

A Behavioral Health Disparities Curriculum Infusion Initiative: Eliminating Behavioral Health Disparities for Racial and Ethnic Minority Populations: Workforce Development to Mobilize Social Work as a Resource

U.S. Department of Health and Human Services, Office of Minority Health and the National Association of Deans and Directors of Schools of Social Work

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ELIMINATING BEHAVIORAL HEALTH DISPARITIES

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Preface

In the last two decades, awareness of the health and behavioral health disparities that impact racial and ethnic minorities has grown. As the population of the United States continues to become more diverse, the consequences of health and behavioral health disparities to society will become even more pronounced. By 2050, an estimated 54% of the population will be comprised of ethnic and racial minorities (U.S. Census Bureau, 2008). Despite persistent efforts on behalf of social workers, health care providers, and behavioral health providers to address this issue, little progress has been made in reducing gaps in health access and outcomes (Williams, Costa, Odunlami, & Mohammed, 2008). Social workers must intensify their efforts to address this social justice issue that is costly to society and results in needless suffering and lost potential. Promoting health and behavioral health equity is central to the profession whose mission is the well-being of all people, particularly vulnerable and oppressed populations.

In an effort to approximate its mission and fully prepare a workforce of social workers to engage in promoting health and behavioral health equity, the U.S. Department of Health and Human Services, Office of Minority Health partnered with the National Association of Deans and Directors of Schools of Social Work and the Council on Social Work Education to form a Behavioral Health Disparities Task Force for Social Work. Undertakings of the task force include reviewing the existing knowledge base on factors that contribute to disparities, exploring interventions that demonstrate evidence of or promise in addressing disparities, and identifying gaps in current research that would shed light on how to resolve this social issue.

Additionally, the Behavioral Health Disparities Task Force for Social Work convened a national panel of researchers, practitioners, and community members with expertise in behavioral health to learn about some of the key factors that play a role in disparities and to

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uncover innovative approaches being used in communities across the country to promote wellness. This diverse panel of experts met on September 22-23, 2011 at Arizona State University in Phoenix, Arizona for a day and half and engaged in facilitated dialogue on the topic of health and behavioral health disparities.

The following section is a review of the academic and grey literature. This review along with insights gleaned from the national panel of experts will be used by the Behavioral Health Disparities Task Force for Social Work to develop behavioral health disparities content and a plan for infusing this content into social work curricula. Integration of behavioral health content into all aspects of social work education will situate future social workers to partner with other health professionals in implementing comprehensive and innovative interventions that promote behavioral health equity.

Introduction

Public health and federal agendas now recognize what social work has long known: that it's impossible to promote well-being if the biological, behavioral-psychological, and social determinants that affect well-being are not taken into consideration. (Gehlert, Mininger, Sohmer, & Berg, 2008). Nor is it possible to promote true wellness without attention to the behavioral health challenges encountered by ethnic and racial minority populations and communities. Health is “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity that enables people to lead socially and economically productive lives” (World Health Organization, 1979).

The United States ranks at or near the bottom among other industrial nations on key health indicators such as infant mortality and life expectancy (Braveman, Egerter, & Mockenhaupt, 2011; Braveman, Egerter, Woolf, & Marks, 2011). Kumanyika and Morssink (2006) note that health disparities are “a problem that is continually being rediscovered rather than resolved” (p. 444) and they cite as evidence the words of W.E.B. DuBois who wrote in *The Philadelphia Negro* in 1899, “One thing of course we must expect to find, and that is a much higher death rate at present among Negroes than among whites. This is one measure of the differences in their social advancement.” (p. 148).

Annually 1.5 million people die from preventable chronic diseases (Woolf et al., 2011). Research shows that people of color have poorer health outcomes; a distinct indicator that health inequalities are a result of both socioeconomic disadvantage, and race and ethnicity, independently and in combination (Braveman, Egerter, & Mockenhaupt, 2011; Braveman, Egerter, Woolf, & Marks, 2011). People of color are overrepresented among those challenged by chronic diseases such as diabetes, HIV/AIDS, mental illness and substance abuse, cancer,

asthma, and obesity combined with poor access to quality care (Agency for Healthcare Research and Quality, 2011; Cook Inlet Tribal Council, 2011; Center for Disease Control, 2011). Health disparities and the resulting adverse impacts on health and behavioral health are well known and documented. Levels of health vary across racial, ethnic and socio-economic groups, with people of color and those challenged by poverty experiencing the poorest health and health outcomes. The middle class is also vulnerable to negative health outcomes and on average is less healthy than more economically advantaged Americans. Greater social and economic advantage generally corresponds with better health, although differences in health continue to persist between ethnic and racial groups at all income levels (Braveman, Egerter, & Mockenhaupt, 2011; Braveman, Egerter, Woolf, & Marks, 2011; Council on Ethical and Judicial Affairs, 1990; Guarnaccia, Martinez, & Acosta, 2005).

History demonstrates that health inequality cannot be eliminated by focusing solely on health care systems and individual change efforts. There is growing recognition that health status is a reflection of a myriad of factors including personal choices, historic disadvantage, and persistent societal inequalities that begin long before entering the health care system. Health equity, therefore, requires broad interventions focused on multiple levels— individual, interpersonal, institutional, community, and policy levels (Kumanyika & Morssink, 2006; Smedley, 2006).

While certain gains in bridging health disparities have been achieved, racial and ethnic minorities overall continue to lag behind on numerous health indicators, or show no improvements whatsoever. In some instances disparities have actually grown (Agency for Healthcare Research and Quality, 2011; Gehlert, Mininger, Sohmer, & Berg, 2008; Kumanyika & Morssink, 2006; Smedley, 2006; U.S. Department of Health and Human Services, 2011a).

For example, African Americans die of colorectal cancer at a rate 1.5 times higher than Whites and the situation is worsening (AHRQ, 2010). Similarly, numerous behavioral health issues challenge ethnic and racial minorities who are among the least likely to receive quality treatment and who collectively experience a greater degree of disability burden than whites (Sue & Chu, 2003; U.S. Department of Health and Human Services, 2001).

Social workers are the largest behavioral health providers working in the medical, social services, behavioral health and public health sectors (US Department of Labor, Bureau of Labor Statistics, 2011). Nearly 650,000 social workers are employed in various settings across the country. The field of social work is committed to issues of social justice and to improving the well-being of oppressed populations (National Association of Social Workers, 1999). With its *person-in-environment* perspective and holistic lens, social work is situated to play a key role in promoting and improving the health of the underserved. To prepare a competent workforce, schools of social work will be required to lead in building the knowledge base, teach effective strategies for advancing wellness, and promote a deeper connection and understanding of the determinants of health and behavioral health. This report is a review of the current knowledge base and provides a glimpse into promising interventions being implemented across the country and will be used as the foundation for developing a Behavioral Health Disparities Curriculum Infusion Initiative.

Methods

A search of the literature was performed utilizing key terms to examine a broad range of databases. Initial literature searches were conducted primarily using PsycINFO and Social Services Abstracts, and employing the key terms of behavioral health disparities, behavioral health, mental health, minorities, minority groups, interventions, and community-based

interventions. Results from initial literature searches were subsequently utilized to conduct a second iteration of searches within various journals. The second round of searches included differing key terms such as behavioral health integration, primary behavioral health, primary care psychology, chronic care model, behavioral health consultant(s), integrated care, collaborative care, mental health, resiliency, and substance abuse.

Grey literature was utilized to capture government reports, policy briefs and community-based efforts used within varying populations disproportionately affected by physical and behavioral health disparities. In an attempt to replicate the previous search through academic peer-reviewed articles, the researchers accessed PsycEXTRA—the grey literature database through PsycINFO—and generated result listings using the same key terms that were used initially: behavioral health disparities, behavioral health, mental health, minorities, minority groups, interventions, and community-based interventions. As before, identical citations within each literature search were discarded through comparisons of results listings. To further explore the area of intervention and innovative techniques, researchers also examined government studies and reports, non-academic literature such as, private agency, foundation, and non-profit organization reports—a significant segment of the above emerged from using common search engines such as Google.

An thorough examination of every article retrieved through research databases was conducted to identify additional research pertaining to the theme of this project. Themes not found through the database key-term-searches mechanism were of particular interest. Relevant research recommended by academic professionals on the project steering committee also were also reviewed and utilized. Although not an exhaustive review of the literature, this report comprises a reflective summary of existing current literature in the area of health and behavioral

health disparities, especially pertaining to the status of social work as a professional applied science and practice.

Public Health Models

Public health models begin with the assumption that promoting health equity entails addressing the conditions that foster disparities. They focus on addressing the root causes or social determinants of disparities and on preventing poor outcomes, while providing guidance on how to proceed in preventing poor health outcomes. “Social determinants of health are life-enhancing resources such as food supply, housing, economic and social relationships, transportation, education, and health care, whose distribution across populations effectively determines length and quality of life” (Ramirez, Baker, & Metzler, 2008, p.6).

Positive health outcomes are influenced greatly by the environments in which people live, work, learn, and play. Downstream factors such as medical care and education delivered in order to change behaviors remain important but, when delivered alone, are unlikely to end population-wide health disparities. A broader focus on community conditions that support educational messages and allow people to choose healthy options are essential (Braveman, Egerter, & Mockenhaupt, 2011; Braveman, Egerter, Woolf, & Marks, 2011).

Housing Patterns and Policy Influences

Although discrimination on the basis of race or ethnicity remains a violation of both federal and state statutes, segregation persists, and people of color remain heavily concentrated in resource-poor communities; environments where access to healthy food may be limited and where employment, quality education, and safe places to exercise and live stress free may be minimal.(Ramirez, Baker, & Metzler, 2008). These conditions, combined with other social

determinants, promote unhealthy outcomes (Healthy Communities Matter, 2010; Woolf et al., 2011).

To achieve population-level changes in health, upstream factors such as policies and creating environments conducive to healthy living must be realized (Braveman, Egerter, & Mockenhaupt, 2011). Policies such as instituting taxes on tobacco, banning indoor smoking, or mandating healthy menus in schools can also alter environmental conditions and precipitate healthy living (Koh, Oppenheimer, Massin-Short, Emmons, Geller, & Viswanath, 2010; Woolf et al., 2011). Environments can be modified, for example, by regulating the number of liquor stores, gas stations, and fast food restaurants in a community, developing planned communities that promote walking and biking and that are well-lit, by ensuring healthy affordable foods are available, and by fluoridating water supplies and limiting environmental pollution (Bournhonesque & Mosbaek, 2002; Healthy Communities Matters, 2010). Furthermore, policies that assist in eliminating poverty and that promote health access for all Americans are instrumental to health equity (Costello, Compton, Keeler, & Angold, 2003; Williams, Costa, Odunlami, & Mohammed, 2008).

Lack of Access to Quality Care

The underutilization of health and behavioral health care by racial and ethnic minorities is well documented and connected to socioeconomics, lack of health insurance, and being underinsured (Greer, 2005; LaVeist, Nuru-Jeter, & Jones, 2003; McGuire & Miranda, 2008, U.S. Department of Health and Human Services, 2001). The 2009 National Healthcare Disparities Report indicates that the lack of health insurance is the biggest predictor of poor quality health care (Agency for Healthcare Research and Quality, 2010). While significant, socioeconomics and lack of insurance do not fully account for health and behavioral health disparities. Even

when resources are available, ethnic and racial minorities remain reluctant to seek mental health services for a myriad of reasons including lack of knowledge of resources, mistrust of institutions and traditional providers, lack of cultural fit between Western interventions and non-Western cultural conceptions of healing and illness, language barriers, and universal stigma associated with mental illness (Greer, 2005; McGuire & Miranda, 2008). Mistrust stems from a history where people of color have been targets of unethical medical research including forced sterilization, experimental surgeries, and denial of treatment as well as other oppressive policies that resulted in spreading diseases and resultant death. This history of oppression lingers in the memory of people of color who encounter institutional oppression daily (Duran & Walters, 2004; Perloff et al., 2006).

Quality of Provider Care

Studies reveal that when racial and ethnic minorities and those with limited English proficiency seek health and behavioral health services, quality of care is often inferior to treatment received by Whites (Escarce & McGuire, 2004; Jha, Fisher, Li, Orav, & Epstein, 2005; Klonoff, 2009; Schneider, Zaslavsky, & Epstein, 2002; Trivedi, Zaslavsky, Schneider, & Ayanian, 2006). Existing literature indicates socioeconomic, geographic factors, communication barriers, and provider bias contribute to poor quality of care. Ethnic minorities are over-represented among low socioeconomic groups, thereby impeding their ability to receive quality services. Disparities in care received by low socioeconomic families are also well documented (Hussey, Anderson, Berthelot, Feek, Kelley, Osborn, Raleigh, & Epstein, 2007). The Agency for Healthcare Research and Quality is mandated by Congress to examine gaps in health care that exist among populations and how these gaps worsen or improve over time. Their research notes

that poor people have worse access to care and receive lower quality of care on core quality measures (Agency for Healthcare Research and Quality, 2011).

A study by Fiscella, Franks, Gold, and Clancy (2000) found that families of lower socioeconomic status receive fewer immunizations, mammograms, diabetic eye exams, and Papanicolaou tests, delayed prenatal care, and lower quality hospital and ambulatory care. Similar results were also found by Miller and colleagues (2004). They note nursing care facilities serving low income patients/consumers primarily Medicaid recipients tend to be located in poor communities, have fewer resources, and are staffed with fewer registered nurses, nurse practitioners, and physician assistants. Lower-tier nursing facilities in this study provided worse care as measured by quality measures that considered incidence of pressure ulcers, use of physical restraints, inadequacy of pain control, and the higher use of psychotropic medication. Overall, lower-tier facilities had more health related deficiencies than upper-tier nursing homes that were located in more affluent communities.

Researchers have begun to explore why socioeconomic disparities in quality of care persist. Studies suggest where care is received impacts quality of services and that place matters. Geographic level differences refers to the likelihood that people of color live in areas where low-quality health and mental health care is provided such as some rural or inner city communities (Miranda, McGuire, Williams, & Wang, 2008; McGuire & Miranda, 2008). One study that examined socioeconomic status and surgical mortality in the elderly found an inverse relationship between income and operative mortality across a range of surgical procedures. The study adjusted for patient characteristics and found the odds of dying were 17-39% higher for low socioeconomic patients. Analysis indicated disparities were largely due to differences in the hospitals where low socioeconomic and more affluent patients were treated (Birkmeyer, Gu,

Baser, Morris, & Birkmeyer, 2008). Another study by Hasnain-Wynia, Baker, Nerenz, Feinglass, Beal, Landrum, Behal, and Weissman (2007) confirmed that quality of care for ethnic minority patients was lower than for nonminority patients as measured by Hospital Quality Alliance (HQA) indicators. Statistically significant disparities between minorities and nonminority patients were observed across numerous HQA measures. After adjusting for site of care, several disparities were reduced and others eliminated. Studies suggest disparities in quality of care may be the result of minorities receiving care in lower performing hospitals with fewer resources and less credentialed physicians (Baicker, Chandra, & Skinner, 2005; Baicker, Chandra, Skinner & Wennberg, 2004).

Socioeconomics and race and ethnicity are intertwined with both impacting quality of care. What happened to language? Numerous studies report ethnic and racial minorities receive less courteous treatment and less intensive services after adjusting for socioeconomic status and health insurance coverage (Hasnain-Wynia, 2007; Klonoff, 2009; LaVeist, Nuru-Jeter, & Jones, 2003) suggesting quality of care may also be connected to provider bias and discrimination. After controlling for medical need, differential referral for HIV, cancer, cardiac procedures, pain management, and depressive and anxiety disorders for ethnic racial minorities is observed (Anderson et al., 2003; Voelker, 2008). A study by van Ryn and Burke (2000) found physicians viewed Blacks and low socioeconomic (SES) patients less favorably than White and/or more affluent patients. They presumed Blacks were both more likely to engage in substance use and less likely to comply with treatment. Perceptions such as these may influence treatment, resulting in less effort by health care professionals to engage at high levels professionally on behalf of ethnic/racial groups. Another study found physicians in emergency rooms were more likely to ask African Americans who presented with chest pain about tobacco, cocaine, and

substance use than white patients who similarly reported chest pain (James, Feldman, & Mehta, 2006; Oliver, Goodwin, Gotler, Gregory, & Strange, 2001). Asking different questions may lead to differential treatment decisions (Klonoff, 2009; Perloff et al., 2006). McGuire and Miranda (2008) reference *statistical discrimination* where, based on group aggregates, mental health providers conclude that people of color have lower rates of mental disorders. As a result of this misrepresentation, they interpret symptoms differently (i.e. a minority patient is less likely to be considered ill than a white patient with similar symptoms and is less likely to receive treatment). Thus, a more severe expression of symptoms must be present for providers operating under such misperceptions to revise their initial assessment. Evidence indicates that bias in diagnoses occurs for minorities resulting from both ends of the misrepresentation spectrum—over-pathologizing *and* minimizing symptoms (Alegria & McGuire, 2003).

Cultural and Linguistic Competence of Providers

The lack of diversity and cultural and linguistic competence amongst health and behavioral health providers is a significant barrier to meaningful access to and quality care for racial and ethnic minorities and those with limited English proficiency. Ethnic and racial minorities comprise 36% of the population but account for 13.9% of psychologists, 28% of physicians, 36.4% of social workers, and 22.8% of registered nurses (U.S. Department of Labor, Bureau of Labor Statistics, 2011; Chapa, T. & Acosta, H, 2010) Not only are ethnic and racial minorities underrepresented in the health and mental health workforce, particular groups are less represented within particular disciplines. For example Hispanics comprise 16% of the population but only 6.6% of physicians, 5.1% of registered nurses, 5.9% of psychologists and 11.2% of social workers. Similarly, Blacks comprise 12% of the population but only 5.3% of physicians, 10.4% of registered nurses, and 5.1% of psychologists but are overrepresented among social

workers at 22.8%. Asians comprise 5% of the population and are the largest group of racial/ethnic minority physicians at 16.1% and comparatively have a high percentage of registered nurses at 7.3%. However, Asians are underrepresented among psychologists and social workers at 2.9% and 2.4% respectively. American Indians comprise 1% of the population yet data on the percentages of American Indians in the workforce is scarce suggesting a dearth of American Indian providers (U.S. Department of Labor, Bureau of Labor Statistics, 2011). None of the workforce figures reflect the language capacity of those individuals. As society has become more diverse, medical school trends reflect increased minority enrollment and graduation, however, remain substantially below the racial/ethnic composition of the U. S. population (U.S. Department of Health and Human Services, 2008). In most states, enhanced skills such as cultural and linguistic competence have yet to be required in academic preparation of providers, licensing and in treatment protocols. While more research must be done to fully comprehend the role of provider and patient variables in health disparities outcomes, smaller studies and evaluations show that a more diverse workforce would improve access and facilitate engagement and adherence to care that is culturally and linguistically competent.(Klonoff, 2009; Street,O'Malley, Cooper, & Haidet, 2008). There is a critical need to recruit culturally and linguistically competent providers , especially ethnic and racial minorities who have a higher propensity for serving minority consumers and communities (Chapa, T. & Acosta, H, 2010; Moreno, Walker, & Grumbach, 2010; Proser & Cox, 2004; Yoon, Grumbach, & Bindman, 2004).

Communication Barriers

Communication barriers further impede access to and provision of quality care.In 2010 the limited English proficient population, those who speak English less than very well, accounted

for 9% of the population over the age 5. The most common language spoken is Spanish with Spanish speakers comprising 66% of the limited English proficient population. The next two most common languages are Chinese and Vietnamese (Pandya, Batalova, & McHugh, 2011). Despite growth in the limited English population and the significant body of literature that indicates language barriers can impede quality health and behavioral health care, consumers consistently report it is difficult to find bilingual providers. Scant literature exists on the precise number of bilingual or Spanish speaking health and mental health providers (Moreno, Walker, & Grumbach, 2010) yet it is generally recognized that there is a shortage in bilingual providers (Collins, Hughes, Doty, Ives, Edwards, & Tenney, 2002; Ida, SooHoo, & Chapa, 2012; Ngo-Metzger, Sorkin, & Phillips, 2007).

In the United States, mutual talk is fundamental to effective medical and behavioral health care and to achieving therapeutic goals. When providers and patients/consumers speak a different language, innumerable communication problems may arise. Limited English proficient speakers may resist seeking care if providers are unable to understand them and/or if interpretation is not available (Perloff, Bonder, Ray, Ray, & Siminoff, 2006). Research demonstrates patients who face language barriers are less likely to have a medical home, to engage fully with a provider, to comply with prescribed treatments, , or return for follow-up visits. Instead, they are more likely to leave the hospital against medical advice (Flores, 2006).

A survey conducted by the Commonwealth Fund (2001) found ethnic and racial minorities encounter greater difficulties in communicating with doctors than White patients. Hispanics were most likely to report communication challenges at 33%, 27% of Asian Americans, and 23% of African Americans reported one or more communication problems (i.e., not understanding the doctor fully, reluctance to ask questions, feeling the doctor was not

listening). Communication problems were compounded among Hispanic and Asian Americans who were limited English proficient with 43% of Hispanics who spoke Spanish at home reporting communication problems. Additionally, ethnic and racial minorities were less satisfied with care received than White patients. Satisfaction was connected to ethnic and racial minorities feeling that doctors did not understand their background and values and did not listen. Asian Americans were least likely to report positive patient physician interaction and this was exacerbated among non-English speaking Asian Americans. Overall, African Americans, Hispanics and Asian Americans were more likely than Whites to report that they were treated with disrespect because of their race or language abilities and they believed they would be treated better if they were of a different race. Findings from the Commonwealth Fund are consistent with other studies that note patients prefer and are more satisfied with practitioners of their same race/ethnic and language background (Cooper & Powe, 2004). Unfortunately, the shortage of ethnic and racial minority practitioners and providers who are bilingual makes cultural and linguistic competence between patients and providers challenging.

Although Federal and state policies require practitioners to provide linguistic services for people who are limited English proficient (US Department of Justice, 2012), National Standards on Culturally and Linguistically Appropriate Services in Health Care (CLAS standards) provide guidance to health organizations regarding making services culturally and linguistically accessible. However, little is known about how hospitals and mental health providers implement these standards. A cross sectional survey of hospital interpreters suggests hospitals are not meeting federal requirements (Diamond, Wilson-Stronks, & Jacobs, 2010). Diamond, Wilson-Stronks, and Jacobs (2010) found 13% of hospitals in their study met all 4 of the CLAS mandated standards whereas 19% met none. Another study found that 46% of limited English

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proficient patients in an emergency room setting did not receive interpreter services (Baker, Parker, Williams, Coats, & Pitkin, 1996). Ad hoc interpreters such as family members, friends, support staff, and strangers found in waiting rooms are routinely used in clinical encounters despite research that indicates interpreter error frequently results in adverse health and mental health consequences (Baker, Parker, Williams, 1996; Barker, 1999; Flores, Laws, & Mayo, Zuckerman, Abreu, Medina, & Hardt, 2003).

In addition to language barriers, studies show that communication challenges are compounded by ethno-cultural differences in symptom representation and expression (Marsella, 2003; Marsella, 2010). For example, cross cultural research documents cultural variation in the experience and expression of depressive disorders. Rather than sadness and guilt, somatic symptoms tend to dominate in non-Western cultures. People from Latino cultures may present with headaches and nerves and those from Asian cultures may present with weakness, tiredness or imbalance (Halbreich et al, 2007; Manson & Kleinman, 1998; Marsella, 2003). Marsella (2003) notes collectivist cultures tend to encourage attachment and bonding to others thus feelings of isolation, loneliness, and perceived helplessness often associated with depression in Western cultures may be reduced or absent in certain ethnic and racial groups. Mental health providers are challenged to recognize how culture can influence the experience and communication of depression and other mental disorders (Manson & Kleinman, 1998). Research strongly points to the need for cultural and linguistic competence of providers as a necessary component for improving access and quality of care for ethnic and racial minorities, and those with LEP.

Informal Systems of Care

Institutional mistrust, cultural and linguistic incongruence, lack of resources or health insurance and stigma and cultural beliefs all contribute to the tendency of many minorities to delay seeking health and behavioral health services, choosing instead to utilize informal sources of care. These delays may result in disease progression and chronic conditions including cancer, diabetes, and severe depression by the time they are connected to a health care system. For example, African Americans often seek support from trusted religious organizations and primary care systems rather than behavioral health care (Davis, 2011). Farris (2005) found that when African Americans receive care from a minister or church, the likelihood of them later obtaining assistance from a behavioral health professional is reduced. American Indians, Native Hawaiians, Hispanic/Latinos, and Alaska Natives too often rely on alternative care such as herbal remedies, folk healers, and prayer as forms of preventative care or adjuncts to care, and often in place of services from health care systems (U.S. Department of Health and Human Services, 2001; Ortiz, Arizmendi, & Cornelius, 2004). Furthermore, public policy deters many immigrants from seeking services, and Mexican immigrants who live near the U.S. Mexico border often opt to return to Mexico for health care, dental services, and medications which can be obtained from pharmacists who are considered front line providers (Ortiz, Arizmendi, & Cornelius, 2004).

Behavioral Health Disparities

In addition to physical health disparities, ethnic and racial minorities experience disparities in mental health and substance use and abuse. Generally, prevalence rates for behavioral health disorders (e.g., mental health, substance abuse) are comparable across ethnic and racial populations; however, people of color are impacted more adversely by these

conditions (McGuire & Miranda, 2008; US DHHS, 2001). For example, higher mortality rates from conditions connected to substance use are reported for minorities (Lo & Cheng, 2011). Alaska Natives and American Indians die at a rate 514% higher than the general population due to alcoholism (Indian Health Service, 2011). Research demonstrates determinants of chronic health conditions are often similar across conditions. Social determinants of physical health affect mental health and conversely, exacerbating the progression of illness and the slowing of wellness. Environmental conditions play a larger role in the *development* of health and mental health issues, whereas the *progression* of a disease is influenced more by prevention, access and quality of care. Thus, interventions to address disparities in rates of disease must focus on determinants external to health care systems that contribute to the onset of illness. When rates of disorders are similar but severity and outcomes differ, as is the case with behavioral health conditions, interventions within health care systems are crucial (Williams, Costa, Odunlami, & Mohammed, 2008). While areas of emphasis may differ, physical and behavioral health promotion requires attention to determinants both within and outside health care systems.

The intersection between health and behavioral health is apparent when the mortality of those challenged by serious mental illness is considered. Several studies reveal that on average people with a serious mental illness served by our public mental health system die 25 years earlier than the general population. An estimated 60% of these premature deaths are due to preventable medical conditions such as cardiovascular disease, diabetes, pulmonary and infectious diseases. Factors that contribute to increased mortality and morbidity among people with a serious mental illness include modifiable behaviors such as smoking, alcohol consumption, IV drug use, poor nutrition, lack of exercise, unsafe sexual behaviors, and residing in group care facilities and shelters where there is increased exposure to tuberculosis and other

infectious diseases. People with mental illness are further vulnerable due to high rates of poverty, unemployment, social isolation, homelessness, lack of access to appropriate health care and a fragmented public health system with insufficient coordination between health and mental health providers. Attention to both environmental conditions and health care systems is required to improve the health outcomes of people with mental illness (National Association of State Mental Health Program Directors, 2006)

Many of the epidemiological studies that assess mental health status are limited to adult samples. These studies reveal rates of mental health disorders within racial and ethnic minorities similar to those of Whites. Notable exceptions include heightened risk for posttraumatic stress disorders (PTSD) and alcohol abuse and dependence for American Indians (McGuire & Miranda, 2008). Identification of psychological symptoms meeting the criteria for diagnosis is substantially under-reported for minorities or resulting in misdiagnoses. For example, the higher rates of diagnosis of schizophrenia for African Americans (McGuire & Miranda, 2008). Surveys on youth conducted by SAMHSA and the CDC: The Youth Risk Behavior Surveillance System (YRBSS) and the SAMHSA: National Survey on Drug Use and Health provide information on youth substance use rates and risky behaviors that contribute to morbidity and mortality. In 2010 substance dependence or abuse rates for youth were 4.1% for Asians, 5.6% for Native Hawaiians or Other Pacific Islanders, 8.2% for Blacks, 8.9% for Whites, 9.7% for Hispanics, and 16% for American Indian or Alaska Natives (Substance Abuse and Mental Health Services Administration, 2011). The YRBSS (2010) monitors behaviors among youth and young adults that contribute to unintentional injuries and violence, tobacco, alcohol and drug use, sexual behaviors that contribute to diseases and unintended pregnancies, unhealthy dietary behaviors and physical inactivity. Variations in health-risk behaviors can be observed by race/ethnicity and

can be used to focus interventions and to monitor progress in decreasing health risk behaviors over time. For example, prevalence rates for feeling sad and hopeless almost every day for 2 or more weeks was higher among Black (27.7%) and Hispanic students (31.6%) than White students (23.7%). Also, the prevalence of not going to school due to safety concerns was higher for Black (6.3%) and Hispanic students (8.1%) than White students (3.5%). Black youth were most likely to have had intercourse and most likely to have had four or more partners. Analysis does not, however, separate the effects of race and ethnicity from socioeconomic status. The YRBSS and the National Survey on Drug Use and Health provide useful information about the realities challenging ethnic and minority youth. Although not comprehensive, available research indicates minority youth do not fare as well as White children on indicators of emotional distress, physical health, teen births, and school achievement (Cauce, Cruz, Corona, & Conger, 2010; Center for Disease Control and Prevention, 2010).

Pervasive Risk Factors

Risk factors include those conditions linked to unsafe, unhealthy and life threatening outcomes. Community risk factors associated with poor mental health include poverty, neighborhood violence, community disorganization, inadequate schools, trauma, racism, discrimination, and stress connected to acculturation (Braveman, Egerter, & Mockenhaupt, 2011 ; Brondolo, Gallo, & Myers, 2009; Department of Health and Human Services, 2001; Healthy Communities Matter, 2010). Gehlert and colleagues (2008) noted deteriorated neighborhood infrastructures and high rates of community violence have been shown to cause community members to retreat into their homes, leading to social isolation.

Risk factors are cumulative; more risk factors increase the likelihood of poor outcomes, and risky conditions often cluster. For example, poverty stricken neighborhoods usually suffer

from high rates of violence and minimal resources, underachieving schools, and social disintegration. Those conditions create high levels of stress that potentially impact parenting practices and health and behavioral health outcomes (Healthy Communities Matter, 2010; Kaholokula, Macapoy, & Dang, 2009). Points of intervention to counteract these risk factors might include policy changes that minimize racism and poverty.

Racism and Perceived Discrimination

Risk factors operate on multiple levels, and researchers continue to investigate factors that have proven to lead to adverse health. For example, racism and perceived discrimination are both directly and indirectly associated with morbidity, poor mental health, physical health, and increase risky behaviors such as substance use (Williams & Mohammed, 2009). Indirect effects of racism include barriers to resources (e.g., housing, health care, employment, etc.) that create stress, which, in turn, is connected to poor physical health, decreased mental health, and substance use. The personal experience of racism through daily interactions also triggers stress.

Chronic Health Conditions

Chronic health conditions are also risk factors for poor mental health. Research demonstrates those with physical illnesses are at greater risk for behavioral health problems and those with behavioral health problems are at increased risk for physical illness. In this way, physical health and mental health are interconnected, each influencing the other (Hogg Foundation for Mental Health, 2008). Chronic stress is also associated with detrimental health and mental health effects. For example, it can activate physiological changes in the body that are connected to psychiatric disorders, accelerated aging, hypertension, diabetes, obesity, heart disease, atherosclerosis, and damage to vital organs and immune defenses (Braveman, Egerter, & Mockenhaupt, 2011; Braveman, Egerter, Woolf, & Marks, 2011; Brondolo, ver Halen, Pencille,

Beatty, & Contrada, 2009; Kaholokula, Nacapoy, & Dang, 2009; Williams & Mohammed, 2009). A better understanding of how risky conditions interact to impact health would provide insights useful in developing potential interventions.

Place Matters

Children growing up in disadvantaged and impoverished neighborhoods are at higher risk for worse mental health outcomes than those growing up in enriched communities (Healthy Communities Matter, 2010). The *Moving to Opportunity* (MTO) programs reveal the impact of place on mental health. MTO programs moved low-income families who were randomly selected but predominantly minority from high-poverty neighborhoods to communities that were less poor. Three years later, the mental health of both parents and children had improved more than those in the comparison group who remained in the poverty-challenged neighborhoods. Other projects that moved residents to newer public housing sites with more resources found that families who moved reported less substance use and greater overall health than those from the original neighborhood (Williams, Costa, Odunlami, & Mohammed, 2008).

Violence and Stress

Economic instability and living in neighborhoods of concentrated disadvantage where there are often high levels of community violence represent risky conditions linked to chronic stress and poor functioning (Healthy Communities Matter, 2010). Numerous studies report a majority of youth who witness or experience violence develops symptoms of posttraumatic stress disorder (PTSD) with a minority developing clinically significant PTSD. Exposure to violence is associated with depression, behavior problems, and poor school performance (Stein et al., 2003). While racial and ethnic minority rates of clinical diagnoses for mental disorders are generally similar to whites, people of color are at greater risk for experiencing more psychiatric symptoms

that impact their functioning and life course because of their exposure to increased levels of violence, stress, impoverished environments, and social disruption (Cauce, Cruz, Corona, & Conger, 2010; Healthy Communities Matter, 2010).

Historical Trauma Effects

An ethnic-specific risk factor receiving growing attention in the literature is historical trauma. “Historical trauma refers to cumulative emotional and psychological wounding, over the life span and across generations” (Brave Heart, 2003, p.7). Genocide, ethnic cleansing, and forced assimilation and acculturation trigger trauma for American Indians and, perhaps, for other people of color. Researchers note the American Indian experience, unlike that of Holocaust survivors, is not limited to one catastrophic period. Rather, losses have persisted for generations with daily reminders of losses through economic conditions, reservation life, discrimination, and cultural demise. A study by Whitebeck, Adams, Hoyt and Chen (2004) demonstrates that historical losses are salient in the minds of Native Americans, and perceptions of loss are linked to emotional responses of anger, avoidance, anxiety and depression.

This historical legacy and ongoing institutional, cultural, and individual oppression fosters unresolved grief that affects the wellbeing of people of color. Furthermore, years of subjugation destroy protective processes and natural ways of healing. Left unresolved, grief is transferred from one generation to the next. Manifestations of this wounding, referred to as *trauma response*, may foster substance use as a way to numb the pain as well as serving as a causal agent for other self-destructive behaviors such as suicide, depression, anxiety, low self-esteem, anger, along with an impaired ability to identify and express emotions (Brave Heart, 2003).

Research also documents intergenerational trauma response features among descendants of Jewish Holocaust and Japanese American internment camp survivors (Nagata, 1998; Steinberg, 1989; Yehuda, 1999). Children of Holocaust survivors report greater degrees of cumulative lifetime stress and have higher rates of PTSD, as do American Indians. While many believe the diagnosis of PTSD does not fit the construct of historical trauma, as it does not capture chronic trauma, trauma across generations, and massive group trauma, it is one indicator of the lingering effects of trauma experienced by these oppressed groups (Nagata, 1998; Steinberg, 1989; Yehuda, 1999).

More research must be undertaken to understand this condition fully and determine how it pertains to American Indians and other racial and ethnic groups who also are survivors of genocide or group inflicted trauma based on race, culture or national origin. Future areas of study should include an examination of how historical losses interact with proximal causes of stress, the prevalence and characteristics of historical trauma, mechanisms of transmission, and effective interventions (Brave Heart, 2003; Whitbeck, 2006; Whitbeck, Adams, Hoyt, & Chen, 2004).

Universal Protective Factors

Protective factors are conditions that increase the likelihood of favorable outcomes. Results from the National Survey on Drug Use and Health provide insight into how parents can create protective conditions that decrease the likelihood that their children will engage in alcohol and drug use. Perceived parental disapproval and parental monitoring were associated with less use among youth. Youth who believed their parents would strongly disapprove of their using substances were less likely to use that substance than youths who believed their parents would somewhat disapprove or neither approve nor disapprove. Similarly past month use of illicit

drugs, cigarettes and binge alcohol use were lower among youths who reported that their parents always or sometimes engaged in monitoring behaviors than among youths whose parents seldom or never engaged in such behaviors. Hence, parents play a key role in creating protective conditions that decrease the likelihood of youth substance use. Perceived risk of substance use was also associated with less use (Substance Abuse and Mental Health Services Administration, 2011).

Protective factors consistently documented in the literature as contributing to positive behavioral health include: optimism; social competence; supportive relationships; parental structure/monitoring; high expectations; schools that are supportive and caring; availability and ready access to social services and health resources; social norms that promote health; a sense of community; opportunities for meaningful involvement; and the practices of spirituality or religion (Department of Health and Human Services, 2001; Mental Health Foundation of Australia, 2005). Generally, research about protective factors remains limited and findings related to how risk and protective factors operate together to promote wellness remain unclear (Gehlert, Mininger, Sohmer, & Berg, 2008). Specifically, there is tremendous opportunity for research on the importance of culturally specific protective factors.

Risk-Protective Relationships

One model that attempts to understand the relationship between risk and protective factors is the Reserve Capacity Model. According to this framework, individuals with low social status (low SES or membership in a minority group) experience frequent stress and fewer positive events that leads to deleterious health outcomes. Stress directly moderates health through influencing behaviors such as diet, physical activity, smoking, seeking health care, and sleep patterns. Stress also directly influences physiological health through alterations in

hormones and immune processes and can act as a catalyst for emotional and attitudinal factors such as depression and anger (Gallo, Penedo, Espinosa de los Monteros, & Arguelles, 2009).

This increased vulnerability necessitates frequent use of resiliency resources with few opportunities to replenish. The term “resiliency resources” refers to stress buffering conditions or factors research has demonstrated are connected to positive physical and mental health. These buffers, identified as childcare, transportation, savings, supportive relationships, optimistic views, positive self-perceptions, and perceptions of control over personal environment and future, are elements of resource capacity. Thus, people with low status have less of the protective reserve capacity (Gallo, Penedo, Espinosa de los Monteros, & Arguelles, 2009).

Resiliency: Cultural Beliefs

A growing number of studies have examined cultural factors in relation to health and behavioral health. Cultural values of Hispanics and other minority populations include familismo or familism and allocentrism. These values reflect a collective view where the needs of the group and family are placed before the needs of the individual and attachments to family and community are central to well-being. An abundance of research documents the protective effects of the different dimensions of familism. Familial stability is connected to seeking medical care; increased family support is associated with psychological wellbeing; and familism is linked to lower rates of substance abuse, lower levels of child maltreatment, and individual depressive symptoms (Ayón, Marsiglia, & Bermudez-Parsai, 2010; Gallo, Penedo, Espinosa de los Monteros, & Arguelles, 2009). Likewise, studies with American Indian populations demonstrate connectedness with family, community, and the natural environment protect against substance use and suicide. Numerous studies document the protective effects of social support that is

derived from being a member of a community (Mohatt, Ting Fok, Burket, Henry, & Allen, 2011).

Resiliency: Religion and Spirituality

Religion and spirituality are salient in many racial and ethnic minority communities and are a source for coping and dealing with stress (Koenig, 2004; Koenig, 2009; Musgrave, Allen, & Allen, 2002). Much research has been done documenting the association between religion/spirituality and positive mental health, less substance use, and better physical health (Koenig, 2004). Koenig's (2009) review of studies conducted prior to 2000 links spiritual beliefs and practices to lower rates of depression, anxiety, substance use and suicide. The protective effects of religion and spirituality are observed across populations, age groups, and diverse locations. Gallo and colleagues (2009) further note spirituality and religiosity are linked to healthy behaviors, positive self-ratings of health, long-term wellbeing, and increased likelihood of seeking treatment for substance use.

The bulk of literature has focused on the impact of religion on wellbeing (Koenig, 2009). While it is recognized that spirituality and religiosity are two distinct and overlapping constructs, they are often used interchangeably in research studies (Hodge, Cardenas, & Montoya, 2001). Religion includes beliefs, practices, and rituals connected to the sacred that are often practiced in community (Hodge, Cardenas, & Montoya, 2001). Spirituality is more personal and includes an experiential relationship with God free of the rules and responsibilities associated with religion. The meaning of spirituality is somewhat ambiguous and consequently challenging to measure (Koenig, 2009; Hodge, Cardenas, & Montoya, 2001). Despite challenges, a body of work is emerging that considers the effects of spirituality on health distinct from religion. For example, a study by Hodge et al., (2001) examined the protective effects of religion and spirituality among

multicultural youth residing in a rural community. Spirituality was linked to never using marijuana or hard drugs but was not significantly associated with alcohol use. Religious participation, on the other hand, was significantly related to alcohol use but not marijuana and hard drug use. This study suggests the pathways by which religion and spirituality are protective may differ. More research is needed that explores how spirituality and religion foster positive outcomes (Hodge, Cardenas, & Montoya, 2001).

Further, religion is a multidimensional concept that is operationalized differently in various studies. Common measures include religious affiliation or exposure to religious norms, attendance in religious activities, and personal salience of religious values. Generally, an inverse relationship exists between religion and substance use, however, the relationship varies across different measures of religion. Results are mixed when affiliation is used as a proxy for religion. Personal salience as a measure of religion is frequently associated with less substance use. Religious attendance, however, is consistently associated with less substance use and appears to be the strongest protective influence across measures of youth substance use. Researchers postulate that being part of a religious network exposes youth to positive adult and youth models and limits time for youth to engage in antisocial behaviors (Hodge, Marsiglia, & Nieri, 2011).

Resiliency: Ethnic Identity

Researchers also have explored ethnic and racial identity as protective processes. Generally, the relationship between ethnic and racial identity and health is poorly understood (Mossakowski, 2003). On one hand, some theorize that a secure ethnic identity provides a sense of belonging which serves as a buffer against discrimination (Brondolo, Brady, Pencille, Beatty, & Contrada, 2009). Ethnic identity is a multidimensional concept that includes ethnic pride, involvement in ethnic practices, and a commitment to a cultural group, suggesting that ethnic

pride and belonging contribute to a sense of well-being. Presumably, a well-developed racial/cultural identity, including both historical and experiential knowledge of the group, would promote pride in oneself and the collective group, and encourage individuals not to internalize or personalize negative racial messages and stereotypes thereby protecting group members from injuries to self-esteem. Studies also suggest a secure ethnic identity is linked with academic achievement, which in turn is associated with positive health (Whitbeck, Hoyt, Studden, & LaFromboise, 2001). However, these positive effects have not been found to ameliorate the effects of racism on depressive symptoms.

An opposing theory is that ethnic identity increases the stress resulting from discrimination because one becomes acutely aware of differences between oneself and the dominant group, resulting in cultural isolation. A review by Brondolo and colleagues (2009) revealed limited evidence for the hypothesis that a strong racial or ethnic identity serves as a buffer to the psychological effects of racism. In twelve of the studies reviewed, only two demonstrated support for a buffering effect. First was a study with Filipino-American adults (Mossakowski, 2003) and second was a study with African American young adults (Fischer & Shaw, 1999).

Numerous methodological issues may be contributing to the inconsistent findings. There are differences of opinion on whether ethnic and racial identities are distinct constructs and there are few ethnic specific measures of ethnic identity. Because the reviewed studies utilized different tools to measure the constructs, comparisons of findings may be rendered invalid. Further research is necessary to ascertain the protective effects of ethnic and racial identity and there is a significant need for empirical research on strategies for coping with racism (Brondolo, Brady, ver Halen, Pencille, Beatty, & Contrada, 2009).

Resiliency: Enculturation

The related construct of enculturation has been identified as a protective factor in some American Indian populations. Enculturation refers to “the process of learning about one’s native culture” (LaFromboise, Hoyt, Oliver, & Whitbeck, 2006, p. 196) and suggests a level of immersion in one’s culture. A study by LaFromboise and colleagues (2006) with 215 American Indian youth living in the upper Midwest who were exhibiting positive outcomes in the face of adversity found that high levels of enculturation were associated with pro-social outcomes.

Components of enculturation measured included participation in traditional activities, identification with one’s own American Indian culture, and traditional spiritual involvement.

The American Indian Cultural Identification Scale used to measure this construct was developed in collaboration with participating tribes. Another study with American Indian adults also living in the upper Midwest revealed that depressive symptoms were strongly associated with discrimination and that participation in traditional practices was inversely related to depression (Children’s Defense Fund, 2011). Interaction effects indicated that engaging in traditional practices such as going to powwows and speaking the traditional language buffered the negative effects of discrimination. This protective influence was reported as strongest for those who had higher than average participation in traditional activities (Whitbeck, McMorris, Hoyt, Stubben, & LaFromboise, 2002).

Examining Risk-Resiliency Relationships

Racial and ethnic minority populations are exposed to multiple risk conditions, thus it is essential to understand how risks interact with protective factors to shield minorities from poor health outcomes. A case in point is the Hispanic Paradox, which asserts that Hispanics, in general, demonstrate better health outcomes than Whites, as indicated by mortality rates and

birth outcomes. Yet, this population continues to be vulnerable to conditions such as HIV/AIDS, obesity, and diabetes. . There are several factors that potentially contribute to the Hispanic health advantage, including ethnic specific protective factors. It is important to understand the elements of resiliency that may protect Hispanics and other racial and ethnic minorities (Gallo, Penedo, Espinosa de los Monteros, & Arguelles, 2009). The NIH sponsored Hispanic Community Health Study – Study of Latinos (HCHS-SOL) is one example of a multi-center epidemiological study designed to describe the prevalence of chronic diseases, including the role of behavioral health, in a cohort of 16,000 Hispanics in San Diego, Chicago, the Bronx, and Miami. The study also aims to identify factors that protect and increase risk for chronic diseases and to understand the role of culture in health (National Institute of Health, National Heart, Lung, and Blood Institute, 2010). Additional epidemiological studies such as this one that consider protective processes and the role of culture are necessary.

Resiliency Paradigm

Resilience refers to the process of successful adaptation despite threatening circumstances within the context of health or wellness and in spite of significant risk (Mental Health Foundation of Australia, 2005; Meschke & Patterson, 2003). Despite the described challenges and multiple oppressive conditions, many communities, families, and individuals live healthy, productive, and happy lives. Contemporary social work research on behavioral health disparities aims at understanding the social and cultural processes that help communities, families, and individuals stay healthy. The resiliency paradigm offers a framework that can be used in conjunction with health, behavioral health and public health models to facilitate understanding of conditions that promote wellness, in spite of adverse life experiences. This framework allows for consideration of individual, family, and community risk and protective

factors, while offering insights into essential elements for the development of prevention strategies and interventions.

Community Health Workers & Promotores de Salud

Community Health Workers (CHWs) and Promotores (as) de Salud have been utilized effectively with low-income populations, in rural and urban communities, and across diverse racial and ethnic and linguistic groups to promote health and behavioral health. These natural leaders are trusted members of the community who have a close understanding of the communities they serve. Also known as peer leaders, patient navigators, health advocates, lay health workers, community health representatives, outreach educators, and family health advocates, they play an important role in promoting community-based health education and prevention in a manner that is culturally and linguistically appropriate, particularly in communities and for populations that have been historically underserved and uninsured (Lewin, Bosch-Capblanch, Aja, van Wyke, Glenton, Scheel, Zwarenstein, & Daniels, 2006; Office of Minority Health, 2012; Spencer, Gunter, & Palmisano, 2010; US DHHS Promotores de Salud Initiative, 2011).

The U.S. Department of Health and Human Services defines CHWs/Promotores de Salud as:

Volunteer community members and paid frontline public health workers who are trusted members of and/or have an unusually close understanding of the community served. Promotores de Salud/Community Health Workers generally share the ethnicity, language, socioeconomic status, and life experiences of the community members they serve. These social attributes and trusting relationships enable CHWs to serve as a liaison, link, or intermediary between health and social services and the community to facilitate access to and enrollment in services and improve quality and cultural competence of service. Promotores/CHWs can enhance provider-patient communication; preventative care; adherence to treatment, follow-up, and referral; disease management; and navigation of the healthcare system. Additionally Promotores/CHWs build individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support, and advocacy among communities such as Hispanic/Latino communities (Adapted from the

American Public Health Association, 2009, Community Health Workers National Workforce Study (HRSA) and the Patient Protection and Affordable Care Act of 2010)

CHWs work with the health and behavioral health care systems and providers, serving as a bridge between the community and systems. The roles of CHWs are wide-ranging and include providing informal support and counseling, connecting community members with health/behavioral health resources, assisting with the navigation of health care systems, providing health education and screenings, and organizing communities to address conditions that foster poor health outcomes (Spencer, Gunter, & Palmisano, 2010). Use of CHWs is an asset-based approach building on the strengths of community residents and networks. Community members act in partnership with health care professionals and systems to promote well-being community-wide (Hanni, Garcia, Ellemberg, & Winkleby, 2009; Spencer, Gunter, & Palmisano, 2010).

Effectiveness in Physical Health Promotion

Existing literature documents the success of CHWs in improving health care access and utilization, increasing health knowledge, and enhancing the health status of people of color (Spencer, Gunter, & Palmisano, 2010). In rural areas and *colonias* (rural, unincorporated neighborhoods along the U.S.-Mexico border) where services are often lacking, CHWs provide vital preventative health education in Spanish. A study by Mier and colleagues (2011), details how economically disadvantaged Mexican-American women living in a *colonia* in Texas were engaged in the Vamos a Caminar (Let's Walk) Program. *Promotores* culturally tailored and implemented the program providing education about the benefits of physical activity and engaging women in problem solving regarding how they could overcome barriers to walking. Although designed as an anti-obesity and diabetes prevention intervention, program outcomes included significant decreases in depressive symptoms and stress. Satterfield and colleagues

(2002) reported 1,400 community health representatives impart disease prevention and care education to more than 400 American Indian and Alaska Natives in rural communities across the United States. These reports suggest these efforts to blend medical knowledge with local knowledge have been successful in promoting early intervention, increasing self-care, and increasing access to health services.

Similarly, in urban settings CHWs have demonstrated positive outcomes in addressing the following health topics: increasing cancer and chronic disease screenings; smoking cessation; increasing knowledge about HIV/AIDs; improving mental health; promoting cardiovascular health; increasing immunization rates; and increasing knowledge and skills necessary to prevent and manage diabetes (Balcázar et al., 2005; Plescia, Herrick, & Chavis, 2008; Reinschmidt et al., 2006; Rhodes et al., 2007; Spencer et al., 2011). For example, a study by Spencer and colleagues (2011) reported on the effectiveness of a CHW intervention with African American and Latino adults with Type 2 diabetes. Participants were engaged in diabetes education classes and home visits with CHWs who promoted cultural and linguistic practices within diverse and underserved communities. CHWs conducted home visits where they assisted participants in setting self-management goals and supported their progress, assisted participants in improving their patient-provider communication skills, and facilitated referrals to community services. When compared to baseline data, outcome data from CHW intervention participants revealed significant decreases in HbA1c levels; decreases greater than for the delayed-intervention control group. This rigorous study is among a small group of CHW inquiries that compare health outcomes of a CHW intervention with outcomes of those receiving health care as usual.

Effectiveness in Behavioral Health Promotion

Fewer studies have addressed the use of CHWs in behavioral health promotion. However, existing research seems promising. An unpublished report by Ayón and Peña (2010) documented the effects of a *promotora* program designed to prevent youth substance use. *Promotores* provided educational workshops and distributed educational materials at community events to educate Mexican immigrant parents about substance use. Outcome data from pre/post surveys indicated increased parent knowledge of the risks associated with substance use. Parents were able to identify protective behaviors they could engage in to decrease the likelihood that their children would use substances.

Spencer, Gunter, & Palmisano (2006) documented the success of a CHW intervention within an African American community. The CHW intervention promoted effective diabetes self-management, facilitated satisfaction with health, and was linked to decreased levels of disease-related emotional distress. The *Amigos en Salud/* (Friends of Health) Project also used CHWs to assist Hispanic adults with co-occurring diabetes and depression in understanding and managing their conditions. Outcomes revealed improved health behaviors and decreased depression scores (Goodwin & Tobler, 2008). These findings serve as an important example of the interconnectedness of physical and mental health, and demonstrate the promise of CHWs in promoting wellness.

Effectiveness in Community-wide Health Promotion

Additionally, CHWs have engaged in civic participation addressing the social determinants of health and behavioral health. A case study of the actions of *promotoras* in Las Lomas, Texas documented how *promotoras* organized the community to improve the substandard housing conditions in the *colonia*. With the leadership of *promotoras*, community

members successfully lobbied the legislature to change a law that prohibited access to utilities in their homes (Gonzalez Arizmendi & Ortiz, 2004).

In another example, *promotoras* worked successfully with *taqueria* (taco shop) owners in Salinas, California to increase healthy food options available on restaurant menus. While not the cause of obesity, diabetes, and cardiovascular problems, restaurant owners began to see themselves as part of the solution for enhancing community health (Hanni, Garcia, Elleberg, & Winkleby, 2009).

Another study by Plescia, Herrick, & Chavis (2008) reported how the efforts of a community coalition in which lay health advisors were central to coalition efforts decreased barriers to health in a predominantly African American community in North Carolina. A farmers market was initiated to bring fresh fruits and vegetables to the community. In conjunction with the initiative, a health education media campaign that utilized Afrocentric messages was established. The local YMCA expanded physical activity programs, and a diabetes quality improvement project was brought to the local health center. These examples of community mobilization suggest CHWs can play a key role in creating community conditions that promote health.

Practice wisdom suggests CHWs, as trusted members of the community, offset the history of distrust that people of color feel towards health and behavioral health systems, which has impeded service utilization. As cultural insiders, CHWs may understand community norms around health care and beliefs about health and illness. They may know the values and strengths of the community and consequently may be able to deliver services that are culturally relevant using acceptable communication approaches.

CHW services blend healing knowledge that stems from the local community with scientific knowledge (McQuiston, Choi-Hevel & Clawson, 2001; Satterfield, Burd, Valdez, Hosey, & Eagle Shield, 2002). As shown by existing literature, CHWs bring cultural and linguistic competence to health and behavioral health systems. They play a pivotal role in promoting health and behavioral health as they work hand in hand with professional health and mental health providers. The role of CHWs may be particularly crucial in assisting providers in providing language and culturally relevant services to immigrant and refugee communities where bilingual/bicultural providers are scarce.

Efforts are underway in various states to develop standards and certification processes for CHWs, and concern has emerged that “institutionalizing” these natural helpers will minimize their effectiveness. As society moves forward, a more thorough understanding of the components of effective CHW interventions will be necessary to inform the existing dialogue and to ensure that the voices of the community remain at the forefront of interventionist considerations (Spencer, Gunter, & Palmisano, 2010).

Integrated Care

Integrated care is the coordination of behavioral and physical health care—an approach that appears more accessible and less stigmatizing than referral to specialty behavioral health care settings, particularly for racial and ethnic minorities. With increased patient and consumer participation in, integrated care models show promise for eliminating health and behavioral health disparities (Sanchez, Chapa, Ybarra, Martinez, 2012). As vital members of the integrated care team, social workers will need special preparation to work in this new care environment.

Racial and ethnic minorities and those with limited English proficiency (LEP) are at greater risk for remaining undiagnosed, wrongly diagnosed and potentially untreated. With a fragmented system of care, primary care appears to be a preferred entrée to all care needs (Chapa, 2004; Sanchez, 2011, Sanchez, Chapa, Ybarra, Martinez, 2012). Studies indicate that up to 70% of primary care visits are connected to mental health needs (Kathol, Saravay, Lobo, & Ormel, 2006). Unfortunately, primary care doctors alone are not prepared and lack the infrastructure to identify and effectively treat behavioral health needs (Ida, SooHoo, & Chapa, 2012; Sanchez, 2011). It is estimated that between 33% and 50% of patients with a mental disorder go undiagnosed by primary care physicians and, of those who are diagnosed, a minority receive the recommended minimal standards of care (Kessler et al., 2005). Similarly, physicians in the primary care setting frequently do not screen or detect substance use disorders; and if recognized connection with treatment is rare (Higgins, 1994; Humphreys, Weingardt, & Aton, 2004; Lo & Cheng, 2011). Physicians report obtaining behavioral health services for their patients is difficult due to provider shortages, lack of health insurance and health plan limitations (Cunningham, 2009). Even when referred for behavioral health care, ethnic and racial minority patients rarely follow through with seeking treatment and do not receive the quality behavioral health care they need (Hogg Foundation for Mental Health, 2008; Sanchez, 2011). Conversely, those patients/consumers who are primarily in a community mental health system often do not receive the primary care needed to lead healthy lives. Research demonstrates 70% of individuals who have a mental or substance use disorder also have at least one chronic physical condition and 45% have two. Yet, there is an overall lack of utilization of primary care services which is a factor in the premature death of people with mental and substance use disorders (Ida, SooHoo, & Chapa, 2012; National Association of State Mental Health Program Directors, 2006).

Integrated care, the coordination of physical and behavioral health services is an effective approach in improving both health and behavioral health outcomes. Models recognize the interconnectedness of physical and behavioral health and merge health, mental health, and substance abuse delivery systems to address multiple health care needs. Co-location, providing services in a common location and/or a team of primary and behavioral health professionals working together allows primary care providers to connect patients with behavioral health care and vice versa (Hogg Foundation for Mental Health, 2008, Sanchez, Chapa, Ybarra, Martinez, 2012).

Access to care improves as consumers no longer have to negotiate a fragmented health and behavioral health care system. This can be particularly beneficial for limited English proficient families for whom negotiating complex care systems can be a barrier to service. Further, the stigma associated with seeking behavioral health care is potentially reduced when services are provided in a primary care setting (Ida, SooHoo, & Chapa, 2012). Numerous clinical trials demonstrate the efficacy of integrated care (Hogg Foundation for Mental Health, 2008; Sanchez, 2011).

Social Workers Role in Integrated Care

Social workers play a key role within integrated care systems. While there are several integrated care models, most necessitate physicians, psychiatrists and other health and behavioral health providers working together. Social workers serve as needed mental health practitioners, but also as care managers---coordinating care and consulting with the provider and the patient/consumer. Functions of a care manager can include tracking patient needs, utilizing preliminary screening tools to detect psychiatric disorders or addiction, referring patients to necessary treatment, educating, assisting with medication management, monitoring responses to

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treatment using clinical assessment tools, and maintaining caseloads in a patient registry. The behavioral health care manager essentially monitors consumer's responses to treatment, consults regularly with psychiatrists and physicians, and planned care is adjusted as needed (Hogg Foundation for Mental Health, 2008; Sanchez, 2011).

Physicians have insufficient time to provide relevant education and follow-up care to patients with chronic conditions. AS partners in a care team, social workers can fulfill this need and actively engage patients in the treatment process by educating them about the psychosocial and behavioral elements of their disease so they are ready to engage in self-management. Health education approaches that focus on nutrition, exercise, and smoking cessation have been used in behavioral health settings demonstrating effectiveness in reducing rates of chronic illness. Health education can include educating patient's family members on behaviors that promote health so they are prepared to support patients. Other educational programs that have demonstrated success include Wellness Recovery Action Plan (WRAP) programs. WRAP involves training those with a mental illness to facilitate educational trainings with their peers. Social workers can take an active role in implementing WRAP programs and in creating peer-support networks (Hogg Foundation for Mental Health, 2008; Sanchez, 2011).

As integrated care systems continue to evolve, so too will the role of social workers within such systems of care. Efforts are taking place across the country to develop integrated systems and to prepare health and behavioral health providers for working within such systems. The Hogg Foundation for Mental Health in collaboration with the U.S. Department of Health and Human Services, Office of Minority Health is developing a national model to improve integrated health care for racial and ethnic minorities and limited English proficient populations. The Center for Integrated Health Solutions funded by the Substance Abuse and Mental Health

Service Administration and Health Resource and Service Administration are working collaboratively to prepare providers with needed tools to use integrated health care service delivery approaches (Center for Integrated Health Solutions, 2012). Social workers must engage in the dialogue and assist in preparing a work force that can implement evidenced-based health and behavioral health practices that are culturally and linguistically competent.

Culturally and Linguistic Competence in Social Work Practice

A core strategy for addressing health and behavioral health disparities include culturally and linguistic competence (CLC) and evidence-based interventions. A generally accepted assumption is that CLC would enhance minority utilization of health and behavioral health care through increased participation, retention, and follow through with recommended interventions (Whaley & Davis, 2007). Likewise, evidenced-based interventions would improve the quality of care and health and behavioral health outcomes. Advocates of evidenced-based interventions note practitioner ethical responsibilities to provide effective interventions to all clients. Proponents of culturally competent practice cite practitioner professional responsibilities when referring to cultural and linguistic competence. The position taken here is that both evidenced-based and culturally competent practices are essential and complementary.

Efficacy of Evidenced-Base Interventions with Minorities

An abundance of research documents the efficacy of a range of physical health, mental health, and substance abuse treatments (Huey & Polo, 2008; Miranda et al., 2005); yet racial and ethnic minority participants have been inadequately represented in empirical research of evidenced-based interventions. Given the sparse representation of racial and ethnic minorities in empirical studies, researchers and practitioners have begun to explore whether evidenced-based treatments can be generalized to diverse population groups. . Also included in the contemporary

discourse are questions about whether or not culturally congruent interventions improve outcomes for minority groups; whether or not culturally congruent interventions are more beneficial than standard treatments; and, if so, how cultural congruence is achieved (Miller, Villanueva, Tonigan, & Cuzmar, 2007; Miranda, Bernal, Kohn, Hwang, & LaFromboise, 2005). From one perspective, professionals assume a universalistic stance believing that common healing elements inherent to evidenced-based interventions apply to all populations. From another are those who support culturally grounded interventions, noting that different groups have their own healing approaches that must be utilized to work effectively with ethnic and racial groups, requiring training in cultural competencies. In the middle are those who purport evidenced-based interventions should be adapted for minority groups (Falicov, 2009). The term “culturally adapted” refers to any modification to an evidenced-based intervention that involves changes in the approach to service delivery, in the nature of the helping relationship, or in components of the treatment itself to accommodate the cultural beliefs, attitudes, and behaviors of the target population (Whaley & Davis, 2007, p 571). In varying degrees, studies support the continuum of positions indicating no single approach is the only solution for addressing disparities.

Efficacy of Universal Approaches

Research demonstrates empirically supported treatments can be effective with some minority groups. Miranda and colleagues, (2005) conducted a comprehensive review of efficacy studies on psychosocial interventions with children and adults that address mental health disorders. Cognitive behavioral therapy (CBT) and interpersonal therapy (IPT) have demonstrated effectiveness with Latinos and African Americans, and smaller studies suggest effectiveness with Asian populations as well. In their review, Miranda and colleagues (2005)

found no research on the impact of these interventions on American Indian/Alaskan Natives. Available literature on effective mental health care for American Indian/Alaskan Native populations has focused on preventive school-based interventions that target all youth. These cognitive-based interventions seem to reduce depressive symptoms and suicidal ideation among native youth (Miranda et al., 2005).

A more recent review by Huey and Polo (2008) examined the literature on efficacious treatments for ethnic minority youth. They utilized the framework developed by the Task Force of the American Psychological Association to classify treatments as well-established, probably efficacious or possibly efficacious. Terms were defined as follows:

A well-established treatment demonstrates the highest level of empirical support and requires two different controlled trials conducted by independent research teams and studies must demonstrate that treatment is better than a wait list, placebo, or equivalent to an established efficacious treatment. To be designated as probably efficacious treatments require one high-quality trial comparing treatment to placebo or an alternative treatment or two trials comparing treatment to no treatment. A possibly efficacious treatment is defined as one study showing treatment to be efficacious and the study does not meet the criteria for well-established or probably efficacious (p. 264).

Universal Mental Health with Minority Youth

Huey and Polo's findings indicate no treatments were well established for ethnic minority youth, yet several evidenced-based treatments for ethnic minority youth do exist. Thirteen treatments met the criteria of probably efficacious and 17 as possibly efficacious. Overall treatments demonstrated medium effect size. Similar to Miranda's review (2005), CBT and IPT were possibly efficacious in treating anxiety disorders and probably efficacious in treating depression with Hispanic and African American youth. Multisystemic Therapy (MST) and Lochman's Coping Power program was likely efficacious in treating conduct disorders with African American youth whereas Brief Strategic Family Therapy (BSFT) was found somewhat efficacious with Hispanics youth experiencing conduct problems. Multidimensional Family

Therapy (MDFT) was likely efficacious in treating substance use among African American, Hispanic, Haitian and Jamaican youth. MST was deemed somewhat efficacious with multiracial Hawaiian youth (Asian, Caucasian, and Pacific Islander) experiencing mixed behavioral and emotional problems. Combined behavioral treatment and stimulant medication were efficacious in treating Attention Deficit/Hyperactivity Disorder with African American and Latino children.¹ This review suggests some variations among efficacy measures of several evidenced-based treatments for minority youth, primarily Hispanics and African Americans. Huey and Polo (2008) report no knowledge of evidenced-based therapies for Native American youth; research on Asian and Pacific Island populations is sparse as well.

Universal Addiction Treatments

Miller and colleagues (2007) report generally, that well specified addiction treatments for the majority population have similar outcomes for ethnic/racial groups. For example, the Anglo-developed intervention of Alcoholics Anonymous has helped members of minority groups, lending support to the notion that some interventions transcend cultural differences or that element of interventions may resonate with different ethnic/racial groups (Falicov, 2009). Another example is the Community Reinforcement and Family Training program (CRAFT). CRAFT assists concerned significant others (CSOs) of loved ones with a drug problem in engaging them in treatment. Studies demonstrate that CRAFT engages more identified patients (IPs) than Al-Anon and Nar-Anon Facilitation Therapy and the Johnson Institute Interventions. One study found two-thirds of IPs were engaged when CRAFT was implemented compared to one-third when Al-anon and Nar-anon were used. CRAFT was not developed as a culturally

¹ (see Huey & Polo (2008) for more information on evidenced-based interventions for minority youth).

specific intervention for Latinos, yet a study by Viets (2007) suggests this approach is culturally congruent and effective with Latinos. A small study engaged 45 CSOs (15 Latino, 25 Euro-Americans, and 5 other ethnicities) in the CRAFT program. Generally, two-thirds of CSOs engaged their IPs to seek treatment, CSO rates of depression were significantly reduced from intake to follow-up points, and family cohesion was significantly improved. Rates of improvement did not differ significantly by ethnicity, demonstrating the benefits of CRAFT for both Latinos and Euro-Americans.

CRAFT teaches CSOs communications skills, how to care for themselves, and utilizes a structured behavioral approach to teach CSOs to identify and avoid triggers for substance use, not to interfere with alcohol-related problems that produce negative consequences for the IP, and to utilize positive reinforcement for alcohol-free activities. Viets (2007) proposed CRAFT as culturally relevant for Latinos because it is consistent with the cultural values of *familism* and *collectivism*. It provides practical solutions and is present-oriented which is consistent with previous research that suggests Latinos and other minorities prefer directive psychotherapies that address immediate concerns (Atkinson, Morten, & Sue, 1993). Similarly, the stigma that minorities often associate with therapy may be avoided by framing the intervention as classes (Viets, 2007). This study provides support for the notion that standard interventions that culturally resonate for minorities are effective.

The dominant recommendation is that evidenced-based interventions serve as a starting point for treating minority clients because they are preferable to untested alternative interventions (Huey & Polo, 2008; Miller, Villanueva, Tonigan, & Cuzmar, 2007; Miranda et al., 2005). Limited comparative studies demonstrate less effective outcomes when an unaltered standard intervention is delivered to mainstream versus ethnic populations; these findings make

it difficult to conclude definitively that culturally adapted or specific interventions are necessary (Huey & Polo, 2008; Falicov, 2009).

Culturally Adapted Interventions

When interventions are not culturally relevant, one would expect participation rates to be low, which in turn would result in a loss of effectiveness. Thus, many argue for the importance of culturally congruent interventions that resonate for ethnic and racial minorities. In research on a culturally relevant diabetes prevention program for African America women, Williams and colleagues (2006) found cultural relevance was associated with program satisfaction and satisfaction was associated with program attendance.

Research on the effectiveness of culturally adapted interventions is growing with a bulk of studies indicating adaptations are as effective as original evidenced-based interventions (Castro, Barrera, & Steiker, 2010; Miranda et al., 2005). Numerous studies have been conducted at the Depression Clinic of San Francisco General Hospital on the cultural adaptation of CBT for adult depression (Miranda et al., 2006). Miranda and colleagues implemented a culturally adapted CBT intervention to low income Latina and African American women. Adaptations included childcare, transportation, use of a manual designed by members of the focal population that was linguistically appropriate, attention to cultural values, and incorporation of culturally relevant stories, expressions, and metaphors. Study participants demonstrated significant decreases in depressive symptoms. Other studies similarly demonstrated culturally adapted CBT interventions decrease depressive symptoms (Kohn et al., 2002; Munoz & Mendelson, 2005).

In a randomized controlled trial, Hinton et al. (2005) examined the efficacy of a culturally sensitive CBT for Cambodian refugees experiencing PTSD and panic attacks. Their sample included clients who had passed through the Cambodian genocide, who were at least 6 years of

age during this experience, and who were considered treatment resistant. Participants in the study had experienced culturally specific neck-focused and orthostasis-triggered panic attacks and flashbacks during the last month. The intervention included 12 weekly, individualized culturally sensitive CBT sessions that included culturally appropriate visualization that encoded Asian cultural values, framing relaxation techniques as forms of mindfulness, and exploration of the neck and orthostatic panic. All sessions were delivered by the first author, who is fluent in Khmer, or Cambodian.² Clients improved on all measures including fear of anxiety-related somatic sensations, PTSD severity, neck and orthostasis panic attacks and associated flashbacks, anxiety and depression related distress, and diagnostic status. The effect sizes were large. Outcomes are particularly impressive given that patients had not previously responded to a medication regimen and supportive psychotherapy. Researchers speculate that CBT may be a particularly useful modality for treating Southeast Asian refugees due to the commonalities of Buddhist principles and CBT.

Miranda and colleagues (2005) reported that when low-income minority women were randomly assigned to a standard CBT intervention, only 36% attended six or more sessions despite significant outreach efforts. Another study by Kohn and colleagues (2002) found that when given the choice between a culturally relevant intervention and a standard intervention, over 80% of African American women chose the culturally attuned intervention. These findings support the importance of adapting programs to make them culturally relevant.

² (See Hinton, 2005 for more information on “Culturally Sensitive CBT”).

Adaptation Trends

Review of the literature demonstrates the promise of culturally adapted interventions. Jani, Ortiz, and Anda (2009) conducted a review of experimental or quasi-experimental studies that adapted interventions to make them culturally appropriate for Latinos. Their review included 23 studies published between 1999 and 2005 that reported health, substance abuse, and mental health outcomes. Overall, culturally modified interventions were associated with positive outcomes. Adaptations included family involvement in interventions, emphasis on the cultural values of *collectivism* and *familism*, use of cultural metaphors, interventions available in Spanish, and use of community members/*promotoras* in the delivery or design of the intervention. In this review, many of the interventions that demonstrated favorable outcomes used a cultural variation of cognitive theory. Fitzgibbon, Gapstur, and Knight (2004) note that the tenets of cognitive theory are not based on majority values such as individualism and autonomy; thus it is argued that CBT is amenable to Latino and other minority groups.

A review by Griner and Smith (2006) examined 76 published and unpublished quantitative studies that reported on culturally adapted mental health interventions beyond ethnic or language matching. Most of the studies involved experimental or quasi-experimental research designs; fifteen used a single intervention group with no comparison/control group. Ethnic breakdown of the studies was 31% African American, 31% Hispanic, 19% Asian American, 11% Native Americans, 5% European Americans and 3% not specified. Results of the meta-analysis reveal an overall positive effect for culturally adapted intervention, weighted actual effect size was moderate ($d = 0.45$), interventions provided to groups of same-race participants ($d = .49$) were four times more effective than interventions provided in mixed-race groups ($d = .12$), interventions where the practitioner spoke the same non-English language as consumers had a

higher effect size ($d = .49$) in comparison to studies that did not describe a language match ($d = .21$), and studies that included Latino participants demonstrated larger effect size for low acculturated participants in comparison to those who were moderately acculturated. The most frequent cultural adaptation included inclusion of cultural values, and was followed by language matching, ethnic matching of clients to practitioner, and treatment at a facility that focused on clients from diverse backgrounds. Since the Griner and Smith (2006) review, new research has emerged that further supports the effectiveness of culturally adapted interventions (see Bernal, 2006; Bernal & Domenech Rodríguez, 2009).

While a significant body of research indicates that culturally adapted interventions are effective, findings remain somewhat mixed. Huey and Polo's (2008) synthesis of evidenced-based treatments for ethnic youth was not supportive of culturally adapted interventions. They compared treatments identified as culturally responsive with standard interventions and found no significant differences in effect sizes between culturally responsive and standard treatments. However, the authors acknowledged that their reviewed studies lacked adequate statistical power for making such comparisons. Few studies compare standard and culturally adapted interventions in randomly controlled trials (Miranda et al., 2005).

Adaptations and Health Outcomes

In addition to the review of cultural adaptations to mental health and substance abuse interventions, several reviews have examined the impact of adaptations to health programs. Mier, Ory, and Medina (2010) reviewed 18 culturally adapted interventions for Hispanics that promoted healthy eating and exercise. The review was limited to randomized controlled trials, and 13 of the 18 studies demonstrated significant differences in eating and exercise post intervention. However, most studies did not assess whether or not the intervention was

successful due to cultural adaptations. Fisher and colleagues (2007) conducted a review of interventions that utilized cultural leverage to reduce racial disparities in health care. Cultural leverage refers to “strategies that use cultural practices, products, philosophies, or environments as vehicles that facilitate behavior change of patients and practitioners” (p. 245S). This review was broader than simply looking at programs. Thirty-eight studies were examined that focused on three intervention areas: (1) modifications in individual health behaviors; (2) increased access to the health care system; and, (3) altered health care systems with the intent of making them more amenable. Their review included studies conducted after 1985. A majority of interventions were for African American and Latino communities. Four focused on American Indians and six on Asian or Asian American groups. Their review included grey literature in addition to six descriptive studies that utilized participant words to describe how interventions positively affected their health. Twenty-three of the studies (descriptive studies excluded) demonstrated significant improvements in a health outcome of interest, although none specifically assessed how cultural aspects brought about improvements in care. Interventions overwhelmingly relied on members of the focal community to develop materials, and on lay educators and culturally specific professionals to deliver interventions. These studies support the promise of culturally adapted health interventions.

Frameworks for Cultural Adaptations

Castro and colleagues (2010) contend the question is not whether culturally adapted programs are justifiable but rather when and how to engage in adaptations. They assert that cultural adaptations must be developed when: 1) evidenced-based interventions ineffectively engage consumers; 2) unique risk and protective factors impact a group or unique symptoms experienced by a group are not addressed by evidenced-based interventions; and 3) evidenced-

based treatments are not effective. Several frameworks now exist to guide researchers and practitioners in how to proceed with adaptations. Frameworks involve variations of four stages: 1) information gathering; 2) developing preliminary adaptation designs; 3) conducting preliminary tests of modifications; and 4) refining adaptations. Crucial to the adaptation process is maintaining fidelity of evidenced-based interventions while addressing the local and cultural needs of participants. Researchers increasingly have turned to bicultural and bilingual professionals and community members as experts on approaches that will meet the unique needs of specific populations. Adaptation models include researching existing literature and evidence to develop interventions that fit the focal community. Ideally, adaptation models are bottom-up and top-down, thereby striking a balance between scientific integrity and community needs and wisdom (Castro, Barrera, & Steiker, 2010).

Surface Structure Adaptations

How interventions are adapted can range from surface to deep structure modifications. Surface structure refers to matching of intervention materials and messages to fit the focal population or ethnic group such as using the language, places, music, food, clothing, people, and brands that are familiar and appealing to a specific group. Surface structure is visible and can include providing services for African Americans in churches or barber/beauty shops. This surface structure adaptation increases feasibility and is a promising approach that has been used with African American populations (Linnan & Ferguson, 2007; Sadler, Thomas, Gebrekristos, Dhanjal, & Mugo, 2000). Another common surface structure adaptation includes using delivery agents who are the same ethnicity as participants. Deep structure adaptations entail incorporating the cultural, social, historical, environmental, and psychological forces that influence the health of the focal population (Resnicow et al., 2000).

Deep Structure Adaptations

Deep structure adaptations necessitate an understanding of cultural values, health, behavioral health and public health. It's how ethnic and racial groups perceive health and illness, and understanding of determinants of health such as racism, historical trauma, and oppressive social and economic institutions. Stressing interdependence or personal development as a way of helping the family and community, emphasizing collective responsibility and the importance of caring for each other, promoting positive cultural and racial development, or using culturally relevant teaching strategies such as witnessing, testimony and storytelling when working with the African American community are examples of deep structure adaptations that have demonstrated promise (Manning, Cornelius, & Okundaye, 2004; Williams-Brown, Baldwin, & Bakos, 2002). Often, adaptation studies do not directly test the effects of cultural adaptations because cultural competence is not operationalized or formally measured during implementation (Fisher et al., 2007; Griner & Smith, 2006, Huey & Polo, 2008; Mier, Ory, & Medina, 2010). Moreover, studies rarely compare the differential effectiveness of strategies used to achieve cultural congruence or of deep structure versus surface structure adaptations (Kreuter, Lukwago, Bucholtz, Clark, & Sanders-Thompson, 2002).

Culturally Grounded Interventions

An alternative to the cultural adaptation of interventions is the use of culturally grounded interventions that emerge from the focal group for which they are specified and that are based on the cultural values and worldview of the focal population. Falicov (2009) used the term “culturally informed” to convey that culture is more of a primary consideration than cultural adaptations. A substantial body of cross-cultural literature documents variations in the etiology, experience, and expression of disorders. Advocates of culturally grounded practice assert that

methods of healing that are grounded in cultural beliefs and values of ethnic/racial groups are both culturally appropriate and more sustainable than interventions that emerge outside of a community (Marsella, 2010). Further, practice rooted in indigenous epistemology can easily incorporate Euro-American models or evidenced-based practices into interventions. However, to begin with dominant models and add elements of culture often results in indigenous knowledge being the subservient partner of perceived superior Western models (Duran, Duran, Brave Heart, & Yellow Horse-Davis, 1998; Naquin, Manson, Curie, Sommer, Daw, Maraku, Lallu, Meller, Dip, Willer, & Deaux, 2008).

Resistance Strategies and Skills Approaches

An example of a culturally grounded drug prevention intervention is the *keepin' it REAL* substance abuse prevention curriculum. This program is based on four strategies of drug resistance: Refuse, Explain, Avoid, and Leave. Three versions of the program were developed including one grounded on Mexican American culture, another modeled on European and African American culture, and a third multicultural version that utilized half of the lessons from the Mexican American version and half from the non-Latino version. Curriculum lessons include videos and materials that emerged from the narratives of local white, Latino and African American youth. Furthermore, youth are included in the videos as protagonists who promote prosocial cultural norms and values.

Each of the three versions of the curriculum incorporates the cultural values and norms of the targeted group. For example, pilot data revealed Mexican Americans are unlikely to simply refuse a drug offer, viewing a direct refusal as disrespectful. Rather, they are more likely to give a reason or explain why an offer cannot be accepted. Hence, the “explain” strategy was emphasized in the Mexican American curriculum. Cultural values are further reflected in

program objectives. For instance, in the Mexican American version, program objectives target the need “to recognize how what the youth does impacts his or her community, group, and family and another is to differentiate between a simple preference and a wise choice – a choice that is honorable and can be respected” (Gosin, Marsiglia, & Hecht, 2003, p. 128). By contrast, in the non-Latino curriculum, student objectives include:

recognizing how what he or she does may have a favorable or unfavorable consequence on his or her own future goals; and to differentiate between a simple preference and a wise choice, defined as a choice that helps the student to achieve his or her personal goals (Gosin, Marsiglia, & Hecht, 2003, p. 128).

This example demonstrates how the values of *familism*, collectivism, and individualism are stressed differentially among the various versions of the curriculum. Evaluations of *keepin' it REAL* revealed that students who participated in the program reported increased use of all resistance skills and embraced healthier norms about future substance use when compared to students in the control schools. Schools participating in the study were stratified by percentage of Latino enrollment, and all significant program effects were limited to the Mexican American or Multicultural curricula. However, no statistically significant differences emerged when the effectiveness of the Latino and Multicultural curriculums were compared. Outcomes suggest inclusion of cultural elements consistent with the target population increases program efficacy, but it is not clear that strict cultural matching of curriculum with ethnicity is necessary (Kulis et al. 2005).

Ethno political Approaches

Ethno political psychology is a culturally informed approach for addressing the needs of racial and ethnic minorities and communities. . Ethno political psychology integrates liberation psychology with an ethnic indigenous perspective. Central to this approach is the recognition that

ethnicity and political ideology interact to affect behavior. Thus, health and behavioral health problems are in part a consequence of oppression and disconnection with culture. Wellness requires reformulating individual and collective ethnic identities and promotion of a critical consciousness. Mainstream interventions and ethnic indigenous healing practices are integrated. Unlike most mainstream psychological interventions, social justice and collectivism are primary to ethno political practice. Intervention strategies include reconnecting individuals with their roots/history, indigenous rituals and ceremonies, and dominant interventions. For example, cognitive-behavior therapy is intermingled with *dicho* therapy, interpersonal therapy with testimony, psychodynamic therapy with calling back the spirit, and family and group therapy with cultural circles (Comas-Diaz, 2007). Comas-Diaz (2007) cites numerous case examples that demonstrate the effectiveness of ethno political practice.

A program that follows in the tradition of ethno political practice is the *Abriendo Puertas: Desarrollando Un Futuro Mejor/Opening Doors: Building a Better Future Program*. Latinos designed this whole-family program for Latino parents who have children between the ages of 0 and 5. It uses a popular education approach, is grounded on Latino cultural values, and sessions are framed by cultural *dichos* and stories. Goals of the program are to increase parent knowledge and confidence in parenting and to increase their ability to advocate for their children's education. Parents learn to negotiate health and educational systems in addition to learning important health and developmental information that better prepares them to rear healthy children. This program was field-tested and demonstrated promise in (a) increasing participants social connections, (b) community involvement, (c) knowledge and access to health resources, (d) actions encouraging others to vote on behalf of children, and (e) confidence in parenting skills (Families In Schools, 2011).

Indigenous Learning and Healing Approaches

Ancestral stories

Similar to ethno political practice is the notion that *la cultura cura*/culture heals. This approach too stems from the belief that “within the ancestral wisdom of a people are the teachings and medicine necessary for growth and healing” (p. 54). Examples include the programs of Jerry Tello who draws from Aztec and cultural stories to promote wellness and cultural values. Programs are premised on the belief that European attempts to conquer the Mexican indigenous people have resulted in a deep imbalancing wound. The final stage of years of oppression across generations has resulted in internalization of falsehoods that affect the actions and behaviors of people of Mexican descent. Destroying the authentic self of a people destroys their spirit. To regain balance, falsehoods must be shed. Tello’s programs use ritual, ceremonies, and stories to teach history and to separate dysfunction from cultural strength (Tello, 2008).

Combined wisdom

Duran and colleagues (1998) also document an indigenous approach that has been effective with numerous tribes. In this approach, providers must be trained in both Western and indigenous treatment and epistemological systems. Providers work closely with traditional medicine people to assess and treat clients who participate in therapy and traditional ceremonies. The focus of treatment is to reconnect native people with traditional beliefs and indigenous identities and to learn history, thus ridding them of internalized oppression.

Elements of this approach are visible in Yéil Jeeyáx—Raven’s Way Adolescent Residential Substance Abuse Treatment Center, which combines conventional substance abuse treatments, adventure-based therapy, and native cultural activities to assist Native Alaska youth.

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The center is modeled after a family style environment. It builds strengths in a balanced way using the medicine wheel as a foundation. The program uses a learning model rather than a disease model with youth engaging in experiential learning through wilderness activities, a way consistent with Native approaches to learning by doing in natural settings. Pride in cultural heritage is promoted as youth engage in cultural activities such as talking circles, sweat lodge, smudging, pouch making, ceremony, drum-making, pow-wow-style drumming, Native recovery stories, rites of passage, and role-modeling by Native and non-Native staff. Other strategies utilized include motivational interventions, an empowerment focus, and problem solving, communication, and relapse prevention skills. The center reports positive outcomes, with 82% of those admitted completing the program. One year after leaving the center, 90% reported using less or no alcohol and 89% reported using less or no drugs (Southeast Alaska Regional Health Consortium, 2011).

Village of care

Another example of the indigenous approach is the therapeutic Village of Care model used by Cook Inlet Tribal Council in Anchorage, Alaska. The therapeutic village of care is modeled after an Alaska Native village environment. The governing structure is organized similar to a traditional village with positions allocated to chiefs and many village council members serve as Elders. The village council facilitates daily house meetings and they are the decision making body of the program. They provide peer guidance using gentle persuasion because personal confrontation is not congruent with Alaska Native tradition. Cultural values of mutual respect, personal responsibility, and cultural identity are emphasized throughout the program.

Integral to the program are work assignments within the house and work therapy outside of the house where individuals engage in micro-enterprises to learn employment skills. Enterprises include producing Alaska Native arts and crafts for sale, catering, and working at Iron Horse Gift Shops and at Two Spirits Art Gallery. Families engage in ceremonies and traditional subsistence activities such as harvesting moose, berry picking, growing traditional foods, carving, fishing, and steam bathing. Staff includes Alaska Natives, and cultural competency training is provided. Mainstream interventions include counseling, case management, and groups to address intergenerational trauma, grief, depression, anger, and other behavioral health concerns. The therapeutic village of care demonstrates promise with treatment completion rates of 69% compared to national completion rates of 35%. At the 6-month follow-up, increases in employment and adequate housing are reported, and reductions in alcohol use in the past 30 days from 57% at intake to 20% are also reported (Manson, Naquin, & Natsuoka, 2009).

Intergenerational healing

Brave Heart (1998) described an intervention that addressed historical trauma and that promoted intergenerational healing. It consisted of a four-day intensive group experience designed to promote culturally congruent bereavement and collective mourning. Core components included looking at history to learn what happened to native people and how they carry their history with them. Videos were viewed and group discussion about history and how native people were affected took place. Participant dialogue about the trauma response included survivor guilt, depression, low self-esteem, and psychic numbing through self-destructive behaviors such as substance use. Also explored were how trauma becomes a way of life that is unconsciously re-created, and how internalized oppression leads native people to abuse them and

commit acts of violence against each other. Participants learn how outlawing traditional ceremonies impaired native ability to grieve. Participants receive communal support and the opportunity to express their collective grief (Brave Heart, 1998).

A study with 45 Lakota adults evaluated the effects of this intervention. A self-report instrument, the Lakota Grief Experience Questionnaire, and a follow-up questionnaire were utilized to monitor outcomes prior to the intervention, post intervention and at 6-month follow-up. Outcomes included a reduction in grief affects at post intervention and participants reported more positive feelings about being Lakota and about themselves (Brave Heart, 1998).

These culturally grounded interventions reflect the centrality of culture and are often provided in conjunction with Western interventions and best practices. While many demonstrate promising outcomes, most often they have not been evaluated using empirically-based science. Within the field, there is growing recognition definitions of evidenced-based practice should include empirically supported interventions, correlational studies, qualitative research, quasi-experiments, and case reports and observations from successful clinicians in the field (Whaley & Davis, 2007). This emerging definition of evidenced-based practices is consistent with what is often referred to as practice-based evidence which includes scientific evidence as well as practitioner experiences (Girard, 2008).

The National Network to Eliminate Disparities (NNED) in Behavioral Health was created to build a national network of diverse racial, ethnic, cultural and sexual minority communities and organizations to promote policies, practices, standards and research to eliminate behavioral health disparities. With support from the Substance Abuse and Mental Health Services administration, The National Institute for minority Health and Health Disparities and the Annie E. Casey Foundation, the NNED supports information sharing, training and technical assistance among organizations and communities dedicated to the behavioral health and well-being of diverse communities. The NNED identifies and links "pockets of excellence" in reducing disparities and promoting behavioral health equity. It strives to avoid the tendency to "reinvent the wheel" (National Network to Eliminate Disparities, 2012).

Comprehensive Community Interventions

Use of community health workers, integrated health care, cultural and linguistically appropriate standards (CLAS) and competence, and evidenced-based practices together serve as effective approaches for increasing access and quality of care for ethnic and racial minorities (Castro, Barrera, & Steiker, 2010; Hogg Foundation for Mental Health, 2008; Spencer, Gunter, & Palmisano, 2010; U.S. Department of Health and Human Services, 2007). To achieve population level change in health and behavioral health, however, interventions also must strive to ameliorate the social and economic conditions that foster poor outcomes. Clinical interventions alone are not likely to bring about population level changes. For example, provider directives about the importance of exercise and healthy eating have done little to stop the obesity epidemic. Providing individuals with coping strategies may minimize depression and anxiety yet broader interventions that alter conditions that foster psychiatric symptoms would likely achieve greater impact.

Existing literature shows that health and behavioral decisions are a function of the environments in which individuals live. Changing environmental conditions requires coordinated efforts among business, government, civic, community, educational, volunteer, faith-based, and clinical partners. Without community buy in and leadership, efforts are not likely to be sustained (Woolf et al., 2011). Successful interventions are often multilevel and necessitate policy changes (Butterfoss & Cohen, 2009).

School-based Initiatives

California Healthy Start was established in 1991 through Senate Bill 620, the Healthy Start Support Services for Children Act, to improve student learning and support families. Healthy Start enhances efforts to close the achievement gap by helping children and their family

members gain access to an array of learning supports. Each local Healthy Start provides comprehensive school-integrated services and activities to meet the unique needs and desired results identified for children, youth, and families, including healthy eating and access to health and behavioral healthcare (California Department of Education, 2012; Malloy & Harlick, 1999; Wagner & Golan, 1996).

Steps to a Healthier New York are an example of a multi-component intervention within a school community. This district-wide intervention specifically altered school wellness policies to address multiple areas such as school lunch menus, immersed nutrition content in school curricula, and community media campaigns that encouraged healthy eating. Outcomes included increases in fruit and vegetables and decreases in fat/saturated fat served in school lunches. School lunch consumption increased whereas in the past when school menus had been adapted there were declines in participation rates (Johnston, Denniston, Morgan, & Bordeau, 2009).

In West Michigan, the YMCA of Greater Grand Rapids implemented a school health program that focused on healthy eating and active living. Outcome data revealed the program did not increase fruit and vegetable consumption to recommended levels. Community data revealed “food deserts” in the neighborhood. Local stores did not sell fresh produce and residents were unable to shop at larger grocery stores due to transportation issues. Residents also reported that the high cost of fruits and vegetables was a barrier to a balanced diet. The YMCA brought community leaders together including government, schools, health care, business, and nonprofit leaders, resulting in the formation of the Activate West Michigan Coalition. The coalition successfully altered community conditions linked to obesity and other chronic conditions by bringing nine community/school gardens and five farmers markets to the neighborhood (Cyzman, Wierenga, & Sielawa, 2009).

Community-based Initiatives

The literature is replete with large community-wide interventions designed to address health disparities. The CDC created Racial and Ethnic Approaches to Community Health across the U.S. (REACH U.S.), which provides funds to communities in select areas across the country to address health disparities. REACH U.S. programs have assisted individuals in decreasing health risks and in managing chronic conditions (Center for Disease Control, 2010). One such project funded by REACH 2010 is the Charleston and Georgetown Diabetes Coalition whose focus is on decreasing diabetes disparities for African Americans in two counties in South Carolina. The coalition was composed of 28 community partners and was organized around community-driven participatory action research. Goals of the coalition were to enhance diabetes care among blacks and to eliminate disparities between white and black patients. The intervention provided education on how to take care of diabetes and provided information on community resources. Activities included health fairs, support groups, clinics within the community, and church-based educational programs. Nurses, a health information specialist, and community health advisors delivered interventions. The coalition demonstrated a decrease in racial disparities as indicated by auditing the medical records of 158 black patients and 112 white patients. At baseline, differences in measures ranged from 11% to 28% but, after 24 months of project implementation, differences were eliminated. Measures included hemoglobin A1C testing, lipid and kidney testing, eye and foot exams, and blood pressure control (Jenkins et al., 2004).

Other community interventions taking place across the country include *Place Matters Initiatives*. The initiatives build the capacity of local leaders to address the social determinants of health and mental health. Sixteen *Place Matters* teams comprised of local government, health

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organizations, businesses, faith groups, educational institutions, and community-based organizations have formed. Each team identifies local issues, develops, and implements strategies that promote health equity. Policy reform and changing inequitable community conditions are the focus of many of the initiatives.

For example, in Alameda, California team objectives included insuring affordable safe housing is available, increasing access to quality education, eliminating institutional oppression that occurs within the criminal justice systems, and increasing living wage and employment opportunities. In Bernalillo County, New Mexico, the team advocates for social policies that reduce environmental burdens that disproportionately affect low-income minority neighborhoods in the county. In Orleans Parish, Louisiana the team addresses community violence. They assess existing violence-related policies and plan a youth violence intervention group. In Boston, Massachusetts team efforts center around racism, a root cause of inequities, and they seek to implement comprehensive racial justice strategies. All of the initiatives begin with the knowledge that place matters and they seek to create conditions that foster health and behavioral health (Joint Center for Political and Economic Studies, 2011).

Research on Community Interventions

Research on the effectiveness of community interventions is growing despite the numerous challenges involved in community research. The effects of interventions on social determinants can take years to manifest, and most research studies are time limited. The gold standard of a Randomized Controlled Trial (RCT) is difficult to implement in community studies. It is difficult to monitor the exposure of a control group, and equally challenging are attempts to control the larger context (Braveman, Egerter, Woolf, & Marks, 2011). However, community-based participatory research (CBPR) is emerging as a successful research and

intervention process. CBPR brings academicians and community members together as equal partners to identify research objectives and develop interventions that address community as well as researcher needs (Koh, Oppenheimer, Massin-Short, Emmons, & Geller, 2010). , While community members provide insight into culturally appropriate strategies that might work for their community, researchers are able to share knowledge of best practices and assist in designing evaluation processes that track outcomes. Many of the community research projects funded by REACH U.S. to address health disparities employ CBPR strategies such as the Charleston and Georgetown Diabetes Coalition project described above (Center for Disease Prevention, 2010).

Another successful example of CBPR is the Start Right Coalition in New York. Disparities in immunization rates are commonplace in communities of color, thus the coalition's mission was to promote the immunization of children between the ages of 0-5 within a low income diverse community in New York City. Coalition members consisted of 23 organizations including one academic partner. The coalition initiated their project by gathering data about immunization rates, conducting focus groups to learn about the communities' experiences with immunization, and by reviewing strategies that have been used previously in the focal community to promote vaccinations. Leadership and decision making was shared between the community and academic partner and together they developed a multipronged educational strategy using evidenced-based approaches to promote community immunizations. The coalition successfully achieved its immunization goals reaching 10,000 children and by year 3 the coalition had eliminated disparities for children whose families participated in the project (Findley, Sanchez, Mejia, Ferreira, Pena, Matos, Stockwell, & Irigoyen, 2009).

Further, there is substantial research on intermediate variables and risk factors linked to poor health and behavioral health. Studies reveal that the presence of parks, bike paths, and perceptions of a safe neighborhood are linked to the amount of physical activity in which residents engage. Access to grocery stores that provide options such as fruits and vegetables is connected to healthier diets. Conversely, density of liquor store outlets, fast food restaurants, accessibility of tobacco products, and prevalence of tobacco advertising are associated with negative health behaviors. This knowledge can be used in designing interventions (Braveman, Egerter, Woolf, & Marks, 2011b).

Research demonstrates that what is sold and advertised in a neighborhood influences community norms. When junk food is available, children will make poor dietary choices more often than not (Miller et al., 2011a; Woolf et al., 2011). Armed with this knowledge, community interventions should tackle the intermediate factors or risky conditions associated with negative health outcomes (Braveman et al., 2011). Similarly, policy interventions should be informed by current available knowledge of the social determinants of health and the protective processes that promote wellness (Adler & Newman, 2002).

Policy to Program Initiatives

A compelling body of research links parent education and the socioeconomic conditions that children grow up in to adult health disparities. For example, children's nutrition varies with parent income and education, and children's nutrition affects future health (Braveman et al., 2011). Numerous stressors encountered by low-income families potentially compromise care giving. Food insecurity, unstable housing, environmental toxins that disproportionately impact disadvantaged children, inadequate childcare services, and lack of health insurance and care are all conditions that impact the well-being of children. Chronic stress encountered by children

without parents to buffer them from sustained adversity can also affect brain development. Overall, research demonstrates that unhealthy children grow into unhealthy adults. Policy initiatives that address these social conditions that impact the lives of children and promote positive development are essential for population level changes (Hernandez, Montana, & Clarke, 2010; Miller, Pollack, & Williams, 2011).

Programs like *Head Start* and the *Nurse-Family Partnership* are directly linked to improved outcomes in childhood as measured by achievement scores, social, emotional behaviors, and IQ scores. A few of these studies have followed children long enough to document higher educational attainment and employment status among those who receive the early childhood intervention, but few have examined adult health and mental health outcomes. Other studies further connect children's socio-emotional and cognitive development with future educational attainment and employment (Braveman et al., 2011). Given the solid body of research that links educational attainment to a variety of adult health outcomes, the Robert Wood Johnson Foundation's Commission to Build a Healthier America inferred that early childhood interventions are an effective strategy for reducing adult health disparities (Braveman & Egerter, 2008). Hence, advocating for funding early childhood programs is an effective policy approach for addressing disparities.

Policy Initiatives and Legislative Change

Policy initiatives have been effective in altering societal conditions associated with disparities (Butterfoss & Cohen, 2009). For example, tobacco control legislation such as banning smoking in public places, price hikes, and tobacco taxes in conjunction with counter-advertising and individual and group counseling/education programs has led to a reframing of tobacco from a hobby to a health hazard. States such as California and Massachusetts that have implemented

comprehensive community initiatives against tobacco have seen declines in per capita consumption with declines being most significant among more educated groups (Koh et al., 2010). These initiatives demonstrate that comprehensive community efforts, inclusive of policy initiatives, can promote population level change (Gehlert, Mininger, Sohmer, & Berg, 2008). To affect disparities, however, efforts must target high-risk groups just as tobacco companies target these groups for advertising. This could include focusing media campaigns on low-income and ethnic minority groups as well as insuring that health insurance for the poor covers smoking-cessation treatment (Adler & Newman, 2002).

Policy efforts to increase access to care by providing health coverage have been moderately successful. With the Affordable Care Act, many low-income families will have access to health care by 2013. Yet, research indicates health care coverage alone is not sufficient for eliminating disparities (Adler & Newman, 2002). In 2006, Massachusetts passed comprehensive health legislation that led to near universal coverage for state residents. Zhu and colleagues (2010) examined the impact of this legislation in comparison to all other New England states. They found coverage rates improved significantly in Massachusetts in comparison to other New England states, and adult reports of financial barriers to health care declined in Massachusetts, whereas throughout the remainder of New England they remained steady. However, access to a personal health care provider and health status as determined through self-reports remained the same in both Massachusetts and the rest of New England. Disparities in health coverage between Blacks and Hispanics in comparison to Whites were not narrowed in Massachusetts because of similar increases in health coverage for Whites. Health care reform in Massachusetts reduced financial barriers for Whites but not for Hispanics and Blacks. This study suggests that in addition to health care coverage, other focused interventions

are necessary to achieve health equity (Zhu, Brawarsky, Lipsitz, Huskamp, & Haas, 2010). Social workers must be engaged in health reform efforts that promote universal coverage and that address barriers that impede access such as a fragmented health care system and/or the lack of a culturally and linguistically competent work force.

Other potential policy interventions that address health care systems could include increasing the quality of care provided in low-performing hospitals. As previously described, low-income and ethnic and racial minority families live in neighborhoods where the quality of available health care is often low (Hasnain-Wynia et al., 2007). Addressing geographic variation in health care could entail increasing resources for particular hospitals or providing incentives for physicians to work in particular areas. In order to guide policy intervention, more research must be conducted that disentangles the myriad of factors that contribute to poor quality care (Baicker, Chandra, & Skinner, 2005).

While it is essential to improve health care systems, available evidence indicates medical care is just one contributor to the overall health of a population. To address disparities, policies must concomitantly tackle upstream determinants of health such as housing, neighborhood conditions, and socioeconomic status (Williams, Costa, Odunlami, & Mohammed, 2008). Socioeconomic status is one of the most fundamental causes of disparities linked to being able to purchase health care and to better nutrition, housing, and schooling. Socioeconomics largely dictates the neighborhood conditions one will live in, including exposure to environmental toxins, community violence, and neighborhood social cohesion and organization. Numerous studies report on the adverse impact of living in poverty on child development and health outcomes. Evidence suggests interventions such as Moving to Opportunity Programs and

income supplement programs that reduce poverty and alter neighborhood conditions can significantly alter health outcomes (Williams, Costa, Odunlami, & Mohammed, 2008).

A study by Herd et al. (2008) documented how additional income for elders on Supplemental Security Income (SSI) reduced disability. For every \$100 increase in monthly income, there was a 4.6% reduction in disability. Another study looked at the impact of income supplements on the mental health of American Indian children. Children in the program received income stipends from the profits of a casino built on the reservation. Additionally, families enrolled in the program were offered preferential employment in the casino, motels and restaurants in the area. Children in the program demonstrated decreases in deviant and aggressive behavior. By the fourth year of the program, their psychiatric symptoms were comparable to children who were never poor (Costello, Compton, Keeler, & Angold, 2003).

While income supplement programs demonstrate potential in promoting positive health outcomes, redistributive policies are likely to be met with controversy. The Earned Income Tax Credit is an example of a federal policy that raises the income of working class families whereas welfare reform is an example of legislation that generally decreased income of recipients. What is essential is that social workers and health advocates consider the health implications of these and all policies and that we continually engage in policy change efforts at the local, state and national level that create conditions conducive to well-being (Adler & Newman, 2002).

Recommendations

Research and practice in health and behavioral health disparities provides a compass for social workers to address disparities that have plagued racial and ethnic minorities for more than a century. The profession must move forward with the recognition that physical health and mental health are interwoven and improvements in one will, in all likelihood, lead to

improvements in the other (Miles, Espiritu, Horen, Sebian, & Waetzig, 2010). Further, social workers must be trained to work with diverse communities towards eliminating health and behavioral health disparities. This will require new investments, approaches and models in the social work curriculum and training guidelines.

The following are recommendations for social work preparation programs and professional development initiatives:

Recommendation 1 - Lead the Way in Creating Collaborative Care Paradigms

Social work practica and professional development programs should integrate the teaching and learning of implementation strategies useful for collaborative leadership and community-based team building to ensure effective social work practices that lead to optimal health outcomes.

As the literature shows, a collaborative community-professional relationship enhances health outcomes at all levels. Referral processes can be simplified and applied across specialties. Effective implementation of strategies such as co-location, collaborative care, combined practice teams, and integrated efforts requires collaborative skills and strategies in addition to professional expertise and, in fact, requires the capacity to allow the community members to be the experts. Training in organizational systems, group process, and collaborative leadership is essential to the success of such efforts and the profession must prepare social workers to embrace interdisciplinary and collaborative approaches (Robiner, 2006).

Recommendation 2 – Infuse Strategies for Wellness

Social work curricula, practica, and professional development programs should infuse strategies for wellness into the teaching and learning of the profession as schools of social work prepare, update, and retrain professionals.

Literature related to strategies of wellness which encourage a strengths-based holistic approach to health and behavioral health and which build on existing elements of resiliency must be infused across all topic areas of social work professional learning. Incorporating principles of building networks of community health workers, combining the foci of physical and behavioral health into a wellness profile, and, ensuring that cultural and linguistic competence and the use of promising and/or proven culturally grounded programs become the focus of professional preparation could positively change the social work approaches implemented with underserved populations affected by health disparities.

Recommendation 3 – Incorporate Universal Protective Factors and Resiliency

Social work curricula, practica, and professional development programs should integrate knowledge and skills related to identification and enhancement of universal protective factors and resiliency resources into all teaching and learning objectives for the preparation, updating, and retraining of professional social workers.

Resources and protective processes that strengthen the resilience of children, families, and all residents are currently in place within communities and are imperative to consider when designing and implementing program services. The literature suggests there are several *universal* factors that appear to be protective across communities and cultures as well as unique characteristics that serve as protective factors. Knowing that these resources may already be in place within communities, and knowing how to draw upon those resources to assist in building resilience is imperative for social workers. Emphasis on protective factors in all program strategies and immediate application in field-based efforts is essential. Giving all social workers “a place to begin” to build resiliency-driven programs and services based upon already recognized protective factors would increase social worker capacity and program effect.

Recommendation 4 – Create Conditions Conducive to Healthy Living

Social workers must be active in creating environments conducive to health living and that promote optimal health for all people. Cognizant that racial and ethnic disparities are a social justice issue, social workers must be prepared to address the oppressive conditions that impede the well-being of disparity populations and communities. .

Public health has been defined as “what we do as a society to assure the conditions for people to be healthy” (Satcher & Higginbotham, 2008, p.400). Public policy is central to creating environments that enhance well-being and social workers must engage actively in creating and implementing both plans and policies that will result in optimal community health responsive to ethnic and racial groups. Addressing the needs of an underserved community will require that social workers work with community infrastructure to modify policies, legislation, and practices that have created barriers to adequate and appropriate health-driven environments.

Recommendation 5 – Build and Strengthen Diversity in the Social Work Workforce

The profession must recruit a workforce reflective of our nation’s growing diversity.

Lack of diversity among health and behavioral health providers is a contributor to the underutilization and poor quality of health and behavioral health care provided for ethnic and racial minorities. Social workers must advocate for funding to market and raise community awareness of the shortage of ethnic and racial minorities in the profession, support policies such as loan forgiveness programs that will encourage ethnic and minority college attendance and completion, and actively engage in workforce development efforts already in process such as the *Alliance for Latino Behavioral Health Workforce Development*. Schools of social work must partner with public and private educational institutions and other community partners to address the educational underperformance of ethnic and racial minorities that occurs at multiple

educational levels and create plans that will facilitate the graduation of minority students. Curriculum that promotes cultural and language competence should be implemented in schools beginning in middle school and continuing through college. Universities must develop plans to recruit and retain ethnic and racial minority students as well as faculty and take steps to provide rich learning environments inclusive of Spanish immersion (and likewise) programs and cultural and social diversity courses (Chapa & Acosta, 2010).

Recommendation 6 – Incorporate Cultural and Linguistic Competency

Mindful of the connection of cultural competence and language to participation rates, satisfaction, and potential health and behavioral health outcomes, social workers must be equipped to provide culturally and linguistically competent care.

Cultural competence is instrumental to the success of interventions. CLAS standards provide mandates, guidelines, and recommendations for health care and other providers that can decrease language barriers to care. Social workers must advocate on behalf of consumers for organizations to comply with existing standards. In addition to linguistic competence, research exists to guide social workers in providing services that are culturally congruent and effective (Castro, Barrera, & Steiker, 2010). Cultural competence and evidenced-based interventions are essential for increasing access and quality of care for people of color (Whaley & Davis, 2007). Evidence-based interventions have demonstrated success with some ethnic and racial groups, and culturally adapted programs likewise reveal they can be as effective as original evidenced-based interventions (Castro, Barrera, & Steiker, 2010; Griner & Smith, 2006; Huey & Polo, 2008; Miranda et al., 2005). Equally promising are interventions that emerge from the culture of the focal population. Interventions grounded on the culture of participants often address the risk and protective factors specific to ethnic and racial groups not addressed by standard interventions.

Recommendation 7 – Implement Effective Strategies in Building Systems of Care

Social workers must be involved in creating systems of care that integrate strategies of wellness, resiliency resources, and enhancement of protective factors that result in optimal physical and mental health.

Systems of care include a continuum of services such as education, medical care, housing resources, early education and childcare, afterschool and recreation programs, and faith based activities and groups (Miles, Espiritu, Horen, Sebian, & Waetzig, 2010). Existing literature describes multiple initiatives that may prove successful across settings. Social workers must be prepared to apply both knowledge and practical approaches to ensure that creative systems are designed and implemented within the communities they serve.

Recommendation 8 – Work Towards Reducing Health and Behavioral Health Disparities

Social workers must be prepared to address determinants of health and behavioral health.

Years of research reveal numerous determinants of health. Interventions that do not take all levels of determinants into account may affect individual outcomes without putting much of a dent in racial and ethnic disparities (Gehlert et al., 2008; U.S. Department of Health and Human Services, 2011b). The U.S. Department of Health and Human Services launched the HHS Action Plan to Reduce Health Disparities in April 2011. This comprehensive plan outlines goals and actions that HHS will take to decrease health disparities among racial and ethnic minorities. Goals and objects are broad and include transforming health care and expanding access, strengthening the health and human service workforce by increasing diversity within the workforce, training more medical interpreters, and training community health workers, and attention to social, economic, and environmental factors that contribute to health disparities (US

DHHS, 2011a, 2011b). Social work must support these efforts and partner with public and private sectors to achieve the goals and objectives outlined in the HHS Action Plan.

Recommendation 9 – Partner with Community Leaders

Social workers must become adept at recruiting, training and working alongside community leaders to engage, support, and educate community members and implement community-based participatory research.

CHWs have been used successfully to improve health care access and utilization, increase health and behavioral health knowledge, and enhancing the health status of ethnic and racial minorities. As members of the focal community, they are able to deliver services in a manner that honors the communication styles, beliefs about illness and health, and cultural values of community members (McQuiston, Choi-Hevel, & Clawson, 2001; Satterfield et al., 2002; Spencer, Gunter, & Palmisano, 2010). Similarly, CBPR is a powerful strategy that necessitates community buy in and input to increase the effectiveness and cultural fit of community research and interventions (Findley, Sanchez, Mejia, Ferreira, Pena, Matos, Stockwell, & Irigoyen, 2009). Social workers must recognize the assets of community members and work effectively with them as equal partners in addressing health and behavioral health disparities.

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APPENDIX A

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