

Background and Purpose

The Governor's Interagency Council on Health Disparities is charged with creating a state policy action plan to eliminate health disparities by race/ethnicity and gender and to update the plan regularly. In June 2010, the Council submitted its action plan to the Governor and Legislature. The plan focused on five priorities: education, health insurance coverage, healthcare workforce diversity, obesity, and diabetes. The Council's update in 2012 will focus on a new set of priorities: environmental exposures and hazards, poverty, behavioral health, adverse childhood experiences, and the state system.

This policy paper provides context and supporting research on behavioral health disparities for the 2012 update. The Council convened a behavioral health disparities advisory committee to review, prioritize, and identify policy recommendations for its consideration. The specific charge of the committee was to identify actions to reduce disparities in access to and quality of behavioral health services and outcomes by race/ethnicity and gender.

Behavioral Health Disparities

Racial/ethnic disparities in behavioral health persist in Washington State and the Nation. Nationally, people of color tend to have less access to behavioral health services, are less likely to seek services, and are more likely to receive poorer quality of care. These inequities are due to a variety of factors, such as differences in insurance coverage, lack of cultural competence among providers, and social factors such as racial discrimination on the part of mental health practitioners and institutions (McGuire and Miranda 2008, U.S. Department of Health and Human Services 2001).

This section provides a summary of available data on disparities for mental disorders and chemical dependency, both nationally and in Washington State. The behavioral health disparities advisory committee found there is a need for improved data collection and analyses to better understand behavioral health disparities, particularly for racial/ethnic subpopulations. These data need to be regularly analyzed to observe changes over time and to evaluate whether interventions are effective in reducing disparities.

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Mental Disorders

Nationally in 2008-2009, 4.6% of adults age 18 or older had serious mental illness¹, 19.7% had any mental illness², 3.7% had serious thoughts of suicide³, and 6.5% had a major depressive episode in the past year⁴ (Substance Abuse and Mental Health Services Administration 2010). Rates for Washington

¹ Serious mental illness is defined as currently or at any time in the past year having had a diagnosable mental, behavioral, or emotional disorder (excluding developmental and substance use disorders) of sufficient duration to meet diagnostic criteria specified within the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) (American Psychiatric Association [APA], 1994) that has resulted in serious functional impairment, which substantially interferes with or limits one or more major life activities.

² Any mental illness is defined as currently or at any time in the past year having had a diagnosable mental, behavioral, or emotional disorder (excluding developmental and substance use disorders) of sufficient duration at any time during the past year to meet diagnostic criteria specified within the DSM-IV (APA, 1994).

³ Self-reported through survey questionnaire.

⁴ Whether a person has a major depressive episode is determined from the criteria specified for major depression in the DSM-IV (APA, 1994).

Behavioral Health Disparities Advisory Committee: Policy Paper
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State tended to be higher (4.7%, 21.2%, 4.6%, and 7.2%, respectively), though differences were not statistically significant.

While some past research has found that communities of color tend to have equivalent or lower rates of mental disorders than whites (McGuire and Miranda 2008, U.S. Department of Health and Human Services 2001), members of the behavioral health disparities advisory committee reject this premise for a variety of reasons:

- Data are often not disaggregated by racial/ethnic subgroups so findings mask true differences.
- Studies undercount populations who do not seek services or participate in research.
- Tools used to assess behavioral health problems have not been adapted to different cultures, so findings based on these tools are inaccurate.
- Research that is not conducted in a culturally competent way will not produce meaningful results.
- Culture shapes the recognition of mental disorders and can lead to underreporting, misdiagnosis and/or inappropriate treatment plans. These issues are further exacerbated by language barriers and lack of access to effective, culturally-competent assessment and treatment.

Similarly, researchers from the Federal Collaborative for Health Disparities Research cautioned that any “discussion of disparities in mental disorders or other aspects of mental function requires recognition of the limits of what is measured, what is known, and how it is referred to, especially when discussing survey results of Americans of varied cultural and linguistic groups” (Safran et al. 2009). They add that diagnostic systems and terms are typically based on Eurocentric perspectives that are not necessarily shared by people of other cultures. And, while researchers are aware of the cultural limitations of such tools, those limitations are often not considered when assessing findings and drawing conclusions (Safran et al. 2009).

Members of the behavioral health disparities advisory committee reject the premise that communities of color tend to have equivalent or lower rates of mental disorders than whites for a variety of reasons. Indeed, numerous studies have found that racial/ethnic disparities in mental health disorders do exist.

Indeed, numerous studies have found that racial/ethnic disparities in mental health disorders do exist. According to briefing documents from the National Asian American Pacific Islander Mental Health Association⁵ and the National Alliance on Mental Illness (2004, 2006, 2007, and 2011) and reports from the Centers for Disease Control and Prevention (2009, 2011):

- Asian American, Native Hawaiian, and Pacific Islander females between the ages of 15-24 have among the highest rates of suicide ideation and depressive symptoms of any ethnic group.
- Southeast Asian refugees are at particular risk for serious emotional/behavioral problems, such as post-traumatic stress disorder.
- Across a recent 15 year span, suicide rates increased 233% among African Americans aged 10 to 14 compared to 120% among Caucasian Americans in the same age group.
- 12.7% of black adults report current depression compared to 7.5% of white adults.
- 21.5% of black women report postpartum depression, compared to 11.9% among white women.
- Suicide rates among American Indian/Alaska Native adolescents and young adults ages 15 to 34 are 1.8 times higher than the national average for that group.

⁵ Asian American, Native Hawaiian, Pacific Islander Mental Health & Health. Fact Sheet from the National Asian American Pacific Islander Mental Health Association. Accessed at: <http://naapimha.org/resources/fact-sheets/>.

Behavioral Health Disparities Advisory Committee: Policy Paper
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- Latinos are a high risk group for depression, anxiety, and substance abuse and yet they are the most likely not to have health insurance. U.S. born and long-term resident Hispanics/Latinos have approximately twice the rate of lifetime mental illness and addictive disorder diagnoses as recent immigrant Latinos.
- Hispanic female high school students in grades 9-12 reported a higher percentage of suicide attempts (14%) than their White, non-Hispanic (7.7%) counterparts.

In Washington State, variation in prevalence of mental disorders was found in a 2000 study (Washington State Department of Social and Health Services 2003). In that study, medium-level mental health need⁶ was highest for Native Americans (5.9%) followed by Whites (4.1%), Blacks (3.9%), Hispanics (2.5%), and Asians (1.5%). Similarly, researchers at the State Department of Health analyzed self-reported survey data from 2004-2006 and found that American Indians and Alaska Natives reported significantly higher rates of poor mental health⁷ (19%) than other racial/ethnic groups—rates were 12% among Blacks, 10% among Whites, 9% among Hispanics, and 7% among Asians and Pacific Islanders (Washington State Department of Health 2007).

Chemical Dependency

Data from the 2010 National Survey of Drug Use and Health revealed that 8.7% of the U.S. population age 12 or older was classified with substance abuse or dependence in the past year (Substance Abuse and Mental Health Services Administration 2011a). The rate among males was about twice as high as the rate for females, 11.6% vs. 5.9%, respectively. Rates varied by race/ethnicity—16% for American Indians or Alaska Natives, 9.7% for persons reporting two or more races, 9.7% for Hispanics, 8.9% for Whites, 8.2% for Blacks, 5.6% for Native Hawaiians or Pacific Islanders, and 4.1% for Asians.

Data from the 2008-2009 National Survey of Drug Use and Health (the most recent state-level data) found that in Washington State, 8.5% of persons age 12 or older were classified with dependence or abuse of illicit drugs or alcohol in the past year (Substance Abuse and Mental Health Services Administration 2010).

Disparities for Other Populations

In addition to racial/ethnic disparities, significant behavioral health disparities persist for other communities, including lesbian, gay, bisexual, transgender, and questioning (LGBTQ) individuals, people with disabilities, and military families (Substance Abuse and Mental Health Services Administration 2011b). While the Council was given the specific responsibility for addressing disparities by race/ethnicity and gender, the behavioral health disparities advisory committee believes actions to improve the responsiveness of the behavioral health system to diverse community needs can improve care and outcomes for these underserved populations as well.

Context for Addressing Behavioral Health Disparities in Washington State

Public Behavioral Health System Changes

The behavioral health disparities advisory committee met from March 7 – May 30, 2012 to discuss and identify strategies for promoting equity in behavioral health care and reducing disparities. The committee met during a time of much change and uncertainty regarding the delivery of behavioral health services in Washington State.

⁶ Medium-level mental health need is defined as having a major mental disorder and having either a functional limitation, using or having the desire to use mental health services, being a danger to self or others, or being dependent on public assistance.

⁷ Poor mental health in adults is defined as having self-reported poor mental health 14 days or more in the past month.

Currently, Washington State provides primary and acute medical care, mental health, and chemical dependency services (as well as other services) through delivery and payment systems that are fragmented and not well-coordinated. The Department of Social and Health Services (DSHS) purchases mental health services for Medicaid recipients through a system of 13 Regional Support Networks (RSNs). The RSNs contract with mental health agencies to provide direct outpatient services and short-term inpatient treatment in community hospitals. DSHS also contracts with counties and Tribes to provide chemical dependency treatment and prevention services. Residential chemical dependency providers are funded directly through DSHS. The Health Care Authority purchases medical services for Medicaid recipients through managed care health plans. Indian Tribes, tribal organizations, and Alaska Native health organizations meeting certain requirements can be reimbursed for Medicaid State Plan services, including mental health services.

The State's long term vision, however, is for a fully integrated system of behavioral health and primary care services (Department of Social and Health Services 2010). In its recent design proposal for Health Path Washington—the State's Medicare and Medicaid Integration Project—health officials state that, "Opportunities for better outcomes, system efficiencies, and cost containment lie in the purchase of increasingly coordinated and managed medical, mental health, chemical dependency and long-term services and supports". The proposal describes the design and implementation plan to integrate care for individuals receiving services from both Medicare and Medicaid and it builds on lessons learned from past integration efforts. For example, in 2009 the DSHS Division of Alcohol and Substance Abuse and the Mental Health Division merged to become the Division of Behavioral Health and Recovery. Such integration allows for better assessment and treatment of patients with co-occurring mental health and chemical dependency disorders.

Similarly, with the passage of HB 1738 (2011), DSHS and Health Care Authority are developing a plan for future purchasing of behavioral health and long-term care services. In March 2012, the agencies provided preliminary recommendations—the final implementation plan is due to the Governor and Legislature by December, 2012. The preliminary report offers the following recommendations (Department of Social and Health Services and Health Care Authority, 2012):

- DSHS should retain responsibility for purchase of long-term services and supports and behavioral health services.
- To ensure coordinated purchasing, DSHS and HCA should collaborate on three integrated purchasing initiatives:
 - Expand service delivery through capitated contracts with health plans.
 - Modernize and simplify the current DSHS system of supports.
 - Embed robust delivery of health home services in all systems.

Medicaid Expansion and the Health Insurance Exchange

Efforts to integrate behavioral health and primary care services in Washington State are occurring within the context of larger changes to implement reform efforts under the Affordable Care Act. Starting January 2014, Medicaid will increase its national eligibility limits for adults to 133 percent of the federal poverty level and open coverage to childless adults, many of whom are currently uninsured. Health officials anticipate these changes will result in enrollment of up to 250,000 newly eligible people and up to 75,000 people who are eligible now but not currently covered (Health Care Authority 2012). A Families USA report estimates that 28% of those who become newly eligible for Medicaid in Washington State in 2014 will be people of color (Families USA 2010).

In addition, efforts are fully under way to develop the Washington State Health Benefits Exchange. In 2011, the Legislature passed SB 5445, the enabling legislation for the Exchange. In March 2012,

members of the Exchange Board were appointed and the Board assumed governance. To date, Washington has applied for and received three rounds of funding from the U.S. Department of Health and Human Services to implement the Exchange—it received a planning grant of nearly \$1 million in August 2010, a Level I Establishment Grant of \$22.9 million in March 2011, and a Level II Establishment Grant of \$128 million in March 2012. The current grant will support the development of policies by the Exchange Board, the creation of an Exchange infrastructure, and the design of a consumer engagement and marketing campaign.

The behavioral health disparities advisory committee recognizes that ongoing efforts to implement provisions of the Affordable Care Act in Washington State offer opportunities to provide input in ways that can improve the behavioral health system for all, as well as to promote more equitable care and reduce disparities for communities of color. The committee also recognizes opportunities to align with and build off past efforts to specifically address disparities in behavioral health outcomes and care.

Past Efforts to Address Behavioral Health Disparities in Washington State

One reason behavioral health disparities persist is the lack of diversity and cultural competence among the behavioral health care provider workforce and the behavioral health care system. Over the past years, a number of organizations and entities through Washington State have been working to increase the diversity of the health care workforce, including the behavioral health care workforce. On their own and in partnership, universities, colleges, schools, state agencies and boards, community based organizations, Tribes, urban Indian organizations, provider associations, clinics and hospitals, health plans, and other entities have implemented such activities and programs. A summary of select efforts was provided in the Council's workforce diversity advisory committee's policy paper⁸.

As examples, two past statewide efforts included the passage of SB 6193 and SB 6194 in 2006, which authorized the Department of Health in collaboration with the Workforce Board to survey health care professionals to collect race/ethnicity and other demographic data and to create a multicultural health education program for health professionals, respectively. Due to budget restraints, the health professions demographics survey has since been eliminated. The multicultural health education program was completed and is available to providers from all sectors of the health care industry (Washington State Department of Health 2010). In addition, the Council's workforce diversity advisory committee's own recommendations were incorporated into the Council's *State Policy Action Plan to Eliminate Health Disparities*. And as an example from the local level, the Regional Support Networks conduct annual reviews of the workforce by mental health specialty and language capacity.

In addition to efforts to improve the diversity of the healthcare workforce, entities in the State have initiated other activities to specifically address disparities in behavioral health outcomes and care. The Division of Behavioral Health and Recovery at DSHS has been leading an ongoing effort to address behavioral health service disparities. In June 2009, the agency sent a Washington State delegate to participate in the National Policy Summit on the Elimination of Disparities in Mental Health Care. At the summit, the team developed a plan to promote comparable access and outcomes for all populations served by the public behavioral health system (Washington State Department of Social and Health Services 2011). The implementation of the plan is now in its third phase. The first phase gathered information about efforts to address disparities through a national literature review, surveys of broadly representative key informants statewide, and guidance from a diverse stakeholder workgroup. The second phase resulted in a working definition of a culturally competent mental health system; a model

⁸ The workforce diversity advisory committee's policy paper and recommendations is available on the Governor's Interagency Council on Health Disparities Web site: http://healthequity.wa.gov/Committees/HWD/docs/20091209_Recs.pdf (see pages 4-5 for the summary of past activities to improve workforce diversity).

to review service data for disparities based on access, utilization and outcomes; and a method to review specialized service capacity at the regional support network (RSN) level. The third phase, currently in progress, is testing the model to review disparities and specialized capacity to provide services and eliminate disparities. This phase is expected to result in a method for RSNs to target disparities and develop strategies to reduce/eliminate one or more in the foreseeable future.

As with efforts to improve the diversity of the health care workforce, community-based organizations, Tribes, urban Indian health organizations, and community health centers have been leading efforts to promote health equity and reduce behavioral health disparities for the diverse populations they serve. At the statewide level, there is much to be learned about effectively integrating care, ensuring culturally competent services, and engaging community members in their own health and healthcare from these community-based programs and services.

Behavioral Health Disparities Advisory Committee Process

Behavioral health is a broad topic, and therefore, the Council’s behavioral health disparities advisory committee invested time in early meetings to define its scope and select focus areas for its recommendations. At its first meeting, the committee received briefings on past behavioral health disparities activities and future directions for the behavioral health system in Washington State. The briefings provided context to assist committee members understand how its work may align with other statewide efforts. At its second meeting, committee members discussed available data on behavioral health disparities in Washington State and the nation and whether improving the behavioral health system for the general population would also reduce disparities. Committee members agreed that improving access to and quality of behavioral health services for all populations was important but not enough to reduce disparities – targeted efforts to improve access to care and quality of care for communities of color were also essential.

In narrowing its scope, the committee brainstormed the following potential areas of focus: (1) changes to the Regional Support Networks (RSNs), which contract with community mental health centers to provide mental health services, (2) incorporating strategies to improve access to and quality of behavioral health services into health reform implementation, (3) developing the behavioral health workforce so it is more responsive to diverse needs, (4) focusing on children, infants, and toddlers as a targeted population, and (5) addressing housing for people with mental disorders. After further deliberations in meetings and during the interim, the committee agreed to focus its recommendations on developing the behavioral health workforce and identifying opportunities to improve care and reduce behavioral health disparities during health reform implementation.

Committee members agreed that improving access to and quality of behavioral health services for all populations was important but not enough to reduce disparities – targeted efforts to improve access to care and quality of care for communities of color were also essential.

In its discussions of the literature and conversations in meetings, the committee identified the following key findings, which formed the basis for its recommendations:

- Health professional diversity results in improved access to care for communities of color, greater patient choice and satisfaction, better communication between patients and providers, and better educational experiences for students in health professions programs (Institute of Medicine 2004).
- Non-English speaking patients receive better interpersonal care, experience greater medical comprehension, and have a greater likelihood of keeping follow-up appointments when they are

treated by a provider who speaks their language, particularly in the mental health setting (U.S. Department of Health and Human Services 2006).

- Interventions to improve the cultural competence of health care providers and systems appear to affect health services utilization, satisfaction, and increases in knowledge, although more research on provider and patient behavior and outcomes are needed (U.S. Department of Health and Human Services 2004). In addition, culturally competent health care decreases the cost burden of ineffective care or poor access to care for communities of color (Sanchez 2012).
- The U.S. Department of Health and Human Services Office of Minority Health issued standards for culturally and linguistically appropriate services (CLAS standards)—the standards include mandates, guidelines, and recommendations to correct inequities that currently exist in the provision of health services and to make these services more responsive to the individual needs of all patients/consumers (U.S. Department of Health and Human Services 2001).
- As more people of color gain health insurance under the Affordable Care Act (Families USA 2010), it is important we do not create new barriers for culturally and linguistically competent providers to serve diverse patient populations, as well as to identify and remove barriers, where appropriate.
- There is a need for improved data collection and analyses to better understand behavioral health disparities, particularly for racial/ethnic subpopulations. These data need to be regularly analyzed to observe changes over time and to evaluate whether interventions are effective (U.S. Department of Health and Human Services 2001, Washington State Department of Social and Health Services 2011, U.S. Department of Health and Human Services 2012).
- Policies that promote access to a culturally and linguistically competent health home for vulnerable patient populations could help reduce or even eliminate health care disparities experienced by communities of color and low-income communities (Beal et al. 2007).
- Tribes, urban Indian organizations, and community-based organizations that are trusted and knowledgeable about local circumstances and opportunities and are culturally and linguistically competent can provide effective outreach and enrollment into public insurance programs. Community-based organizations tend to offer a more comfortable, approachable setting than government agencies, especially for diverse communities (The Colorado Trust 2010, California Coverage and Health Initiatives 2011).
- Care coordination that include peer support and other support services for adults with mental disorders can enhance access to treatment, lower health care costs, and result in additional social benefits, such as increased employment, reduced incarcerations, and reduced homelessness⁹.
- Evidence-based screening tools and practices used to assess behavioral health problems need to be adapted to different cultures and languages (U.S. Department of Health and Human Services 2001, Lau 2006, Altschul 2009, Loo 2012).

⁹ Care Coordination, Peer Support, and Discretionary Fund Improve Quality of Life and Reduce Costs for Adults with Serious Mental Illness. Accessed on the Agency for HealthCare Research and Quality Web site at: <http://www.innovations.ahrq.gov/content.aspx?id=3387> on May 24, 2012.

Recommendations to the Council

The behavioral health disparities advisory committee offers the following recommendations to the Council for its consideration. The committee recognizes that the respective state agencies may require additional resources and staffing needs to fully and effectively implement the recommendations.

RECOMMENDATION 1: WORKFORCE DEVELOPMENT

- A. Development:** The Office of Superintendent of Public Instruction should collaborate, support, and seek funding opportunities with community-based organizations, Tribes, and urban Indian health organizations in providing outreach and programming to students of color and their families about resources and programs that can assist students to prepare for careers in the behavioral health field. Such programs include but are not limited to Navigation 101, IBEST, various OSPI sponsored dropout prevention, intervention, and retrieval programs, as well as exploratory and dual credit career and technical education opportunities in the health sciences program. In addition, health professions training institutions should actively recruit people of color and people devoted to serving communities of color into health programs, including behavioral health programs.
- B. Credentialing:** The Department of Health should consult with agencies, facilities, federally recognized Indian Tribes within the State, or counties that can employ agency affiliated counselors before any changes to agency affiliated counselor scope of practice and/or credentialing requirements are made in rule.
- C. Training for Providers:** The disciplinary authorities for behavioral health professions should: (1) consider cultural competency training as acceptable to meet part of the total required continuing education hours and (2) include providers of acceptable cultural competency training among those approved to provide continuing education.

RECOMMENDATION 2: HEALTH REFORM IMPLEMENTATION

As Washington State develops an integrated, publicly-funded primary and behavioral health care system, the State should assure meaningful engagement and participation from primary care stakeholders, behavioral health stakeholders, and communities, particularly those impacted by health disparities, as well as government-to-government consultation with Tribes. Specific recommendations for an integrated system that is responsive to community needs include the following:

- A. Data:** Health Care Authority and Department of Social and Health Services should routinely collect, analyze, and disseminate data on access to behavioral health services, quality of behavioral health services, and behavioral health outcomes. Metrics should be based on multiple data sources and disaggregated to the finest subpopulation level possible. At a minimum, data should be disaggregated in accordance with Department of Health and Human Services' standards for data collection on race, ethnicity, sex, primary language and disability status, as required by Section 4302 of the Affordable Care Act. However, Health Care Authority and Department of Social and Health Services should consider using the standards adopted by the Office of Superintendent of Public Instruction¹⁰.

¹⁰ See appendix Y and appendix Z in the Comprehensive Education Data and Research System (CEDARS) Data Manual for the 2011-2012 school year available at: <http://www.k12.wa.us/CEDARS/pubdocs/2011-12/2011-12CEDARSAppendices.pdf>.

- B. Qualified Health Homes:** Health Care Authority and Department of Social and Health Services should ensure the definition of qualified health homes allows for the inclusion of Tribes, urban Indian health organizations, community-based organizations and school-based health centers to be a part of qualified health homes. Qualifying health homes should be patient-centered, encourage integrated care, and cover chronic health conditions, including substance abuse and mental disorders.
- C. Incentivizing Culturally Competent Care:** Health Care Authority and Department of Social and Health Services should ensure payment models incentivize culturally competent care coordination and other supports and services that promote engagement and positive health outcomes (e.g., language access services, patient self-management, tobacco prevention and cessation services, and peer support specialists). Care coordination should reflect the integration of behavioral health and primary care in a setting most appropriate for the client.
- D. Access and Engagement:** Health Care Authority and the Health Benefit Exchange Board should ensure that culturally and linguistically competent community-based organizations, Tribes, and urban Indian health organizations are eligible to serve as navigators and be compensated for providing outreach to and increase enrollment of diverse communities into Medicaid Expansion and plans offered under the Health Benefit Exchange. Health Care Authority and Department of Social and Health Services should ensure any mandated evidence-based screening tools and practices allow for flexibility to include promising practices and cultural and linguistic adaptation.

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