., Sisirak, J., & Larson, S. (2013). The State of the Science of Health and Wellness for Adults With Intellectual and Developmental Disabilities. *Intellectual and Developmental Disabilities*, 51(5), 385–398. doi: 10.1352/1934-9556-51.5.385

[121] Raymaker, D. M., Mcdonald, K. E., Ashkenazy, E., Gerrity, M., Baggs, A. M., Kripke, C., . . . Nicolaidis, C. (2016). Barriers to healthcare: Instrument development and comparison between autistic adults and adults with and without other disabilities. *Autism*, 21(8), 972-984. doi:10.1177/1362361316661261

[122] Cruise, K., Evans, L., Pickens, I. (2011). Integrating mental health and special education needs into comprehensive service planning for juvenile offenders in long-term custody settings. *Learning and Individual Differences*. 21. 30-40. 10.1016/j.lindif.2010.11.004.

[123] Bjorgaas, H. M., Hysing, M., & Elgen, I. (2012). Psychiatric disorders among children with cerebral palsy at school starting age. *Research in developmental disabilities*, 33(4), 1287–1293. https://doi.org/10.1016/j.ridd.2012.02.024

[124] Anderson, L. L., Humphries, K., Mcdermott, S., Marks, B., Sisirak, J., & Larson, S. (2013). The State of the Science of Health and Wellness for Adults With Intellectual and Developmental Disabilities. *Intellectual and Developmental Disabilities*, 51(5), 385–398. doi: 10.1352/1934-9556-51.5.385

[125] Raymaker, D. M., Mcdonald, K. E., Ashkenazy, E., Gerrity, M., Baggs, A. M., Kripke, C., . . . Nicolaidis, C. (2016). Barriers to healthcare: Instrument development and comparison between autistic adults and adults with and without other disabilities. *Autism*, 21(8), 972-984. doi:10.1177/1362361316661261

[126] ibid

[127] ibid

[128] Bolat, N., Dogangun, B., Yavuz, M., Demir, T., Kayaalp, L. (2011). Depression and anxiety levels and self-concept characteristics of adolescents with congenital complete visual impairment. *Türk psikiyatri dergisi = Turkish journal of psychiatry*. 22. 77-82.

[129] Dunn, D. S., & Andrews, E. E. (2015). Person-first and identity-first language: Developing psychologists' cultural competence using disability language. *American Psychologist*, 70(3), 255–264. https://doi.org/10.1037/a0038636

[130] Battaglia, M., Detrick, S., & Fernandez, A. (2016). Multidisciplinary Treatment for Adults with Autism Spectrum Disorder and Co-Occurring Mental Health Disorders: Adapting Clinical Research Tools to Everyday Clinical Practice. *Journal of Mental Health Research in Intellectual Disabilities*, 9(4), 232–249. https://doi.org/10.1080/19315864.2016.1192708

- Over-prescription of medications; [131, 132, 133]
- Lack of perceived autonomy; [vii, 134] and
- Perceived poor communication with providers.[135]

Another issue that people with developmental disabilities face is a lack of understanding systemically on what therapies work for them, ABA being one such therapy. On its surface, using pleasure, or adding positive reinforcement or removing negative reinforcement, to increase behavior as ABA does, might seem harmless enough. This can be especially true if one justifies it with the idea of avoiding aversive experiences through the use of positive and negative punishment as much as possible.[136] After associating the therapist with feelings of pleasure through pairing, ABA associates pleasure with pleasing the therapist and lack of pleasure, or deprivation, with noncompliance.[137] This is problematic because that lack of enjoyment or unmet needs from an insufficient amount of breaks, love, or attention are aversive, even if not framed as such by ABA practitioners, and do irreparable damage to the human psyche.[138] Pleasure becomes a privilege that someone earns through compliance, which should, according to ABA best practice, occur during every moment of a person's life.[139] ABA best practice considers unearned pleasure to be a missed opportunity, or even damaging to someone's therapy.[140] Using someone's human needs in this manner is harmful because it puts clients in an unstable situation where their needs will be met on a contingent basis.[141, 142]

Research illustrates that when caregivers or people in power fail to meet someone's needs, it can cause mental health problems, problems with attachment, and patterns of brain development that indicate trauma similar to what is seen in people with PTSD.[143,144] It is therefore irrelevant whether the industry polices itself in terms of setting ethical goals with client input, since ABA itself is abusive, regardless of the goals.[145] Further, a literature review and a report by The Department of Defense shows a lack of correlation between the receipt of ABA services and the outcomes it's

[131] Anderson, L. L., Humphries, K., Mcdermott, S., Marks, B., Sisirak, J., & Larson, S. (2013). The State of the Science of Health and Wellness for Adults With Intellectual and Developmental Disabilities. *Intellectual and Developmental Disabilities*, 51(5), 385–398. doi: 10.1352/1934-9556-51.5.385

[132] Scheifes, A., De Jong, D., Stolker, J. J,, Nijman, H. L.I., Egberts, T. C.G, & Heerdink, E. R. (2013). Prevalence and characteristics of psychotropic drug use in institutionalized children and adolescents with mild intellectual disability. *Research in Developmental Disabilities*, 34(10), 3159-3167.

[133] National Council on Disability (U.S.). (2009). *The Current State of Health Care for People with Disabilities*. Washington, D.C.: National Council on Disability

[134] Nicolaidis, C., Raymaker, D., Kapp, S. K., Baggs, A., Ashkenazy, E., McDonald, K., Weiner, M., Maslak, J., Hunter, M., & Joyce, A. (2019). The AASPIRE practice-based guidelines for the inclusion of autistic adults in research as co-researchers and study participants. *Autism*, 23(8), 2007–2019. https://doi.org/10.1177/1362361319830523

[135] van der Meer, L., Waddington, H., Sigafoos, J., Balandin, S., Bravo, A., Ogilvie, E., Matthews, T., & Sawchak, A. (2017). Training direct-care staff to implement an iPad®-based communication intervention with adults with developmental disability. *International Journal of Developmental Disabilities*, 63(4), 246–255. https://doi.org/10.1080/20473869.2017.1297013

[136] Evenstad, C., Flynn-Privett, A., &; Gudding, J. (2020). Establishing Instructional Control. PDF. Marshal, MN; Southwest West Central Service Cooperative.

[137] ibid

[138] Erozkan, Atilgan. (2016). The Link between Types of Attachment and Childhood Trauma. Universal Journal of Educational Research. 4. 1071-1079. 10.13189/ujer.2016.040517.

[139] Evenstad Establishing Instructional Control

[140] ibid

[141] ibid

[142] Erozkan The Link between Types of Attachment

[143] Sandoval-Norton, Aileen Herlinda, & Shkedy, Gary. (2019). How much compliance is too much compliance: Is long-term ABA therapy abuse? Cogent Psychology, 6(1), 1641258. https://doi.org/10.1080/23311908.2019.1641258

[144] Erozkan The Link between Types of Attachment

[145] ibid

practitioners claim.[146, 147] If one takes the ethical stance that abuse should not occur regardless of the circumstances, the argument that ABA keeps people out of institutions becomes irrelevant. The lack of evidence for its efficacy invalidates the argument entirely.[148, 149] The evidence shows that ABA has little or no correlation with whether an autistic person will achieve specific outcomes.[150, 151]

Local Mental Health and Substance Abuse Authorities can help people with developmental disabilities by addressing the contributing factors. For example, by working to reduce stigma in the community, by honoring the autonomy of people with developmental disabilities, providing more appropriate forms of therapy, and by promoting research and specialized services. In the clinical setting, local authorities can reduce disparities by providing meaningful trainings, increasing knowledge among clinicians and other treatment providers, and by accommodating communication needs of clients.

[146] Fernandes, F. D., & Amato, C. A. (2013). Applied behavior analysis and autism spectrum disorders: literature review. CoDAS, 25(3), 289–296. https://doi.org/10.1590/s2317-17822013000300016
[147] Donovan, M. (2020). The Department of Defense Comprehensive Autism Care Demonstration Annual Report 2020. Report to the Committees on Armed Services of the Senate and House of Representatives.
[148] Fernandes Applied behavior analysis
[149] Donovan The Department of Defense Comprehensive Autism
[150] Fernandes Applied behavior analysis
[151] Donovan The Department of Defense Comprehensive Autism

Summary of Health Disparities for People with Intersectional Identities

When looking at health disparities within underrepresented communities, it is necessary to look at intersectionality of identities. Intersectionality refers to the "complex, cumulative way in which the effects of multiple forms of discrimination (such as racism, sexism, and classism) combine, overlap, or intersect especially in the experiences of marginalized individuals or groups."[152] There are many possible intersectionalities among the four target populations identified in this needs assessment. The references below are provided as examples.

Examples of intersectionality with youth in transition and race/ethnicity:

- Youth that are uninsured are often BIPOC;[153]
- Youth of Color are less likely than their White peers to seek and receive care after age eighteen; [154]
- During this transition-age period, many BIPOC are likely to experience mental illness for the first time in their lives; [155]
- There is an overrepresentation of Youth of Color in the foster care system and youth in this system are more likely to have a mental illness.[156]

Examples of intersectionality with youth in transition and the LGBTQ+ community:

- Transgender youth lose housing due to unsupportive parents and become homeless which negatively impacts mental health;[157]
- LGBTQ+ youth are more likely to have a lifetime of suicidal ideation than their straight and cisgender counterparts;[158]
- LGBTQ+ youth are less likely to seek services because of a combination of not wanting to discuss their gender or sexuality and their age group norms;[159]
- Many providers feel uncomfortable and unknowledgeable when treating transgender youth;[160]
- Transgender youth are less likely to disclose their gender to their providers due to discomfort compared to cisgender youth.[161]

[152] "intersectionality." Merriam-Weberster.com. 2021. https://merriam-webster.com (6/1/2021)
[153] Price, J. H., Khubchandani, J., Mckinney, M., & Braun, R. (2013). Racial/Ethnic Disparities in Chronic Diseases of Youths and Access to Health Care in the United States. BioMed Research International, 2013, 1–12. doi: 10.1155/2013/787616
[154] Pottick, K. J., Warner, L. A., Stoep, A. V., Knight, N. M., & Vander Stoep, A. (2014). Clinical characteristics and outpatient mental health service use of transition-age youth in the USA. Journal of Behavioral Health Services & Research, 41(2), 230–243. https://doi.org/10.1007/s11414-013-9376-5
[155] Smokowski, Paul R, Evans, Caroline B R, Cotter, Katie L, & Webber, Kristina C. (2014). Ethnic Identity and Mental Health in American Indian Youth: Examining Mediation Pathways Through Self-esteem, and Future Optimism. Journal of Youth and Adolescence., 43(3), 343–355. https://doi.org/10.1007/s10964-013-9992-7
[156] Garland, Ann F, Landsverk, John A, & Lau, Anna S. (2003). Racial/ethnic disparities in mental health service use among children in foster care. Children and Youth Services Review., 25(5-6), 491–507. https://doi.org/10.1016/S0190-7409(03)00032-X
[157] Rhoades, H., Rusow, J. A., Bond, D., Lanteigne, A., Fulginiti, A., & Goldbach, J. T. (2018). Homelessness, Mental Health and Suicidality Among LGBTQ Youth Accessing Crisis Services. Child Psychiatry and Human Development, 49(4), 643–651. https://doi.org/10.1007/s10578-018-0780-1
[158] Berona, J., Horwitz, A. G., Czyz, E. K., & King, C. A. (2020). Predicting suicidal behavior among lesbian, gay, bisexual, and transgender youth receiving psychiatric emergency services. Journal of Psychiatric Research, 122, 64–69. https://doi.org/10.1016/j.jpsychires.2019.12.007
[159] McDermott, E., Hughes, E., & Rawlings, V. (2018). Norms and normalisation: understanding lesbian, gay, bisexual, transgender and queer youth, suicidality and help-seeking. Culture, Health & Sexuality, 20(2), 156–172. https://doi.org/10.1080/13691058.2017.1335435
[160] Vance, S. R., Halpern-Felsher, B. L., & Rosenthal, S. M. (2015). Health Care Providers Comfort With and Barriers to Care of Transgender Youth. Journal of Adolescent Health, 56(2), 251–253. doi: 10.1016/j.jadohealth.2014.11.002
[161] McKay, T. R., & Watson, R. J. (2020). Gender expansive youth disclosure and mental health: Clinical implications of gender identity disclosure. Psychology of Sexual Orientation and Gender Diversity, 7(1), 66–75. https://doi.org/10.1037/sgd0000354

Examples of intersectionality with youth in transition and developmental disabilities:

- Youth with developmental disabilities are less likely to have conversations with their providers about transitioning to adult care and health insurance retention than nondisabled youth;[162]
- Youth with developmental disabilities are less likely to feel in control of their treatment and treatment plans; [163]
- Youth with ADHD are likely to have a mental illness occurring;[164]

Examples of intersectionality with race/ethnicity and developmental disabilities:

- BIPOC who have a developmental disability are less likely to receive a second opinion in healthcare and less likely to be referred to specialty services than people who identify with either group independently;[165]
- Providers feel less capable diagnosing BIPOC with a developmental disability than White clients with a developmental disability;[166]
- Black and Latinx children with autism had reported worse health care quality as compared with White children with autism;[167] and
- Youth of Color with a developmental disability are more likely to be brought to juvenile justice services than White peers with developmental disabilities.[168]

Examples of intersectionality with race/ethnicity and the LGBTQ+ community such as:

- LGBTQ+ BIPOC are more likely to report depressive symptoms than people who identify with either identity independently[169]
- This population is more likely to perceive more discrimination than people who identify with either identity independently;[170]
- LGBTQ+ BIPOC are more likely to terminate treatment early or postpone treatment than people who identify with either identity independently;[171]
- Latinx LGB youth attempt suicide at higher rates than Latinx or LGB without intersectional identities;[172, 173]

[162] Cheak-Zamora, N., Yang, X., Farmer, J., & Clark, M. (2013). Disparities in Transition Planning for Youth With Autism Spectrum Disorder. Pediatrics, 131(3), 447–454. doi: 10.1542/peds.2012-1572d
[163] ibid
[164] Price Racial/Ethnic Disparities in Chronic Diseases
[165] Son, E., Magaña, S., Pedraza, F. D. M., & Parish, S. L. (2020). Providers' guidance to parents and service use for Latino children with developmental disabilities. *American Journal on Intellectual and Developmental Disabilities*, 125(1), 64–75. https://doi.org/10.1352/1944-7558-125.1.64
[166] ibid
[167] Magaña, S., Parish, S. L., Rose, R. A., Timberlake, M., & Swaine, J. G. (2012). Racial and Ethnic Disparities in Quality of Health Care Among Children with Autism and Other Developmental Disabilities. *Intellectual and Developmental Disabilities*, 50(4), 287–299. doi: 10.1352/1934-9556-50.4.287
[168] Cruise, K., Evans, L., Pickens, I. (2011). Integrating mental health and special education needs into comprehensive service planning for juvenile offenders in long-term custody settings. *Learning and Individual Differences*. 21. 30-40. 10.1016/j.lindif.2010.11.004.
[169] Gattis, M. N., & Larson, A. (2017). Perceived Microaggressions and Mental Health in a Sample of Black Youths Experiencing Homelessness. *Social Work Research*, 41(1), 7–17. https://doi.org/10.1093/swr/svw03
[170] Ibid
[171] Moore, K., Lopez, L., Camacho, D., & Munson, M. (2020). A Qualitative Investigation of Engagement in Mental Health Services Among Black and Hispanic LGB Young Adults*. Psychiatric Services (Washington, D.C.),* 71(6), 555-561.
[172] Sutter, M., & Perrin, P. B. (2016). Discrimination, mental health, and suicidal ideation among LGBTQ people of color. *Journal of counseling psychology*, 63(1), 98–105. https://doi.org/10.1037/cou0000126
[173] Boyas, J. F., Villarreal-Otálora, T., Alvarez-Hernandez, L. R., & Fatehi, M. (2019). Suicide ideation, planning, and attempts: the case of the Latinx LGB youth. *Health Promotion Perspectives*, 9(3), 198–206. https://doi-org.libprox1.slcc.edu/10.15171/hpp.2019.28

- LGBTQ+ BIPOC are more susceptible to homelessness than those who identify with either identity independently.[174]

Examples of intersectionality exist with LGBTQ+ people and people with developmental disabilities such as:

- This population is more likely to be denied services;[175]
- Transgender people with developmental disabilities are told they are not transgender due to their disability;[176]
- Autistic transgender people have higher rates of anxiety and depression than either group without intersectionality;[177] and
- Providers lack confidence in talking to LGBTQ+ people with developmental disabilities about sexuality.[178]

Local Mental Health and Substance Abuse Authorities can help people with intersecting identities by addressing the contributing factors. For example, by working to reduce discrimination and stigma in the community and by actively welcoming these populations to treatment. In the clinical setting, local authorities can reduce disparities by providing meaningful trainings, increasing knowledge, and rejecting discrimination through policy and practice.

[174] Ecker, J., Aubry, T., & Sylvestre, J. (2019). A Review of the Literature on LGBTQ Adults Who Experience Homelessness. *Journal of Homosexuality*, 66(3), 297-323.

[175] Hall, J. P., Batza, K., Streed, C. G., Boyd, B. A., & Kurth, N. K. (2020). Health Disparities Among Sexual and Gender Minorities with Autism Spectrum Disorder. *Journal of Autism and Developmental Disorders*, 50(8), 3071-3077.

[176] Ibid

[177] Murphy, J., Prentice, F., Walsh, R., Catmur, C., & Bird, G.. (2020). Autism and transgender identity: Implications for depression and anxiety. *Research in Autism Spectrum Disorders*, 69, 101466.

[178] McCann, E., Lee, R., & Brown, M. (2016). The experiences and support needs of people with intellectual disabilities who identify as LGBT: A review of the literature. *Research in Developmental Disabilities*, 57, 39-53.

METHODS

Data Collection and Reporting Process

All instruments used for the needs assessment were developed and approved through an interactive and collaborative process, centered on the lived experience of individuals from the target populations. The process included the research team, workgroups, liaisons, and a steering committee, all of which are described below. The general process involved the following steps:

- Collaboration between the research team and the workgroups to complete a comprehensive literature review with regard to disparities and the drivers of disparities.
- The workgroup then used the literature and perspectives from their own experiences in the treatment systems to develop protocols and survey tools for data collection.
- Once the protocols or surveys were ready for review, the instruments went to liaisons for agency perspectives about the items.
- The protocols or surveys were then revised by the research team and workgroups for final liaison approval.
- Liaison-approved protocols or surveys then went to the steering committee for final approval.

Research Team

Research team members included one research consultant and two research assistants. All team members identified with at least one of the target populations and had first-hand experience receiving treatment from Utah's mental health or substance use treatment systems.

Workgroups

There were four workgroups for this project. Each one represented one of the target populations of the project: transition-age youth, BIPOC, LGBTQ+ people, and people with developmental disabilities. The workgroups were made up of people from each of these groups and each member had some lived experience in the public mental health or substance use treatment systems. This was significant because the research team wanted to make sure that people with lived experience were informing the project to better understand the experiences and elevate the voices of people from the target populations.

These workgroups informed the needs assessment from beginning to end. The workgroups started by looking into literature to better understand what peer reviewed articles knew about the disparities these target populations were facing and the outcomes from these disparities. This literature review also helped educate the workgroups and researchers on existing techniques that were being used to combat these disparities. The information from this needs assessment was also used to help with the next step of the research process which was creating protocol points for the data collection methods.

The workgroups wrote every key part of the data collection methods such as survey questions, focus group questions, and things to look for during the facility walkthroughs. The workgroups then also helped determine how these things would be measured. For example, the workgroups came up with ideal answers for each focus group question and determined the point worth for each answer to create a weighted checklist for researchers to help analyze qualitative data. Several workgroup members also helped code the data once it was collected. Finally, the

workgroups came up with a set of recommendations, based on literature, and found resources to help assist the agencies with these recommendations.

Liaisons

In order to facilitate buy-in and maximize the voice of each agency included in this study, the research team called for a representative, or liaison, from each of the public mental health or substance use agencies. Working for that agency was the only requirement for membership. The liaisons for this project were tasked with reviewing the data collection tools and giving feedback to the research team on how to best tailor the tools to their agency's needs. Once their input was received and integrated into the project by the research team, the item would then go to the steering committee. Liaisons were also tasked with keeping the agencies informed about the progress of the study and communicating results back to the agencies once data were analyzed.

Steering Committee

After the liaisons approved a data collection tool, it would go to the steering committee, who would then give their input on the tool as well. Whatever input the committee gave was incorporated into the data collection tool before the tool was used. The steering committee was made up of individuals who identified with at least one of the four target populations and who had lived experience with public mental health. Several of these members acted as representatives of the workgroups. By doing so, the research team was able to elevate voices from underserved populations within the needs assessment.

Data Collection Tools and Protocols

Demographic Survey

Purpose

The health disparities needs assessment research team used data from the demographic survey to identify needs at the **operational** and **services levels**.

Rationale

Researchers studying ethnic diversity in health care have highlighted the importance of cultural representation at the leadership, or organizational, level.[179] At the organizational level, a sense of belonging and of being valued by culturally diverse members of the workforce is a proxy for cultural responsivity within the agency and could lead to retention and promotion of diverse staff within. Representation is equally important at the treatment level. For example, research has shown that civilian psychologists without working knowledge of military jargon, daily life, and social systems are disadvantaged when attempting to diagnose soldiers.[180] Similarly, Betancourt et al. showed a correlation between clients who share similar racial/ethnic backgrounds with their providers and higher client satisfaction rates.[181] Other studies have shown a relationship between

[179] Nair, L., & Adetayo, O. A. (2019). Cultural competence and ethnic diversity in healthcare. *Plastic and Reconstructive Surgery Global Open*, *7*(5).

[180] Reger, Mark A, Etherage, Joseph R, Reger, Greg M, & Gahm, Gregory A. (2008). Civilian Psychologists in an Army Culture: The Ethical Challenge of Cultural Competence. *Military Psychology,* 20(1), 21–35. https://doi.org/10.1080/08995600701753144

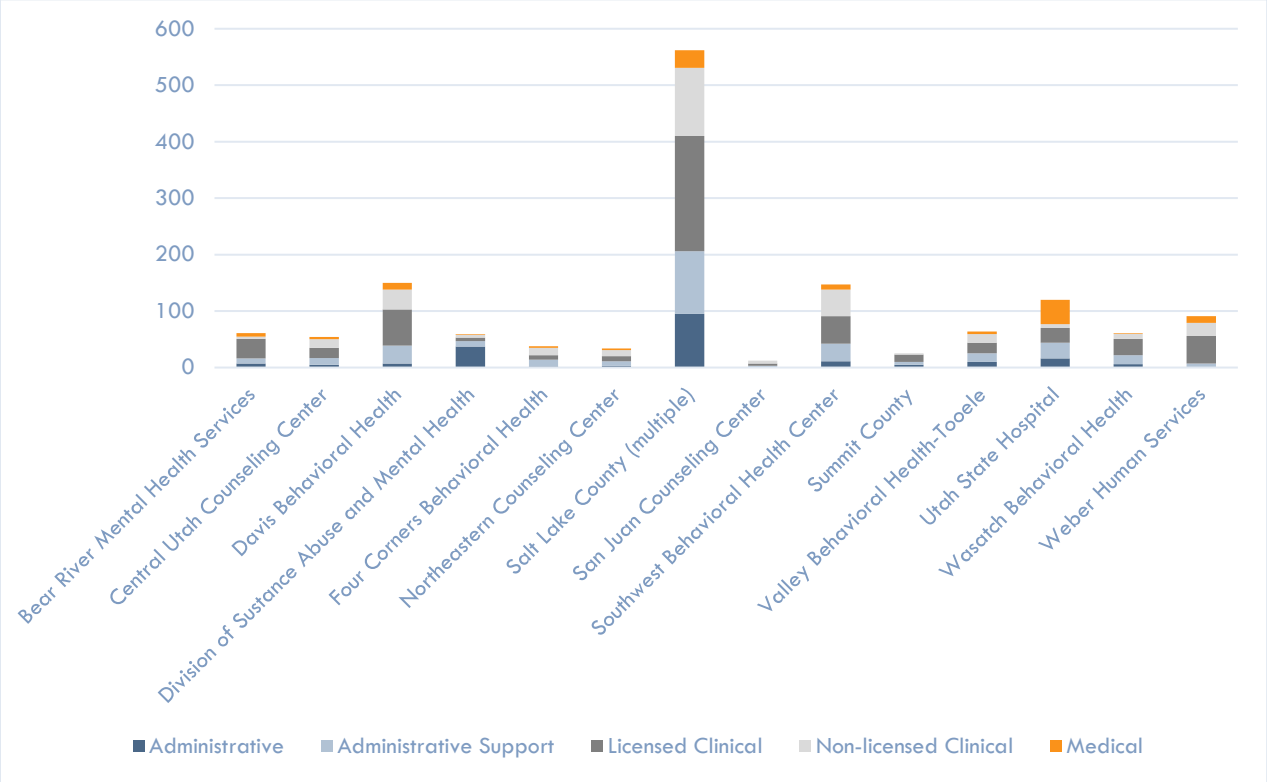
[181] Betancourt, Joseph R, Green, Alexander R, Carrillo, J. Emilio, & Ananeh-Firempong, Owusu. (2003). Defining Cultural Competence: A Practical Framework for Addressing Racial/Ethnic Disparities in Health and Health Care. *Public Health Reports* (1974), 118(4), 293–302. https://doi.org/10.1093/phr/118.4.293

therapists' understanding of the gay and lesbian culture and therapeutic outcomes for gay and lesbian clients.[182]

Implementation

This project distributed a demographic survey in English and Spanish to all employees of each agency being evaluated through this study. The survey was emailed to workforce email lists by the liaisons and reminders were sent out once a week. The survey was open for three weeks and can be found in Appendix A. In total, 1478 workforce members from Utah's public mental health and substance use treatment agencies completed the survey. Figure 1 provides a summary of the number of responses by job category and agency.

Figure 1. Numbers of Demographic Survey Respondents, by Agency and Job Category



Public-Facing Document review

Purpose

The health disparities needs assessment research team used data from the public-facing documents review to identify needs at the **structural level**.

Rationale

A review of public-facing documents was important for several reasons. These public-facing documents are often found by clients when they are looking up general resources for mental

[182] Liddle, B.J. (1999). Gay and lesbian clients' ratings of psychiatrists, psychologists, social workers, and counselors. *Journal of Gay and Lesbian Psychotherapy*, 3, 81-93.

health as many people, especially youth, do.[183] People using these websites are often looking for easy and stigma free information on how to help with their mental illness(es) or address substance use.[184] It is important to evaluate this ease and stigma to best provide services and resources to clients. Having welcoming public-facing documents is also one of the first steps to welcoming clients into a practice because it is often what clients look at before they come into the office.[185] This is especially true for people with developmental disabilities, many of whom often prefer non-face-to-face interaction.[186] People often use these websites for making decisions about their next steps with healthcare.[187] Effective and welcoming websites, and other public facing documents, are more likely to lead to longer lasting clients than ineffective documents.[188] Ensuring that public-facing documents are inclusive of, and relate to, target populations helps build satisfaction and comprehension from clients.[189]

Implementation

Looking at public facing documents included looking at websites, social media, blogs, YouTube pages, and online portals. The workgroups created a checklist for each target population to go through the websites with to evaluate how welcoming they were to these communities. This checklist was based on a combination of literature and personal experiences from the workgroup members. This checklist can be found in Appendix B. Two or three workgroup members, depending on the subjectivity of the item, used the checklist to review each public-facing document. The scores for each agency were then summarized by taking the item average scores, by item, for all of the public-facing documents within that agency.

Focus Groups with Leadership

Purpose

The health disparities needs assessment research team used data from the focus groups with leadership teams to identify needs at the **operational level**.

Rationale

Cultural awareness and knowledge among leaders and decision-makers contribute positively to sensitive policies and practices within an organization that reflect community needs. Conversely, key barriers to successful reduction of health disparities include a lack of buy-in or engagement from leadership and failure from organizations to acknowledge and prioritize the reduction of

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[183] Good, A., &; Sambhanthan, A. (2014). Accessing Web Based Health Care and Resources for Mental Health: Interface Design Considerations for People Experiencing Mental Illness. *Design, User Experience, and Usability. User Experience Design for Everyday Life Applications and Services*, 25–33. https://doi.org/10.1007/978-3-319-07635-5_3

[184] ibid

[185] Affandy, H. B., Hussain, A., &; Nadzir, M. M. (2018). Web visual design principle used in public universities website design. *AIP Conference Proceedings*, (2016). https://doi.org/10.1063/1.5055416

[186] Watfern, Chloe, Heck, Chloe, Rule, Chris, Baldwin, Peter, & Boydell, Katherine M. (2019). Feasibility and Acceptability of a Mental Health Website for Adults With an Intellectual Disability: Qualitative Evaluation. *JMIR Mental Health*., 6(3). https://doi.org/10.2196/12958

[187] Tao D, LeRouge C, Smith K, De Leo G Defining Information Quality Into Health Websites: A Conceptual Framework of Health Website Information Quality for Educated Young Adults, *JMIR Hum Factors* 2017;4(4):e25 DOI: 10.2196/humanfactors.6455

[188] Garett, R., Chiu, J., Zhang, L., & Young, S. D. (2016). A Literature Review: Website Design and User Engagement. *Online journal of communication and media technologies*, 6(3), 1–14.

[189] Nguyen, Minh Hao, Smets, Ellen M A, Bol, Nadine, Loos, Eugène F, & Van Weert, Julia C M. (2018). How Tailoring the Mode of Information Presentation Influences Younger and Older Adults' Satisfaction with Health Websites. *Journal of Health Communication.*, 23(2), 170–180. https://doi.org/10.1080/10810730.2017.1421729

health disparities.[190] Leadership focus groups were held to better understand leadership awareness, knowledge, engagement and buy-in and to contribute to our understanding of the ways that each agency was addressing the needs of the four target populations.

Implementation

Leadership was defined as a staff person who held the role of CEO, Clinical Director, or an equivalent role with a similar ability to make policy decisions within the agency. Based on this definition, leaders were recruited for participation in the focus groups by each agency's liaison. The questions asked in the focus group centered around awareness of systemic cultural issues, knowledge about the target populations, and ways that the agency's policy, practice, and service delivery guidelines addressed and considered health disparities among the target populations. Focus groups were facilitated by two rotating members of the research team. Each focus group was scheduled to last an hour and a half. The leadership focus group protocols can be found in Appendix C.

Focus Groups with Clients

Purpose

The health disparities needs assessment research team used data from the focus groups with clients to identify needs at the **services level**.

Rationale

To better understand what clients were experiencing, the research team conducted focus groups with consumers of public mental health and substance use treatment services. Participants had to be a transition-age young adult (18-25 years old) and had to belong to at least one of the other target populations. The purpose of these focus groups was to understand how clients felt about the services they were currently receiving. The questions were targeted about how welcomed they felt from providers as well as other staff. This was important because the research team wanted to cover beyond just client-to-provider relationships because front desk staff also impact how clients experience services.

Implementation

After receiving IRB approval to conduct focus groups with clients, the focus groups were advertised via email and with flyers posted within facilities. Focus groups were facilitated by two rotating members of the research team. Each focus group was scheduled to last an hour and a half. All focus groups were virtual. Participants of the focus group were given a $20 check for their participation. The client focus group protocol can be found in Appendix D.

Facility Walkthroughs

Purpose

The health disparities needs assessment research team used data from the facility walkthroughs to identify needs at the **structural level**.

Rationale

The facility walkthrough, or site visit, is a data collection technique associated with comprehensive needs assessments. This technique uses first-person observation to systematically collect data inaccessible through other methods and to give context to quantitative data that are collected in

[190] Betancourt, J. R., Tan-McGrory, A., Kenst, K. S., Phan, T. H., & Lopez, L. (2017). Organizational change management for health equity: perspectives from the disparities leadership program. *Health Affairs*, *36*(6), 1095-1101.

other ways. Research has shown site visits to have convergent validity with quantitative data;[191] to be effective for informing needs assessments at a structural level;[192] and to generally enhance evaluations.[193]

The literature specific to the importance of the waiting room experience is clear. For example, a recent study found that "*the stressful nature of health care settings can be mitigated by improved design of waiting spaces.*"[194] Another recent study found the way clients perceived the waiting room to impact how they behaved in the waiting room and how they behaved going into therapy.[195]

Because the design of this needs assessment included a structural level (including facilities and materials), a facility walkthrough was the only viable way to collect meaningful data about the facilities where the services were provided.

Implementation

The protocol used in our facilities walkthroughs is available in Appendix E and is summarized in Table 1. Facility Walkthrough Protocol Summary. Data were collected by teams of four, with one representative from each of the target populations. Approximately 50 facilities were visited in-person and 5 walk-throughs were conducted virtually.

Table 1. Facility Walkthrough Protocol Summary

Work group	Number of items	Example item
Youth in Transition	12	Guest WiFi and password available
LGBTQ+	7	Facility has at least one non-binary bathroom
Developmental Disabilities	13	Facility is fragrance free
People of Color	21	BIPOC represented in art or pictures

Staff Survey

Purpose

The health disparities needs assessment research team used data from the staff survey to identify needs at the **treatment level**.

Rationale

Nearly 30 years ago, researchers began to consider the importance of culturally responsive services with a seminal paper that posited three critical components: attitudes/beliefs, knowledge,

[191] Daley, J., Forbes, M. G., Young, G. J., Charns, M. P., Gibbs, J. O., Hur, K., ... & Khuri, S. F. (1997). Validating risk-adjusted surgical outcomes: site visit assessment of process and structure. *Journal of the American College of Surgeons*, *185*(4), 341-351.
[192] Lawrenz, F., Keiser, N., & Lavoie, B. (2003). Evaluative site visits: A methodological review. *American journal of evaluation*, *24*(3), 341-352.
[193] Patton, M. Q. (2015). Evaluation in the field: The need for site visit standards. *American Journal of Evaluation*, *36*(4), 444-460.
[194] Kearns, R. A., Neuwelt, P. M., & Eggleton, K. (2020). Permeable boundaries? Patient perspectives on space and time in general practice waiting rooms. *Health & Place*, 63, 102347.
[195] Wikkerink L., & Kanakri, S. (2020). Measuring Behavior in Counseling Clinic Waiting Areas. *Measuring Behavior*, 1, 87-90. doi:10.6084/m9.figshare.13013717

and skills.[196] Since that time, different models have been proposed, including Sperry's four factor model[197] (awareness, knowledge, sensitivity, and action) and Bernhard et al.'s five factor model[198] (motivation/curiosity, attitudes, skills, empathy, and knowledge/awareness). The health disparities research team selected four factors most often supported by psychometric testing and associated with culturally responsive services in a health care setting: awareness, attitudes, knowledge and skills.[199,200,201]

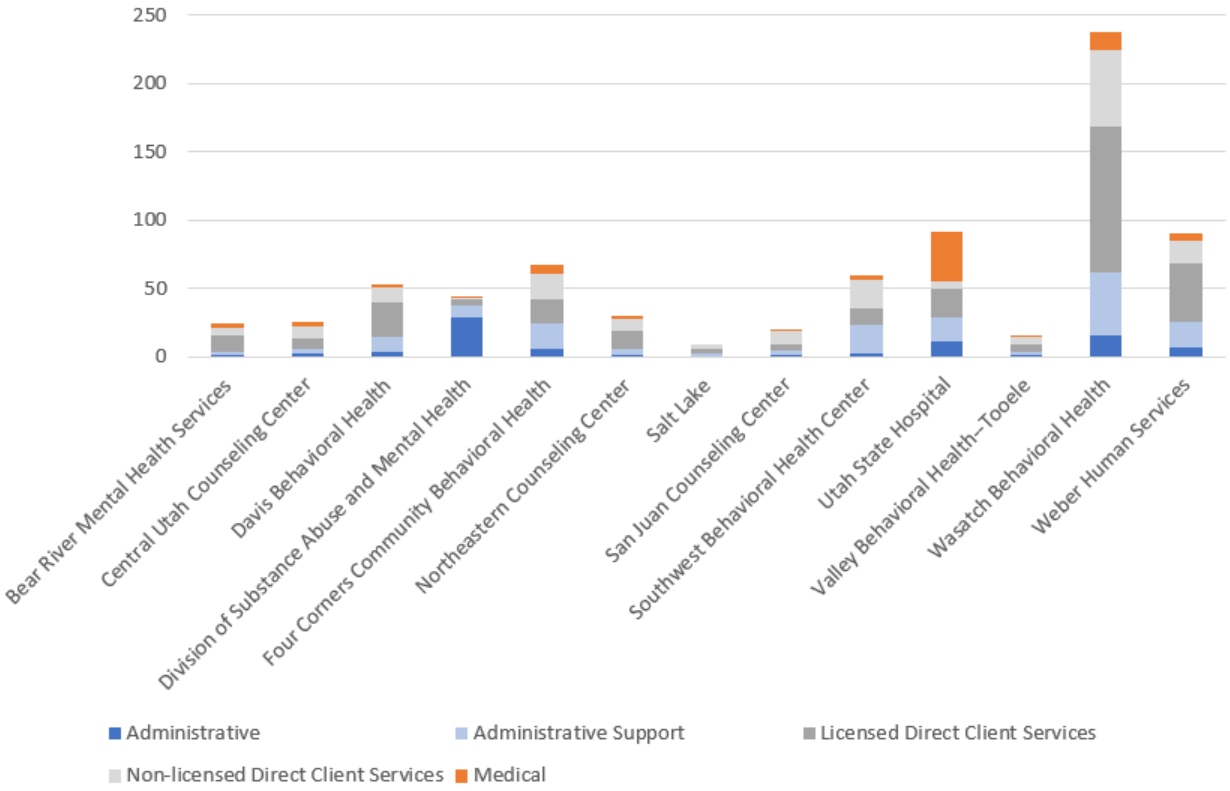
Because the design of this needs assessment included a treatment level, it was important to measure these critical factors (awareness, attitudes, knowledge, and skills) in clinicians and other staff as they related to each of the target populations. The staff survey was the tool used to assess levels of awareness, attitudes, knowledge and skills within service providers.

Implementation

Survey questions were adapted for administrative-only agencies, such as DSAMH and Optum, by removing the service-specific questions in the skills section (e.g., I am well-equipped to provide services specific to people in the LGBTQ+ community) and suppressing open-ended questions applicable only to direct service providers (e.g., how do you know your clients understand oral, written, and non-verbal communications?).The survey questions can be found in Appendix F. The survey was sent from the liaisons to staff at each of the agencies during the second week of May. Respondents were given 3 weeks to complete the survey, and liaisons were able to access real-time numbers to know how many individuals from their agencies had completed the survey. A summary of the respondents by agency and by job category is available in Figure 1. Numbers of Demographic Survey Respondents, by Agency and Job Category.

[196] Sue, D. W., Bernier, J. B., Durran, M., Feinberg, L., Pedersen, P., Smith, E., & Vasquez-Nuttall, E. (l982). Position paper: Cross-cultural counseling competencies. *The Counseling Psychologist*, 10, 45-52.
[197] Sperry, L. (2012). Cultural Competence: A Primer. *Journal of Individual Psychology*, 68(4
[198] Bernhard, G., Knibbe, R. A., Von Wolff, A., Dingoyan, D., Schulz, H., & Mosko, M. (2015). Development and Psychometric Evaluation of an Instrument to Assess-Cultural Competence of Healthcare Professionals (CCCHP). *PloS one, 10*(12), e0144049.
[199] Alizadeh S, Chavan M. Cultural competence dimensions and outcomes: a systematic review of the literature. *Health & social care in the community*. 2016;24(6):117–30.
[200] Beach MC, Price EG, Gary TL, Robinson KA, Gozu A, Palacio AM, et al. *Cultural competence: A systematic review of health care provider educational interventions.* J Gen Intern Med. 2004;19:134.
[201] Betancourt JR, Green AR, Carrillo JE, Owusu A-FI. *Defining Cultural Competence: A Practical Framework for Addressing Racial/Ethnic Disparities in Health and Health Care.* Public Health Rep. 2003;118(4):293–302.

Figure 2. Number of Survey Respondents by Agency and Job Category



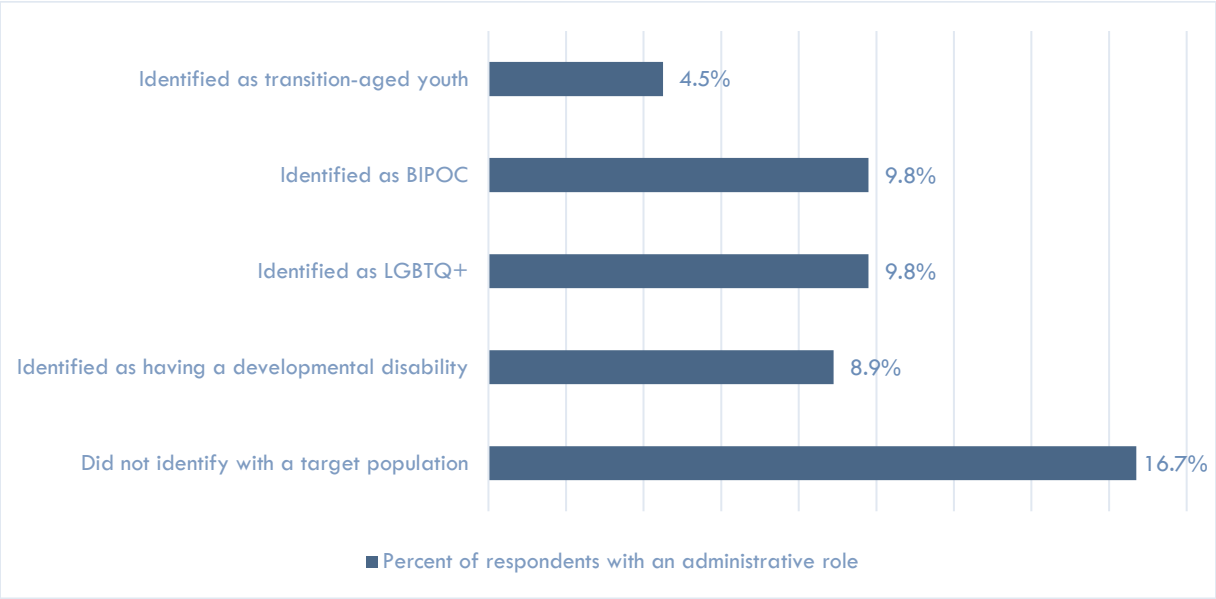
RESULTS

Organizational Level Results

Q1: If an employee identified with one of the target populations, how likely were they to have an administrative role?

A: Workforce members who were employed by public mental health and substance use providers were less likely to be in administration if they identify with any of the target populations compared to people who do not identify with a target population. Figure 3 shows the extent to which target populations are excluded from administrative roles.

Figure 3. Percent of Respondents in Administrative Roles, By Target Population



Q2: To what extent does the workplace offer an inclusive atmosphere where members of the target populations feel valued and heard?

A: Within Utah's public mental health and substance use treatment agencies, employees who identify with the target populations are <u>less likely</u> to feel included, valued or heard than employees who don't identify as members of the target population. Figure 4, Figure 4, Figure 6, and Figure 7 show the percent of employees who agreed with each of the statements about inclusion by target population (TAY, BIPOC, LGBTQ+, and DD, respectively).

Figure 4. Feelings of Inclusion, by Age

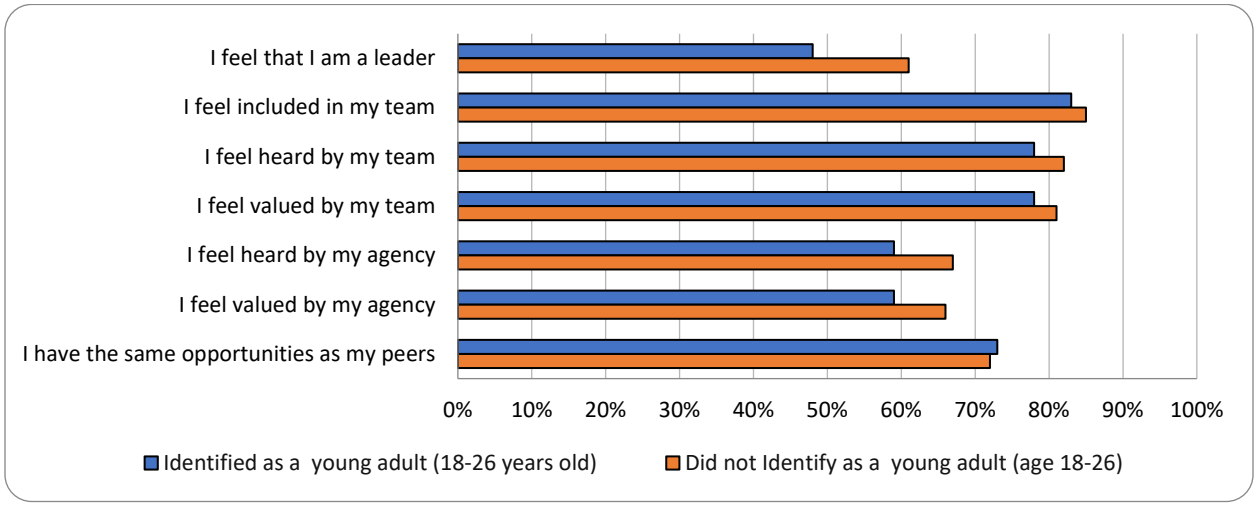


Figure 5. Feelings of Inclusion, by Race and Ethnicity

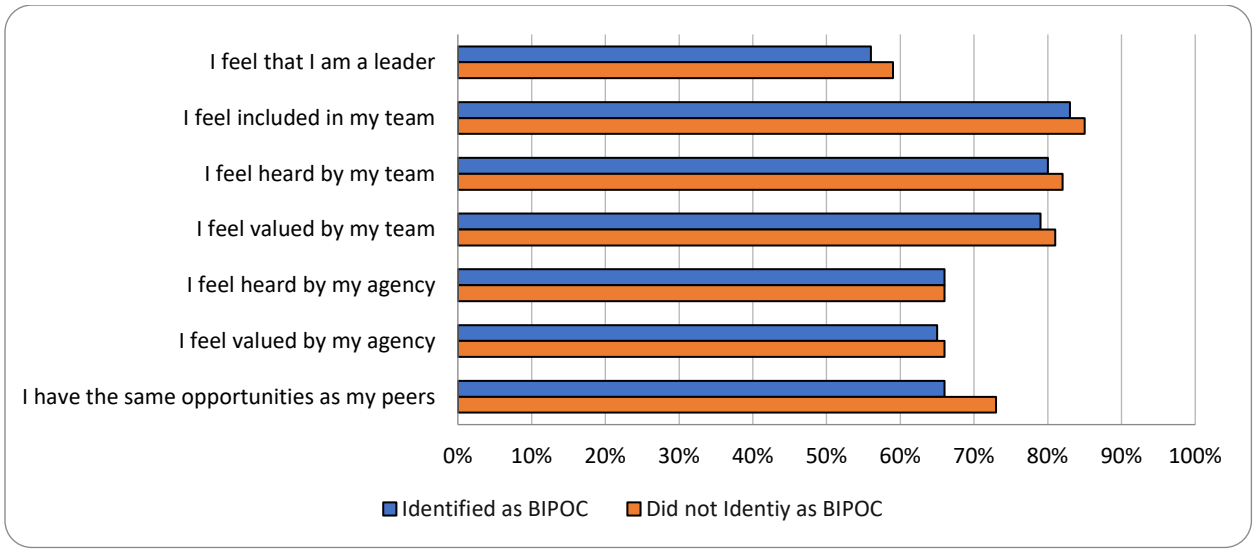


Figure 6. Feelings of Inclusion, by Sexual Orientation and Gender Identity

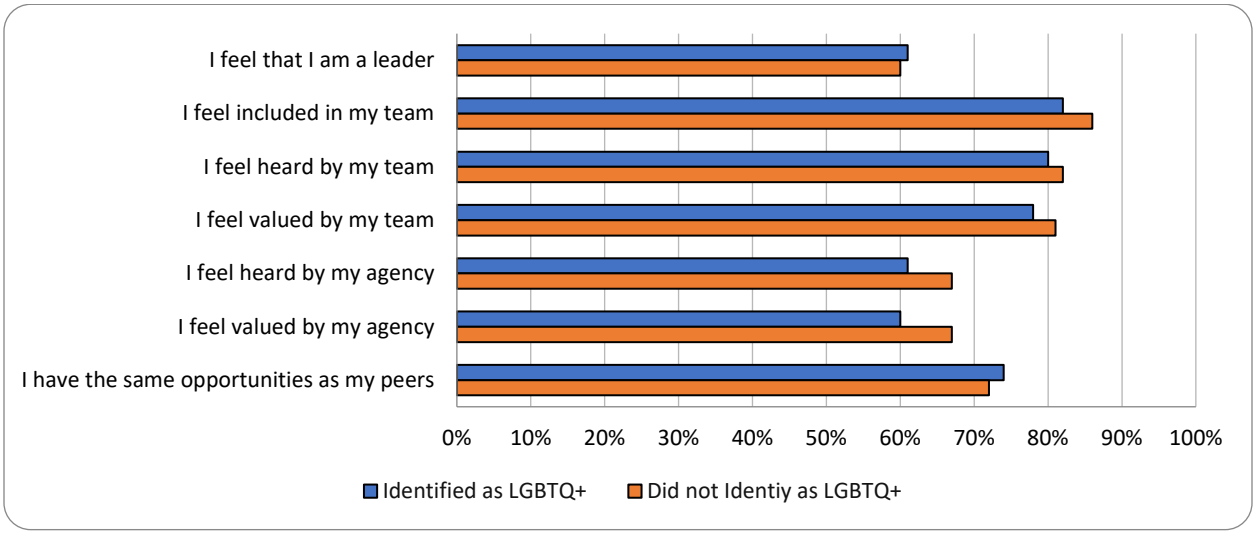
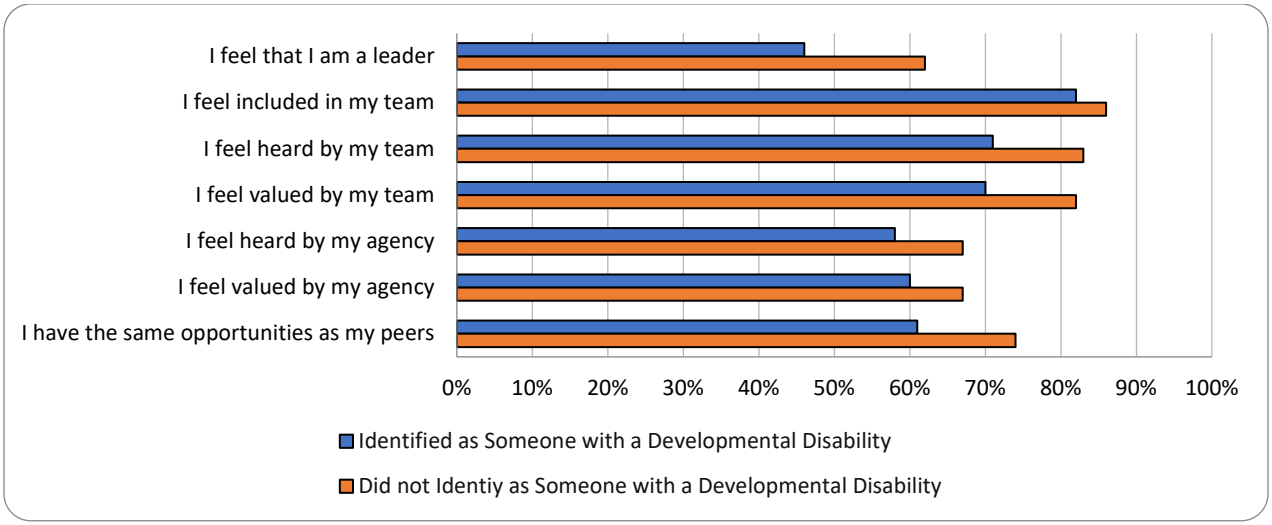


Figure 7. Feelings of Inclusion, by Developmental Disability Status



Q3: To what extent are Utah's public mental health and substance use treatment system employees safe from discrimination and microaggressions in the workplace?

A: Approximately 4% of all respondents (11% of respondents who identified with one or more of the target populations) reported problematic experiences with regard to discrimination or microaggressions in the workplace. Transphobic, racist, homophobic, and other disparaging comments were made by a small percentage (1.3%) of survey respondents when asked about this issue.

Problematic experiences

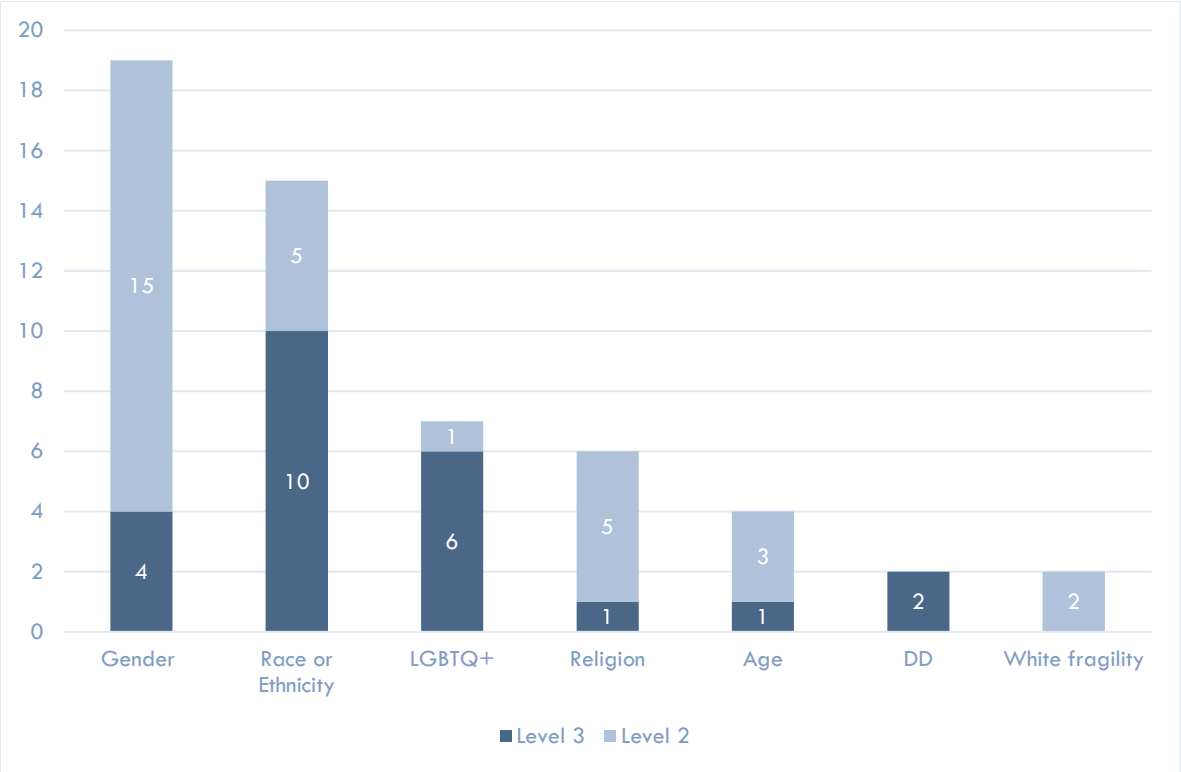
After asking respondents from the workforce to enter demographic information and to answer questions about how included they felt in their workplace, we asked the open-ended question- "*would you like to share any personal experiences as they relate to the questions on this survey?*" Fifty-four respondents (4% of total respondents; 11% of those who identified with a target population) shared first or second-hand problematic experiences. We coded problematic experiences by seriousness. Table 2 describes the coding and gives examples; Figure 8 shows the types of comments, by protected class.

Table 2. Coding Framework and Examples of Problematic Experiences

Code and definition	Examples
Level 3—Discrimination: comment conveyed first or second-hand experiences of discrimination based on protected class membership	● Examples of racial discrimination or microaggressions; ● Refusal by authorities in the workplace to use correct pronouns; ● Reports of homophobic and transphobic comments; ● Fear of job loss if one's "true self" was revealed; ● Refusal to make disability accommodations, even with a doctor's note.
Level 2—Devaluation: comment conveyed feelings of being undervalued, over-burdened or made to feel "less than" based on protected class membership	● Patronization from males in leadership; ● Expectations to know about a culture due to ethnic surnames; ● Feelings that white, LDS, males are more valued by agency; ● Assumptions of modal religious, sexual orientation and gender identities by co-workers and leadership ● White fragility*

Note: Responses from two people were coded as Level 2 **white fragility responses: straight, cis-gender, white people "walking on eggshells" in an effort to not offend (two comments) or straight white men worried about promotions lost due to race, sexual orientation or gender.*

Figure 8. Numbers and Types of Problematic Experiences, by Protected Class



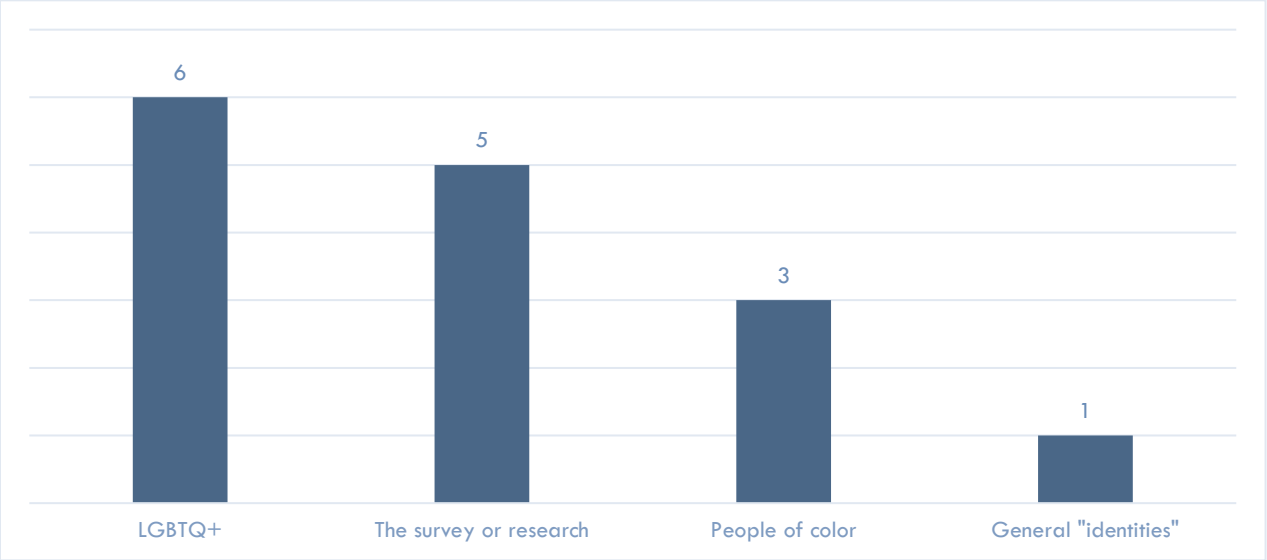
Disparaging comments

The request for comments not only brought to light experiences of discrimination and feelings of devaluation in the workplace, but also sparked disparaging comments about the target populations or about the attempt to study health disparities. Twenty respondents made disparaging comments. There was a tendency among these respondents to enter multiple comments and to make comments that were disparaging of multiple target populations and of the survey. Respondents were coded as having made either directly disparaging or passively disparaging comments (see examples of disparaging comments, by comment type in Table 3), with the most serious comment taking precedence in coding. Figure 9 shows the numbers of directly disparaging comments, by target.

Table 3. Examples of Disparaging Comments, by Comment Type

Comment type	Examples
Directly disparaging	● "All lives matter" ● Transgender is a mental illness ● People should keep sexual orientation to themselves ● This survey is "left-wing rubbish" ● It's challenging to supervise people who are "passionate about their identity"
Passively disparaging	● Entering "Milky Wayian" as race, "happy" as sexual orientation, or "neutered" as gender identity ● Minimizing disparities (e.g., "we all face something" and "it's just life")

Figure 9. Frequency of Directly Disparaging Comments, by Target



Q4: To what extent did leadership focus group responses align with the culturally responsive responses that workgroup members had envisioned?

A: Across all focus groups, participants from leadership teams addressed, in any way, about 30% of the material that workgroups expected leaders to address. To make this determination, each workgroup provided a rubric for scoring "ideal responses" with each of their questions. An example scoring rubric for one question, is provided below. Across all focus groups, participants from leadership teams addressed 30% of the items in any way. When considering depth of response, that percentage fell to less than 10%. Figure 10 shows the percentage of items from each ideal response that were touched upon during focus groups.

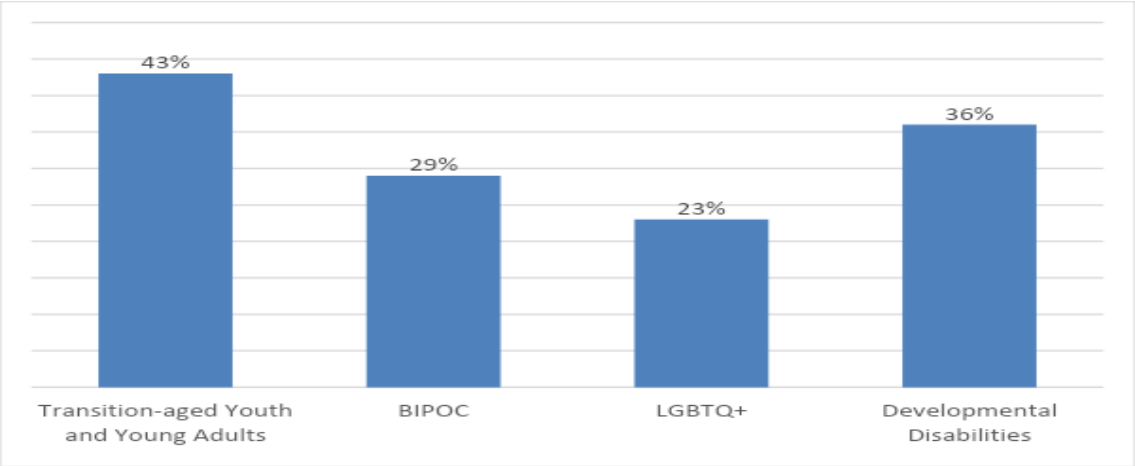
Example of workgroup question for leadership teams and the scoring rubric for that question:

Question from the Developmental Disabilities workgroup. *Can someone talk about what stimming is? [a definition is provided if unfamiliar with the term] What are your agency's thoughts on stimming? How does your agency approach stimming and other repetitive behaviors? Follow question: How does your agency address stimming that may involve self-harm?*

Ideal answer includes

- Acknowledgment that stimming is a human need
- Acknowledgement that most stims are healthy
- Suggest that the agency only addresses repetitive behaviors if they are causing distress to the individual
- States that they work with clients to understand the cause of the behavior
- States that they teach helpful stims to replace harmful ones
- Make it clear that agencies have a plan beyond restraints and calling the police when a client needs to be immediately stopped from self-harming

Figure 10. Percentage of "Ideal Response" Items that Focus Group Members Touched on, by Target Population



Facility Level Results

Q5: How welcoming, accessible and inclusive are the facilities where Utah's mental health and substance use treatment services are provided?

A: In walk-throughs of the facilities, the research team and workgroup members observed items that workgroups identified as important to their communities about 37% of the time (37% of the Transition-age youth items; 39% of the BIPOC items; 37% of the LGBTQ+ items; and 32% of the developmental disability items). Table 4, Table 5, Table 6, and

Table 7 **provide details about the percentage of sites where each item was observed.**

Table 4. Facility Walk-through Results--Transition-age Youth and Young Adults

Percent of facilities where item was observed	Work group identified item
7%	Guest Wi-Fi and password readily available
18%	Pamphlets are available explaining types of treatment in readable, non-clinical ways
24%	Comfortable chairs in waiting area that are not too close together
32%	Youth are not required to fill out forms in the waiting room with their parents
36%	If reading material is available, there is something for all ages
36%	If there is a youth designated area that is separate, it is not just for small children
37%	Discreetly placed resources in office waiting room that help youth (transit maps, food resources, job boards, treatment options)
39%	Modern and age appropriate décor
41%	Information about HIPAA rights and other related privacy information is easily accessible in the waiting area, as well as distributed to any new patients
47%	Decor/posters on walls don't promote outdated treatments (Example: "Say 'no' to drugs")
56%	Staff appear present. People are warmly welcomed when they enter the facility (e.g. smiling, waving)
69%	Environment does not come across as feeling sterile or harsh

Table 5. Facility Walk-through Results--BIPOC

Percent of facilities where item was observed	Work group identified item
2%	At least 1/3 of resources for other services in multiple languages
2%	Bilingual staff are easily identifiable

Percent of facilities where item was observed	Work group identified item
3%	All signage is available in English, as well as one non-English language
4%	If food is offered, collaborated cultural foods are also being offered
6%	There are Black Indigenous People of Color (BIPOC) represented in art/pictures/decorations
8%	There are Black Indigenous People of Color (BIPOC) represented in brochures/fliers
10%	Ethnic holidays are acknowledged and décor around the office, including non-Christian religious holidays
14%	Have posters that encourage inclusion and multiculturalism
16%	At least ½ of COVID-19 signage is available in multiple languages
24%	There is a comment or feedback box available with pens and paper close by and feedback forms in different languages
29%	There are Black Indigenous People of Color (BIPOC) represented in staff physically in the facility
33%	Signs that indicate on how to access services in another language are written in that language
36%	At least one facility is located w/in 5 miles of a known community of color
50%	(Bottled) beverages are offered when people come in
57%	If a TV is on, it should be on a program that does not perpetuate negative stereotypes about communities of color (e.g. no news showing POCs as “thugs”)
69%	Multiple furniture pieces are big enough for people of all sizes to sit comfortably
73%	There is a place with toys for families with children to wait
95%	Furniture quality and size is the same for all staff
98%	Waiting areas are clean with furniture that is well kept
100%	Furniture is used to allow for easy and open communication
100%	There is a common space that is available to clients & agency members to sit

Table 6. Facility Walk-through Results--LGBTQ+

Percent of facilities where item was observed	Work group identified item
0%	Staff have some way of visually sharing their pronouns
7%	If a suicide hotline is visually available, the Trevor Project line is available as well
9%	If pamphlets, flyers, or handouts are available, at least one represents the LGBTQ+ community
26%	At least one subtle pride flag, LGBTQ passing couple photo, “safe space” indicator, or similar LGBTQ affirmation is observed the facility
42%	Patient is able self-identify gender, pronouns (beyond the binary) and/or some open response option is available
79%	This clinic had at least one gender neutral bathroom with an inclusive and professional sign
95%	If reading materials are available, there are materials outside of tabloid magazines

Table 7. Facility Walk-through Results--Developmental Disabilities

Percent of facilities where item was observed	Work group identified item
7%	Pamphlets and educational materials on Autism emphasize neurodiversity and strengths-based approaches
14%	Disabled needs are represented in materials like exercise and mental health recommendations
14%	Disabled people are visually represented in images and these representations are not inspiration porn[202]
15%	If a sensory room is available, there are options for all ages
15%	All signs are available in braille
26%	Lighting is not fluorescent
29%	Fragrance free in the facilities including the restroom (no diffusers, air fresheners, perfumes, hand sanitizer, minimal scent soap in the bathroom)
32%	There is a designated private waiting area that is separate from the main waiting room for people with noise sensitivity/ social anxiety to wait
33%	Therapists have clear masks or face shields available for those that read lips
39%	Adaptive technology users can access forms
39%	Clear visible signs with graphics/ images/ symbols
50%	Available fidget toys
58%	Receptionists desks are low enough to make eye contact with a seated person
76%	If food is available they follow Allergy Safety Standards: food ingredients available to patients, food is prepared without cross contamination, nut free zones

[202] Inspiration Porn: “Inspiration porn is the portrayal of people with disabilities as inspirational solely or in part on the basis of their disability” (Ellis 2016). An example of this is giving extra appreciation to a disabled singer on *America’s Got Talent* over a non-disabled singer with the same level of talent. Inspiration porn only benefits the abled person. It is used to make the abled person feel good about themselves and creates inappropriate expectations of the disabled individual. It also creates an unfair hierarchy of disabled people which puts people against each other. https://www.ted.com/talks/stella_young_i_m_not_your_inspiration_thank_you_very_much
Ellis, Katie; Kent, Mike (10 November 2016). "Confirming normalcy. 'Inspiration porn' and the construction of the disabled subject?". Disability and Social Media: Global Perspectives. Taylor & Francis. ISBN 978-1-317-15028-2.

Q6: How welcoming, accessible, and inclusive are the websites and social media platforms of the agencies that provide Utah's public mental health and substance use treatment services?

A: Workgroup and community members reviewed the public-facing materials from each agency and found the items that workgroups identified as important to their communities about 36% of the time (16% of the Transition-age youth items; 43% of the BIPOC items; 28% of the LGBTQ+ items; 17% of the developmental disability items; and 60% of the technical accessibility items). Table 8, Table 9, Table 10, and Table 11, and Table 12 provide details about the percentage of sites where the welcoming, accessible and inclusive materials were found.

Table 8. Public-facing Review Results--Transition-age Youth and Young Adults

Percentage of online spaces where item was observed	Workgroup-identified item
0%	Directions to the facility are easily available and include public transportation instructions
2%	Online portals which provide: scheduling, canceling of appointments, intake forms and ROI's
10%	Financial policies, fees, and missed and late appointment penalties are clearly stated and publicly available
27%	Profiles of providers are easily accessible
38%	Materials for Youth in Transition are available, and when available speak to and address Youth in Transition and not parents

Table 9. Public-facing Review Results--BIPOC

Percentage of online spaces where item was observed	Workgroup-identified item
0%	Website, selected/online forms, and informational documents are fully available in at least two languages
9%	Website and outreach materials acknowledge health disparities and address the importance of cultural responsiveness as they pertain to communities of color

Percentage of online spaces where item was observed	Workgroup-identified item
38%	Pictures or graphics are free of implicit bias. For example, white people being presented as professionals or BIPOC presented as lower-class, blue-collar workers[203]
83%	Public-facing documents are free of condescending, prejudiced, and/or biased language towards people/communities of color
93%	Visual materials reflect racial and ethnic demographics of clientele respectfully (i.e., no tokenism, no condescending or prejudiced images)

Table 10. Public-facing Review Results--LGBTQ+

Percentage of online spaces where item was observed	Workgroup-identified item
16%	The LGBTQ+ hotline is included when posting the overall crisis hotline
26%	When photos are used, at least one of the pictures represents the LGBTQ+ community
27%	Facility has at least one therapist with a LGBTQ+ distinction available and locatable via public facing documents
34%	LGBTQ+ people acknowledged in the text at least once
40%	Gender neutral language is always used (e.g., they instead of he/she)

[203] The "free of bias item" (38%) focuses on ways in which BIPOC are presented that lead to implicit messages of being less than. Some questions that coders asked themselves when looking for implicit bias included:

- Are there any images of BIPOC?
- Are BIPOC presented as having a similar power dynamic as any White people in the image(s)?
- Are BIPOC in the fringes of the photo?
- Are certain BIPOC more or less likely to be shown?

This is different from the "reflect respectfully" item (93%) which focuses on *how* BIPOC are presented. When coding images to determine respectfulness, the research team would often ask the following questions:

- Are BIPOC dressed well or at least similar to any White people around them or White people in other images?
- Are BIPOC engaging in activities or expressing emotions that are similar to that of any White people around them or in other images?
- Is a Person of Color present in a group photo only to make the group appear more diverse? Are they the only Person of Color in the image?
- Do the BIPOC present appear to be "saved" by the White people in the image?

Due to the varying nature of these questions, it is possible to have visual material that is respectful, but also shows implicit bias.

Table 11. Public-facing Review Results--developmental disabilities

Percentage of online spaces where item was observed	Workgroup-identified items
0%	Information is presented using plain Language (6th grade reading level)
20%	There is a clear and easy statement on how to contact for accommodations before the first appointment and throughout services
21%	Developmental disabilities mentioned in text at least once Of the sites that mentioned developmental disabilities, 44% mentioned in way that were free of ableism or condescending language

Table 12. Public-facing Review Results—Website accessibility

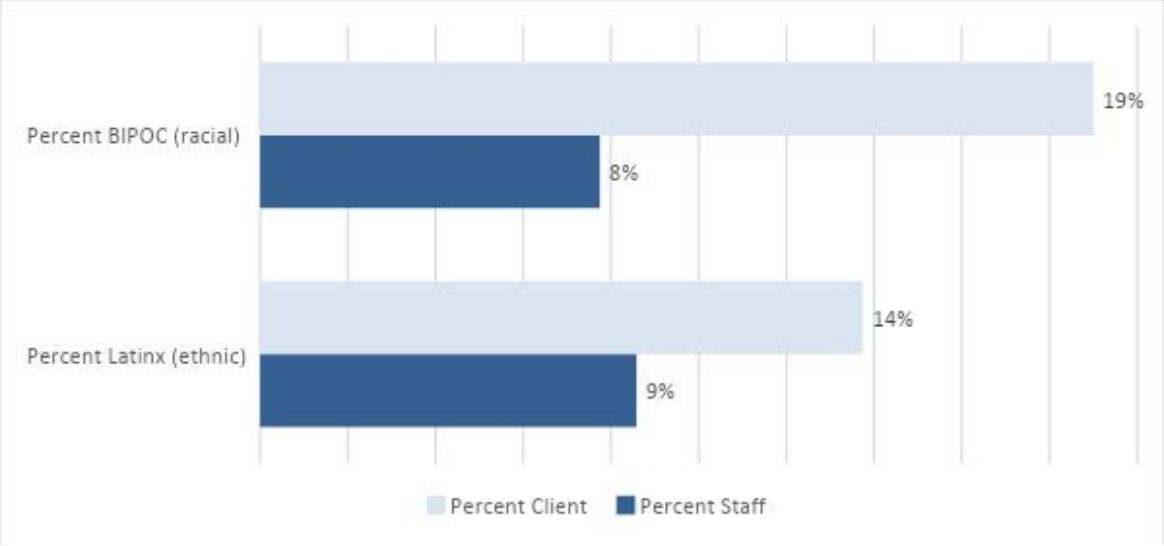
Percentage of sites	W3 website accessibility standards
18%	Users are helped to avoid mistakes when filling out forms and to correct mistakes if they occur (only applicable if there are forms that can be filled out online)
50%	Captions or other alternatives are available for multimedia
58%	Content is presented in a way that is easy to see without adaptive software
64%	Content appears and operates in predictable and consistent ways
67%	Content can be presented in different ways
75%	Users can easily navigate the website, find content, and determine where they are
83%	Text alternatives are available for non-text content
100%	Functionality is available from a keyboard

Treatment Level

Q7: With regard to race and ethnicity, how well does the public mental health and substance use workforce align with the clientele?

A: Workforce members are significantly less racially and ethnically diverse than are clients.[204, 205] Figure 11 shows the racial and ethnic demographics of clients compared to the racial and ethnic demographics of staff, statewide.[206]

Figure 11. Racial and Ethnic Comparison, Clientele and Workforce.



[204] Chi-square for independence with Yates correction comparing BIPOC staff with clients is 81.9259 (1, 54014), p<.000001.
[205] Chi-square with Yates correction comparing Latinx staff with clients is 48.3887 (1, 53123), p<.000001.
[206] Client demographics retrieved from samhis (substance abuse and mental health information system); staff demographics were self-reported in the demographic survey.

Q8: To what extent do service providers demonstrate the awareness, attitudes, knowledge and skills necessary to provide responsive services to the target populations?

A: Overall scores on the set of awareness, attitude, knowledge, and skill questions developed by workgroup members showed much higher agreement with the attitude questions than did scores on the skills question. Figure 12 shows average agreement with each question. [207] **To better contribute to the understanding of clinicians, the scores on this page reflect answers of DOPL licensed direct service providers only.**

Table 13 provide average agreement rates of clinicians to each question.

Figure 12. Overall Agreement Percentages to Awareness,[208] Attitude, Knowledge and Skills Items from Staff Survey

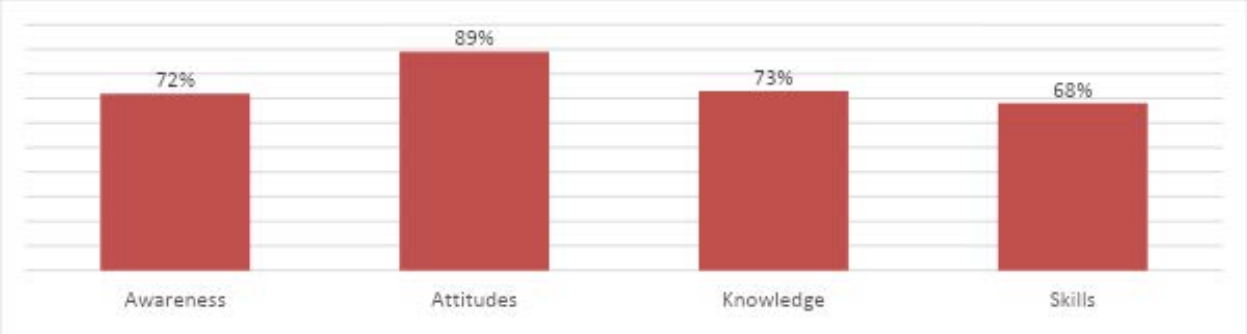


Table 13. Average Agreement with Each Awareness, Attitude, Knowledge and Skills Item

Awareness Items	Percent agreed
People with Developmental Disabilities lack access to quality mental health care.	76%
I have noticed racial or ethnic discrimination at the place where I work*	21%
I am totally unbiased and not racist	52%
Homo and transphobia contribute to health disparities for LGBTQ+ people in our community.	84%
Transition-age youth and young adults do not receive adequate mental health and substance use services.	74%
Attitude Items	**Percent agreed**
Our services would improve with more input from youth and young adults.	94%
I am willing to report a coworker's racist comments.	85%
I am willing to be uncomfortable while receiving and giving feedback about cultural/ethnic humility.	95%
It is important to treat people with disabilities in a way similar to same-aged peers.	89%

[207] Results from "*I have noticed racial or ethnic discrimination at the place where I work*" were not included in the overall awareness score and the "I am totally unbiased and not racist" item was reverse coded as disagreement indicated higher levels of awareness.
[208] I have noticed racial or ethnic discrimination at the place where I work was not included in the Awareness score reflected in

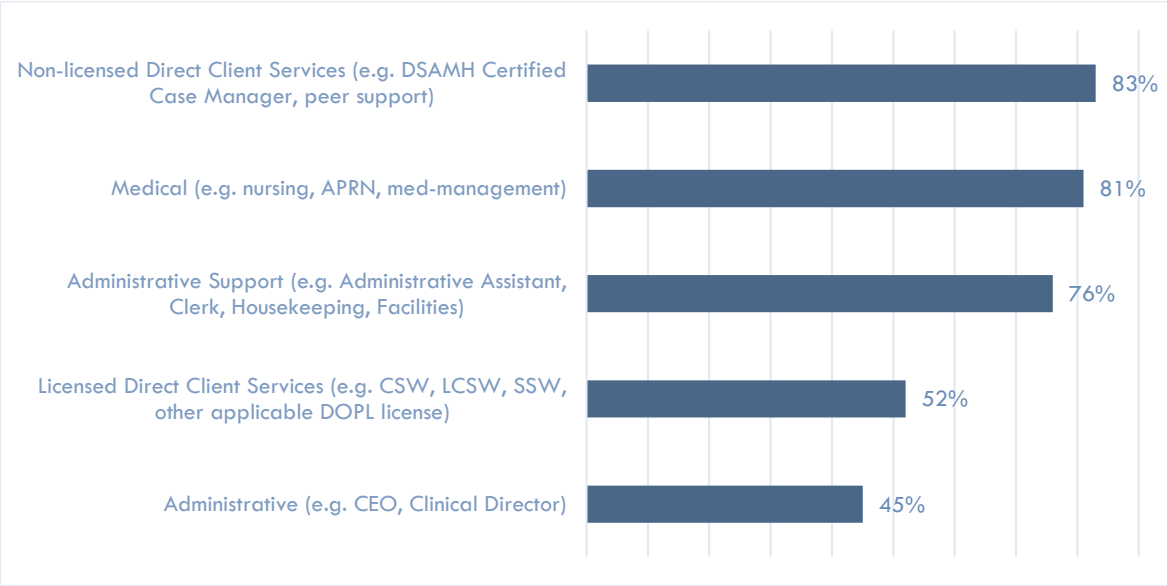
Table 13

Sharing personal pronouns is a valuable way to ensure we respect all clients.	82%
Knowledge Items	Percent agreed
I am knowledgeable about unique issues that affect transition-age youth.	70%
I know a lot about disability history, subcultures and identities.	52%
I have been learning about racial and ethnic identities.	89%
I have intentionally sought information to enhance my knowledge of the LGBTQ+ community.	82%
Skills Items	Percent agreed
I am well-equipped to provide services specific to people in the LGBTQ+ community.	60%
I have the skills to combat racism.	82%
I have a skill set that allows me to address the mental health or substance use treatment needs of people with developmental disabilities.	67%
I have utilized opportunities to build specific skills to treat transition-age youth.	63%

Q9: To what extent are workforce members and treatment providers aware of their own racial and ethnic biases?

A. Sixty-seven percent (67%) of all workforce members agreed with the statement, "I am completely unbiased and not racist" and about 33% disagreed with the statement. This indicates poor awareness of implicit bias among workforce members. Responses to this question varied significantly by job type. Figure 13 shows the percentage of respondents agreeing to the "I am completely unbiased and not racist" statement, by job type.

Figure 13. Agreement with "I am completely unbiased and not racist" by Respondent Type



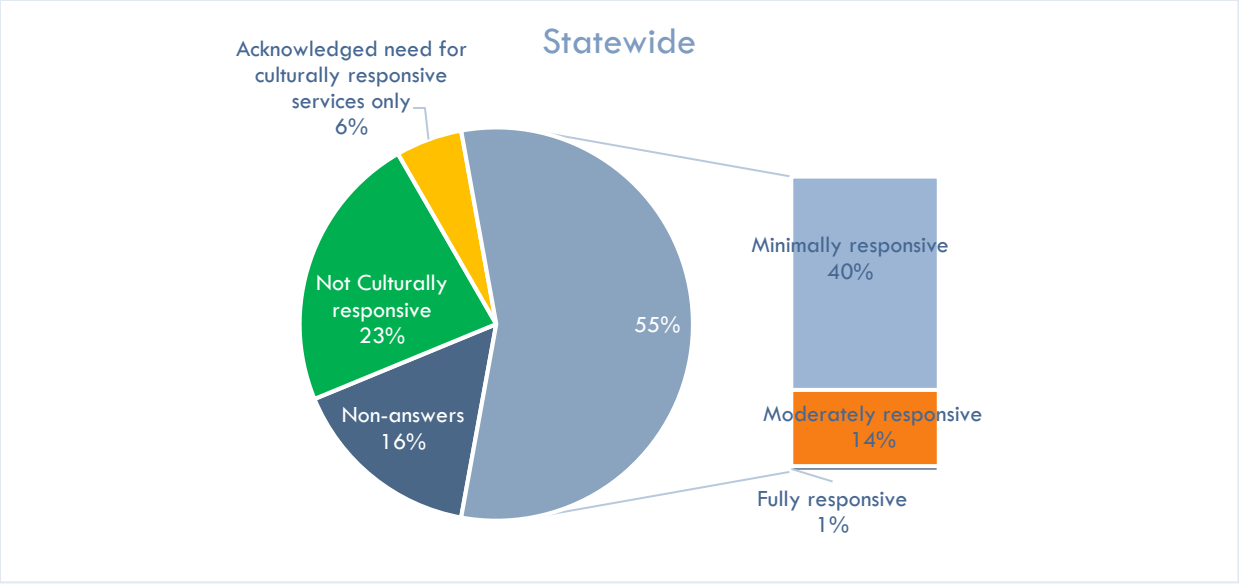
Q10: How are culturally responsive approaches integrated into the services delivered by mental health and substance use treatment providers in Utah?

A: Direct service providers answered this open-ended question. Responses were coded by two evaluators. Examples of guidance for coding is shown in Table 14. As seen in Figure 14, 55% of responses were determined to be culturally responsive approaches. Of those, just under 75% were coded as minimally responsive approaches.

Table 14 .Response type Coding for Culturally Responsive Approach Question

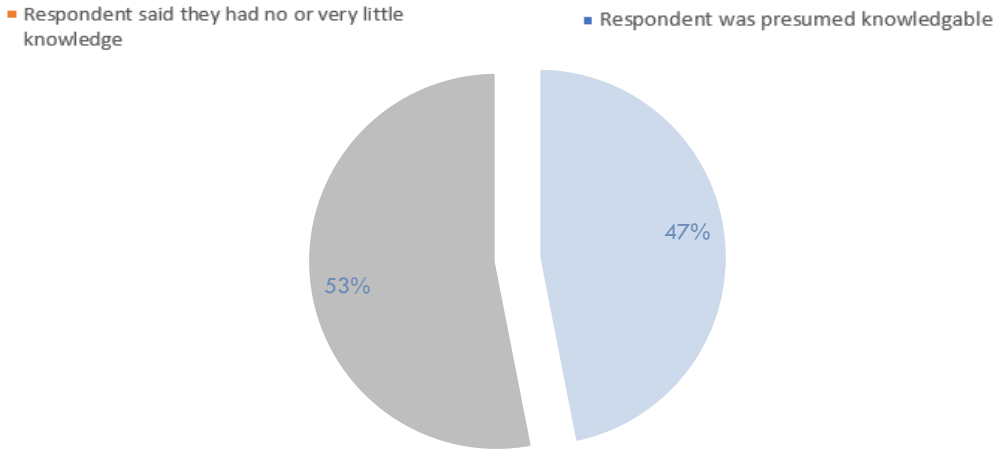
Response type	Examples and coding criteria
Non-answers	Not applicable; Not sure; We do a good job; haven't worked with a person of color
Not responsive	Treat everyone the same; I don't see color; Don't make assumptions/let them teach me; Angry responses
Minimally responsive	Ask to be told about culture; Offer translation services; Use inclusive language' being "mindful" "aware" or "considerate" of culture or challenges
Moderately responsive	Self-educates; Validation of experiences; Mention of specific cultural practices; Community partnerships
Fully responsive	Self-educates to validate client histories and experiences; takes cultural and linguistic backgrounds into account when selecting standardized tools; Account for norming of tool when making a determination; utilizing culture-based support systems

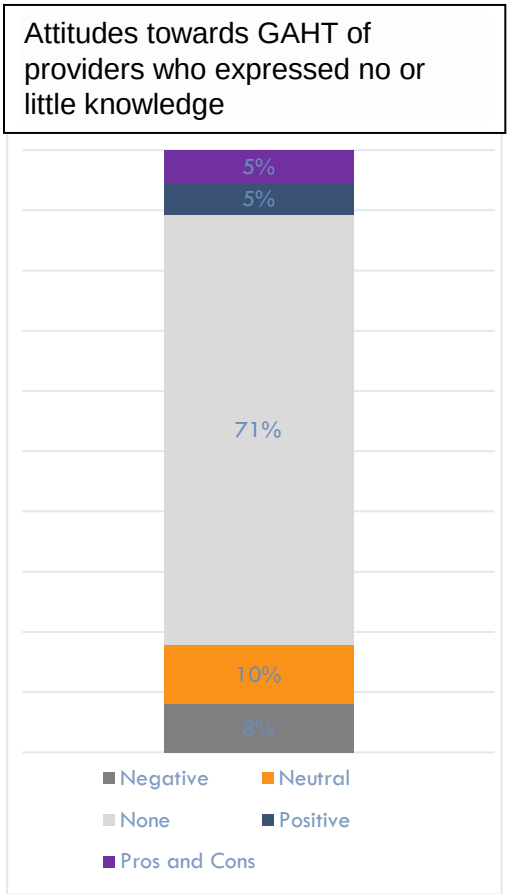
Figure 14. Summary of Answers to Culturally Responsive Approach Question

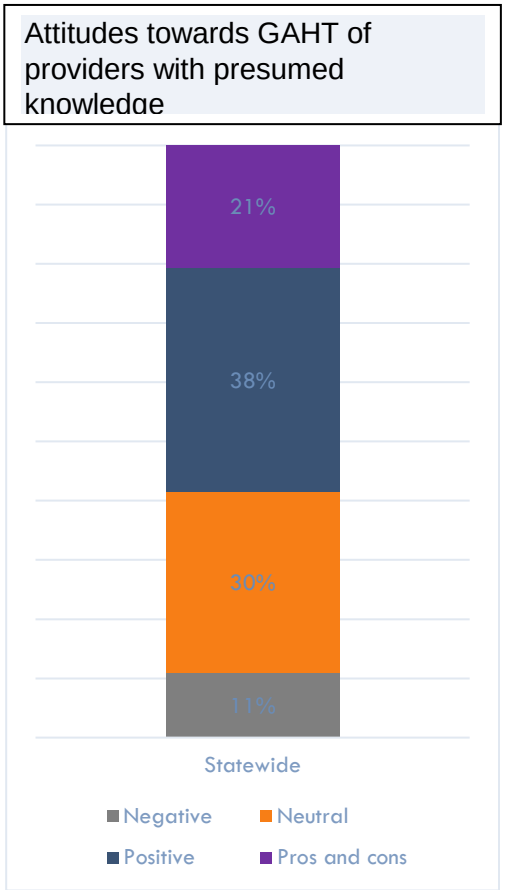


Q11: To what extent are knowledge and attitude related?

A: One example from the data provided some insight into this question. As displayed below, 53% of respondents claimed no or very little knowledge about gender affirming hormone therapy (GAHT) and 47% of respondents were assumed to have knowledge. Of those who claimed no or little knowledge, 28% who offered opinions had negative opinions. Of those with presumed knowledge, 11% who offered opinions had negative opinions.







CONSIDERATIONS AND RECOMMENDATIONS

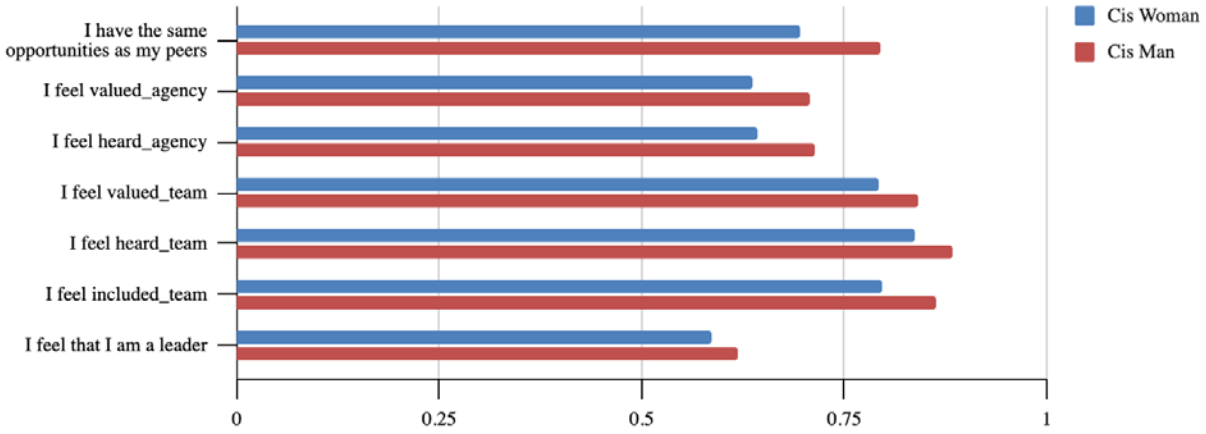
Considerations

This section offers a number of points that the research team encourages stakeholders to consider while addressing health disparities within Utah's public mental health and substance treatment system. Also included are recommendations from workgroup members for which supporting data were not collected and findings that were beyond the scope of the project.

- More data was collected and is available than what is presented in this document. The research team is willing and able to provide additional data in aggregate form, conduct additional analysis, and provide additional recommendations. If you are interested in learning more about these opportunities, please contact Kristin Swenson at kristinswenson@utah.gov.

- An analysis of disparities between cisgender women and cisgender men were beyond the scope of this project. However, many survey responses addressed disparities, or perceived disparities, affecting cisgender women when compared to cisgender men in the workplace. When analyzing results from the demographic survey we found significant differences between cisgender women and cisgender men with regard to feelings of opportunity and inclusion. Figure 15 shows these differences at the state level.

Figure 15. Inclusivity, by Gender



- Multiple comments entered into the demographic survey contained complaints about religious discrimination. Respondents were concerned about discrimination against themselves and about harmful treatment of some clients based on values promoted by The Church of Jesus Christ of Latter-day Saints (LDS), specifically. When conducting facility walkthroughs, the influence of the LDS church and other Christian religions was clear. Religious discrimination and health disparities related to religious influence is something that can be researched in the future and, overall, is something for mental health authorities to consider. Intentional inclusion of religious minorities in decision-making at all levels could do a lot to address this issue.

- In the review of focus groups transcripts with leadership teams and in the review of comments to open-ended survey questions from the workforce, the idea of "treating all clients the same" was touted multiple times. Along this line, many leadership teams and providers endorsed the idea that their agencies, or they themselves, were "color blind." Treating all clients the same does not address and can only perpetuate health disparities, and a color blind approach intentionally ignores differences, including disparities, based on race or ethnicity. To address disparities, providers should consider moving from an unhelpful color-blind approach to a helpful anti-racist approach.

- The following example illustrates one simple way in which agencies that idealize equal treatment for everyone simply do not live up to that ideal.
    - During the six-week period that the research team was conducting walkthroughs there were a number of religious and cultural holidays and events, as well as a number of national and international celebrations. These holidays, events and celebrations included:
        - Passover
        - **Easter**
        - Ramadan
        - Holi
        - Rama Navami
        - **St. Patrick's Day**
        - Vesak
        - Autism Awareness Month
        - Trans Awareness Day
        - Ostara (Spring Equinox)
        - **Spring**
        - Earth day
        - Hexennacht
        - Traditional New Year

  In bold are the holidays, events, and celebrations that were observed at the sites we visited. Clearly, the holidays of Christian clients are celebrated and the holidays of clients from other religious traditions are not. Similarly, cultural holidays from the Western European tradition are celebrated and cultural holidays from other traditions are not. One cafeteria we visited had a graphic representing a St. Patrick's Day special that they had offered, but could not accommodate a person observing dietary restrictions associated with Passover, on the day of our visit. In spite of the belief that all clients are treated the same, this example demonstrates the fallacy of that belief.

- Paradoxically, many agencies that promoted equal treatment of all clients actually gave examples of cultural accommodations in responses to other questions during the same interview. Examples of cultural accommodations made by agencies include:

    - Providing "newcomers" classes for staff who are new to Utah so that they have an opportunity to learn about, and be responsive to, "Utah culture."

    - Multiple examples of accommodating the preference for LDS clients to receive treatment from LDS providers.

  - Providing staff training and question and answer sessions to learn more about plural families and polygamist communities.
  - Special and targeted efforts to reduce disparities by providing outreach and targeted suicide prevention outreach to farmers, ranchers, and gun owners.

- We heard from several leadership teams that assessments were not normed with diverse communities and that evidence-based practices were oftentimes ethnocentric. The most common evidence-based practice used by Utah's Local Mental Health providers is the Outcome Questionnaire (OQ).[209] The OQ is an assessment tool used to evaluate acuity of mental health concerns and measure progress towards recovery. Use of the instrument itself is considered to be an evidence-based practice. A review of the tool demonstrated several examples of non-responsivity to the diverse needs of targeted populations. For example:
  - One question asked about "feeling blue." Feeling blue is an idiom that may not be appropriate for some English language learners and may be confusing or even upsetting for some neurodiverse clients who are more likely to apply literal interpretations.
  - A set of questions asks clients to rate their sex lives and love relationships. These questions may not be applicable or may skew results for some aromantic or asexual clients. A not applicable option is not available and selecting "Never" skews results towards a higher acuity.
  - Another set of questions asks about how often work/school are satisfying and about how often clients are stressed at work/school. People in several of the target populations, particularly those with developmental disabilities, are more likely to be unemployed than individuals not in the target populations. Instructions about how to more broadly interpret those questions can be found in the margin of the paper tool. In contrast, instructions for those who don't drink or use drugs are provided with the response options.
  - Finally, a large set of questions asks about physiological symptoms (e.g., I tire quickly, I have headaches, I have sore muscles). These symptoms are more often experienced in the day-to-day life of clients with developmental disabilities. Inclusion of these questions skews results for some clients and, due to chronic conditions, reduces the likelihood that a client will be assessed as "recovered."

- The idea that "we don't treat disabilities" came out of multiple focus groups with leadership teams. A review of data from the Substance Abuse and Mental Health Information System (SAMHIS) showed that approximately 10% of clients seen by Local Mental Health Authorities do have developmental disabilities. The idea that these clients are not being treated is a barrier to providing culturally responsive treatment to literally thousands of clients who do have developmental disabilities.

[209] Lambert, M. J., Gregersen, A. T., & Burlingame, G. M. (2004). The Outcome Questionnaire-45. In M. E. Maruish (Ed.), *The use of psychological testing for treatment planning and outcomes assessment: Instruments for adults* (pp. 191–234). Lawrence Erlbaum Associates Publishers.

- There was a noticeable level of discomfort by leaders and providers when referring to people in the target populations. While some terms that we heard (e.g., "colored people") will never be appropriate, there are few guidelines about how individuals would like to be referred to. Consider that the best guideline about how to refer to individuals is to be sensitive to how they refer to themselves. For example, some people prefer identity first language (autistic person) while others prefer person first language (a person with autism). Increased exposure to people from the target populations and connections with the communities can help guide what language is and is not currently comfortable within the communities. The use of "the" to refer to diverse populations is stigmatizing and should be avoided (i.e., "the gays").

- Although developmental disabilities and intellectual disabilities do co-occur, developmental disabilities are distinctly different and can exist independently from intellectual abilities. Review of leadership focus group transcripts and open-ended survey comments from providers showed that developmental disabilities were often conflated with intellectual disabilities and that an assumption about intellectual deficits were often attributed to people with developmental disabilities. Finally, there was a tacit implication in a number of responses that people with disabilities want to or need to be "cured." This assumption is not strength-based, not pro-neurodiverse, and not supported by a growing number of people in the disability community. Increased representation of people with developmental disabilities within agencies and more meaningful connections with people from the disability community could positively influence these conflations and misconceptions.

- The following recommendations were provided by some workgroups after data collection tools were finalized. Although we were not able to collect data and make formal recommendations, the research team thought the ideas were worth considering.
    - Provide transportation vouchers (e.g., UTA vouchers) for clients struggling to get to therapy
    - Provide a 10-minute free consultation for potential clients to explore therapists
    - Implement flexibility in policies around cancellation, tardiness, and rescheduling. Penalizing people who miss appointments may differentially impact people with disabilities as comorbidity with chronic illness and executive dysfunction can lead to missing appointments without notice. As noted in some focus groups, different cultures may value time differently. Strict adherence to a schedule is not responsive to all clientele.

Recommendations

The health disparities research team is providing targeted recommendations to each agency based on data collected during this study. A complete set of all recommendations and the criteria used to target recommendations to each agency is provided.

System Level Recommendations

- Improve higher education programs so as to teach more SUD content and have more culturally responsive exams.
- Increase and support research by, and for, target populations, to include all research that contributes to the development of assessments, evaluation tools, and evidence-

based practices.

Organization Level Recommendations

Organizational Level Recommendation	Criteria for making recommendations
Demonstrate tangible commitment of leadership teams to understanding bias, stigma, and history that contribute to disparities	Low scores on systemic racism question in leadership focus group
Demonstrate tangible commitment by agency to make cultural shifts within the organization to ensure work is based in anti-oppressive frameworks.	Under-representation of target populations among leadership
Increase connections with the target populations, directly or through close contact with grassroots organizations, to better understand their needs.	Low scores on "connection with communities" question or no score on connects with communicates in "success" question
Address training deficits by providing not necessarily a higher quantity, but rather better, more effective trainings. In order to maximize effectiveness, these trainings must be held with target population community members or target population-led organizations with content that focuses on what is important to that particular target population and should open a dialogue between the agency and target population stakeholders.	ALL
Proactively seek out antiracist and antidiscrimination workshops for ALL staff.	Majority of survey respondents believe that they are "completely unbiased and not racist"
Promotion of target population staff to leadership roles.	Workforce members from target population less likely to be administrators
Include target populations in all policy decision making.	Under-representation of target populations among leadership
Hire BIPOC and native speakers of non-English languages.	Significant differences between demographics between clients and providers
Implement a strategic plan for workforce development, recruitment, and retention for BIPOC. This entails providing mentorship and financial support in order to secure a path for BIPOC to obtain licensure and become mental health providers.	Significant differences between demographics in workforce and client demographics
Improved data collection and analysis	breakout below

Organizational Level Recommendation	Criteria for making recommendations
Add flags and indicators to current tools for LGBTQ+ community	Was told data were not collected in leadership focus groups
Analyze satisfaction and outcome data by subgroup to understand disparities	Low scores on "how do you measure success" for LGBTQ+ question
Create inclusive intake forms that ask about name, pronouns, and whether the client would like to discuss their identity during the session. If the client is a transition-aged youth or young adult and LGBTQ+, ask whether they are out to their parents or guardians.	Notes on intake forms from walkthroughs
Reduce interactions between clients and law enforcement	Observations from walk throughs; Mentioned law enforcement in focus groups (stimming question)
Have leadership actively seek out information concerning discriminatory experiences (from clients and staff alike) and respond appropriately	Any respondents reporting discrimination or making derogatory comments
Develop policies that provide clear guidance to support clients and from target populations (see below in italics)	SEE BELOW
Have a policy readily available for staff or patients who may change their names or gender markers	Low scores on LGBT--leadership focus groups
Create a policy to protect the privacy of youth as much as possible	Low scores on privacy question
Give a tangible plan to every transition aged youth who needs to switch from youth to adult services	Low scores on infantilization question
Create or improve accommodation policy for people with developmental disabilities	Low scores on accommodation question
Develop materials to support therapist interactions with target populations	SEE BELOW
Create a guide on BIPOC issues and definitions for therapists to use in between trainings with references	BIPOC scores below median value on staff survey
Create a guide on developmental disability issues and definitions for therapists to use in between trainings with references	DD scores below median value on staff survey
Create a guide on LGBTQ+ issues and definitions for therapists to use in between trainings with references	LGBTQ+ scores below median value on staff survey
Create a guide on transition-age youth issues and definitions for therapists to use in between trainings with references	TAY scores below median value on staff survey

Organizational Level Recommendation	Criteria for making recommendations
Hire a youth coordinator to improve social connection for youth and young adults and provide youth voice to materials and policies	>80% of staff that said organization would improve with more youth voice

Structural Level Recommendations

Recommendation	Criteria
Address specific areas of need from facility walkthroughs to provide a welcoming and respectful physical environment for all	Any area with scores of 0 on walkthrough
Address specific areas of need from public-facing documents review to provide a welcoming and respectful online environment for all	Any area with scores of 0 on public facing review
Remove stigmatizing pamphlets and information	Notes on walkthrough form
Work with agencies to correct language and develop better materials for target populations	DSAMH
Resources for target populations should be reviewed by the target populations	Implicit bias detected in 50% or more of public facing spaces
Offer a variety of communication options - phone, email, adapted communication tools	Low scores on communication questions on group score sheet

Treatment Level Recommendations

Recommendation	Criteria
Increase knowledge about therapeutic guidelines for targeted populations	Staff survey knowledge scores below median value.
Increase number of service providers from target populations	Significant differences in demographics
Providers need to share pronouns in order to encourage clients to share pronouns	20% or more of respondents to staff survey disagreed with the idea that sharing pronouns is a way to create a respectful environment
Work to increase social connections and sense of community among target populations	Mental Health clients had lower than national average on "Social Connectedness" question (MHSIP 2020)
Ensure Evidence Based Practices are culturally relevant and responsive	Percent of providers entering culturally responsive comments into staff survey being less than state average

Therapists have connections to clinics with gender affirming services	More providers indicated very little or no knowledge about GAHT than statewide average
Ensure that programs tailored to target populations are available, particularly for the following target population(s):	See breakout below
• Transition-age youth	Low percentage of respondents indicated programs, services or treatments specifically targeting both youth and young adults (i.e., youth only programs didn't count)
• BIPOC	Low percentage of respondents indicated programs, services, or treatments specifically targeting BIPOC
• LGBTQ+ community	Low percentage of respondents indicated programs, services, or treatments specifically targeting LGBTQ+ clients
• People with developmental disabilities	Low percentage of respondents indicated programs, services, or treatments specifically targeting clients with developmental disabilities
Some indicator on client's file if they are LGBTQ+ but still in the closet so that information is not accidently shared with their parents	Lower than State average on privacy score in leadership focus group
Allow youth to have input in their treatment plan by, for example, creating a worksheet that is given to all youth and updated regularly	Infantilizing scores, from licensed providers, lower than state average
Provide resources on harm reduction and recognize that abstinence from substances isn't the goal for everyone	If abstinence is an agency goal or if the agency does not support harm reduction
Give youth autonomy around which and how much of a medication is prescribed, if they are given any	Low infantilizing scores by medical providers
Create a manual for parents around privacy and how to debrief therapy with youth	Low scores for educating parents on the importance of confidentiality
Recognize and address limits of some traditional therapies, screenings, and tools for some disabled people. For example, screenings or therapeutic tools that require reading or writing	Supportive of ABA in focus group transcripts or materials supportive of ABA in facility walk-throughs.

RESOURCES

The resources listed in this section have been recommended by the health disparities needs assessment work groups. Please contact Theo Schwartz (aschwartz@utah.gov) to connect with the workgroups for technical support in finding additional resources or in implementing recommended changes at any level.

Resources specific to Transition-age Youth and Young Adults

A summary of Harm Reduction

A playbook on action steps from providers

Incorporating youth voice

Youth friendly materials about the medical system

Tip sheets around TAY issues

Resources Specific to BIPOC

What Does BIPOC mean?

Racial Equity Tools

YWCA Get Involved Challenge

How to Be an Antiracist by Ibram X. Kendi

My Grandmother's Hands: Racialized Trauma and the Pathway to Mending Our Hearts and Bodies by Resmaa Menakem

White Fragility: Why It's So Hard for White People to Talk About Racism by Robin DiAngelo

The Problem with Color Blindness

Color Blind or Color Brave?

Resources Specific to LGBTQ+

Creating an LGBTQ+ affirming space

American Psychological Association LGB Guidelines

One guide to affirming care for LGBTQ+ patients

The Gay, Lesbian, Bisexual and Transgender Health Access Project's Standards of Care

The Transgender Training Institute

An infographic on Testosterone

Tips for affirming care for transgender people

A guide on talking about pronouns in the workplace

Examples of gender-neutral language

A guide to collecting data in an LGBTQ+ affirming way

Resources Specific to Developmental Disabilities

The Academic Autistic Spectrum Partnership In Research and Education (AASPIRE)

Autism and Health website

A guide for provider on developmental disability friendly care

Fact sheet on using a strength-based approach

Recommendations on including people with developmental disabilities in mental health care

A guide on care for people with developmental disabilities and mental illnesses

Trauma-informed care when caring for people with developmental disabilities

A guide for direct service givers for people with developmental disabilities

Tool for testing the color blindness accessibility of any URL

A guide to treating neurodiverse people how they like to be treated

The principles of disability justice

Other resources

A short online course about unconscious bias

A course on what bias looks like and how to confront it

A podcast on how to start conversations on diversity

APPENDICES

Appendix A: Demographic Survey

Demographic Survey (English)

Thank you for taking about five minutes of your time to contribute to this Health Disparities project. Health disparities are avoidable and unjust differences in mental health and substance abuse outcomes experienced by socially disadvantaged populations. The purpose of this project is to identify needs in the public mental health system that, if addressed, may reduce health disparities within four identified populations:

- People of Color
- People with Developmental Disabilities
- Member of LGBTQIA+ community
- Transition-Age Youth and Young Adults

This demographic data that you provide will deepen our understanding of staff and leadership demographics within Utah's public mental health and substance use treatment systems.

What agency do you work for?

- Bear River Mental Health Services
- Central Utah Counseling Center
- Davis Behavioral Health
- Division of Substance Abuse and Mental Health
- Four Corners Community Behavioral Health
- Healthy U Behavioral
- Northeastern Counseling Center
- San Juan Counseling Center
- Salt Lake County
- Salt Lake County Mental Health-Optum
- Salt Lake County Prevention
- Southwest Behavioral Health Center
- Summit County Health
- Utah County Department of Drug and Alcohol Prevention and Treatment
- Valley Behavioral Health--Salt Lake County
- Valley Behavioral Health--Tooele County
- Wasatch Behavioral Health (specify location) _____
- Weber Human Services
- Utah State Hospital
- An organization that is not listed (specify name of organization) _____

Please mark the job option that best applies to you:

- Administrative (e.g. CEO, Clinical Director)
- Support Staff (e.g. Administrative Assistant, Clerk, Janitor)
- Licensed Direct Client Services (e.g. LCSW)
- Non-licensed Direct Client Services (e.g. CSW)
- Nursing Services (e.g. RN, LPN)

What is your race/ethnicity? Please check all that apply.

- Asian
- Black or African American
- Latinx/a/o or Hispanic
- Middle Eastern or West Asian
- Native American/Indigenous
- Pacific Islander
- White
- Prefer to self-describe
- Prefer not to answer

How do you identify your sexuality?

- Asexual
- Bisexual
- Gay
- Heterosexual (straight)
- Lesbian
- Pansexual
- Prefer to self-describe
- Prefer not to answer

What is your gender? Please check all that apply.

Cisgender is when someone identifies wholly and solely with the gender assigned at birth. An example of cisgender is if you were assigned "female" when you were born and you identify as a woman, then you are a cisgender woman.

- Agender
- Genderqueer
- Man (cisgender)
- Man (transgender)

- Non-binary
- Woman (cisgender)
- Woman (transgender)
- Transgender Woman
- Prefer to self-describe
- Prefer not to answer

Do you identify as being someone with developmental disability? Please check all that apply.

- No
- Yes: prefer not to disclose specific disability
- Yes: Attention Deficit/Hyperactivity Disorder
- Yes: Autism Spectrum
- Yes: Cerebral Palsy
- Yes: Fetal Alcohol Spectrum Disorders
- Yes: Hearing Loss or Deafness
- Yes: Intellectual Disability
- Yes: Kernicterus
- Yes: Language and Speech Disorders
- Yes: Muscular Dystrophy
- Yes: Tourette Syndrome
- Yes: Traumatic Brain Injury
- Yes: Vision Loss or Blindness
- Yes: Prefer to self-describe
- Prefer not to answer

What is your age group?

- >18
- 18-26
- 27-30
- 31-35
- 36-40
- 41-45
- 46-50
- 51-55
- 56-60
- 61-65
- 66-70
- 71-75
- 76-80
- 81+

- Prefer not to answer

How much do you agree with the following statements?

	Prefer not to answer	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
I feel I am a leader in my workplace.						
I feel included in my immediate work team.						
I feel my experiences and/or voice are **heard** in my *immediate team*.						
I feel my experiences and/or voice are **valued** in my *immediate team*.						
I feel that my experiences and/or voice are **heard** by my *agency*.						
I feel my experiences and/or voice are **valued** by my *agency*.						
I feel I have the same opportunities as my peers in my agency.						

Unless you specifically give permission in the text, neither quotes nor details about what you share below will be used in any reports. Your information will be coded by a research team and combined with information from other respondents to present a general picture of inclusion at your agency. The research team is committed to protecting your anonymity. If you have questions about how your responses will be used, please contact monicascott@utah.gov. You can quit the survey and return anytime in the next seven days.

Would you like to share any personal experiences as they relate to the above questions?

_____

Do you have any additional comments or concerns?

_____

Demographic Survey (Español)

Gracias por tomarse unos cinco minutos de su tiempo para contribuir a este proyecto de disparidades de salud. Las disparidades de salud son diferencias evitables e injustas en los resultados de salud mental y abuso de sustancias que sufren las poblaciones socialmente desfavorecidas.El propósito de este proyecto es identificar necesidades en el sistema público de salud mental que, si se abordan, pueden reducir las disparidades de salud en cuatro poblaciones identificadas:

- Gente de color
- Personas con discapacidades del desarrollo
- Miembro de la comunidad LGBTQIA +
- Jóvenes en edad de transición y adultos jóvenes

Estos datos demográficos que usted nos da profundizarán nuestro entendimiento de la demografía de Utah del personal y el liderazgo dentro de los sistemas públicos de tratamiento de salud mental y uso de sustancias.

¿Para qué agencia trabaja usted?

- Bear River Mental Health Services
- Central Utah Counseling Center
- Davis Behavioral Health
- Division of Substance Abuse and Mental Health
- Four Corners Community Behavioral Health
- Healthy U Behavioral
- Northeastern Counseling Center
- San Juan Counseling Center
- Salt Lake County
- Salt Lake County Mental Health-Optum
- Salt Lake County Prevention
- Southwest Behavioral Health Center
- Summit County Health
- Utah County Department of Drug and Alcohol Prevention and Treatment
- Valley Behavioral Health--Salt Lake County

- Valley Behavioral Health--Tooele County
- Wasatch Behavioral Health (especificar ubicación) _____
- Weber Human Services
- Utah State Hospital
- An organization that is not listed (specify name of organization) _____

Marque la opción de trabajo que mejor se aplique a usted:

- Administrativo (por ejemplo, Director Ejecutivo, Director clínico)
- Personal de apoyo (por ejemplo, asistente administrativo, secretario, conserje)
- Servicios de cliente directo con licencia (por ejemplo, trabajador/a social clínico licenciado/a)
- Servicios de cliente directo sin licencia (por ejemplo, trabajador/a social certificado/a)
- Servicios de enfermería (por ejemplo, enfermera registrada,Enfermero/a práctica licenciado/a)

¿Cuál es su raza/etnicidad? Por favor marque todos los que apliquen.

- Asiático/a/x
- Negro/a/x o Afroamericano/a/x
- Latino/a/x o Hispano/a/x
- Medioriental o Asiano occidental
- Nativo Americano/a/x/ o Indígena/x
- Isleño/a/x del Pacífico
- Blanco/a/x
- Prefiero auto identificarse
- Prefiero no responder

¿Cómo identifica su sexualidad?

- Asexual
- Bisexual
- Gay
- Heterosexual (hetero)
- Lesbiana
- Pansexual
- Prefiero auto identificarse
- Prefiero no responder

¿Cuál es su género? Por favor marque todos los que apliquen.

Cisgénero es cuando alguien se identifica total y exclusivamente con el género asignado al nacer. Un ejemplo de cisgénero es que si te asignaron "mujer" cuando naciste y te identificas como mujer, entonces eres una mujer cisgénero.

- Agénero (no te identificas con ningún género)
- Género/a/x queer
- Hombre (cisgénero)
- Hombre (transgénero/a/x)
- No binario/a/x
- Mujer (cisgénero)
- Mujer (transgénero/a/x)
- Prefiero auto identificarse
- Prefiero no responder

¿Te identificas como alguien con discapacidad del desarrollo? Por favor marque todos los que apliquen.

- No
- Sí: Prefiero no revelar discapacidad específica
- Sí: Desorden hiperactivo y deficit de atencion
- Sí: Espectro Autista (Autismo)
- Sí: Parálisis Cerebral
- Sí: Trastornos del Espectro Alcohólico Fetal
- Sí: Pérdida Auditiva o Sordera
- Sí: Discapacidad Intelectual
- Sí: Kernícterus
- Sí: Trastornos del Lenguaje y del hablar
- Sí: Distrofia Muscular
- Sí: Síndrome de Tourette
- Sí: Lesión cerebral traumática
- Sí: Pérdida de visión o Ceguera
- Sí: Prefiero auto identificarse
- Prefiero no responder

¿Cuál es su grupo de edad?

- >18
- 18-26
- 27-30
- 31-35
- 36-40

- 41-45
- 46-50
- 51-55
- 56-60
- 61-65
- 66-70
- 71-75
- 76-80
- 81+
- Prefiero no responder

¿Qué tan de acuerdo estás con las siguientes declaraciones?

	Prefiero no responder	Completamente de Desacuerdo	Desacuerdo	Ni de acuerdo ni en desacuerdo	Acuerdo	Completamente de Acuerdo
Siento que soy un/a líder en mi lugar de trabajo.						
Me siento incluido en mi equipo inmediato de trabajo.						
Siento que mis experiencias y / o mi voz se **escuchan** en mi *equipo inmediato*.						
Siento que mis experiencias y / o mi voz son **valoradas** en mi *equipo inmediato.*						
Siento que mi *agencia* **escucha** mis experiencias y / o mi voz.						
Siento que mi *agencia* **valora** mis						

experiencias y / o mi voz.						
Siento que tengo las mismas oportunidades que mis compañeros en mi agencia.						

A menos que específicamente nos dé permiso en el texto, ni las citas ni los detalles sobre lo que comparte a continuación se utilizarán en ningún informe. Su información será codificada por un equipo de investigación y combinada con información de otros encuestados para presentar una imagen general de inclusión en su agencia.El equipo de investigación se compromete a proteger su anonimato. Si tiene preguntas sobre cómo se utilizarán sus respuestas, comuníquese con monicascott@utah.gov. Puede salir de la encuesta y regresar en cualquier momento en los próximos siete días.

¿Le gustaría compartir alguna experiencia personal relacionada con las preguntas anteriores?

¿Tiene algún comentario o preocupación adicional?

Appendix B: Public-Facing Document Checklist

Youth in Transition Checklist

- Directions to the facility are easily available and include public transportation instructions (website only)
- Financial policies, fees, and missed and late appointment penalties are clearly stated and publicly available for clients (website only)
- Profiles of providers are easily accessible (website only)
- Online portal which provides: scheduling, canceling of appointments, intake forms and ROI's (website only)
- Materials for YIT, when available, speak to and address YIT and not parents

BIPOC Checklist

- Website, selected/online forms, and informational documents are fully available in at least 2 languages
- Public facing documents are translated by native speakers and/or verified by a local community organization (N/A: no translations available)
- Website and outreach materials acknowledge health disparities and address the importance of cultural responsiveness as they pertain to communities of color
- Public-facing documents are free of condescending, prejudiced, and/or biased language towards people/communities of color.
- Visual materials reflect racial and ethnic demographics of clientele respectfully (i.e., no tokenism, no condescending or prejudiced images).
- Pictures or graphics are free of implicit bias. For example, white people being presented as professionals or upper administration or are POC presented as lower-class, blue-collar workers

LGBTQ+ Checklist

- When photos are used at least 1 of the pictures visually represents the LGBTQ community
- Gender neutral language is always used (use they instead of he/she)
- The LGBTQ+ hotline is included when posting the overall crisis hotline
- LGBTQ+ people acknowledged at least once
- The facility has at least one therapist with a LGBTQ distinction publicly available and locatable via public facing documents (website only)

Developmental Disabilities Checklist

- Text alternatives are available for non-text content
- Captions or other alternatives are available for multimedia
- Content can be presented in different ways
- Content is presented in a way that is easy to see without adaptive software
- Functionality is available from a keyboard
- Users can easily navigate the website, find content, and determine where they are
- Content appears and operates in predictable and consistent ways

- Users are helped to avoid mistakes when filling out forms and to correct mistakes if they occur (only applicable if there are forms that can be filled out online)
- Plain Language (4th grade reading level) Paste into word and enter reading level here
- Documents acknowledge developmental disabilities at least once
- When talking about developmental disabilities is that piece free of ableism
- Do therapies for people with developmental disabilities follow pro Neurodiversity guidelines?
- There is a clear and easy statement on how to contact for accomodations before the first appointment and throughout accessed services (website only)

Appendix C: Protocol for Leadership Focus Groups

Before Start of Focus Group

1. Potential participants will be provided with the following by the liaison:

- Intro to the Health Disparities Needs Assessment
- The set of interview categories
- A consent form, with instructions to email signed and dated consent, leaving the witness section blank, to Monica

2. Once a consent form is received, the participant will receive a calendar invite to the meetings and additional instructions for participation (test to ensure platform is compatible with their computer, join focus group from a private place, mute while not speaking, respectful discourse including use of "I' statements).

At the Start of Focus Group

1. One facilitator will provide introductory comments:

- Welcome and thank everyone for volunteering to participate
- Introduce self and the co-facilitator(s)
- Clarify that the session will be audio recorded
- Review consent forms

2. All participants will be asked to provide verbal consent by stating their name and answering yes or no to the following questions:

- Do you agree to participate in this focus group?
- Do you agree to have this meeting recorded?

Any dissenters will be dismissed; consent of the assenters will be witnessed by the co-facilitator and appropriate consent forms signed and dated.

3. Give a very brief overview of the project and goals for the focus group. For example, "We are talking to you to get your response to mental health disparities that occur within the State as they pertain to people of color, LGBTQ+ folks, people with developmental disability, and transition-age youth & young adults (ages 14-26). We also want to learn what you, as a staff member of a Local Mental Health Authority, the Utah State Hospital, or the Division of Substance Abuse & Mental Health, engage with the aforementioned demographic groups to reduce health disparities."

4. Give participants information about the process, times, and breaks.

5. Provide basic guidelines for the focus group:

- If you feel uncomfortable during the meeting, you have the right to leave or to pass on any question. There is no consequence for leaving. Being here is voluntary.
- The meeting is not a counseling session or support group.

- Keep personal stories “in the room”; do not share the identity of the attendees or what anybody else said outside of the meeting.
- Keep clients and coworkers’ identities confidential; do not share the names, client IDs, or employee IDs of any clients or coworkers
- Everyone’s ideas will be respected. Do not comment on or make judgments about what someone else says, and do not offer advice.
- One person talks at a time.
- It’s okay to take a break if needed or to help yourself to food or drink.
- Everyone has the right to talk. The facilitator may ask someone who is talking a lot to step back and give others a chance to talk and may ask a person who isn’t talking if they have anything to share.
- Everybody has the right to pass on a question.
- Please be honest and truthful in your responses; there are no right or wrong answers.
- Does anybody have any questions?

6. We will provide a set of questions so participants can make notes, read the questions and follow along.

7. Begin asking questions:

POC Questions

- How does your agency influence or reduce systemic racism on an organizational level (e.g.: hiring practices, training offered, investments in DEI [Diversity, Equity, and Inclusion] work, diversity statements, committees and what goals they feel they have achieved as set by the State Division)?
- How does your agency create and maintain connections or relationships with communities of color? Follow-up question: Is this done through a community organization, and if so, how did your agency identify this community agency?
- Does your agency have a space that is welcoming and respectful for people who do not speak English? How has your organization achieved or has not achieved such a space? *ask together*
- Can someone talk about what white privilege is and the impact it has had on your agency's professional development and service delivery so far? Service delivery can be anything, for example, customer service, maintenance, billing, therapy, etc.

LGBTQ+

- How does your agency assess success in providing care to the LGBTQ+ community?
- When people refer to the LGBTQ+ community, what identities might be included in the “+”?
- If you have one, what is included in your agency's in-house training specific to LGBTQ+ people? This may include annual training, employee orientation, etc., but not a conference. Follow-up question: How often are these staff trainings offered ? Are they required?
- Please describe your agency’s knowledge on gender affirming hormone therapy. How does this impact mental health?

Developmental Disabilities

- How does your agency know your client understands your oral, written, and non-verbal communication including patient forms?
- How does your agency let your clients know about requesting and updating accommodations?
- How does your agency engage with those that have different communication needs such as speech differences, sign language, or adaptive communication devices (e.g. screen readers, speech boards)?
- Can someone talk about what stimming is? What are your agency's thoughts on stimming? How does your agency approach stimming and other repetitive behaviors? Follow question: How does your agency address stimming that may involve self-harm?

Youth & Young Adults

- What barriers exist for transition-age youth seeking or receiving treatment for stigmatized disorders such as substance use disorder and borderline personality disorder? Follow-up questions: Where do these barriers come from? Why do they exist? What barriers do providers have to treating these disorders?
- What is your agency doing to ensure that services for youth in transition (ages 14-26) are age appropriate and not infantilizing?
- In an ideal world, what resources would your agency need to reduce the use of higher levels of care for youth ? (e.g. State Hospital, residential care, in-patient care, juvenile justice services)?
- How would your agency balance an adolescent's right to patient privacy and a guardian’s right to know the content of therapy sessions or interactions?

9. Let participants know when the last question is going to be asked. This cues participants to share relevant information that may not have come up in answer to your key questions. “Is there anything else you want to share that we haven’t talked about yet?”

10. Remind participants that they can follow up with Monica Scott (monicascott@utah.gov) if they have any questions about the focus groups or the general Needs Assessment. Please note that within a week participants will be sent a follow-up email if they have any additional comments on the questions presented in the focus groups.

11. Thank you all for participating.

Appendix D: Protocol for Client Focus Groups

At the Start of Focus Group

1. One of the two facilitators will provide introductory comments:

- Welcome and thank everyone for volunteering to participate
- Introduce self and the co-facilitator
- Clarify that the session will be audio recorded

- Make sure Monica has contact information so we can get them their check

2. Review of consent forms. A facilitator will read each name from each consent form and ask participants to provide verbal consent and answering yes or no to the following questions:

- Do you agree to participate in this focus group?
- Do you agree to have this meeting recorded?

Any dissenters will be excused; consent of assenters will be witnessed by the facilitator and appropriate consent forms signed and dated.

3. Provide basic guidelines for the focus group:

- This focus group will last for one and a half hours. Please take care of yourself during this time. If you need to do things like take a break, get food, or use the bathroom, please do so. We want you to be comfortable. You can make a note in the chat box to let us know that you are stepping out and make another note when you return.
- Please don't feel like you need to respond to every question. Not everyone will have an answer for every question and that is fine. Even if you do have an answer, you should not respond if answering will exceed your comfort level. Even if someone asks for your feedback directly, you can just say "pass" and we will pass you. If you feel uncomfortable and want to excuse yourself for a minute or for the rest of the meeting, you have the right to do so. There is no consequence for leaving. Being here is voluntary.
- The meeting is not intended to be a counseling session or a support group. There will be a balance between sharing, which is helpful for our purposes, and over-sharing, which is not. A facilitator may help guide the conversation back into the helpful range, if necessary. That said, if anything you hear or share in the meeting causes you distress and you need to talk with someone outside of your agency, there is contact information for Amanda Alkema on your fact sheet. Amanda is a licensed clinical social worker and will talk with you about what has happened and help you find resources.
- Keep everything that is said during this meeting "in the room"; do not share the identity of the attendees or what was said outside of the meeting. If you are sharing stories about people at the agency, please do not share names. You can share initials, but we need to make sure all identities remain confidential. We will let you know when the recording starts. Once it starts please be careful not to share names or identities.

- Everyone's ideas and time speaking will be respected. Do not comment on or make judgments about what someone else says or offer advice, even if it is well-intentioned. If you need to respond to someone, remember to use respectful "I statements" rather than "you statements." For example, if someone offends you with a comment, please say something like "I found that offensive" rather than "you are offensive."
- Everyone has the right to talk. The facilitator may ask someone who is talking a lot to step back and give others a chance to talk and may ask a person who isn't talking if they have anything to share. If you are asked to share and don't want to, please just say "pass" and we will respect that request.
- Please be honest and truthful in your responses; there are no right or wrong answers. We are trying to learn from your experiences about what is going well and not so well that this agency with regard to health disparities.
- Does anybody have any questions?

4. An opening question will be used to help break the ice. "Before we turn on the recorder, please take a minute or less to share your first name and pronouns with the group and say a little about why you decided to participate in this focus group."

5. The recorder will be turned on at this time. At the time the recorder is turned on, the facilitator will state that the recording has begun and that all participants have agreed to participate and to have the session recorded.

6. The questions will then be asked, one at a time. Each question will be shown on a shared screen while it is being asked.

Overview: This focus group is to help us understand disparities within our mental health and substance use treatment systems. These disparities are unfair and preventable differences in access and outcomes that affect

- young people,
- people of color,
- LGBTQIA+ folks and
- people with developmental disabilities.

All of the questions that we are going to ask are based on what research says about why disparities exist within these groups. We won't ask questions specific to any particular group or groups that you identify with but we want to make sure that when you answer the questions, you have your own experiences as a member of one or more of these groups in mind. So, when we ask about micro-aggressions, for example, we are interested in any time that someone made you feel "less than" or "othered" because of your disability, or your gender identity, or your sexual orientation, or your race or ethnicity, or your age. Does anyone have any questions about this?

1. With your culture or identity in mind, what has <u>your agency</u> done to make you feel welcomed and respected?

    a. Follow-up question: What has prevented you from feeling welcomed and respected by your agency?
2. In what ways have your providers (therapists, med providers, caseworkers, etc.) shown that they honor or understand your culture or identity?
    a. Follow-up question: Have there been times when you felt the need to educate your providers about your culture or identity?
3. Has your provider ever made you feel uncomfortable or uneasy due to your culture or identity?
    a. Follow-up question: if yes, what steps, if any, were taken to ensure it didn't happen again?
4. Talk a little about your involvement in your own treatment plan. In what ways does your provider empower you to set your own goals and make your own decisions?
5. How often and when do you feel you can be your natural self in therapy?
6. How do staff (including secretary staff) respond when you are struggling emotionally and/or physically?
7. If you have ever needed an accommodation related to your culture or identity, how was the experience? Were you able to get what you needed? What were the barriers?
8. Many young adults report that confidentiality and privacy are barriers to treatment for people living with parents/caregivers or on the insurance of parents/caregivers. Please say a little about the barriers of confidentiality and privacy and any ways that this agency has worked with you to reduce these barriers.
9. What kinds of unintended microaggressions or unintended discrimination have you experienced at this agency?
10. Do you think diversity matters at your agency? Why or why not?
11. Based on your own experiences, how could this agency improve the services you receive or any other aspect of your treatment?

7. If time permits, close with a general open-ended question. "Is there anything else you want to share that we haven't talked about yet?"

8. Remind participants that they can follow up with Monica Scott (monicascott@utah.gov) if they have any questions about the focus groups or the general Needs Assessment. And they can follow up with Amada Alkema (aalkema@utah.gov) if they need to talk with someone outside of their agency about their feelings or responses associated with the session.

9. Thank everyone for participating.

Appendix E: Facility Walkthrough

Transition-age Youth Checklist

- Modern and age appropriate decor
- Guest WiFI with the password on the wall
- Discreetly placed resources in office waiting room that help youth (transit maps, free food places, job applications, other treatment options)
- Comfortable chairs are not too close together
- Staff appear present. People are warmly welcomed when they enter the facility (e.g. smiling, waving)
- Environment does not come across as feeling sterile or harsh
- If there is a youth designated area separate, it is not just for small children
- Pamphlets are available explaining types of treatment in readable, non-clinical way
- Information about HIPAA rights and other related privacy information is easily accessible in the waiting area, as well as distributed to any new patients
- Decor/posters on walls don't promote outdated treatments (Example: "Say 'no' to drugs")
- If reading material is available, there is something for all ages
- Youth are not required to fill out forms in the waiting room with their parents

BIPOC Checklist

- There are Black Indigenous People of Color (BIPOC) represented in staff physically in the facility
- There are Black Indigenous People of Color (BIPOC) represented in at least ⅓ of the brochures/fliers
- There are Black Indigenous People of Color (BIPOC) represented in at least ⅓ of the art/pictures/decorations
- Signs that indicate how to access services in another language in that language. Must be easily accessible at all times
- At least one facility is located within 5 miles of a known community of color. The bigger the city, the bigger the community must be to qualify as a COC.
- All signage is available in English, as well as one non-English language
- There is a place with toys for families with children to wait while loved one is receiving treatment
- If a TV is on, it should be on a program that does not perpetuate negative stereotypes about communities of color (e.g. no news showing POCs as "thugs")
- Have posters that encourage inclusion and multiculturalism
- Waiting areas are clean with furniture that is well kept
- There is a comment or feedback box available for people to leave comments with pens and paper close by. If applicable, feedback forms must be available in different languages. Blank paper can be used in lieu of forms.
- Bilingual staff are easily identifiable
- If food is offered, cultural foods are also being offered, which have been collaborated on with communities of color or community of color-led organizations.
- Ethnic holidays are acknowledged in decor around the office, including non-

Christian religious holidays
- At least ⅓ of resources for other services are in multiple languages
- At least ½ of COVID-19 regulations & sanitation station signage is available in multiple languages
- (Bottled) beverages are offered when people come in. Water fountains/dispensers can count.
- There is a common space that is available to clients & agency members to sit and talk
- Furniture is used to allow for easy and open communication
- Furniture quality and size is the same for all staff
- Furniture is big enough for people of all sizes to sit comfortably. There should be at least 2 bigger chairs available for people.

LGBTQ+ Checklist

- This clinic had at least one gender neutral bathroom with an inclusive and professional sign
- Patient is able self identify gender, pronouns, and sexuality beyond the binary and/or some open response option
- At least one subtle pride flag, LGBTQ passing couple photo, or “safe space” indicator is in the facility
- Staff have some way of visually sharing their pronouns
- If pamphlets, flyers, or handouts are available, at least one represents the LGBTQ+ community
- If a suicide hotline is visually available, the trevor project line is as well
- If reading materials are available, there are materials outside of tabloid magazines

Developmental Disabilities Checklist

- Fragrance free in the facilities including the restroom (no diffusers, air fresheners, perfumes, hand sanitizer, minimal scent soap in the bathroom)
- There is a designated private waiting area that that is separate from the main waiting room for people with noise sensitivity/ social anxiety to wait
- Lighting is not fluorescent
- If food is available they follow Allergy Safety Standards: food ingredients available to patients, food is prepared without cross contamination, nut free zones
- Adaptive technology users can access forms
- Clear visible signs with graphics/ images/ symbols
- Therapists have clear masks or face shields available for those that read lips
- If a sensory room is available, there are options for all ages
- All signs are available in braille
- Available fidget toys
- Receptionists desks are low enough to make eye contact with a seated person
- Disabled needs are represented in materials like exercise and mental health recommendations.
- Disabled people are visually represented in images and these representations are not inspiration porn

- Pamphlets and educational materials on Autism emphasize neurodiversity and strengths based approached

Appendix F: Staff Survey

Staff Survey (English)

Thank you for taking time to contribute to this Health Disparities project. **Health disparities are avoidable and unjust differences in mental health and substance abuse outcomes experienced by socially disadvantaged populations.** The purpose of this project is to identify needs in the public mental health system that, if addressed, may reduce health disparities within four identified populations:

- People of Color
- People with Developmental Disabilities
- Member of LGBTQIA+ community
- Transition-Age Youth and Young Adults

There are no right answers to the question on this survey. Please answer as honestly and truthfully as possible. The survey is anonymous and no direct quotes are being shared. We welcome any input and appreciate your feedback. If you have questions, please email Monica Scott, Project Manager, at monicascott@utah.gov.

If you participated in the Leadership Focus Group, there is no need to take this survey.

What agency do you work for?

- Bear River Mental Health Services
- Central Utah Counseling Center
- Davis Behavioral Health
- Division of Substance Abuse and Mental Health
- Four Corners Community Behavioral Health
- Healthy U Behavioral
- Northeastern Counseling Center
- San Juan Counseling Center
- Salt Lake County
- Salt Lake County Mental Health-Optum
- Salt Lake County Prevention
- Southwest Behavioral Health Center
- Summit County Health
- Utah County Department of Drug and Alcohol Prevention and Treatment
- Valley Behavioral Health--Salt Lake County
- Valley Behavioral Health--Tooele County
- Wasatch Behavioral Health
- Weber Human Services
- Utah State Hospital
- An organization that is not listed (specify name of organization) _____

Please mark the job option that best applies to you:

- Administrative (e.g. CEO, Clinical Director)
- Administrative Support (e.g. Administrative Assistant, Clerk, Housekeeping, Facilities)
- Licensed Direct Client Services (e.g. CSW, LCSW, SSW, other applicable DOPL license)
- Non-licensed Direct Client Services (e.g. DSAMH Certified Case Manager, peer support)
- Nursing Services (e.g. nursing, APRN, med-management)

What have you done in the past year to increase your **knowledge** about the target populations specifically (select all that apply):

	Took a class	Read a book or books	Attended a webinar, seminar, or lecture	Personal interactions with the intention of learning	Watched movies or engaged with other media	Nothing specific
Transition-aged youth and young adults (14-25)						
People of color						
People with developmental disabilities						
LGBTQ+ folks						

Feel free to enter any comments here: _____

What have you done in the past five years to build **skills** specific to serving the target populations?

	Completed a course	Read a book or books	Attended a webinar, seminar, or lecture	Participated in a workshop	Read an article or articles in a peer reviewed	Nothing specific

					journal	
People of color						
People with developmental disabilities						
LGBTQ+ folks						
Transition-aged youth and young adults (14-25)						

Feel free to enter any comments here: _____

Awareness

Please agree or disagree with the following statements:

	Agree	Somewhat agree	Somewhat disagree	Disagree	Not applicable or no opinion
People with developmental disabilities lack access to quality mental health care.					
I have noticed racial or ethnic discrimination at the place where I work.					
I am totally unbiased and not racist.					
Homo- and transphobia contribute to health					

disparities for LGBTQ+ people in our community.					
Transition-age youth and young adults (14-25) do not receive adequate mental health and substance use services.					

Feel free to enter any comments here: _____

Attitude
Please agree or disagree with the following statements:

	Agree	Somewhat agree	Somewhat disagree	Disagree	Not applicable or no opinion
Our services would improve with more input from youth and young adults.					
I am willing to report a coworker's racist comments.					
I am willing to be uncomfortable while receiving and giving feedback about cultural/ethnic humility.					
It is important to					

treat people with disabilities in a way similar to their same-aged peers.					
Sharing personal pronouns is a valuable way to ensure we respect all clients.					

Feel free to enter any comments here: _____

Knowledge
Please agree or disagree with the following statements:

	Agree	Somewhat agree	Somewhat disagree	Disagree	Not applicable or no opinion
I am knowledgeable about unique issues that affect transition-age youth.					
I know a lot about disability history, subcultures and identities.					
I have been learning about racial and ethnic identities.					
I have intentionally sought information to enhance my					

knowledge of the LGBTQ+ community.					

Feel free to enter any comments here: _____

---

*This question was only displayed if participants *did not* select Division of Substance Abuse and Mental Health

Skills
Please agree or disagree with the following statements:

	Agree	Somewhat agree	Somewhat disagree	Disagree	Not applicable or no opinion
I am well-equipped to provide services specific to people in the LGBTQ+ community.					
I have the skills to combat racism.					
I have a skill set that allows me to address the mental health or substance use treatment needs of people with developmental disabilities.					
I have utilized opportunities to build specific skills to treat transition-age youth.					

Feel free to enter any comments here: _____

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*This question was only displayed if participants *did* select Division of Substance Abuse and Mental Health

Skills
Please agree or disagree with the following statements:

	Agree	Somewhat agree	Somewhat disagree	Disagree	Not applicable or no opinion
I have the skills to combat homophobia					
I have the skills to combat transphobia					
I have the skills to combat racism.					
I have the skills to combat ableism					
I have the skills to combat ageism					

Feel free to enter any comments here: _____

---

*These questions were only displayed if participants selected their job type as either Licensed Direct Services, Non-Licensed Direct Services, or Medical

The set of questions below were developed by work-group members and are specific to your clinical practices that reduce health disparities within the target populations. Any information you can provide is helpful.

HEALTH DISPARITIES NEEDS ASSESSMENT

From the LGBTQ+ Workgroup--How does an understanding of a client's sexual or romantic orientation and gender identity influence your therapeutic interactions with the client?

_____

From the Transition-age Youth & Young Adult Workgroup--How do you adapt your treatments of transition-age youth and young adults to ensure that services are age appropriate and not infantilizing?

_____

From the Transition-age Youth & Young Adult Workgroup--Please say a little about what substance use harm reduction is and how your agency approaches substance use harm reduction.

_____

From the Developmental Disabilities Workgroup--To what extent do the therapies you provide for people with disabilities follow pro neurodiversity guidelines?

_____

From the LGBTQ+ Workgroup--Please describe your knowledge on gender affirming hormone therapy (GAHT). How does GAHT impact mental health?

_____

From the People of Color Workgroup--How are culturally responsive approaches integrated into the services that you deliver?

_____

FINAL QUESTION. Please briefly summarize efforts that [your agency] has engaged in to reduce health disparities for the target populations:

Youth and Young Adults_____

People of Color_____

LGBTQ+ folks_____

People with developmental disabilities_____

Clicking next will submit the survey. If you have any final thoughts, you can enter them below.

_____

HEALTH DISPARITIES NEEDS ASSESSMENT

Staff Survey (Español)

Gracias por tomarse el tiempo para contribuir a este proyecto de disparidades en la salud. **Las disparidades de salud son diferencias evitables e injustas en los resultados de salud mental y abuso de sustancias que siente las poblaciones socialmente desfavorecidas.** El propósito de este proyecto es para identificar necesidades en la sistema pública de salud mental que, si se abordan, pueden reducir las disparidades de salud dentro de cuatro poblaciones identificadas:

- Personas de razas (no caucásicas)
- Personas con discapacidades del desarrollo
- Miembros de la comunidad LGBTQIA+
- Jóvenes y adultos jóvenes en edad de transición (edades 14-26)

No hay respuestas correctas a la preguntas de esta encuesta. Por favor responda de la manera más honesta y sincera posible. La encuesta es anónima y no se comparten citas directas. Agradecemos cualquier comentario y apreciamos sus comentarios. Si tiene preguntas, envíe un correo electrónico a Monica Scott, Gerente de Proyectos, a monicascott@utah.gov.

Si participó en el Grupo de Enfoque de Liderazgo, no es necesario que llenes esta encuesta.

¿Para qué agencia trabaja usted?

- Bear River Mental Health Services
- Central Utah Counseling Center
- Davis Behavioral Health
- Division of Substance Abuse and Mental Health
- Four Corners Community Behavioral Health
- Healthy U Behavioral
- Northeastern Counseling Center
- San Juan Counseling Center
- Salt Lake County
- Salt Lake County Mental Health-Optum
- Salt Lake County Prevention
- Southwest Behavioral Health Center
- Summit County Health
- Utah County Department of Drug and Alcohol Prevention and Treatment
- Valley Behavioral Health--Salt Lake County
- Valley Behavioral Health--Tooele County
- Wasatch Behavioral Health
- Weber Human Services
- Utah State Hospital
- Una organización que no estas en la lista (mencione el nombre de la organización)

_____

Por favor marque la opción de trabajo que mejor le aplique a usted:

- Administrativo (por ejemplo, director ejecutivo, director clínico)
- Apoyo administrativo (por ejemplo, asistente administrativo, secretaria, limpieza, mantenimiento)
- Servicios de cliente directo con licencia (por ejemplo, trabajador social clínico licenciado, trabajador social certificado, trabajador del servicio social, otra licencia aplicable por DOPL)
- Servicios al cliente directo sin licencia (por ejemplo, administrador de casos certificado por DSAMH, otra certificación aplicable)
- Médico (por ejemplo, enfermería, gestión médica)

¿Qué has hecho el año pasado para aumentar su **conocimiento** sobre las poblaciones objetivo específicamente (seleccione todas las opciones que correspondan):

	Tomé una clase	Leí un libro o libros	Asistí a un seminario web, seminario o conferencia.	Tuve interacciones personales con la intención de aprender	Vi películas o interactué con otros medios	Nada específico
Jóvenes y adultos jóvenes en edad de transición (14-25)						
Gente de color						
Personas con discapacidades del desarrollo						
Gente LGBTQ+						

Siéntase libre de escribir cualquier comentario aquí: _____

¿Qué ha hecho en los últimos cinco años para desarrollar **habilidades** específicas para servir a las poblaciones objetivo?

	Completé un curso	Leí un libro o libros	Asistí a un seminario web, seminario o conferencia.	Participó en un taller	Leí un artículo o artículos en una revista revisada por pares.	Nada específico
Gente de color						
Personas con discapacidades del desarrollo						
Gente LGBTQ+						
Jóvenes y adultos jóvenes en edad de transición (14-25)						

Siéntase libre de escribir cualquier comentario aquí: _____

Conciencia

Por favor indica si estas de acuerdo o en desacuerdo con las siguientes afirmaciones:

	De acuerdo	Un poco en acuerdo	Un poco en desacuerdo	En desacuerdo	No aplica o sin opinión
Las personas con discapacidades del desarrollo le falta acceso a una atención de salud mental de calidad.					

He notado discriminación racial o étnica en el lugar donde trabajo.					
Soy totalmente imparcial y no racista.					
La homofobia y la transfobia contribuyen a las disparidades en la salud de las personas LGBTQ+ en nuestra comunidad.					
Los jóvenes en edad de transición y los adultos jóvenes (14-25) no reciben servicios adecuados de salud mental y abuso de sustancias.					

Siéntase libre de escribir cualquier comentario aquí: _____

Actitud

Por favor indica si estas de acuerdo o en desacuerdo con las siguientes afirmaciones:

	De acuerdo	Un poco en acuerdo	Un poco en desacuerdo	En desacuerdo	No aplica o sin opinión
Nuestros servicios mejorarían con más aportes de jóvenes y adultos jóvenes.					

Estoy dispuesto(a) a informar los comentarios racistas de un compañero de trabajo.					
Estoy dispuesto(a) a sentirme incómodo al recibir y dar realimentación sobre la humildad cultural / étnica.					
Es importante tratar a las personas con discapacidad de manera similar a sus compañeros de la misma edad.					
Compartir pronombres personales es una forma valiosa de garantizar que respetamos a todos los clientes.					

Siéntase libre de escribir cualquier comentario aquí: _____

Conocimiento
Por favor indica si estas de acuerdo o en desacuerdo con las siguientes afirmaciones:

	De acuerdo	Un poco en acuerdo	Un poco en desacuerdo	En desacuerdo	No aplica o sin opinión
Conozco las					

problemas únicas que afectan a los jóvenes en edad de transición.					
Sé mucho sobre la historia, las subculturas y las identidades de la discapacidad.					
He estado aprendiendo sobre identidades raciales y étnicas.					
He buscado información intencionalmente para mejorar mi conocimiento de la comunidad LGBTQ+.					

Siéntase libre de escribir cualquier comentario aquí: _____

---

*This question was only displayed if participants *did not* select Division of Substance Abuse and Mental Health

Habilidades
Por favor indica si estas de acuerdo o en desacuerdo con las siguientes afirmaciones:

	De acuerdo	Un poco en acuerdo	Un poco en desacuerdo	En desacuerdo	No aplica o sin opinión
Estoy bien equipado para ofrecer servicios específicos para personas de la comunidad LGBTQ+.					

Tengo las habilidades para combatir el racismo.					
Tengo habilidades que me permite abordar las necesidades de tratamiento de salud mental o abuso de sustancias de las personas con discapacidades del desarrollo.					
He aprovechado las oportunidades para desarrollar habilidades específicas para tratar a los jóvenes en edad de transición.					

Siéntase libre de escribir cualquier comentario aquí: _____

---

*This question was only displayed if participants *did* select Division of Substance Abuse and Mental Health

Habilidades
Por favor indica si estas de acuerdo o en desacuerdo con las siguientes afirmaciones:

	De acuerdo	Un poco en acuerdo	Un poco en desacuerdo	En desacuerdo	No aplica o sin opinión
Tengo las habilidades para combatir la homofobia					

Tengo las habilidades para combatir la transfobia					
Tengo las habilidades para combatir el racismo					
Tengo las habilidades para combatir el capacitismo.					
Tengo las habilidades para combatir la discriminación por edad					

Siéntase libre de escribir cualquier comentario aquí: _____

---

*These questions were only displayed if participants selected their job type as either Licensed Direct Services, Non-Licensed Direct Services, or Medical

Las preguntas a continuación fueron desarrolladas por miembros del grupo de trabajo y son específicas de sus prácticas clínicas que reducen las disparidades de salud dentro de las poblaciones objetivo. Cualquier información que pueda darnos es útil.

Del Grupo de Trabajo LGBTQIA+: ¿Cómo influye la comprensión de la orientación sexual o romántica y/o la identidad de género de un cliente en sus interacciones terapéuticas con el cliente?

_____

Del Grupo de Trabajo de Jóvenes y Adultos Jóvenes en Edad de Transición: ¿Cómo adapta sus tratamientos para los jóvenes y adultos jóvenes en edad de transición para asegurarse de que los servicios para los jóvenes en transición (de 14 a 25 años de edad) sean apropiados para su edad y no infantilicen?

_____

Del Grupo de Trabajo de Jóvenes y Adultos Jóvenes en Edad de Transición: Por favor, diga un poco sobre qué es la reducción de daños por uso de sustancias y cómo su agencia enfoca la reducción de daños por uso de sustancias.

_____

Del Grupo de Trabajo de Discapacidades Del Desarrollo: ¿Hasta qué punto las terapias para personas con discapacidades siguen las pautas a favor de la neurodiversidad?

_____

Del Grupo de Trabajo LGBTQIA+: Por favor describa sus conocimientos sobre la terapia hormonal de afirmación de género. ¿Cómo afecta esto a la salud mental?

_____

Del grupo de trabajo de Gente de Color - ¿Cómo se integran los enfoques culturalmente receptivos en los servicios que ofrece?

_____

PREGUNTA FINAL. Resuma brevemente los esfuerzos que [su agencia] se ha comprometido a reducir las disparidades en la salud de las poblaciones objetivo:

Jóvenes y adultos jóvenes en edad de transición (14-25) _____

Gente de color _____

Gente LGBTQ+ _____

Personas con discapacidades del desarrollo _____

Si haces clic en siguiente, se enviará la encuesta. Si tiene algún pensamiento final, puede escribirlo a continuación.

_____