Review of Findings:
Behavioral Health Inequities & Disparities in Washington State from a Behavioral Health Community Perspective

UW Medicine Behavioral Health Institute
at Harborview Medical Center

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Executive Summary

This executive summary provides an overview of the Behavioral Health Inequities project, in which behavioral health inequities and disparities in Washington state were evaluated from the perspective of behavioral health key informants. The project team developed the recommendations in this report based on input provided through a survey, four community listening sessions, and the guidance and experience of members of the Behavioral Health Inequities Workgroup.

Project Background

In response to inequities in behavioral health access and disparities in behavioral health outcomes, the Washington State Legislature funded the Health Care Authority (HCA) and the UW Medicine Behavioral Health Institute at Harborview Medical Center (BHI) to evaluate behavioral health inequities and disparities and identify recommendations to advance equity and reduce disparities.

Project Activities

The project comprised several activities that informed the development of the recommendations:

- **Behavioral health community survey:** Gathered community input using a survey administered to the attendees of the September 2022 Race, Equity, and Social Justice Conference – Re-imagining Behavioral Health. A total of 180 responses were received, representing 24 of Washington's 39 counties.
- **Community listening sessions:** Facilitated four listening sessions focused on behavioral health inequities and disparities to gather more in-depth feedback. The 154 participants were members of the behavioral health community from around the state.
- **Behavioral Health Inequities Workgroup:** Convened an 18-member Behavioral Health Inequities Workgroup composed of individuals with diverse areas of expertise, backgrounds, and perspectives on behavioral health and equity. Workgroup members reviewed and synthesized community feedback, and informed development of the recommendations in this report.
- **Environmental scan:** Conducted a comprehensive search for initiatives and programs addressing behavioral health inequities and disparities in Washington state and nationally. There are no known statewide initiatives focused specifically on behavioral health equity.
- **Report and literature review:** Reviewed relevant literature and reports, starting with information focused on behavioral health inequities and disparities in Washington State and expanding to national resources. There is limited information specifically focused on behavioral health inequities and disparities in Washington state.

Focus Areas

The project team synthesized and coded the information collected from the survey and four listening sessions, identifying 23 themes based on their frequency of mention. With input from the members of the Behavioral Health Inequities Workgroup, the 23 themes were synthesized to the following eight focus areas and two foundational concepts integral to all the of focus areas.

Foundational concepts:

1. The impact of systemic discrimination, racism, intergenerational trauma
2. The impact of social determinants of health on behavioral health equity

Focus areas:

1. Lack of insurance coverage, limitations of insurance (including Medicaid), and/or inability to pay for services
2. Lack of sustainable funding – for both ongoing services and innovative programs
3. Workforce shortage
4. Lack of workforce diversity
5. Lack of needed behavioral health services for specific communities
6. Unique behavioral health challenges faced by rural communities
7. Systemic lack of culturally responsive, person-driven behavioral health supports
8. Lack of access to services

Recommendations

The project team developed recommendations based on feedback and insights from the behavioral health key informants involved in the project. The recommendations represent a culmination of the community feedback and aim to guide future actions for advancing behavioral health equity in Washington state. The six key recommendations are:

1. Create a statewide Behavioral Health Equity Center of Excellence or a similar organizing body.
2. Resource the Center of Excellence (or similar organizing body) with the necessary staff support and expertise.
3. Develop a statewide Behavioral Health Equity Strategic Plan with short-, medium-, and long-term goals.
4. Establish shared statewide metrics for measuring progress in reducing behavioral health inequities.
5. Coordinate with existing efforts to leverage and develop work already underway.
6. Create a Behavioral Health Equity Toolkit to provide resources for public and private Washington state entities that want to advance equity.

The workgroup also developed additional recommendations that can be integrated into the longer-term strategy to advance behavioral health equity in Washington state (in Appendix D).

Project Introduction

Despite progress in areas, behavioral health inequities continue to negatively affect many Washington state community members. In recognition of this, the Washington State Legislature funded the Health Care Authority (HCA), in partnership with the UW Medicine Behavioral Health Institute at Harborview Medical Center (BHI), to evaluate behavioral health inequities and disparities in Washington and identify strategies to advance behavioral health equity and reduce behavioral health disparities.

In recent years, there has been growing interest in and attention to addressing health disparities nationally and in Washington state. One health disparity that is frequently cited is disparity in life expectancy based on residential zip code. For example, the average life expectancy in Auburn, located in south King County, is 73 years, while on Mercer Island, a wealthier community just east of Seattle, the life expectancy is 86 years [1]. Although there is significant work around the state focused on advancing health equity, both by the government and private sector, more attention is required to address health inequities and disparities across the state. Behavioral health equity is part of that larger picture of health inequities and disparities. However, inequities within the behavioral health system have received far less attention, despite the fact that individuals living with severe mental illness die on average 10 to 20 years earlier than individuals living without mental illness [2].

The goal of this project was to look at behavioral health inequities and disparities across Washington state and to better understand some of the factors driving those inequities. For the purposes of this project, the project team used the following definitions:

Behavioral health equity is the right to access high-quality, culturally responsive behavioral health care for everyone, regardless of their race, ethnicity, abilities, gender identity, age, socioeconomic status, sexual orientation, geographical location, and more.

Behavioral health disparities are different behavioral health outcomes experienced by groups based on their social, ethnic, or economic status, which can result from behavioral health inequities.

Data published in the 2022 Comparative and Regional Analysis Report [3] showed that there are behavioral health inequities based on race and ethnicity in Washington state. In all behavioral health measures, individuals who identified as Black were statistically less likely to receive behavioral health-related care as

[1] "Life Expectancy." Communities Count. Communities Count, January 12, 2022. https://doi.org/c8c10665-61f0-4b8f-904c-483de6b0975b.
[2] L.D. de Mooij, M. Kikkert, J. Theunissen, A.T.F. Beekman, L. de Haan, P.W.R.A. Duurkoop, H.L. Van, and J.J.M. Dekker, "Dying Too Soon: Excess Mortality in Severe Mental Illness," Frontiers in Psychiatry 10 (December 6, 2019): 855, doi:10.3389/fpsyt.2019.00855, PMID: 31920734, PMCID: PMC6918821.
[3] "2022 Comparative and Regional Analysis Report" (Seattle, WA: Comagine Health, December 2022).

compared to people who identified as White. This included follow up after a mental health-related hospitalization, substance use treatment rates, and use of medication for opioid use disorder.

As a first step toward understanding behavioral health inequities, this project sought to engage and understand the perspective of behavioral health key informants including peers, navigators, clinicians, administrators, researchers, and others who work in behavioral health. In particular, the project team sought to elevate voices of those with lived experience in behavioral health and those most impacted by behavioral health disparities, including Black, Indigenous, and other People of Color (BIPOC); the lesbian, gay, bisexual, transgender, and queer (LGBTQ+) communities; and those in rural areas. The project team gathered key informant feedback through a survey, community listening sessions, a Behavioral Health Inequities Workgroup, and other targeted interviews.

In addition to the community feedback, project staff conducted an environmental scan to identify aligned work and a literature and report review focused on behavioral health inequities.

Process: Survey of Behavioral Health Community Members

The first step in gathering community input for this project was asking the 927 attendees of the September 2022 Race, Equity, and Social Justice (RESJ) Conference – Re-imagining Behavioral Health – to complete a survey regarding inequities in the Washington behavioral health system. The annual RESJ conference is a collaborative effort between the Behavioral Health Institute (BHI) and the Washington Health Care Authority to create a forum for the state's behavioral health community to learn about and address RESJ issues specific to behavioral health. Among the 647 people who completed the conference evaluation form, 80% identified as working in the behavioral health field and 20% identified as "other," which included community members.

A total of 180 survey responses were received from people representing 24 of Washington's 39 counties. Eighty-four percent (84%) of the respondents were from counties categorized as urban by the Washington Department of Health.[4] For comparison, 79% of Washington's residents live in counties categorized as urban.

The survey asked three questions about the survey respondent:

1. What WA county do you represent?
2. What is your primary role in the behavioral health community?
3. Would you be willing to participate in a Zoom feedback session? If so, respondents were asked to provide their name and email address.

The survey had four content questions, which are listed in Table 1, along with a summary of the most frequent responses. A fuller list of common survey responses is in Appendix A.

[4] "Rural Urban Counties Map" (Reviewed in 2021), Washington State Department of Health, accessed May 15, 2023, https://doh.wa.gov/sites/default/files/2022-09/609003.pdf?uid=6451dfb204fde.

Table 1: Summary of Abbreviated Responses to October 2022 Post-Conference Survey

Survey Questions	Summary of Responses
1. In your area, what populations do you see the most impacted by behavioral health inequities?	● Members of BIPOC communities ● Those who are unhoused (This was reported equally among respondents from rural and urban counties.)
2. What do you see as barriers to accessing behavioral health services in your area?	● Lack of insurance coverage or difficulty finding a provider who accepts certain insurances, coupled with a lack of ability to pay for services not covered. ● Workforce shortage (leading to a lack of services and long waitlists) and workforce diversity (i.e., finding a provider who reflects the community, life experiences, and/or language of those seeking behavioral health [BH] services)
3. What successes have you seen in addressing behavioral health inequities?	● Having BH providers who reflect the community, life experiences, and/or language of those seeking service. ● Offering peer support/peer counselor programs
4. Is there anything else we should know about behavioral health inequities in WA state?	● Systemic racism and discrimination are barriers to BH care and to overall BH wellbeing. ● Concern about a lack of sustainable funding

Process: Behavioral Health Community Listening Sessions

In January 2023, the project team conducted four listening sessions to gather more in-depth information about the focus areas identified in the survey. The combined survey and listening session feedback provided a broad range of perspectives from diverse voices from the behavioral health community throughout the state.

The listening sessions were open to anyone. The 78 people who indicated interest in further participation when completing the survey were invited to a listening session and were also asked to share the invitation email with other Washington state residents with an interest in behavioral health equity. Additionally, information about the listening sessions was shared through social media, behavioral health email lists, and sent directly to individuals working with diverse communities for further distribution.

Each listening session focused on either rural/frontier areas or urban/suburban areas. This was to ensure those from rural areas had an opportunity to voice their unique experiences and concerns. However, participants could participate in whichever listening session fit their schedule, regardless of the type of community in which they live or work, and the questions were the same in all the listening sessions.

"Transportation and poverty are huge barriers. There isn't a functioning bus system, taxis, or Ubers in this area, and this [rural] county is HUGE. It's not like someone can walk if they live 50+ miles away from the clinic."

Each listening session included a brief anonymous Zoom poll to identify group demographics. Among the four listening sessions:

- 75% identified as having lived behavioral health experience.
- 55% identified as White or European American and 16% identified as being "two or more races."
- 53% of the participants identified as being from rural areas.
- 82% identified as female.
- 24% identified as LGBTQ+.
- 94% identified as speaking English at home.

Table 2 includes additional information about the listening session participants gathered through the Zoom poll. Please note that to minimize the number of demographic questions in the poll, the project team inadvertently neglected to ask about ethnic identity. Because of this omission, the listening session data did not capture the number of participants who identify as Hispanic or Latino/a.

Table 2: January 2023 Listening Session Participant Information

	Jan. 4	Jan. 5	Jan. 10	Jan. 12	Total*
Number of participants**	52	35	35	32	**154**
Focus of listening session	Rural/ frontier	Urban/ suburban	Rural/ frontier	Urban/ suburban	
Percent who responded to the Zoom poll	84%	71%	77%	78%	**77%**
Percent who responded "yes" to working in a rural or frontier area	69%	28%	74%	28%	**53%**
Percent who identify as: * +**					
- American Indian or Alaska Native	0%	0%	7%	4%	**3%**
- Asian American	2%	12%	4%	20%	**8%**
- Black or African American	7%	20%	4%	4%	**8%**
- Other	5%	4%	11%	12%	**8%**
- Two or more races	12%	16%	22%	16%	**16%**
- White or European Amer.	71%	36%	44%	56%	**55%**

Percent who identify as: * +**					
- Administrator	55%	40%	26%	52%	**45%**
- Direct client/patient care	17%	20%	48%	16%	**36%**
- Other	29%	20%	26%	32%	**27%**
Gender: * **					
- Female	79%	76%	85%	92%	**82%**
- Male	14%	20%	11%	4%	**13%**
- Transgender, non-binary, or non-conforming	5%	4%	4%	4%	**4%**
Percent who identify as LGBTQ+	21%	24%	19%	32%	**24%**
Percent who identify as having a long-term disability	12%	12%	19%	28%	**17%**
Percent who identify as a person with lived behavioral health experience	74%	64%	78%	84%	**75%**
English is primary language spoken in household	95%	96%	96%	92%	**94%**

** Percentages are of the 119 people who completed the poll.*

*** There is some duplication, as a small number of people registered for and/or participated in more than one session.*

**** Some categories do not total to 100% because for some questions some people selected more than one response or selected "prefer not to answer" and/or rounding errors.*

+ The project team inadvertently omitted a question about Hispanic or Latino/a ethnic identity and, therefore, the table does not indicate how many people in the listening sessions identified as Hispanic or Latino/a.

Due to a limitation with Zoom polls, participants were asked what region in the state they were from, rather than asking what county they were from. Responses were grouped based on the Accountable Communities of Health regions.[5] All sessions had participants from various WA regions, and among the four sessions, all nine Washington regions were well represented, including 19 participants (12%) who identified as having "statewide representation."

The listening sessions were led by facilitators with expertise in equity, diversity, and inclusion. At the listening sessions, the facilitator asked the following questions:

1. What does behavioral health equity, or inequity, mean to you?
2. In your area, what populations do you see the most impacted by behavioral health inequities?
3. In your experience, what do you see contributing to behavioral health inequities and/or making it worse?
4. What successes and innovations do you see making behavioral health inequities better?
5. What ideas and recommendations do you have for advancing behavioral health equity in Washington state?
6. What voices are not represented in this room that we should include?

[5] "ACH Regions Map" (April 2023), accessed February 8, 2023, https://www.hca.wa.gov/assets/program/ach-map.pdf.

The listening session participants provided responses both in discussion and in the Zoom chat function. The listening sessions were recorded (with participant awareness), and after the listening sessions, project staff reviewed the sessions and read and coded the Zoom audio transcripts and chat text. The same coding themes were used for both the listening sessions and the survey.

Data Compilation Methodology

Project staff reviewed and coded all information and input gathered from the survey and four listening sessions, using the following 23 codes (listed in alphabetical order), identified in the comments more than two times:

1. Access/comfort using technology needed for telehealth, online communication
2. Challenges accessing care, including geographic considerations, scheduling access (e.g., conflicts with work schedules, especially for agricultural workers), transportation issues (especially in rural areas), and confusing protocols/processes for accessing care
3. Disability as a barrier (including intellectual disabilities)
4. Funds to develop new, innovative programming
5. Family responsibilities
6. Homelessness/unstable housing/access to housing
7. Lack of ability to pay for services (including difference between insurance and costs)
8. Lack of insurance coverage or type of insurance coverage
9. Lack of services for high-acuity mental health
10. Lack of services for substance use disorder (SUD, including high-acuity SUD)
11. Lack of services for youth and young adults
12. Lack of services/access for those involved with the criminal justice system
13. Lack of sustainable funding
14. Peer support/peer counselors
15. Poverty (including food insecurity)
16. Pregnant & parenting individuals
17. Prevention
18. Rural behavioral health is inherently more inequitable than urban behavioral health
19. Stigma
20. Systemic discrimination/racism/intergenerational trauma
21. Systemic lack of person-centered treatment interventions (e.g., culturally specific treatment, alternative strategies/therapies, addressing intersecting identities)
22. Workforce diversity
23. Workforce shortage

After identifying which of the 23 codes were mentioned most frequently, project staff aggregated them into nine themes, which were later revised based on input from the Behavioral Health Inequities Workgroup, as described in the next section.

Survey and Listening Session Findings

The 23 ranked themes that emerged when project staff coded the survey and listening session data generated these nine preliminary themes (listed in a random order).

1. Systemic lack of person-centered treatments
2. Workforce shortage
3. Workforce diversity
4. The impact of systemic discrimination, racism, and intergenerational trauma
5. Challenges accessing care
6. Lack of behavioral health services for specific services and communities
7. Unique behavioral health challenges faced by rural communities
8. Lack of insurance coverage, limitations of insurance (including Medicaid), and/or inability to pay for services
9. Lack of sustainable funding – for ongoing services and innovative programs

> *"We need more clinicians to meet the demand. We can't get more if the choice to be a behavioral health worker puts them in or near poverty."*

The workgroup members reviewed and discussed those nine preliminary themes and suggested a revised list of eight (reworded and reordered) themes, along with two foundational concepts that apply to all the themes. The members recommended re-ordering the list to take into consideration the interdependency of the focus areas. For example, they moved the two items related to funding to the top of the list because without additional funding and higher reimbursement rates, the subsequent focus areas cannot be effectively addressed.

The two foundational concepts that are integral to all the focus areas are:

1. The impact of systemic discrimination, racism, and intergenerational trauma
2. The impact of social determinants of health on behavioral health equity

The following is the revised list of eight focus areas, based on feedback from the Behavioral Health Workgroup:

1. Lack of insurance coverage, limitations of insurance (including Medicaid), and/or inability to pay for services
2. Lack of sustainable funding – for both ongoing services and innovative programs
3. Workforce shortage

4. Workforce diversity
5. Lack of needed behavioral health services for specific communities
6. Unique behavioral health challenges faced by rural communities
7. Systemic lack of culturally responsive, person-driven behavioral health supports
8. Lack of access to services

Environmental Scan

Throughout this project, the project team researched and collected information about initiatives and programs with aligned goals related to understanding and addressing behavioral health inequities and reducing disparities. Most of the resources were from Washington state, and a few were national. Resources were identified by searching the Web and following up on leads from project participants and key informants. In Appendix B is a chart that outlines the resources identified.

One notable theme was that most health equity work does not specifically call out behavioral health, and most behavioral health advocacy and planning work does not explicitly call out inequities and disparities. That said, many health equity programs and initiatives include behavioral health, and many behavioral health programs and initiatives include a strong focus on equity.

Most health equity work does not specifically call out behavioral health, and most behavioral health advocacy and planning work does not explicitly call out inequities and disparities.

Report and Literature Review

The project team conducted a review of relevant literature and reports with the goal of identifying key findings related to behavioral health inequities and disparities. The report and literature review can be found in Appendix C. The report review process began with the following search criteria: created within the last five years, Washington state-specific, and primarily focused on behavioral health inequities and disparities. As anticipated, there was very little information available that met the criteria, highlighting the need for the development of additional resources for use in clinical practice and administrative work. The search criteria was expanded to include national reports on behavioral health inequities and disparities, and state-specific resources on the issues of health equity and related behavioral health issues, such as access.

The review of reports and literature revealed inequities and disparities in both overall health and behavioral health that were accentuated due to circumstances related to the COVID-19 pandemic. The social determinants of health, systemic racism, and lack of access to care for members of BIPOC communities, LGBTQ+ communities, and those with fewer financial resources combined to result in increased challenges accessing and paying for high-quality, culturally relevant care. Key findings from the report and literature review (in Appendix C) were distributed to the Behavioral Health Inequities Workgroup participants for review and consideration.

Behavioral Health Inequities Workgroup

The workgroup for this project consisted of 18 behavioral health key informants with diverse backgrounds, expertise, perspectives, experiences, and statewide geographic representation. The majority identified as having lived experience in behavioral health. The workgroup membership included:

- Five Washington State employees (four from the Health Care Authority and one from the Department of Health)
- Five people from non-profit agencies (three peer specialists and one from a tribal organization)
- Three people from large health systems
- Three people from local or county government
- Two community volunteers

In addition to the members' formal roles, all of them brought diverse perspectives from groups they personally identified with, worked with, and/or advocated for. The members were invited to join the group based on their active participation in a listening session or a suggestion from a key informant. Members who participated on uncompensated time were offered a modest stipend for their time.

The Workgroup had three Zoom meetings (in March, April, and May 2023), in addition to several smaller-group optional meetings, where they:

- Reviewed processes and findings from the survey and listening sessions.
- Deliberated the preliminary nine themes that emerged from the survey and listening sessions.
- Revised and re-ordered the original list of nine themes into a list of eight focus areas with two foundational concepts.
- Discussed policies and programs that could address the state's behavioral health inequities and disparities.
- Reviewed a draft of this report, with a focus on the recommendations.

Workgroup discussion points:

- Foundational role of racism & intergenerational trauma
- Interdependence of behavioral health & social determinants of health
- Long-term nature of behavioral health equity work
- Importance of linking behavioral health equity to housing insecurity & homelessness
- Critical importance of partnerships

Recommendations

The members of the Behavioral Health Inequities Workgroup provided the guiding key principles in formulating the recommendations:

1. Advancing equity and reducing disparities in behavioral health is critical and cannot and should not be ignored in funding and policy priorities going forward.

2. Truly beginning to address the historic and systemic impacts of racism and other forms of discrimination that manifest in our behavioral health system requires a long-term, coordinated, and strategic approach. The effect of historical and current racism on the issues related to behavioral health inequities and disparities should not be minimized or oversimplified.

> *"We need to tackle racism in healthcare institutions."*

3. There is an urgency to move from talking about the problem of inequities and disparities in behavioral health to creating tangible action resulting in change. Members of the Behavioral Health Inequities Workgroup were long-time, passionate advocates of and champions for equity – in behavioral health and in other spheres. Many of them have been sharing their perspectives on inequities and disparities for decades. It is important that their voices do not get lost in an echo chamber of problem identification, without moving to problem solving. The problem of overwhelm and paralysis – for behavioral health staff, other key informants, and policy makers – was identified as a strong concern in how the recommendations are formulated.

4. Future strategies should be based on principles of targeted universalism[6] and designed to meet the need of those most impacted by behavioral health inequities and disparities with the understanding that all populations will obtain benefit of centering around those most affected by inequities and disparities.

The recommendations below are a culmination of the information received from the behavioral health community members who participated in the project, including members of the Behavioral Health Inequities Workgroup, who reviewed, informed, and refined the community feedback.

Recommendation 1: Create a statewide Behavioral Health Equity Center of Excellence, or similar organizing body, with a long-term and dedicated focus on advancing behavioral health equity and eliminating behavioral health disparities in Washington state.

There is existing work happening around the state to address behavioral health inequities and disparities. However, what presents as lacking is a strategic, coordinated, and collaborative approach and a centralized resource for the behavioral health community that is focused on providing long-term support and technical expertise to advance these aims. The ongoing behavioral health equity work could be structured as a center of excellence, or as a sub-group within a larger behavioral health-focused effort, agency, or organization with

[6] john a. powell, Stephen Mendendian, and Wendy Ake. "Targeted Universalism Policy & Practice." Othering & Belonging Institute at UC Berkeley, May 2019. Accessed June 26, 2023. https://belonging.berkeley.edu/sites/default/files/2022-12/Targeted%20Universalism%20Primer.pdf.

statewide involvement and influence, such as the recently funded Joint Legislative and Executive Committee on Behavioral Health.

The center of excellence would serve as a statewide behavioral health equity resource for the community that would highlight and disseminate best practices for increasing behavioral health equity and reducing disparities, identify unaddressed priority areas to avoid duplication of efforts, and maximize the use of resources and the corresponding impact. Additionally, the center of excellence would work closely with the Legislature to develop policy recommendations that advance equity and decrease disparity.

To avoid perpetuating inequities, it is crucial that the effort is situated within a lead organization that is grounded in equity principles, is guided by an awareness of the impact of historical power and oppression, and has a demonstrated commitment to engaging and empowering community and marginalized voices. This recommendation includes seeking direction from Tribal leadership regarding alignment and the potential establishment of a group specific to addressing behavioral health inequities within the Tribal and Urban Indian healthcare systems if requested.

Recommendation 2: Resource the Center of Excellence with the staff support and expertise needed to effectively develop, lead, coordinate, and implement the statewide strategy.

Meaningful progress toward reducing behavioral health inequities is not possible without adequate resources, including funding and support from the behavioral health community, community leaders, the Legislature, and other policy makers.

Recommendation 3: Develop a behavioral health equity strategic plan with short-term, medium-term, and long-term goals.

Build on the findings from this project as the foundation and first step towards a longer-term, coordinated strategy that would include short-term goals (within 2 years), medium-term goals (within 5 years), and long-term goals (10+ years). Organize the strategy around the identified focus areas in this report and establish sub-groups dedicated to each area, all with the overarching objective of addressing the needs of individuals and communities most impacted by behavioral health inequities and disparities.

The center of excellence would assume responsibility for developing and implementing the strategic plan, in partnership with communities and experts across the state, which will serve as a guiding framework for policy and program development.

Recommendation 4: Establish shared statewide metrics based on the strategic plan, which will measure progress toward advancing behavioral health equity and reducing disparities.

Shared statewide metrics are critical for aligning efforts and tracking progress toward common goals. To measure progress in behavioral health equity, the metrics should be specific to Washington state and meaningfully measure progress toward behavioral health equity. These metrics should also:

- Be developed in collaboration with statewide behavioral health partners and coordinate with existing behavioral health equity initiatives.
- Minimize additional administrative burden and build on current data collection processes, such as the annual Comparative and Regional Analysis Report to Washington Apple Health and Washington Health Care Authority and other data sources reported in Appendix C.
- Lead to improvements in access and quality for the state's entire behavioral health system, taking into account diverse communities' unique needs and considerations.

Recommendation 5: Coordinate with existing efforts already taking place to identify equity work that can be leveraged, and gaps in the current work that need to be addressed.

To ensure the effective advancement of behavioral health equity work, it is essential that efforts align with existing related work regarding behavioral health equity. Coordination, communication, and collaboration are key to avoiding competition for resources, duplication of efforts, and inefficiencies. Of particular importance is coordination in policy development and requests for legislative action.

The following are examples of potential initiatives to align with, and additional related work can be found in the Environmental Scan in Appendix B:

- Behavioral Health Advisory Committee
- CARE for Kids & Families (Part of UW CoLab)
- Children and Youth Behavioral Health Workgroup
- Crisis Response Improvement Strategy (CRIS)
- Governor's Interagency Council on Health Disparities
- State Prevention Enhancement (SPE) Policy Consortium
- Substance Use Recovery Services Advisory Committee
- Washington Health Care Authority's initiatives on Health Equity
- Washington's Workforce Training and Education Coordinating Board

Recommendations 6: Create a Behavioral Health Equity Toolkit

There was strong support from the behavioral health key informants who were involved in this project to prioritize addressing behavioral health equity, and there is also an opportunity to develop centralized state-specific resources for behavioral health agencies, organizations, and staff who are looking for meaningful ways

to advance equity. A behavioral health equity toolkit is a resource to empower organizations and clinicians to drive change toward more equitable access and outcomes. The proposed center of excellence would be responsible for developing and maintaining the toolkit, and it could be modeled after existing resources, such as the HCA Health Equity Toolkit.[7] The proposed toolkit could include:

1. Definitions of behavioral health equity, behavioral health inequities, and behavioral health disparities.
2. Recommended shared language and definitions to use when speaking about and navigating behavioral health equity and disparities.
3. Guidance for implementing organizational and clinical practices that promote behavioral health equity, for example integrating an Equity Pause [8] and using an Equity and Empowerment Lens [9] that center equity in decision making.
4. Strategies for effectively navigating resistance to implementing behavioral health equity.
5. Metrics that can be integrated into clinical practice, organizational management, and system-wide planning to measure progress towards health equity.
6. Vetted training resources that promote behavioral health equity.
7. Evidence-based and promising practices that have been developed or adapted for use with diverse populations.

Additional Recommendations

In addition to the recommendations above, the Behavioral Health Inequities Workgroup developed some preliminary recommendations that represent the type of activities and goals that could be integrated into a longer-term strategy. The comprehensive list of the recommendations identified during Workgroup meetings can be found in Appendix D.

Conclusion

Meaningfully addressing behavioral health inequities can feel daunting. The complexity of the problem can make it difficult to know where to start. Like many other societal issues related to social justice and equity, there are many behavioral health community members who have the knowledge, experience, passion, and dedication to increase behavioral health equity. This issue will not be solved using a top-down approach, but rather by empowering individuals within the behavioral health community to make changes to individual, organizational, community, and state practices that increase equity and reduce disparities. That empowerment must include providing the structure and resources to facilitate the process of increasing behavioral health equity through policy and funding changes.

[7] Washington State Healthcare Authority, "Health Equity Toolkit" (September 2021), accessed May 3, 2023, https://inside.hca.wa.gov/sites/default/files/health-equity-lens-toolkit.pdf.
[8] Public Design for Equity, "Equity Pause Questions," accessed May 24, 2023, https://www.publicdesignforequity.org/resources/2020/5/25/equity-pause-questions-H71mB.
[9] Equity and Empowerment Lens, Multnomah County, accessed May 24, 2023, https://www.multco.us/diversity-equity/equity-and-empowerment-lens.

Appendices

1. Appendix A: List of the Common Survey Responses
2. Appendix B: Environmental Scan
3. Appendix C: Report and Literature Review
4. Appendix D: Additional Recommendations

Appendix A: List of the Common Survey Responses

Survey Question	Common Responses
1. In your area, what populations do you see the most impacted by behavioral health inequities?	• Members of BIPOC communities • Individuals with low incomes • Those who are unhoused (This was reported equally among respondents from rural and urban counties.)
2. What do you see as barriers to accessing behavioral health services in your area?	• Workforce shortage (leading to a lack of available services and long waitlists) • Challenges accessing care, including: • Transportation • Geographical considerations • Scheduling obstacles (such as not being able to get appts outside of their working hours) • Lack of information on the available services • Confusing/complex processes to initiate care • Lack of insurance coverage or difficulty finding a provider who accepts their insurance • Lack of ability to pay for services not covered by insurance • Workforce diversity (i.e., finding a provider who reflects the community, life experiences, and/or language of those seeking behavioral health [BH] services) • Homelessness • Stigma associated with receiving BH services • Systemic racism and other discriminations, and intergenerational trauma • Lack of sustainable funding for BH programs and services

3. What successes have you seen in addressing behavioral health inequities?	● Having BH providers who reflect the identity, life experiences, and/or language of those seeking services ● Addressing the challenges of accessing care (e.g., transportation, lack of information, and scheduling) ● Addressing workforce shortage through better pay and/or working conditions ● Providing BH services for youth in schools ● Offering peer support/peer counselor programs
4. Is there anything else we should know about behavioral health inequities in WA State?	● The workforce shortage is a big problem, and low pay was mentioned as the most common reason. ● Lack of workforce diversity prevents many people from accessing and engaging in BH services. ● Homelessness was a salient concern, because people cannot effectively address their BH issues if their basic needs aren't met. ● There was a lot of concern about insurance, primarily whether people's insurance is accepted. ● There were many concerns re. access to care, such as lack of transportation, scheduling conflicts, and a lack of knowledge of the services available and how to access them. ● Many expressed that systemic racism and discrimination are barriers to BH care and to overall BH wellbeing. ● Many were concerned about a lack of sustainable funding.
Select additional ideas from the post-conference survey	● To increase access to BH services, we should invest more in low-barrier and harm-reduction programs. ● We should invest in culturally appropriate outreach to inform people about the available BH services and how to access them. ● There is a lack of trust in the community in the BH system. ● Some respondents expressed concern that not all families/parents are supportive of their children/youth utilizing BH services. ● Some respondents suggested that non-BH healthcare personnel (such as nurses) who work in a BH setting need training in BH concepts and DEI topics. ● Several people mentioned the need for additional DEI training for BH professionals. *(Note: This may be addressed with the forthcoming DEI training requirement for licensed healthcare personnel.)* ● Some respondents mentioned the benefit of BH professionals working with primary care providers and other cross-sector collaborations.

Appendix B: Environmental Scan

Please note that the list below is not exhaustive. There are certainly additional organizations and initiatives that are addressing behavioral health inequities in Washington state and nationally. The project team anticipates that the ongoing work related to the recommendations in this report will include the identification of additional activities to add to this initial list.

Organization or Initiative	Activities and Relevance
National	
National Network to Eliminate Disparities in Behavioral Health (NNED)	NNED is a "network of community-based organizations focused on the mental health and substance use issues of diverse racial and ethnic communities." The NNED webpage has information and resources, including opportunities for professional development and funding. This report – Evidence-Based and Culturally Relevant Behavioral Health Interventions in Practice: Strategies and Lessons Learned from NNEDLearn (2011-2020) – (32 pages) "provides findings from a qualitative analysis of evidence-based and culturally relevant behavioral health practices offered at NNEDLearn, a SAMHSA training, offered from 2011 to 2020. It includes an overview of NNEDLearn, case studies, strategies and lessons learned, and conclusion."
SAMHSA's Partnership for Equity webpage	SAMHSA's Partnership for Equity works to "achieve behavioral health equity for all under-resourced groups by building diverse, sustainable partnerships that maximize resources."
SAMHSA's Behavioral Health Equity webpage	SAMHSA's behavioral health (BH) equity website has abundant background information, data, reports, and issue briefs related to behavioral health equity. They have webpages devoted to specific demographic groups, and their policy webpage has several reports and other documents.
SAMHSA's Rural Behavioral Health webpage	This SAMHSA webpage has information about funding opportunities, programs, and models for rural communities.
CDC Health Behaviors in Rural America	This CDC website has a lot of information on different health behavior topics in rural areas. The BH topics they include are drug overdose and suicide. Regarding drug overdose, they report: "Rates of drug overdose deaths are rising in rural areas, surpassing rates in urban areas. Although the percentage of people reporting illicit drug use is lower in rural areas, the effects of use appear to be higher." Regarding suicide, they report: "In the past two decades, suicide rates have been consistently higher in rural America than in urban America. Between 2000-2020, suicide rates increased 46% in non-metro areas compared to 27.3% in metro areas. White non-Hispanic people have the highest suicide rates in urban areas

	(metropolitan counties), while non-Hispanic American Indian and Alaska Native people have the highest rates in rural areas. Moreover, rural residents have 1.5 times higher rate of emergency department visits for nonfatal self-harm than urban residents."
Health Equity and Behavioral Health Integration | The Academy (ahrq.gov)	This AHRQ webpage has an "overview of the role of behavioral health integration in reducing disparities in health and healthcare and shares practical strategies and resources for ensuring integrated practices are advancing health equity." Although the focus of this webpage is integrated care, there is good background information on health equity and the interconnectedness of physical and behavioral health in one's overall wellbeing as it relates to equity in health and social determinants of health.
Behavioral Health Equity Research Group (bheresearch.org)	"The goal of our group is to improve behavioral health equity by designing and testing innovative behavioral treatments. We design clinical trials that consider the dynamic interaction of mental health, physical health, and health behavior choices. We are particularly interested in providing these treatments in modalities and settings that increase access to behavioral health care for under-served communities." (Based in Minneapolis, MN)
Deconstructing the Mental Health System DMHS - The Anti-Racist & Equity-Minded Nonprofit (dmhsus.org)	They "founded DMHS as a means to bring anti-racist therapists together to address the mental health system's racial and financial inequities, through education and other initiatives, such as a free provider listing for BIPOC Therapists." They have a directory of BIPOC BH providers, a free therapy program, culturally relevant resources, free and low-cost workshops for clinicians, and more.
The National Council for Mental Wellbeing	NCMW has many resources, including this paper on the national BH workforce crisis that includes a number of recommendations that states can implement to increase the number of BH providers and overall access to BH services.
National Culturally and Linguistically Appropriate Service Standards (Health & Human Services)	"National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organization"
Washington State	
Health Workforce Research Center – Health Equity – UW CHWS	The Health Workforce Research Center is part of the UW Center for Health Workforce Studies (CHWS). This part of CHWS focuses on health equity and its intersection with the health workforce, with a focus on SDOH. The website has links to their studies and reports. It doesn't appear to have a specific focus on BH.
The Governor's	This Council was formed in 2006 through Senate Bill 6197 (which resulted in RCW

Interagency Council on Health Disparities Home | Health Equity (wa.gov)	43.20.275). They "provide recommendations to the Governor and the Legislature on ways to promote health equity and eliminate health disparities in Washington." Among other things, they: ● Hold four public meetings per year ● Publish a State Action Plan to Eliminate Health Disparities Report (This webpage has all of their reports) ● Organize advisory committees to address important health issues ● Collaborate with the WA State Board of Health on Health Impact Reviews ● Facilitate community forums to gather feedback from the public on making state government more equitable ● "Develop proposals to support language assistance and gather and share information to legislators, public health and health care professionals, and other state agencies on how government contributes to health disparities." They don't appear to have a specific focus on BH.
Health equity | Washington State Health Care Authority	WA HCA has various resources related to health equity but nothing specific to BH. For example, HCA offers a health equity toolkit, a guide to help HCA employees apply an equity lens to all of their work. HCA's BH webpage has many activities and documents/reports, but none that are specially about health equity (although we know that much of their work entails improving access and other factors related to equity).
Health Equity | Washington State Department of Health	WA DOH also has a webpage dedicated to health equity. Like HCA, the DOH BH webpage doesn't specifically call our health equity and their health equity page doesn't specifically call out BH. The DOH BH website focuses on resources related to BH needs during the pandemic. They produce monthly situation reports, and they have separate reports for youth and older adults.
About Gov. Inslee's Poverty Reduction Work Group (PRWG) (dismantlepovertyinwa.com)	This group does not focus specifically on BH, but many SDOHs and Institute many issues related to BH inequity are also related to poverty. This webpage has information on the overall Dismantling Poverty initiative.
2022 Behavioral Health Workforce Assessment: A reports of the Behavioral Health Workforce Advisory Committee	This is the most recent update of the 2016 statewide BH workforce report, containing many policy recommendations related to strengthening the BH workforce in WA. Many of the recommendations relate to diversifying the workforce and meeting the needs of our state's diverse population. As stated in the Recruitment & Retention section: "Healthcare workforce planning requires policymakers to pay attention to the underlying systemic, structural, and perception challenges that affect the **ability to recruit and retain a sufficiently large and diverse workforce** to provide needed behavioral health services statewide."

Re-Imagining Behavioral Health: Race, Equity and Social Justice Conference - Harborview Behavioral Health Institute (uw.edu)	Re-Imagining Behavioral Health: Race, Equity and Social Justice Conference is a virtual annual conference hosted by Harborview Behavioral Health Institute. It brings together diverse presenters and audience members to interactively discuss a wide range of issues related to race, equity, and social justice in relation to behavioral health.
The Feb. 16 2023 Convening on BIPOC Mental Health	As part of the Behavioral Health Institute's Call to Action series, this four-hour convening brought together BIPOC behavioral health key informants in a lively and thought-provoking discussion of issues of concern regarding behavioral health services for BIPOC communities.
CARE for Kids & Families	CARE (Culturally Affirming & Responsive Mental Health) for Kids & Families, facilitated by the UW CoLab, is a statewide collaborative to promote culturally responsive behavioral healthcare while centering youth, caregivers, and community members with lived experience/expertise in the behavioral health system. This is accomplished in part by training BH leaders to facilitate this type of change in their BH organizations. CARE also addresses the workforce shortage and the need to expand access to culturally responsive behavioral health services for children and youth.
WA Therapy Fund Foundation	WTFF provides funding for Black community members to get free therapy provided by Black BH providers and some vetted non-Black providers who are committed to do anti-racist work.
Local (Within Washington)	
The City of Seattle's Race and Social Justice Initiative	The Seattle Race and Social Justice Initiative (RSJI) is a citywide effort to end institutionalized racism and race-based disparities in City government. RSJI builds on the work of the civil rights movement and the ongoing efforts of individuals and groups in Seattle to confront racism. The Initiative's long-term goal is to change the underlying system that creates race-based disparities in our community and to achieve racial equity.
Racism as a Public Health Crisis in King County - King County	On June 11, 2020, King County declared racism a public health crisis. All of King County government is committed to implementing a racially equitable response to this crisis, centering on community, and to being intentionally anti-racist and accountable to Black, Brown, and Indigenous People of Color. The goal of the activities related to the declaration is to meet the needs of and implement positive changes for Black, Brown and Indigenous People of Color here in King County, with a deliberate focus on Black and Indigenous people, children, and families.
King County Behavioral Health Advisory Board - King	King County has a BH Advisory Board, but there is not anything specific about health equity on their webpage. “The board works to promote the importance of prevention, treatment, recovery and the de-stigmatization of mental illness and addiction. The

County	board was created in RCW 71.24.300 and is recognized in King County Code 2.32.010. The board reviews services in the public behavioral health (mental health and substance use disorder) system and provides feedback about how the system could be made better."
MEND Seattle – Dedicated to Social Change	MEND officers counseling services and workshops with a strong intersectional feminist orientation

Appendix C: Report and Literature Review

Please note that the list below is not exhaustive. As was noted in Appendix B (the environmental scan), there are certainly additional publications related to behavioral health inequities in Washington state and nationally. The project team anticipates that the ongoing work related to the recommendations in this report will include the identification of additional publications to add to this initial list.

Source	Related Information
General Information: Behavioral Health and Health Equity	
2022 National Healthcare Quality and Disparities Report (Agency for Healthcare Research and Quality, 2022)	• "Life expectancy in the United States decreased for the first time in 2020 due to COVID-19. The decline in life expectancy was also greater for Hispanic and non-Hispanic Black groups than for non-Hispanic White groups, thus widening a health disparity among these groups." • "The most common cause of unintentional injuries was drug overdose (which accounted for over 40% of unintentional injury deaths)." • "Social determinants of health—social, economic, environmental, and community conditions—may have a stronger influence on the population's health and well-being than services delivered by practitioners and healthcare delivery organizations." • "Overall, racial, and ethnic minority communities have similar outcomes as White communities for just under half of quality-of-care measures. However, when disparities exist, racial and ethnic minority communities exhibit worse outcomes than White communities on a larger number of measures than better outcomes. For example, American Indian and Alaska Native communities have worse quality of care than White communities on 43% of measures and better outcomes on only 12% of measures. An exception is the experience of Asian communities, which have worse outcomes than White communities on 28% of measures and better outcomes on 28% of measures."

The State of Mental Health in America (Mental Health America, 2022)	• 15% of adults have an SUD disorder; 93.5% did not receive treatment. • 11% of adults who identify as two or more races have thoughts of suicide. • 55% of adults with mental illness receive no treatment, which is more than 28 million individuals.
The Implications of COVID-19 for Mental Health and Substance Use (Kaiser Family Foundation, 2023)	• "Symptoms of anxiety and depression increased during the pandemic and are more pronounced among individuals experiencing household job loss, young adults, and women. Adolescent females have also experienced increased feelings of hopelessness and sadness compared to their male peers." • "Deaths due to drug overdose increased sharply across the total population coinciding with the pandemic – and more than doubled among adolescents. Drug overdose death rates are highest among American Indian and Alaska Native people and Black people." • "Alcohol-induced death rates increased substantially during the pandemic, with rates increasing the fastest among people of color and people living in rural areas."
Health Inequities and Their Causes (World Health Organization, 2018)	• "Health inequities are systematic differences in health outcomes." • "There is ample evidence that social factors, including education, employment status, income level, gender and ethnicity have a marked influence on how healthy a person is. In all countries – whether low-, middle- or high-income – there are wide disparities in the health status of different social groups. The lower an individual's socio-economic position, the higher their risk of poor health."
Mental Health, Substance Use, and Suicidal Ideation during the Covid-19 Pandemic (Center for Disease Control, 2020)	• "The coronavirus disease 2019 (COVID-19) pandemic has been associated with mental health challenges related to the morbidity and mortality caused by the disease and to mitigation activities, including the impact of physical distancing and stay-at-home orders." • "Overall, 40.9% of respondents reported at least one adverse mental or behavioral health condition, including symptoms of anxiety disorder or depressive disorder (30.9%), symptoms of a trauma- and stressor-related disorder (TSRD) related to the pandemic (26.3%), and having started or increased substance use to cope with stress or emotions related to COVID-19 (13.3%). The percentage of respondents who reported having seriously considered suicide in the 30 days before completing the survey (10.7%) was significantly higher among respondents aged 18–24 years (25.5%), minority racial/ethnic groups (Hispanic respondents [18.6%], non-Hispanic Black [Black] respondents [15.1%]), self-reported unpaid caregivers for adults (30.7%), and essential workers (21.7%). Community-level intervention and prevention

	efforts, including health communication strategies, designed to reach these groups could help address various mental health conditions associated with the COVID-19 pandemic."
Embedding Equity into 988: Imagining a New Normal for Crisis Response (Kennedy Satcher Center for Mental Health Equity)	• National 988 policy brief
The Economic Burden of Mental Health Inequities in the United States (Satcher Institute, 2022)	• This report has a national focus and does not focus exclusively on economics.
US Health Data University of Washington Institute for Health Metrics and Evaluation	• State and county level data on health outcomes
Washington State-Specific Information: Behavioral Health and Health Equity	
2022 Comparative and Regional Analysis Report (Comagine & WA Health Care Authority, 2022)	WA State trends: • "Behavioral Health – In general, there is a lot of variation in performance for the behavioral health measures. Some observations about a few of the measures: ○ Follow-up after emergency department visit for alcohol and other drug abuse dependencies - (FUA), 30-day and 7-day, total – The statewide average and all plans compare well to the national benchmarks. ○ Follow-up after hospitalization for mental illness (FUH) – Many of the plans are below the national 50th percentile. Many of the plans also experienced a year-over-year decline. ○ Follow-up care for children prescribed ADHD medication (ADD), initiation – The results for this measure are consistently below the national 50th percentile. There has been no year-over-year improvement.

	○ Mental health service rate, broad definition (MH-B), 6-64 years – The statewide weighted rate had a statistically significant decline. The results for the individual MCOs were mixed. MHW performed the best when compared to the benchmark. ○ Substance use disorder (SUD) treatment rate, 12-64 Years – The statewide weighted rate had a statistically significant decline. The results for the individual MCOs were mixed. CHPW and UHC performed the best when compared to the benchmark." ● "Access/availability of care – There is some variation for the other access/availability of care measures, especially in terms of comparisons to benchmarks. There is a lot of variation in performance across the MCOs in terms of comparisons to benchmarks for the prenatal and postpartum care (PPC) measures." Health equity: ● "The stress of COVID-19 pandemic on the Medicaid system has revealed several important patterns in health disparities, which suggest areas for further investigation and offer insights into potential strategies for addressing health disparities. The impact has been worse on non-White communities." ● "The two primary views of the health equity data are the Statewide Measure Results by Race/Ethnicity and the Statewide Measure Results by Language." ● "The results of the health equity analysis are very similar to the results reported in the 2021 Comparative Analysis report." ● "Understanding these inequities and being able to identify other more subtle disparities will require new approaches and additional data sources. This is a topic of national interest and, as such, there is a growing body of experience from which to learn. Comagine Health will continue to explore innovative ways to analyze this data to address the important topic of health equity, including research, analysis, and recommendations of mental health parity as a health equity issue." ● "It is worth noting that Washington State has two large federally qualified health centers run by and for the Hispanic community. It would be helpful to understand the degree to which these delivery systems are driving the observed favorable outcomes and strategies they are using to achieve these outcomes." ● "In Washington State, there is an emerging cadre of community health workers. One of the largest of these is devoted entirely to hiring, training, and supporting Latin American immigrant health workers through grant-funded initiatives providing educational outreach to the migrant and refugee population focusing their efforts on preventive care, immunizations, and

	cancer screening. It would be helpful to better understand the impact of such programs on engagement of their target communities in addressing health disparities." ● "There have been improvements in the behavioral health measures at the statewide level, but that improvement does not translate into improvements for all race/ethnicity categories: ○ The improvement in mental health and substance use disorders was due primarily to improvement in members identifying as White. ○ Measure performance for members who identify as Black was statistically significantly below the other race/ethnicity categories. All indications from external data point to a marked increase in the need for treatment of mental health and substance use disorders during the COVID-19 pandemic. The severity of COVID-19 impact has been worse for disadvantaged communities, especially for non-White groups."
The State of Mental Health in America (Mental Health America, 2022)	● State by state comparison of performance on nine measures related to behavioral health. ● WA ranks 32 out of 51 states based on prevalence of mental illness and access to care (1 being lowest prevalence of MI and higher rate of access to MH care). ● 30th for adult ranking in WA; 40th for youth ranking in WA. ● 13th for access to care ranking; 18.59% prevalence of SUD in WA compared to 15.35% nationally, ranked 48th; youth with MDE in WA 19.57% compared to 16.39% nationally (SAMHSA data). ● WA had better access to MH providers – 230:1, compared to 350:1 nationally. ● 25.5% of adults have a mental illness in WA, compared to the national average of 21%. ● 19% have an SUD, compared to 15% national average.
Mental Health, Substance Use, and Suicidal Ideation during the Covid-19 Pandemic (Center for Disease Control, 2020)	● "Overall, 40.9% of respondents reported at least one adverse mental or behavioral health condition, including symptoms of anxiety disorder or depressive disorder (30.9%), symptoms of a trauma- and stressor-related disorder (TSRD) related to the pandemic (26.3%), and having started or increased substance use to cope with stress or emotions related to COVID-19 (13.3%)." ● "The percentage of respondents who reported having seriously considered suicide in the 30 days before completing the survey (10.7%) was significantly higher among respondents aged 18–24 years (25.5%), minority racial/ethnic groups (Hispanic respondents [18.6%], non-Hispanic Black [Black] respondents

	[15.1%]), self-reported unpaid caregivers for adults (30.7%), and essential workers (21.7%)."
Statewide High-Level Analysis of Forecasted Behavioral Health Impact from COVID-19 (WA State Department of Health)	• "This document provides a brief overview of the potential statewide behavioral health impacts from the COVID-19 pandemic. The intent of this document is to communicate potential behavioral health impacts to response planners and organizations or individuals who are responding to or helping to mitigate the behavioral health impacts of the COVID-19 pandemic."
Crisis State (University of Washington Magazine, 2021)	• "Washington has one of the highest rates of individuals struggling with mental health and addiction problems in the country, but we don't have nearly enough mental-health professionals,"
Here are the Basic Facts about Mental Health and Treatment in the State (Seattle Times, 2021)	• In Washington, more than one in five adults has a diagnosable mental illness. • "And all signs suggest mental health issues became more prevalent — and more extreme — over the past 18 months." • "In the spring, Gov. Jay Inslee declared a youth mental health crisis. National data shows 40% of adults have experienced a mental or behavioral health condition during the pandemic." • "Failure to get help can bring dire consequences: People with severe mental illness die, on average, 10 to 25 years earlier than those without a mental health condition."

County Health Rankings & Roadmaps (2023)	• "In Washington, 14% of adults reported experiencing poor mental health for 14 or more of the last 30 days. This ranged from 12% to 18% of adults across counties in the state."
	• Highest percentages of frequent mental distress were report in:
	  ○ Ferry 18%
	  ○ Okanagan 18%
	  ○ Grey's Harbor 17%
	  ○ Asotin 17%
	  ○ Lewis 17%
	  ○ Yakima 17%
	• Lowest percentage of frequent mental distress was reported in King County at 12%
	• WA average was 14%

Four Ways WA Lawmakers Want to Improve WA Mental Health System (Seattle Times, 2022)	• "The mental health workforce is leaving the profession in droves as wages stagnate and burnout takes hold. Community-based providers who treat low-income folks say a lack of resources has forced them to turn patients away." • "In October 2021, more than half of the state's community behavioral health centers, which largely serve low-income people enrolled in Medicaid, reported they had to turn away clients because they lacked the workforce to care for them."
Mental Health in Washington (Kaiser Family Foundation, 2023)	• "The pandemic has coincided with an increase in substance use and increased death rates due to substances. In 2021, there were over 106,600 deaths due to drug overdose in the U.S.– the highest on record. This marks a 51% increase in drug overdose deaths from prior to the pandemic (there were over 70,630 deaths in 2019). The uptick in substance use and deaths disproportionately affects people of color. While White people continue to account for the largest share of deaths due to drug overdose per year, people of color are accounting for a growing share of these deaths over time."
The Race Gap, King County WA (City of Seattle, 2020)	• "Across the lifespan, Black residents in King County face systemic racism and disadvantages that disproportionately impact physical, mental and social health as well as the educational and economic opportunities of Black communities." • "In King County, Black adults are more than 4 times as likely to run out of food without money to purchase more than White adults." • "In King County, Black adults are more than 1.5 times as likely not to have a bachelor's degree compared to White adults."
Communities Count, King County	• "Communities Count is a resource that supports King County communities in the use of data in promoting and achieving equity. Communities Count does this by providing a platform for community data & stories; highlighting data on disparities, inequities, and strengths in our community; complementing existing civic, social, economic, and health indicators; and providing data support and trainings to King County communities." • "In our data reports on population and community indicators, Communities Count emphasizes prevention and a long-term view of change while using data to understand how to advance equity work to sustain healthy communities and families."
Behavioral Health Barometer, Washington	• "The Behavioral Health Barometer: Washington, Volume 6: Indicators as measured through the 2019 National Survey on Drug Use and Health and the National Survey of Substance Abuse Treatment Services is one of a series of

Volume 6 (SAMHSA, 2020)	national, regional, and state reports that provide a snapshot of behavioral health in the United States."

The Well-Being of Washington State's Children During the COVID-19 Pandemic Behavioral Health Trends (Dept. of Social and Health Services, 2023)	• "This report uses Medicaid claims data to examine trends in children's behavioral health diagnoses and services before and during the COVID-19 pandemic in Washington State."
	• Key findings:
	  ○ Mental health outpatient services for children under 18 declined at the outset of COVID but had spikes in October 2020 and March 2021 before declining over the rest of 2021.
	  ○ Unlike mental health outpatient services and claims with specific diagnoses, claims associated with acute, or crisis events did not decline over calendar year 2021.
	  ○ Gender differences in utilization emerged after the onset of the pandemic while sizable race/ethnicity differences in utilization were maintained over the study period. Girls and boys had similar levels of utilization prior to the pandemic, while after the pandemic utilization for girls became higher relative to boys.

Impact of Systemic Racism and Discrimination	

BIPOC Mental Health (Mental Health America)	• Provides useful statistics on the impact of mental health issues on the BIPOC community with a focus on race and policy.
	• Overview of behavioral health issues by population
	• Infographic with findings from a mental health screening starting in 2014 that 5 million people have completed. Findings:
	  ○ LGBTQ+ were more likely to screen positive or at risk.
	  ○ Multiracial people were most likely to screen positive for depression, anxiety, and SUD

Racism and Mental Health (Mental Health America)	• Useful statistics on specific impacts of racism in BH treatment. • "BIPOC people experience disproportionately high rates of disability from mental disorders." • "People who identify as being two or more races (24.9 percent) are more likely to report any mental illness within the past year than any other race/ethnic group." • "Native and Indigenous American adults have the highest reported rate of mental illnesses of any single race-identifying group."

Racism as a Determinant of Health: A Systematic Review & Meta Analysis (National Library of Medicine, 2015)	• "Despite a growing body of epidemiological evidence in recent years documenting the health impacts of racism, the cumulative evidence base has yet to be synthesized in a comprehensive meta-analysis focused specifically on racism as a determinant of health." • "Age, sex, birthplace, and education level did not moderate the effects of racism on health. Ethnicity significantly moderated the effect of racism on negative mental health and physical health: the association between racism and negative mental health was significantly stronger for Asian American and Latino(a) American participants compared with African American participants, and the association between racism and physical health was significantly stronger for Latino(a) American participants compared with African American participants."
Structural Racism in Historical and Modern Healthcare Policy (Health Affairs, 2022)	• "The COVID-19 pandemic has illuminated and amplified the harsh reality of health inequities experienced by racial and ethnic minority groups in the United States. Members of these groups have disproportionately been infected and died from COVID-19, yet they still lack equitable access to treatment and vaccines. Lack of equitable access to high-quality health care is in large part a result of structural racism in US health care policy, which structures the health care system to advantage the White population and disadvantage racial and ethnic minority populations. This article provides historical context and a detailed account of modern structural racism in health care policy, highlighting its role in health care coverage, financing, and quality."
Life expectancy by county, race, and ethnicity in the USA, 2000–19: a systematic analysis of health disparities (Lancet, 2022)	• "There are large and persistent disparities in life expectancy among racial–ethnic groups in the USA, but the extent to which these patterns vary geographically on a local scale is not well understood. This analysis estimated life expectancy for five racial–ethnic groups, in 3110 US counties over 20 years, to describe spatial–temporal variations in life expectancy and disparities between racial–ethnic groups." • "Disparities in life expectancy among racial–ethnic groups are widespread and enduring. Local-level data are crucial to address the root causes of poor health and early death among disadvantaged groups in the USA, eliminate health disparities, and increase longevity for all."
Racial/Ethnic Differences in Mental Health Service Use Among Adults (SAMHSA, 2015)	• SAMHSA report of service use based on 2008 - 2012 data. • "The purpose of this chartbook is to provide more recent, nationally representative estimates of mental health service utilization among adults aged 18 or older across different racial/ethnic groups in the United States. These data may serve as a benchmark for examining future national-level

	changes in mental health service utilization." ● "Service cost or lack of insurance coverage was the most frequently cited reason for not using mental health services across all racial/ethnic groups. The belief that uses of mental health services would not help was the least frequently cited reason for not using mental health services across all racial/ethnic groups."
Considerations for Conducting Evaluation Using a Culturally Responsive and Racial Equity Lens (Center for Culturally Responsive Engagement, 2021)	● This document is a practical guide to conducting evaluation using this lens. ● "It becomes clear that the work of traditional researchers conducting traditional evaluations has had limited impact in helping organizations and communities move toward racial equality. Evaluators, mostly White, often have limited understanding of the priority populations (often minorities) that social investments serve. Many times, evaluators fail to talk to the consumers of services or misunderstand them when they do. Moreover, traditional evaluation may not even assess diversity, inclusion, and equity; an omission that makes disparities hard to recognize, let alone address."
Social Determinants of Health	
Social Determinants of Mental Health: Where We Are and Where We Need to Go (Curr Psychiatry Rep., 2018)	● "Social determinants of Health - Improving Behavioral Health Equity through Cultural Competence Training of Health Care Providers - focus on understanding how the circumstances in which people live and work shape their health outcomes. These circumstances (i.e., social determinants) are believed to drive many deep-rooted world health inequalities, such as lower life expectancy, higher rates of child mortality, and greater burden of disease among disadvantaged populations." ● "Overall, they found that poor and disadvantaged populations are most affected by mental disorders, and that cumulative stress and physical health serve as mechanisms through which the impacts of social determinants multiply across the lifespan. Other research describes how cumulative advantages and disadvantages impact health across multiple generations."
Social Determinants of Health in Mental Health Care and Research (J Am Med Inform Assoc., 2019)	● Better mental health equity is unlikely without a deeper understanding and targeting of the causal factors related to social determinants of health (SDOH). The importance of income, housing security, education, unemployment, child abuse and neglect, neighborhood conditions, and social support have repeatedly been demonstrated to influence mental health outcomes.

Social Determinants of Health (Center for Disease Control)	• Social Determinants of Health FAQ
1. Lack of Insurance Coverage, Limitations of Insurance (Including Medicaid), and/or Inability to Pay for Services	
The State of Mental Health in America 2023 (Mental Health America, 2023)	• "23% of adults who report experiencing 14 or more mentally unhealthy days each month were not able to see a doctor due to costs." • "28% of adults with mental illness were not able to receive the treatment they needed - most report that they did not receive care because they couldn't afford it"
National Healthcare Quality and Disparities Report, 2022 (Agency for Healthcare Research and Quality, 2022)	• "The percentage of people with health insurance coverage has increased greatly in the past decade. However, those gains vary by race and ethnicity. Non-Hispanic American Indian or Alaska Native groups and Hispanic groups are significantly less likely to be insured."
National Healthcare Quality and Disparities Report, 2022 (Agency for Healthcare Research and Quality, 2022)	• "The percentage of people under age 65 with health insurance coverage is at the highest level recorded in the NHQDR, but people in low-income households, minority communities, and 'inner city' and 'rural' communities are significantly less likely to have health insurance coverage."
2. Lack of Sustainable Funding – for Both Ongoing Services and Innovative Programs	
3. Workforce Shortage	
National Healthcare Quality and Disparities Report, 2022 (Agency for Healthcare Research and Quality, 2022)	• "A loss of healthcare workers in professions that require less educational attainment accounts for much of shrinking workforce size."
Behavioral Health Workforce Assessment (Behavioral Health Workforce Advisory Committee, 2022)	• "Prior to March 2020, the state was already experiencing the challenges of ensuring a workforce sufficient to serve the behavioral health needs of Washington's residents. Throughout the ongoing pandemic, the need for behavioral health services, defined in this report as mental health and substance use disorder (SUD) treatment, has continued to grow. The number of children and teens needing behavioral health services, particularly crisis

	services, has remained higher than was typical before the pandemic. Deaths from drug overdoses have continued to increase for all ages of Washington residents, with a 66 percent increase in deaths in 2021 compared to 2019."
4. Workforce Diversity	
5. Lack of Needed Behavioral Health Services for Specific Communities	
National Healthcare Quality and Disparities Report, 2022 (Agency for Healthcare Research and Quality, 2022)	Child and Adolescent Mental Health has become an urgent concern. ● "Rates of emergency department visits with principal diagnosis related to mental health diagnoses per 100,000 population increased by 24.6% for children ages 0-17 years between 2016 and 2018, while rates for older age groups showed no statistically significant changes." ● "The rate of death from suicide among adolescents ages 12-17 increased by 70.3% between 2008 and 2020, rising from 3.7 to 6.3 deaths per 100,000 population. This increase was greater than the suicide rate increase for the overall population, which grew by 16.4%, rising from 14.0 to 16.3 deaths per 100,000." ● "Disparities data show that in 2020, among adolescents ages 12-17 years, non-Hispanic White adolescents (7.4 deaths per 100,000 population) were more likely to die from suicide than Hispanic (5.0 deaths per 100,000 population) or non-Hispanic Black (4.6 deaths per 100,000 population) adolescents."
LGBTQ+ Communities and Mental Health (Mental Health America)	LGBTQ+ ● LGBTQ+ teens are six times more likely to experience symptoms of depression than non-LGBTQ+ identifying teens. ● LGBTQ+ youth are more than twice as likely to feel suicidal and over four times as likely to attempt suicide compared to heterosexual youth. ● Forty-eight percent of transgender adults report that they have considered suicide in the last year, compared to 4 percent of the overall US population.
National Healthcare Quality and Disparities Report, 2022 (Agency for Healthcare Research and Quality, 2022)	Substance Use Disorder ● "Overall rates of overdose deaths involving any opioid increased by 36.8% between 2019 and 2020, rising from 15.2 to 20.8 deaths per 100,000 population in a single year." ● "Deaths related to opioids increased in all racial and ethnic groups and in all rural-urban locations although disparities among groups exist. Deaths from any opioid in 2020 were highest in non-Hispanic American Indian or Alaska Native (28.1), non-Hispanic Black (26.6), and non-Hispanic White (25.5) communities, followed by Hispanic (13.1) and Asian (2.6) communities."

	● "Despite the rising incidence of opioid-related deaths, the percentage of people aged 12 and over who needed treatment for illicit drug use and who received such treatment at a specialty facility was only 9.9% in 2020, indicating a need for better access to treatment and recovery programs."
Synthetic Estimates of SUD Treatment Needs in WA State (Dept. of Social and Health Services, Research and Data Analysis, 2022)	SUD - Estimated Treatment Need Among Low-Income Populations ● "About 4.4 percent of low-income youth (ages 12-17) in Washington State had SUD treatment needs." ● "About 15.8 percent of low-income adults (ages 18 and older) in Washington State had SUD treatment needs." ● "There is variability in SUD treatment need across counties. In 2019, the rates of SUD treatment need among low-income youth ranged from 3.9 percent in Kitsap County to 5.9 percent in Ferry County. Rates of SUD treatment needs among low-income adults ranged from 13.5 percent in Columbia County to 18.1 percent in Grays Harbor County."
Washington State Behavioral Health Treatment and Recovery Support Services Utilization (Dept. of Social and Health Services, Research and Data Analysis, 2022)	SUD - Reports Related to the Roadmap to Recovery Planning Grant Current State Assessment ● Four reports: ○ Report 1: Prevalence of Substance Use Disorder Diagnoses among Medicaid Beneficiaries ○ Report 2: Variations in Behavioral Health Treatment Penetration Rates ○ Report 3: Variations in Utilization of Substance Use Disorder Treatment Modalities ○ Report 4: Physical Health and Social Outcomes among Medicaid Beneficiaries with and without Behavioral Health Diagnoses.
First Episode Psychosis Estimating Annual Incidence Using Administrative Data (Dept. of Social and Health Services, Research and Data Analysis, 2022)	First Episode Psychosis ● "In 2019, the Washington State Legislature passed Senate Bill 5903, which requires the Health Care Authority to implement evidence-based coordinated specialty care programs like New Journeys to provide early identification and intervention for individuals with psychosis and ensures that each regional service area has an adequate number of such programs based on FEP incidence and population size. This report estimates annual incidence rates of FEP among Washington's Medicaid population in State Fiscal Year (SFY) 2021." ● Breakdown of demographic characteristics of Medicaid Enrollees with First Episode Psychosis
Mental Health in Washington (Kaiser	SUD - Related deaths

Family Foundation, 2023)	• "The pandemic has coincided with an increase in substance use and increased death rates due to substances. In 2021, there were over 106,600 deaths due to drug overdose in the U.S.– the highest on record. This marks a 51% increase in drug overdose deaths from prior to the pandemic (there were over 70,630 deaths in 2019). The uptick in substance uses and deaths disproportionately affects many people of color. While White people continue to account for the largest share of deaths due to drug overdose per year, people of color are accounting for a growing share of these deaths over time."
Mortality Gap and Physical Mortality of People with Severe Mental Disorders: A Public Health Scandal (Annals of Psychiatry, 2021)	Severe Mental Illness • "Patients suffering from severe mental disorders, including schizophrenia, major depression and bipolar disorders, have a reduced life expectancy compared to the general population of up to 10–25 years." • "Factors associated with the high mortality rates in patients with severe mental disorders can be grouped into four groups: those related to the patients, to psychiatrists, to other non-psychiatrist medical doctors and to the healthcare system. Each of these factors should become the target of specific and dedicated interventions, in order to reduce the morbidity and mortality rate in patients with severe mental disorders. All these elements contribute to the neglect of physical comorbidity in patients with severe mental disorders." • "The premature mortality in patients with severe mental disorders is a complex phenomenon resulting from the interaction of several protective and risk factors. Therefore, a multilevel approach is needed, in which the different stakeholders involved in health care provision establish workforces for the long-term management of physical and mental health conditions."
Criminal Justice & Equity	• Webinar series featuring a roundtable on Criminal Justice and Equity
6. Unique Behavioral Health Challenges Faced by Rural Communities	
Geographic Disparities in the Availability of Mental Health Services in U.S. Public Schools (Journal of Preventative Medicine, 2022)	• Half (51.2%) of schools reported providing mental health assessments, and 38.3% reported providing treatment. After adjusting for enrollment and grade level, rural schools were 19% less likely, town schools were 21% less likely, and suburban schools were 11% less likely to report providing mental health assessments than city schools. Only suburban schools were less likely than city schools to provide mental health treatment (incidence rate ratio=0.85; 95% CI=0.72, 1.00). Factors limiting the provision of services included inadequate access to professionals (70.9%) and inadequate funding (77.0%), which were most common among rural schools."

A Call to Action to Address Rural Mental Health Disparities (Journal of Clinical and Translational Science, 2020)	• "Approximately one-fifth of the US population live in a rural area, and about one-fifth of those living in rural areas, or about 6.5 million individuals, have a mental illness. Though the prevalence of serious mental illness and most psychiatric disorders is similar between US adults living in rural and urban areas, adults residing in rural geographic locations receive mental health treatment less frequently and often with providers with less specialized training, when compared to those residing in metropolitan locations." • "The reasons underlying this mental health treatment disparity are well documented and include reduced access to providers and limited availability of specialty mental health care in rural areas, lack of trained mental health providers and care coordination in rural medical care, and underutilization of available services. In addition, the uptake of innovative approaches to mental health care has not been as consistent in rural areas as it has in metropolitan areas, thus exacerbating already wide differences in access and quality of care."
7. Systemic Lack of Person-Centered Treatment Interventions	
Evidence-Based and Culturally Relevant Behavioral Health Interventions in Practice: Strategies and Lessons Learned from NNEDLearn (2011-2020) (SAMSHA, 2021)	• Recommendations for adapting evidence-based practices for diverse communities • List of resources for diverse communities • "Provides findings from a qualitative analysis of evidence-based and culturally relevant behavioral health practices offered at NNEDLearn, a SAMHSA training, offered from 2011 to 2020. It includes an overview of NNEDLearn, case studies, strategies and lessons learned, and conclusion." • "Despite decades of research on effective interventions, behavioral health disparities continue to negatively affect Black, Indigenous, and other communities of color."
8. Challenges Accessing Care - (See SDOH Section)	

Appendix D: Additional Recommendations

The recommendations below were suggested by members of Behavioral Health Inequities Workgroup to address the focus areas that emerged through the survey, listening sessions, and workgroup discussions. Please note that the recommendations do not address all the focus areas covered in this project.

Focus Area	Example Recommendations
The Impact of Systemic Discrimination, Racism, & Intergenerational Trauma	● Ensure legislators and policy makers understand the specific and bi-directional impact of race, racism, and intergenerational trauma on behavioral health inequities and disparities. Behavioral health inequities and disparities are a result of and are exacerbated by racism. ● Advise legislative and executive branch policy makers and elected officials to apply behavioral health (BH, including both mental health and substance use disorders) lens to non-BH initiatives and legislation. ● Advise legislative and executive branch policy makers and elected officials to apply a DEIB (diversity, equity, inclusion, and belonging) lens to all funding and policy decisions. ○ Require that all new policies and programs consider whether communities most impacted by BH disparities are being prioritized. ○ Make equity a core part of all funding and policy decisions; it should not be an afterthought or add on. ○ Consider using a "targeted universalism" framework. (This approach calls for funding and designing programs to ensure they are effective for disadvantaged/impacted communities and making those programs available to everyone. Like civil rights, targeted universalism helps everyone.)
Lack of Sustainable Funding – For Both Ongoing Services and Innovative Programs	● Incentivize BH equity ○ Consider a system like the carbon exchanges used to address climate change. ○ Incentivize providers to meet the needs of diverse communities through special funding. > Provide a higher reimbursement rate for agencies that specifically serve populations disproportionately impacted by BH inequities. > Tie funding to supporting the agencies that are diversifying their staff and serving communities disproportionately impacted by inequities. > Provide funding and coverage for BH supports that do not require establishing medical necessity based on a diagnosis; fund preventive services that are more upstream. Many people may not meet diagnostic criteria but have symptoms and can benefit from BH supports that help avoid a BH crisis or other more serious situation. ● Include a DEIB impact in the analysis of all policy options; all new funding has to be beneficial to BIPOC and other disproportionately impacted populations. ○ Use money/funding as a tool to increase DEIB. ● Add a statement to all funding announcements and decisions regarding who the funding should benefit (e.g., allocate funding specific to BIPOC communities and programs). ● Secure a commitment from legislative and executive branch policy makers to fund programs that serve populations impacted by BH inequities (e.g., Seattle Counseling

	Services served the LGBTQ+ community until it closed in 2022). ● Create budgets that specifically address BH inequities and disparities. ○ Develop budgets with an equity lens. ○ Identify the communities most impacted by BH issues and prioritize funding for those communities. ○ "Money talks": Fund programs that address both BH and DEIB needs.
Workforce Diversity and Workforce Shortage	● Democratize behavioral health systems. ○ Invest in growing the peer navigator workforce. ○ Develop more roles and supports for BH paraprofessionals. ○ Fund expansion of effective strategies that don't require masters- or doctoral-level training. ● Incentive programs that address BH as a collective community responsibility.
Systemic Lack of Culturally Responsive, Person-Driven Behavioral Health Supports	● Fund and support programs and services tailored for specific cultural groups. ○ Fund and support practice-based programs and strategies that are successful with specific populations. ○ Fund and support programs that are not officially considered "evidence-based" but would promote ongoing inclusion of people of color. ○ Support flexible responses, rather than requiring rigid, manualized implementation of evidence-based practices. ○ Support creation of new inclusive and accessible treatment norms. ● Fund and support "person-driven support," which is based on what the person seeking help knows is best for them (in contrast to "person-centered care," which is based on a medical model and pathologizes the person seeking help.) ○ Support programs and organizations that move away from the medical model of a provider identifying a pathology who then "treats" that pathology. ● Support an updated version of the type of support services previously provided by "special populations consultations."
Challenges Accessing Care	● Through public education campaigns, address stigma related to receiving behavioral health care. ○ Create campaigns that specifically address BH stigma in communities and cultures where behavioral health care carries a higher level of stigma. ○ Target the education campaigns toward normalizing BH as a part of overall health and wellness; utilize lessons from the education campaigns that helped to normalize not smoking. ● Develop accessible sources of information regarding available BH services, and who, when, why, and where to access those services. ○ Make information available in multiple languages and in locations where all community members can easily access it.