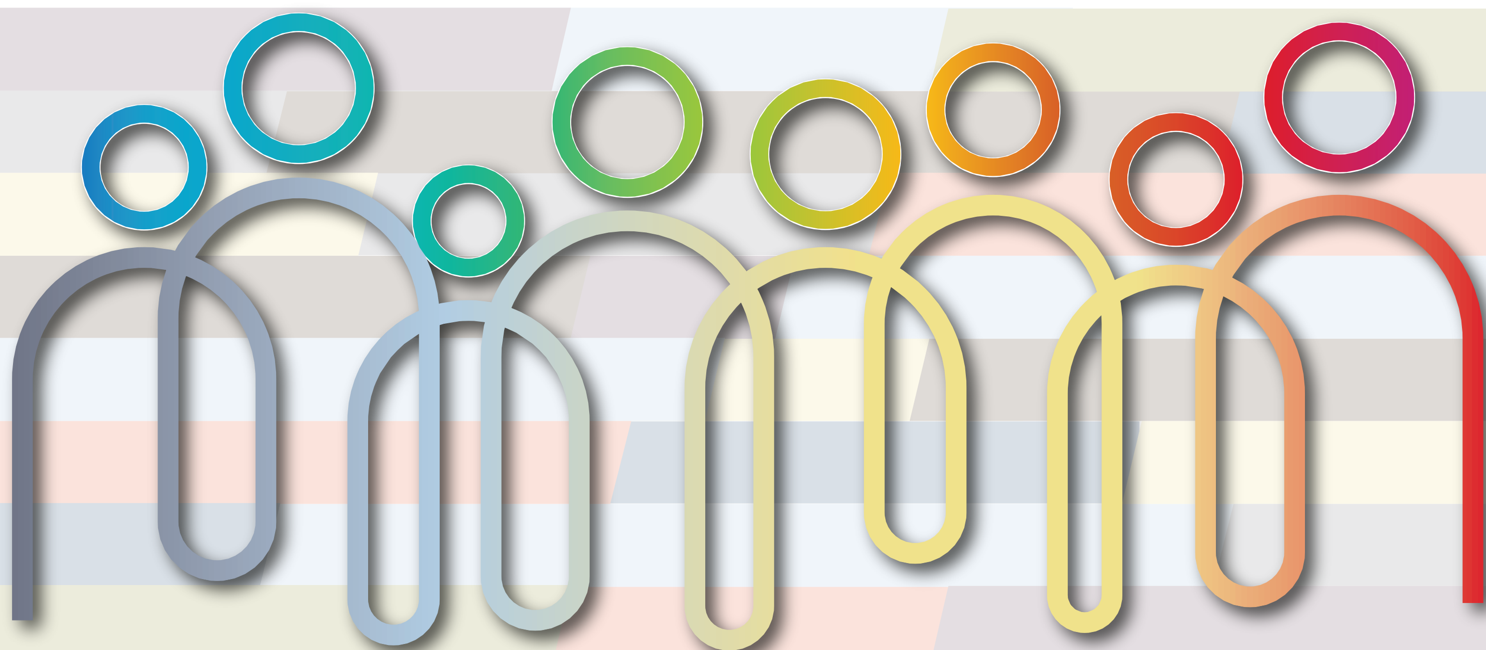
Equity as a Foundation for Leadership:



Experiences and Recommendations for Behavioral Health Leaders

January 2022

The College for Behavioral Health Leadership

Central East (HHS Region 3) ATTC
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Authored by The College for Behavioral Health Leadership (CBHL) in partnership with the Just Health Collective, LLC and the Prevention Institute.

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The College for Behavioral Health Leadership (CBHL) was proud to join the Central East Addiction Technology Transfer Center (CE-ATTC), a technical assistance program under the auspices of The Danya Institute, funded by SAMHSA, to develop this report. CBHL partnered with the Just Health Collective, LLC and the Prevention Institute to create evidence- and experienced-based content.

The College for Behavioral Health Leadership (CBHL) serves as a resource for leaders from across sectors whose work focuses on or intersects with behavioral health. We advocate for innovative, equity-grounded leadership practices fostering cross-sector collaborations. Distinctly different from other leadership organizations, we continually evolve to ensure alignment with our vision and mission. We draw from the opinions of our valued membership, which reflects a diversity of experience, expertise, and perspective. And we seek guidance from our strategic partners who—along with our members—serve as co-creators and active participants in our work.

Just Health Collective is a consulting and strategic advisory firm, dedicated to transforming a healthcare system that is fair, impartial, and representative of the community. By prioritizing education, inclusiveness, equity, and belonging, Just Health Collective is committed to creating environments for healthcare clients in which everyone has the opportunity to achieve optimal health outcomes, free of bias, discrimination, and disparities.

Prevention Institute is a national nonprofit with offices in Oakland, Los Angeles, Houston, and Washington, DC. Our mission is to build prevention and health equity into key policies and actions at the federal, state, local, and organizational levels to ensure that the places where all people live, work, play, and learn foster health, safety, and well-being. Since 1997, we have partnered with communities, local government entities, foundations, multiple sectors, and public health agencies to bring cutting-edge research, practice, strategy, and analysis to the pressing health and safety concerns of the day. We have applied our approach to injury and violence prevention, healthy eating and active living, land use, health systems transformation, and behavioral health and well-being, among other issues.

Contents

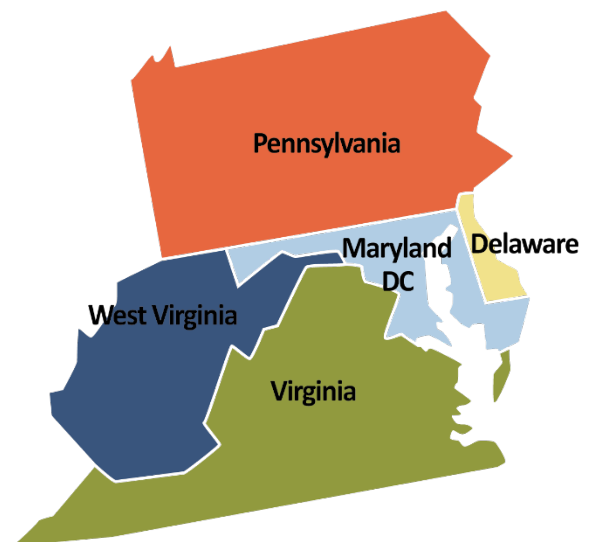
Executive Summary **5**
Introduction **8**
Who Should Read This Report? 9
Limitations 9
Facts and Stats **10**
Lived Experience of Leaders **12**
Survey Results and Themes 12
Interview and Focus Group Themes 16
What Is Equity-Grounded Leadership? **20**
Characteristics of Equity-Grounded Leaders 20
Positive Impacts of Equity-Grounded Leadership 21
Recommendations **22**
For Region 3 Leaders and Policy Makers 22
Recommendations for Developing Equity-Grounded Leaders 22
Recommendations for Leaders to Prioritize Health Equity 24
APPENDIX A **27**
State Profiles 30
APPENDIX B **34**
Lived Experience 34
Survey of HHS Region 3 Leaders 34
Key Informant Interviews 38
Focus Groups 39
APPENDIX C **40**
Supplementary Information 40
NOTES **47**

Executive Summary

Racial inequities are pervasive in the behavioral health system and one of the underlying reasons such vast differences exist in social and health outcomes between communities today. Addressing this complexity presents challenges, but also opportunities. Currently, leadership in behavioral health does not reflect the population served. However, seasoned leaders are more intentionally focused on addressing issues of equity. New leaders are entering systems not currently built upon a foundation of equity, but are well-positioned to transform the culture and disrupt status quo. Barriers exist for people of color stepping into behavioral health leadership positions—as well as opportunities for increasing the level of consciousness of the importance of diversity and inclusion. How can new leaders receive support so they thrive and create meaningful, equitable, and lasting change? Is the next generation of leaders prepared to succeed in this critical but difficult work?

The Central East Addiction Technology Transfer Center (CE-ATTC), funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) and operated by The Danya Institute, contracted with The College for Behavioral Health Leadership (CBHL) to develop a report describing and defining *Equity-Grounded Leadership* for use by behavioral health leaders in Health and Human Services Region 3 states. This report builds on the Institute's ongoing efforts to improve diversity, increase cultural competency, and address population-specific needs of people receiving and delivering behavioral health services in Region 3.

CBHL partnered with Just Health Collective and the Prevention Institute to develop this report. The purpose is to define and describe equity-grounded leadership, incorporating the experiences and perspectives of Region 3 behavioral health leaders via a survey, key informant interviews, and focus groups; make the case for the importance of focusing on equity as an foundational element of leadership; and offer recommendations for local, state, and national leaders and policy makers.



Region 3 is a diverse region including Delaware, the District of Columbia, Maryland, Pennsylvania, Virginia, and West Virginia. With a population of nearly 31,000,000 people, the region consists of a mix of dense, urban metropolitan areas and rural communities. Two-thirds of the population overall is White, and one-third are residents of color, but significant diversity is seen by state and community. Clear racial disparities exist in three indicators of health equity—poverty, education, and home ownership—across the region. Data on regional diversity of the behavioral health workforce and leadership are unavailable, but anecdotally are widely believed to comprise White females.

A survey was designed to assess leaders' perceptions of diversity, equity, inclusion, and belonging in the organization for which they work, and within the community or region they serve. Key informant interviews and focus groups were designed to go a little deeper into leaders' perspectives on equity as a foundation for leadership, needs, and barriers.

Key Findings Among Survey Participants

- Half agree a career development path exists for all employees in their organization.
- Half report leaders are representative of staff and the population served.
- Less than two-thirds agree the process for promotion into leadership is fair.
- Most generally feel their organization encourages belonging, but fewer feel safe to challenge status quo.
- Two-thirds believe leaders within their organization lead from a foundation of equity.
- Three out of four survey respondents believe diversity among the behavioral health workforce can improve.
- Four out of five believe diversity among behavioral health leadership in their community or region can improve.

Key Themes of Interviews and Focus Groups

- Cross-disciplinary leadership resources and education
- Funding infrastructure and contracting practices
- Bold policies and declarations to promote equity
- Representative leadership and emerging leaders
- Mentorship
- Technical and psychological anti-racism training for leaders
- Standardized data collection to measure equity
- Language and communication
- Moving from status quo to action

Equity-Grounded Leadership

Equity-grounded leadership stems from the understanding that the current systems are unjust. It empowers leaders to mobilize themselves and others to create positive change. Equity-grounded leadership begins with courageous inquiry of personal and professional biases that impact how one views him/herself and others, and how to collectively influence others to create communities that are rooted in resilience and promote healing.

Equity-grounded leadership recognizes the danger caused by unchecked power and hierarchies in all forms and works to mitigate them. It demands transformative solutions away from the status quo. Equity-grounded leadership is person-centered, recovery-oriented, trauma-informed, and acknowledges that individuals have different experiences, abilities, and needs. It allows leaders to account for those needs and develop strategies for decision making to include all voices. It is different than leading from a place of equality, which is about sameness and assumes that all individuals will benefit from being provided the exact same support.

Equity-grounded leadership ensures leaders are equipped to lead with influence and from a position of love and humility.

Recommendations

Equity-grounded leaders are needed to eliminate health disparities and related traumas stemming from deeply entrenched structural racism in behavioral health. To do this difficult work, leaders must develop their voice, power, and courage to disrupt status quo and pave the way for innovative solutions. Based

upon our interpretation of the experiences of leaders in Region 3, we offer two sets of recommendations: **recommendations for developing equity-grounded leaders,** and **recommendations for leaders to prioritize health equity**.

Recommendations for Developing Equity-Grounded Leaders

- **Competency: Enhance knowledge, skills, and capabilities of current and new leaders**
  - Create safe spaces
  - Assess lived experiences within the organization
  - Understand the community and population served
  - Offer training and education
  - Create a framework for accessing resources
- **Coaching: Provide leadership support through mentoring, allyship, and sponsorship**
  - Create a scalable mentorship structure
  - Develop allies
  - Identify and promote emerging leaders of color
- **Collaboration: Promote development of meaningful networks and partnerships**
  - Develop and/or support participation in leadership networks
  - Provide experiential learning opportunities
  - Promote emerging leaders outside the organization

Recommendations for Leaders to Prioritize Health Equity

- **Purpose: Intentionality for health equity**
  - Apply a health equity lens
  - Address privilege, bias, discrimination, institutional and structural racism, and classism
  - Account for community trauma
  - Foster connections between people, systems, issues, and opportunities
- **People: Leadership and engagement**
  - Create a shared vision
  - Lift up community voice, participation, and leadership
  - Promote multi-sector engagement
  - Prioritize and fund leadership development
- **Practice: Methodology and capacity**
  - Develop health equity tools, approaches, and methodologies
  - Train and build capacity across systems and sectors
  - Standardize data collection
- **Platform: Infrastructure for success**
  - Declare racism a public health crisis
  - Make the case through communications
  - Leverage financing and funding to support equity
  - Prioritize investments to close racialized gaps
  - Establish metrics and measurement

Introduction

Over the past 18 months, the complex interaction between the COVID-19 pandemic, race- and hate-based violence, and associated behavioral health inequities has brought greater attention to the devastating impacts of deeply ingrained structural racism.[1] Racial inequities are pervasive in the behavioral health system and one of the underlying reasons such vast differences in social and health outcomes exist between communities today.

Even pre-pandemic, inequities in access to behavioral health services were pervasive.[2] Many differences in access to or quality of care and law enforcement response to behavioral health crises, for example, are the result of historically racist systems and policies. People of color with behavioral health issues, especially Black men and boys, are more frequently directed to justice systems with harsher disciplinary practices.[3] Moreover, the behavioral health system rests on a historically inequitable foundation that perpetuates an ingrained distrust by people of color due to resultant trauma.[4]

Addressing this complexity presents challenges, but also opportunities. Seasoned leaders are becoming more intentionally focused on addressing issues of equity. New leaders are entering systems not currently built upon a foundation of equity—but are well-positioned to shift the conversation, transform the culture, and disrupt status quo.

Currently, leadership in behavioral health does not reflect the population served. A lack of diversity and lived experience of communities exists in the current workforce, and people of color stepping into behavioral health leadership positions encounter barriers. Leaders from the BIPOC community and those with lived experience do not have a prominent voice at decision-making tables. When asked about the continuing barriers for people of color in the behavioral health system, leaders—both nationally and in the Department of Health & Human Services (HHS) Region 3—cite competing priorities, lack of workforce, and too little time to do "one more thing." They also report workforce shortages and high rates of turnover.

Are leaders prepared both psychologically and technically to succeed in this critical but difficult work? How can new leaders be supported so they thrive, with the support, training, and infrastructure to create meaningful, equitable, and lasting change?

This report provides an understanding of the importance of and recommendations to achieve equity-grounded leadership in behavioral health and adjacent sectors. The report should be used as a foundation on which regulatory, administrative, service delivery, and other systems can build a structure so that leaders can thrive individually and have impact within their respective organizations and communities.

Who Should Read This Report?

The report was developed by and for leaders whose work intersects with behavioral health in HHS Region 3. Although the information contained in this report is specific to HHS Region 3, the rationale and recommendations have applicability across all HHS regions. Those who should read this report include:

- Those who plan, administer, fund, and regulate behavioral health, addiction, and related systems, including legislators, state and county administrators, providers, health systems, managed care plans, advocates, and other community leaders.
- Individuals aspiring to be leaders capable of impacting the behavioral health and well-being of their organizations and communities as well as through local, state, and national policy and programmatic work.
- Anyone interested in thoughtful and reasonable opportunities to support the transformation of behavioral health systems to support equitable prevention, access to care, treatment, and community support efforts.

Limitations

This report was limited in its scope by several factors. First, the abbreviated timeline for data collection limited our ability to thoroughly capture leaders' lived experience. Although we made significant efforts to disseminate the survey broadly and solicit responses, we could neither control for who responded, nor know how their views are similar or different from those who did not respond. Similarly, we made significant efforts to secure key informant interviews and focus group participants. We believe leaders participating in these efforts reflected a range of perspectives and experiences and were representative of the region.

Facts and Stats

About Region 3 States

HHS Region 3 states include Delaware, the District of Columbia, Maryland, Pennsylvania, Virginia, and West Virginia. The total population of Region 3 in 2019 according to the U.S. census was 30,854,848. The region consists of a mix of dense, urban metropolitan areas and rural communities. The population overall is distributed similarly by age across in each state, except for the District of Columbia, which trends younger—67% of the population in the District of Columbia is younger than 44 years of age, compared to 56% for the region as a whole. Significant differences exist in the racial and ethnic makeup of the populations in each state, as shown in Exhibit 1.[5]

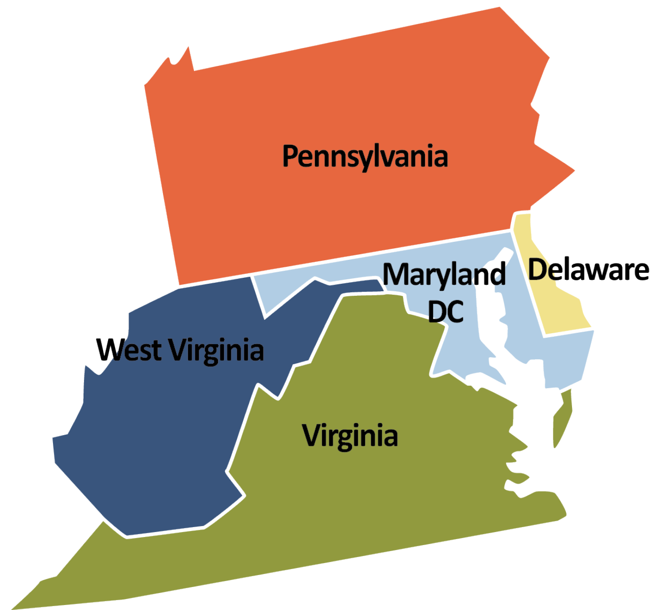
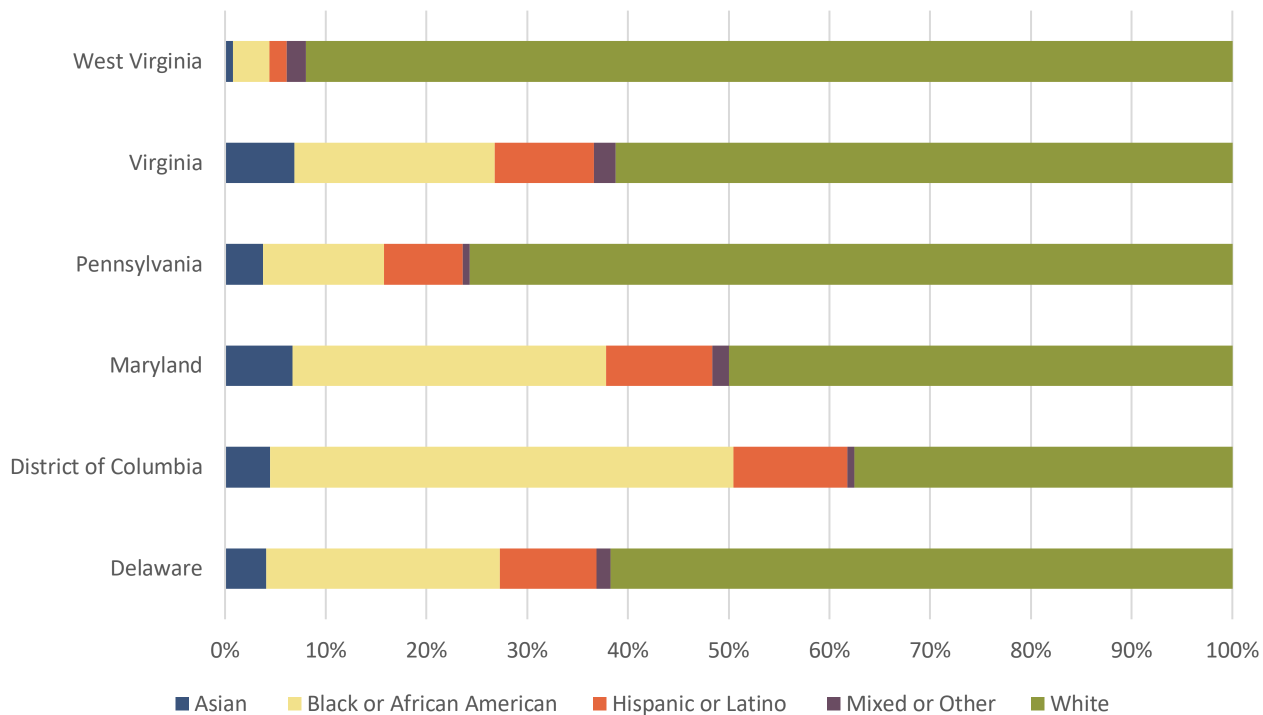


Exhibit 1: Race and Ethnicity by State, HHS Region 3, 2019



Although data on behavioral health leadership demographics are not available, key informant interviewees noted the behavioral health workforce in Region 3 and nationally has historically been comprised predominantly of non-Hispanic, White females, and leadership in particular is predominantly non-Hispanic White.

From 2017–2019 in Region 3, 46% of adults aged 18 and older received behavioral health services in the prior year; slightly higher than the national average of 44%.[6] Ideally, data would be available at the local level to understand the percentage of the population receiving behavioral health services by race and ethnicity in relation to the overall population. Similarly, data should provide an understanding of the percentage of population receiving behavioral health services by race and ethnicity in relation to behavioral health leaders and clinicians in organizations, local communities, statewide, and by region.

The National Equity Atlas identifies key indicators of health equity, three of which are poverty, education, and homeownership.[7] Clear racial disparities between and within states surfaced during this study:[8]

- In all Region 3 states, Black, Latino, and Native American residents were more likely to live in poverty than White or Asian/Pacific Islander residents; the rates were approximately double in most states.
- In all Region 3 states except West Virginia, Black, Latino, and Native American residents were less likely to have attended at least some college compared to White or Asian/Pacific Islander residents. The disparity was most striking in the District of Columbia. In West Virginia, White residents were less likely to have attended some college than people of color.
- In all Region 3 states, White and Asian/Pacific Islander residents were more likely to own a home than Black, Latino, and Native American residents.

The consequences of these indicators are far-reaching and may not only affect the health and economic well-being of individuals receiving care, but also the health and well-being of the service delivery workforce and behavioral health leaders in states.

For additional detail on the demographics of the populations of each state, indicators of equity demonstrating clear disparities by race and ethnicity, declarations of racism as a public health crisis, and state profiles, see Appendix A.

Lived Experience of Leaders

Survey Results and Themes

We distributed an organizational survey by email throughout Region 3 that targeted leaders at all levels, in different roles, and of varied backgrounds. To protect individual participants' privacy, we removed personally identifiable demographics. Full details on survey methods and results are detailed in Appendix B. Important themes and recurring patterns surfaced regarding respondents' perceptions of their organizations, communities, leadership, and workforce, which helped us provide overall recommendations.

Survey Respondents

The survey findings are derived from a total of 201 responses. The greatest number of responses came from leaders in Pennsylvania, but when considering the size of each state's population, West Virginia and the District of Columbia were most represented, and Virginia and Delaware were least represented. Participants indicated a range of leadership experience from greater than 20 years (20%) to less than four years (11%). Thirteen percent indicated they are not in a leadership position.

The 183 survey respondents who reported their race and ethnicity were predominantly non-Hispanic White (69%), female (71%), and aged 35–64 years (79%). The 176 survey respondents who reported their age group were aged 45–64 years, compared to 37.5% of the population. This is not unexpected given the survey was designed for those in leadership roles. Among those (n=179) who reported their gender or gender identity, 72.6% were female, compared to 51.1% of the Region 3 population. With consideration for a small survey sample size, gaps are present in representation among survey respondents by race and ethnicity (Exhibit 2).

Exhibit 2: Region 3 Population Distribution in 2019 Compared to Survey Respondents

	Region 3 Population (%)	Survey Respondents (%)
Race and Ethnicity		
White (Non-Hispanic)	66.3	68.9
Black or African American	18.6	14.7
Hispanic or Latino	8.7	4.9
Asian	5.1	1.1
American Indian or Alaskan Native	1.4*	2.2
More than one race or ethnicity	1.4*	8.2
Age Group		
25-44 years	37.4	28.5
45-64 years	37.5	62.5

65+ years	25.1	9.0
Gender		
Male	48.9	26.3
Female	51.1	72.6
Trans Male, Trans Female, Nonbinary	n/a	1.1

*Represents the percent of the population within the region reporting more than one race or ethnicity, or other, including American Indian or Alaska Native. Source: U.S. Census QuickFacts. https://www.census.gov/quickfacts/fact/table/WV,VA,PA,MD,DC,DE#

Organizational Perceptions

The first set of questions assessed leaders' perceptions of their organization. For the purposes of the survey, *organization* refers to where the participant works. Just Health Collective identifies four primary competencies related to advancing equity and belonging in organizations. These competencies are the fundamental building blocks to foster an environment where leaders—particularly leaders of color—can grow in diverse spaces. The competencies are further defined in Appendix B (Exhibit 11) are:

- Career development and paths to leadership
- Diversity and representation among leadership
- Fairness and equal opportunities to advance
- Psychological safety and well-being

Half agree a career development path exists for all employees in their organization.

Regarding **career development and paths to leadership**, less than 50% agree a career development path exists for all employees within the organization. Only 44% reported *leaders* are provided with diversity, equity, and inclusion (DEI) training prior to assuming their roles, even though 71% report their organization provides training programs that promote an understanding of various dimensions of diversity.

Half report leaders are representative of staff and the population served.

Two-thirds of respondents (66%) agree their organization is diverse, but when asked about **diversity and representation among organizational leadership**, a lower percentage reported that leaders were representative of staff (55%) and populations served (53%).

Less than two-thirds agree the process for promotion into leadership is fair.

There were stronger reports of **fairness and equal opportunities to advance,** with 76% reporting they agree their organization's policies and procedures promote DEI, and 73% of employees in different demographic groups are provided a fair opportunity to apply and be considered for leadership positions. However, only 62% report that the process for promoting people into leadership positions is fair.

Most generally feel their organization encourages belonging, but fewer feel safe to challenge status quo.

Respondents reported stronger reports of **psychological safety and well-being**, with 84% agreeing that their organization encourages belonging and 77% reporting the people in their organization appreciate others whose backgrounds, beliefs, and experiences are different from their own. By comparison, however, only 64% report they feel safe to challenge the status quo at their organization.

Two-thirds believe leaders within their organization lead from a foundation of equity.

Nearly two-thirds of survey participants (65%) agree that leaders within their **organization lead from a foundation of equity**, while 15% disagree.

Community Perceptions

Over the last decade, an increasing awareness of the need for cross-sector change using population health strategies inclusive of the community to impact overall health and wellness has grown.[9] Survey questions thereby focused on perceptions of diversity, equity, and inclusion as they relate to the behavioral health workforce and leadership in the community or region in which the survey respondent works.

When asked about the **behavioral health workforce** in their community or region, only 49% of respondents agreed that the workforce was diverse, and 48% reported the workforce was representative of the population(s) served. Three out of four respondents (75%) reported diversity among the behavioral health workforce can improve.

When asked about **behavioral health leadership** in their community or region, only 44% of survey respondents agreed that leadership was diverse, and 41% reported the workforce was representative of the population(s) served. Four out of five respondents (80%) reported diversity among the behavioral health leadership can improve.

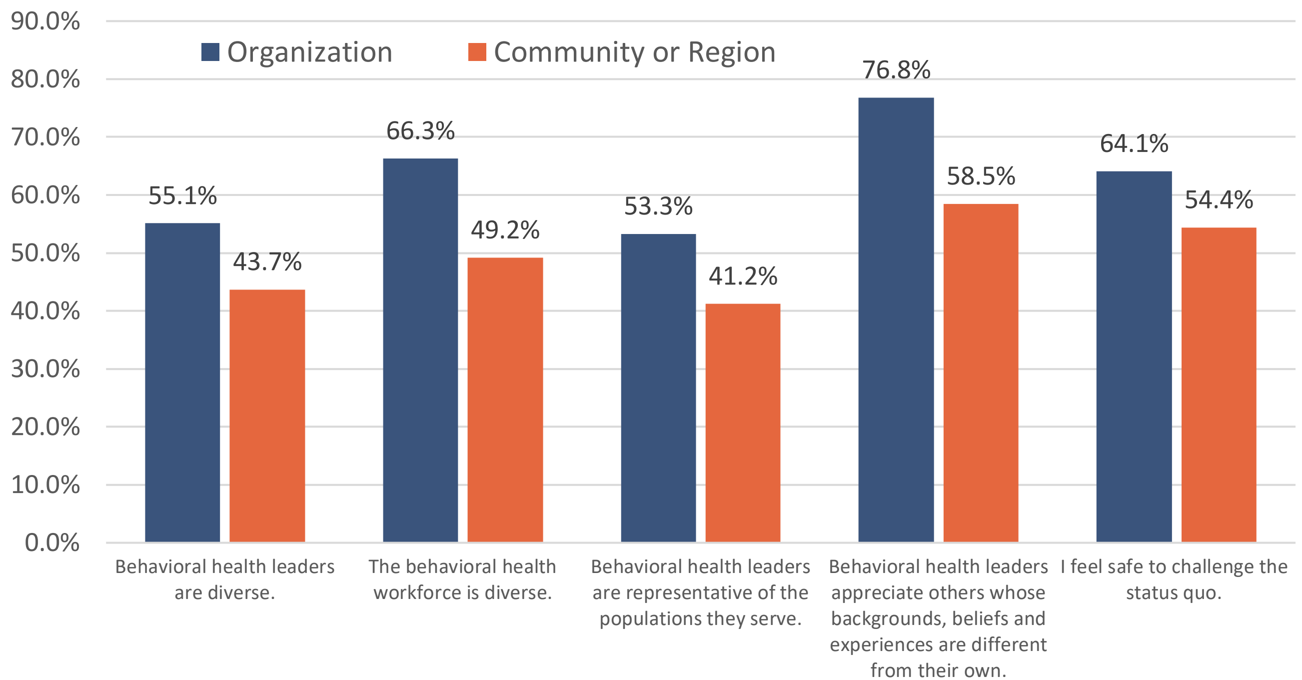
*Three out of four survey respondents believe **diversity among the behavioral health workforce can improve**. Four out of five believe **diversity among behavioral health leadership in their community or region can improve.***

Similarly, just 47% of survey respondents reported that **community partnerships or collaboratives** formed to address behavioral health needs in their community or region are representative of the population(s) served.

Organizational Versus Community Leadership and Workforce Perceptions

Interesting themes emerged between similar questions about diversity and feelings of safety within organizations compared to the community or region. When compared to behavioral health leaders in the community or region, survey participants generally believed that their organization's leadership and workforce were more diverse and representative of the populations they serve (Exhibit 3). Leaders also reported with greater frequency beliefs of safety within their organization when compared to their community or region. Although we do not have sufficient data to run cross-tabulations or to further explore responses, we can speculate that leaders responding to the survey may have considered community or regional leadership at a level different than within their own organization, for example, local or state government leaders or elected officials. It is also not uncommon for people to think "others" need to make more changes than they do, or that "others" hold more of the responsibility for inequity. These data are important as a tool to start effective community conversations.

Exhibit 3: Survey Responses Reporting Strongly Agree or Agree on Questions of Diversity and Safety



Interview and Focus Group Themes

Fourteen key informant interviews were completed across various levels of leadership, tenure, and role, as well as two focus group sessions with a total of six participants. To protect individual participants' privacy, we removed personally identifiable demographics. Participants ranged from medical directors, to state and county systems administrators, to leaders of community-based organizations. Interview and focus group methods and questions are available in Appendix B. The important themes and recurring patterns we identified are outlined below.

Key Findings and Themes

- **Cross-disciplinary leadership resources and education:** Most Region 3 leaders demonstrated passion for their work and reflected a good working knowledge of equity. However, when putting equity into practice, leaders do not have the financial, educational, and human resources available across disciplines to support their efforts. Leaders also need a dependable framework for accessing and using resources and up-to-date educational materials related specifically to identifying and addressing systemic inequities and racist policies and practices in behavioral health.

  "We really just lack a supportive infrastructure, in terms of data collection, resources, reporting, and support for leaders." —Focus Group Participant

- **Funding infrastructure and contracting practices:** Improved funding and contracting infrastructure at the local, state, and federal level can greatly support local efforts to advance

health equity. Specifically, improved access to funding for Black, Indigenous, and People of Color- (BIPOC) led, community-based, and/or grassroots organizations, either directly or through improved contracting, grantmaking, and purchasing systems can widen opportunities for growth. The infrastructure and practices currently in place often function to maintain status quo.

> "Historically funding has not been equitable. Year after year the same ten organizations get funded and they are not doing the work, but regardless they are funded. Is this because they can afford to have a grant writer write a great application? And those really doing the work can't hire a grant writer? It all comes down to how the money falls. It all comes down to a good old boy network." —Key Informant Interview Participant

- **Bold policies and declarations to promote equity:** Local, state, and federal agencies can raise collective consciousness and help local leaders secure buy-in and support across sectors within communities by implementing bold policies and declarations designed to promote equity (e.g., government agencies at all levels declaring racism a public health crisis).

> "Consciousness has been raised now for counties and associations; this has really been helped by the broad public health initiative declaring racism a public health crisis." —Key Informant Interview Participant

- **Representative leadership and emerging leaders**: Many respondents reported behavioral health leaders within organizations often are not representative of staff, nor are they representative of the populations served. This results in the inability of recipients of services to "see" themselves among the workforce, and for the workforce to "see" themselves in leadership, culminating in lack of trust in the system. Policies and programs must be implemented to ensure diverse representation among the workforce and leadership.

> "There are lots of people of color who are competent in leadership, but just not given the opportunity. We need programs and policies in place to identify these individuals and provide for them." —Focus Group Participant

- **Mentorship:** The United States is at the forefront of a significant workforce and cultural shift. A younger generation of leaders are competing with seasoned professionals, bringing with them significant differences in both learning and leadership styles. Emerging leaders are more oriented toward equity than past generations of emerging leaders, but need a deeper understanding of organizations, funding structures, and methodologies for systems change. Bi-directional mentorship will be critical to the success of future leaders in dismantling systemic racism, but better models of group mentorship and coaching are necessary. Although individual leaders recognize the need for formal and informal mentoring, intentional mentorship structures within organizations, and more broadly within the profession, are needed to recruit, support, and retain emerging leaders in behavioral health. These structures need to include opportunities to develop networks with other leaders for support and to learn new strategies.

> "There are informal opportunities for mentorship in place, but on a large scale they simply won't affect lasting change. Behavioral health is a very diverse niche in itself, so there is a need for a robust system to support such diverse individuals looking to advance in this space." —Focus Group Participant

- **Technical and psychological anti-racism training for leaders:** Past approaches to leadership development, particularly related to advancing the practice of equity, focused primarily on technical skills, tools, and resources. Now, with greater attention to and understanding of the impact of racial trauma and the recognition of systemic racism, leaders must also be trained in anti-racist practice. Additionally, and perhaps more importantly, they must be prepared psychologically. Understanding how to effectively deal with conflict—and how to avoid burnout—must be second nature to leaders. Finally, leaders are generally aware of the concept of unconscious bias; however, leaders have a crucial responsibility to unlearn concepts of color blindness and the "closed door" rhetoric that predominantly excludes individuals of color and other marginalized groups.

  "We need to teach leaders how to deal with issues of conflict and not shut down or get angry." —Key Informant Interview Participant

- **Standardized data collection to measure equity:** Although individual organizations may be collecting data on metrics such as the diversity of their client population, workforce, and/or leadership, a lack of standardized data collection currently exists on metrics like attitudes and perceptions within the workplace, diversity of the behavioral health workforce, and equity in the community, such as equitable delivery of services.

  "We need to bring a value perspective to leadership. We need to inspire leaders who want to advance this work to put in the time and effort to measure change. It isn't going to happen easily or quickly—but if leaders are not seeing a clear benefit to their efforts on a small scale it probably won't happen on a large scale." —Key Informant Interview Participant

  Language and communication: Across nearly all interviews, leaders discussed the importance of language, including communication with one another, and how words can be inclusive or divisive to various groups, communities, or populations based on their individual understanding, experiences, and perspectives. Additionally, the use of consistent definitions has been challenging in behavioral health generally, and in equity and anti-racism work language becomes even more critical.

  "Our language has always been othering. We need to change this. We need a new perspective in society. There must be a willingness to educate ourselves with the difficult truth. This difficult truth must be born in two kinds of realities. The reality of being self-emancipated and knowing what it means to be who we are." —Key Informant Interview Participant

- **Moving from status quo to taking action:** Several leaders commented that although it is important to understand equity and talk about the impacts of racism, it is time to move beyond talking and take action. The toughest challenge among leaders who have worked on issues of equity for many years is the status quo.

  "We are always coming to a point of being shocked into making a change and addressing a reality. And every time we are shocked by an incident we can't believe one human would treat another that way. And we talk about it. Why do we need to keep being shocked in order to take action?" —Key Informant Interview Participant

Perspectives of HHS Region 3 leaders are consistent with feedback from county behavioral health leaders in Ohio following completion of training in Winter 2021 on structural racism using the *Groundwater Approach*.[10] Participants noted the need for training, data/information, and guidance in addition to financial resources specifically dedicated to DEI work.[11] In its July 2021 *Year in Review* report, the Ohio Association of County Behavioral Health Association's (OACHBA) Health Equity, Diversity and Inclusion Council identified eight strategic priorities, including support for individual leadership development. Specifically, OACHBA plans to "develop, enroll in, or fund local formalized programs that promote individual competencies in equity-grounded leadership so that leaders are equipped to confidently step into their own voice, courage, and power to advance anti-racism and health equity."[12]

What Is Equity-Grounded Leadership?

Equity-grounded leadership stems from the understanding that everyone is affected by unjust systems. It is a framework that allows leaders to mobilize themselves and others to create positive change. Equity-grounded leadership begins with courageous inquiry of personal and professional biases that impact how one views him/herself and others, and how to collectively influence others to create communities that are rooted in resilience and promote healing.

Equity-grounded leadership recognizes the danger caused by unchecked power and hierarchies in all forms and works to mitigate them. It demands transformative solutions away from the status quo. Equity-grounded leadership is person-centered, recovery-oriented, trauma-informed, and acknowledges that individuals have different experiences, abilities, and needs. It allows leaders to account for those needs and develop strategies for decision making to include all voices. It is different than leading from a place of equality, which is about sameness and assumes that all individuals will benefit from being provided the exact same support.

Equity-grounded leadership ensures leaders are equipped to lead with influence and from a position of love and humility.

Characteristics of Equity-Grounded Leaders

Leaders who operationalize equity:

- Support grassroots leadership and emerging, community-based groups
- Invest in community and culturally rooted practices
- Share decision making across sectors and with communities
- Change community factors to change health outcomes
- Take a collaborative approach to training, technical assistance, and resource allocation
- Attach funding to equity guidelines
- Examine practices and policies for implicit bias (racial, gender, socioeconomic, and others)
- Create action plans focused on equity and anti-racism
- Advance a broad regional health equity platform through all programs and policies
- Integrate and lead across silos
- Work further upstream to impact the most people
- Conduct ongoing outcomes and process evaluation
- Develop emerging leaders through mentorship and sponsorship

Specific skills and attributes of an equity-grounded leader include:

- Learning from both quantitative and narrative data—continually educating oneself
- Seeking strengths and approaching work with cultural humility
- Are mindful of who is at the table—and who is not
- Being aware of how personal experiences and lineage impacts views and biases
- Sharing leadership and work alongside community members
- Understanding and acknowledging the impact of community trauma
- Being introspective and willing to change
- Asking tough questions, calling out long-standing biases, and challenging status quo
- Persevering despite conflict
- Leading with love for the mission, the people they serve, the community, and their team

Positive Impacts of Equity-Grounded Leadership

Equity-grounded leadership has positive impacts across organizations working within the broader behavioral health system, for individuals served, and for communities both served by and participating in the system. Leaders who serve from a foundation of equity can positively impact:

Organizations by

- Improving employee engagement and a sense of belonging
- Increasing respect and understanding between employees and customers
- Allowing for decisions grounded in fairness and equity
- Improving key performance indicators (e.g., financial, engagement, quality)

Individuals by

- Establishing greater confidence and trust in the behavioral health system
- Creating more culturally responsive care models
- Improving health outcomes through shared decision making about care plans
- Addressing issues of concern based on lived experience

Communities by

- Increasing community participation and engagement
- Aligning diverse stakeholders for shared problem solving by building trust
- Creating pathways for economic, social, environmental, and political justice
- Reducing health disparities and improving outcomes

"When I think about equity-grounded leadership I think of a leadership team that understands everybody at the table. They understand where each individual is coming from, and what they can bring to the table. I picture a round table with no head of the table. A round table with chairs where everyone has a seat, and everyone feels comfortable and confident in their seat at the table. When I think about equity-grounded leadership, it is about sitting at the table and knowing my voice matters, without worrying about how I am perceived." —Key Informant Interview Participant

Recommendations

For Region 3 Leaders and Policy Makers

Equity-grounded leaders are needed to eliminate health disparities and related traumas stemming from deeply entrenched structural racism in behavioral health. To do this difficult work, leaders must develop their voice, power, and courage to disrupt status quo and pave the way for innovative solutions. Based upon our interpretation of the experiences of leaders in Region 3, we offer two sets of recommendations: recommendations for developing equity-grounded leaders, and recommendations for leaders to prioritize health equity.

Recommendations for Developing Equity-Grounded Leaders

The following recommendations for *developing equity-grounded leaders* apply to organizations and more broadly behavioral health as a profession.

Competency: Enhance knowledge, skills, and capabilities of current and new leaders

- **Create safe spaces:** Leaders—both current and new—need a safe space for conversation and interaction on topics of racism and health equity at and between multiple levels of leadership to encourage allyship, mentorship, and leadership development. This could be in the form of affinity groups, facilitated discussions, anonymous surveys, or other mechanisms to give and gather feedback with consideration for various levels of comfort in sharing. It is important to ensure all voices are heard and to provide opportunities for engagement to learn from one another. It is also an excellent opportunity for leaders to learn about oneself, including how their own experiences have shaped internal biases.
- **Assess lived experience within the organization:** Collect data within your organization via surveys, focus groups, and conversation to understand the diversity of staff and leaders, experiences, perspectives and needs related to fairness and opportunities for leadership development and advancement within the organization. These data should be used to understand if leadership is representative of workforce and if workforce is representative of the population served. It should then be used to inform the development of equity action plans, fair policies, practices, and training to support equity-grounded leadership development.
- **Understand the community and population served:** Equity-grounded leaders are rooted in an understanding of the injustices experienced by communities and populations served. Collect data within your community and among the population served to understand their diversity, experiences, perspectives, and needs, and use this to guide the development of training and education, and action plans to advance equity both internal to the organization and more broadly in the community.
- **Offer training and education:** Current and emerging leaders need to be supported by training and education to develop their voice, courage, and power to thrive as change agents to dismantle systemic racism and inequity. Training and education should focus on both technical and psychological support to serve as an equity-grounded leader. Competencies should include understanding the history and impact of systemic racism and recognizing inadvertent conditioning to status quo; cultural humility; allyship; communication skills and mastery of language, including facilitation of difficult conversations (within the organization and in the community); intentional community engagement and how to meaningfully build trust; trauma-

informed and equity-driven system transformation and strategies for effective change; and evaluation to measure equity and change in systems and communities.
- **Create a framework for accessing resources:** Equity-grounded leaders need readily accessible and up-to-date data and information, educational materials, toolkits, and other resources to advance health equity. Resources and information should be organized via an easy-to-use framework. Recognizing not all communities nor organizations are the same, the framework should be adaptable based on the specific population served.

Coaching: Provide leadership support through mentoring, allyship, and sponsorship

- **Create a scalable mentorship structure:** Individual, informal mentoring will always be relevant and important, but to address current equity-grounded leadership needs—including growing a competent emerging leader pool—a scalable and intentional mentorship structure is needed. This structure should include multiple forms of engagement, such as one-on-one and small-group coaching, provide access to mentors both within and external to organizations, consider the specific experiences and goals of the mentee and the mentor, and should use multiple technologies to support engagement. Processes and protocols for participation need to be designed to be fair and inclusive. Importantly, the structure should include bi-directional mentoring to support the growth of seasoned leaders based on the experiences and strengths of emerging leaders.
- **Develop allies:** Equity-grounded leadership includes developing allies to support, empower, and promote colleagues of color. Equity-grounded leaders understand that to build real unity and reach goals of building strong communities, all are affected when any one person or group is not treated fairly. Allies need to be equipped with how to speak up and act when witnessing inequity, proactively lead difficult conversations, respond to conflict, and maneuver when experiencing retaliation.
- **Identify and promote emerging leaders of color:** Current leaders should intentionally seek out emerging Black or African American, Hispanic or Latino, Asian/Pacific Islander, Native American, and other leaders of color to promote their work and provide opportunities for sponsorship. There must be intentional effort to develop diverse, equity-grounded leaders within organizations, including pipelines for equitable advancement. Organizations need to create structures and policies that support fair opportunities to access training and education and for promotion into leadership positions.

Collaboration: Promote development of meaningful networks and partnerships

- **Develop and/or support participation in leadership networks:** Equity-grounded leadership can be difficult and at times can feel lonely. Developing and participating in leadership networks and learning collaboratives can provide direct support from colleagues engaged in similar work, as well as opportunities for shared problem solving. Connecting in a safe space with leaders who have experienced varied paths to leadership, different backgrounds and experiences, and different skill sets can be beneficial to the growth of leaders at all levels. It can also help to avoid burnout and feelings of loneliness through the development of meaningful connections.
- **Provide experiential learning opportunities:** While training and education in equity-grounded leadership competencies is critical, real learning occurs while doing. Leaders at all levels should be given opportunities for experiential learning, to practice equity-grounded leadership competencies in a real-world setting. Experiential learning should complement existing work and

should be guided by skilled advisors, either internal or external to the organization. It should be driven by the development of an action plan, implemented collaboratively to ensure the right voices are at the table—not just the convenient voices—and measured. Experiential learning is moving from learning to action.

- **Promote emerging leaders outside the organization:** Equity-grounded leadership includes intentional promotion of emerging Black or African American, Hispanic or Latino, Asian/Pacific Islander, Native American, and other leaders of color within the profession by providing opportunities for emerging leaders to represent the organization externally. Intentional efforts to develop diverse, equity-grounded leaders within the profession of behavioral health might include offering access to external training and leadership development, participating in activities that will expand leaders' networks, such as conferences and community events, and representing the organization at collaborative meetings.

Recommendations for Leaders to Prioritize Health Equity

The following recommendations for *leaders to prioritize health equity* are intended to serve as a starting point for taking action to disrupt status quo.

Purpose: Intentionality for Health Equity

- **Apply a health equity lens:** Without explicit attention to improving health outcomes for communities with low-average household incomes and communities of color and other marginalized groups, the outcomes are not likely to improve. This means that for each action—policy, law, practice, procedure, or project—these questions must be asked: Is this increasing health equity? How will this improve health equity? Does this counter the production of inequities? Equity as a foundation of leadership includes a sense of responsibility and accountability in understanding each individual ability, skills, and potential challenge. The baseline to lead through a health equity lens requires empathy, compassion, humility, and open mindedness.
- **Address privilege, bias, discrimination, institutional and structural racism, and classism:** At its core, any purpose that is focused on changing the culture and norms within institutions, sectors, and across systems provides an anchor for equity-oriented decisions and actions. Organizations should perform internal policy reviews to identify "blind spots" that may perpetuate differences in the treatment and outcomes of the communities they serve. Specific trainings that relate to anti-racism, privilege, and social justice should be regularly implemented across all leadership and staff.
- **Account for community trauma:** Because trauma serves as a barrier to effective solutions, it is critical to acknowledge the legacy and impact of practices and policies that have produced inequities as a first step toward healing and moving forward with solutions.[13] People need a re-education regarding public health problems in the context of race, ethnicity, and socioeconomic status. Re-educating the historical context of racism in healthcare as a component of leadership training puts the current state of disparities into perspective for the next generation of leaders.
- **Foster connections between people, systems, issues, and opportunities:** To maximize health equity outcomes, new connections become vital conduits for information, ideas, and emergent solutions. These connections can be tangible, such as linking two program areas or grantees together, or conceptual, as in exploring the connections between issues that haven't typically

been connected. To bridge the current gap between leadership, staff, and communities served and provide opportunities to hear diverse perspectives, leaders should provide safe spaces for open, transparent dialogue in daily environments.

People: Leadership and Engagement

- **Create a shared vision:** A shared vision can be an overarching framework for multiple partners to rally around and can galvanize the imagination of a nation. Strong leadership can bring key partners and diverse elements of a growing movement together to advance a shared vision and promulgate the tools and standards needed to hold others accountable. In creating a shared vision, implementing individual leadership competencies (as a form of personal development) regarding equity, social justice, anti-racism, and discrimination encourages personal development cross-functionally.
- **Lift up community voice, participation, and leadership:** A system of health equity moves from "community as recipient" to "community as participant." The voices of those traditionally underrepresented in leadership and decision making, including youth, must be elevated as stewards of the system. The perspectives of vulnerable communities must be centered in every effort, supporting authentic community-based participation and power, resulting in shared decision making while also strengthening the health and well-being of the entire region.
- **Promote multi-sector engagement:** Multi-sector engagement and collaboration is a very specific form of fostering connections. Advocates must develop skills to be able to engage multiple sectors and agencies to encourage collaboration and identify win-win solutions. Intentionally creating spaces for the underrepresented stakeholders in formal decision making processes ensures representation.
- **Prioritize and fund leadership development:** Leaders of all levels must be prepared technically and psychologically in anti-racist practice. They must develop their voice, power, and courage, and feel confident disrupting status quo to pave the way for innovative solutions. This requires an intentional focus, protected time, and funding to support education, training, and leadership development.

Practice: Methodology and Capacity

- **Develop health equity tools, approaches, and methodologies:** Existing resources should be made available to health equity advocates and new tools should be developed and disseminated to multiple audiences, making them available to inform the field of new developments that further advance the practice of health equity.
- **Train and build capacity across systems and sectors:** Building organizational capacity at the local level is critical. Training and capacity-building across sectors should foster collaboration and comprehensive approaches, and shift cultures and norms that may produce inequities.
- **Standardize data collection:** Consistently collecting cultural humility data (both race, ethnicity, and language (REAL) and sexual identity and gender identification (SOGI)) as part of day-to-day operational functions, will ensure equity-based data competency is engrained in the strategic plan. Regularly collecting these data (whether monthly or quarterly) identifies patterns and discrepancies, and purposefully warrants outward reporting to stakeholders and community members.

Platform: Infrastructure to Support Success

- **Declare racism a public health crisis:** Declarations of racism as a public health crisis are an important first step in the movement to advance racial equity and justice because they acknowledge the need to focus on systems and structures. Local, state and national leaders are able to leverage such declarations to develop more direct strategic action and allocation of resources.
- **Make the case through communications:** Communicate using diverse channels to convey positive messages about achieving health equity. Effective communication will also require building the skills of participants within the health equity system to feel comfortable talking about health equity and developing the language to integrate health equity aims across diverse sectors. Integrating specific strategies into the organizations or initiative's strategic plan will ensure that equity is embedded in all operational facets and day-to-day business. Tying equity-related goals to performance outcomes will help in building leadership accountability to themselves, staff, stakeholders, and communities served.
- **Leverage financing and funding to support equity:** Diversify resources, financial investments, and incentives across multiple sectors, remove funding silos, and build partnerships for long-term investments in community change. Investing in health equity requires greater integration of funding across sectors to create a larger pool of funding sources that can be flexibly and efficiently woven together. It is critical to implement a form of checks and balances to maintain accountability between different funding methods to ensure resources are going where they are supposed to.
- **Prioritize investments to close racialized gaps:** It is critical to incentivize and prioritize funding for BIPOC-led, community based, and/or grassroots organizations. Investments should be prioritized especially by wealth, environmental burden, and existing amenities in a way that will improve work, economic, and health opportunities for underinvested communities.[14]
- **Establish metrics and measurement:** Measuring progress on the social, economic, and political determinants of health is a key element to creating a system of health equity. It is critical for leaders of all levels to have a deep understanding of the sociopolitical factors that contribute to health disparities. Metrics are important both as a tool for measurement of health inequity at all levels, and for fostering understanding of solutions. Establishing metrics that measure and track progress on the determinants of health can help set priorities and inform necessary actions.[15]

APPENDIX A

Facts and Statistics about HHS Region 3

Exhibits 4—8 presents facts and statistics from the state level based on most recent data available to offer insight into HHS Region 3 demographics.

Exhibit 4: Demographics by State, 2019

State	Population	Race/Ethnicity	%	Age	%
Delaware	973,764	White	61.7	<24 years	29.4
		Black/African American	23.2	25–44 years	24.8
		Hispanic or Latino	9.6	45–64 years	26.3
		Asian	4.1	65+ years	19.5
		Mixed/Other	1.4		
District of Columbia	705,749	White	37.5	<24 years	28.3
		Black/African American	46.0	25–44 years	38.7
		Hispanic or Latino	11.3	45–64 years	20.5
		Asian	4.5	65+ years	12.0
		Mixed/Other	0.7		
Maryland	6,045,680	White	50.0	<24 years	30.0
		Black/African American	31.1	25–44 years	26.6
		Hispanic or Latino	10.6	45–64 years	26.7
		Asian	6.7	65+ years	16.0
		Mixed/Other	1.6		
Pennsylvania	12,801,989	White	75.7	<24 years	29.0
		Black/African American	12.0	25–44 years	25.2
		Hispanic or Latino	7.8	45–64 years	26.6
		Asian	3.8	65+ years	19.0
		Mixed/Other	0.7		
Virginia	8,535,519	White	61.2	<24 years	31.1
		Black/African American	19.9	25–44 years	26.9
		Hispanic or Latino	9.8	45–64 years	25.9
		Asian	6.9	65+ years	16.0
		Mixed/Other	2.2		
West Virginia	1,792,147	White	92.0	<24 years	29.0
		Black/African American	3.6	25–44 years	24.0
		Hispanic or Latino	1.7	45–64 years	27.0
		Asian	0.8	65+ years	21.0
		Mixed/Other	1.9		

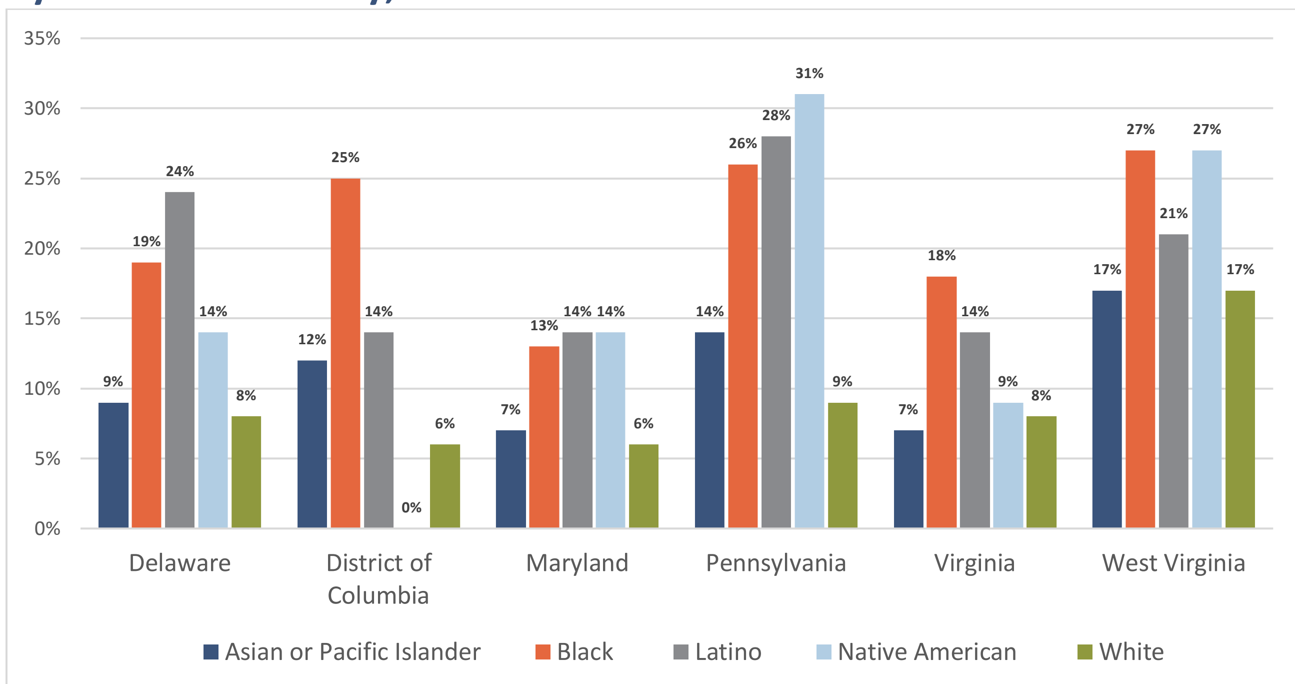
Source: U.S. Census QuickFacts. https://www.census.gov/quickfacts/fact/table/WV,VA,PA,MD,DC,DE#

Exhibit 5: Select Social Determinant Indicators by State, 2019

State	Less Than a High School Degree (%)	Poverty Rate (%)	No Health Insurance (%)	Foreign Born (%)
Delaware	10.0	11.3	5.7	9.6
District of Columbia	9.1	13.5	3.7	13.7
Maryland	9.8	9.0	6.1	15.2
Pennsylvania	9.5	12.0	5.7	6.9
Virginia	10.3	9.9	8.6	12.4
West Virginia	13.1	16.0	6.0	1.7

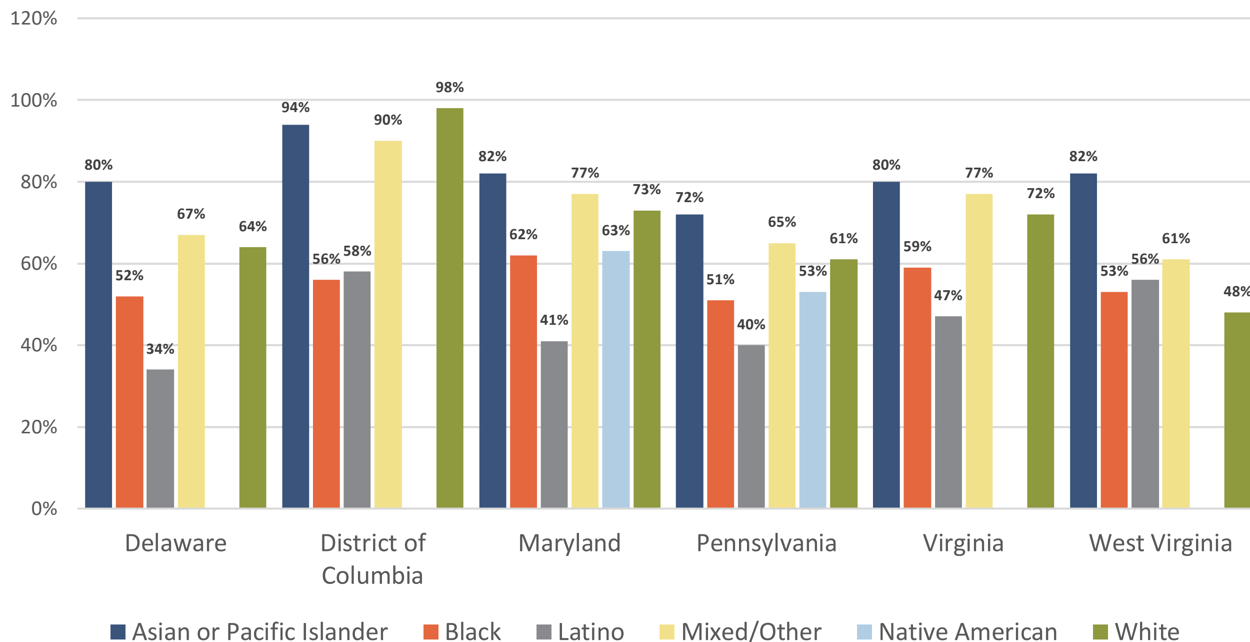
Source: U.S. Census QuickFacts. https://www.census.gov/quickfacts/fact/table/WV,VA,PA,MD,DC,DE#

Exhibit 6: Health Equity Indicator: Percent of People Below Poverty, by Race and Ethnicity, 2019



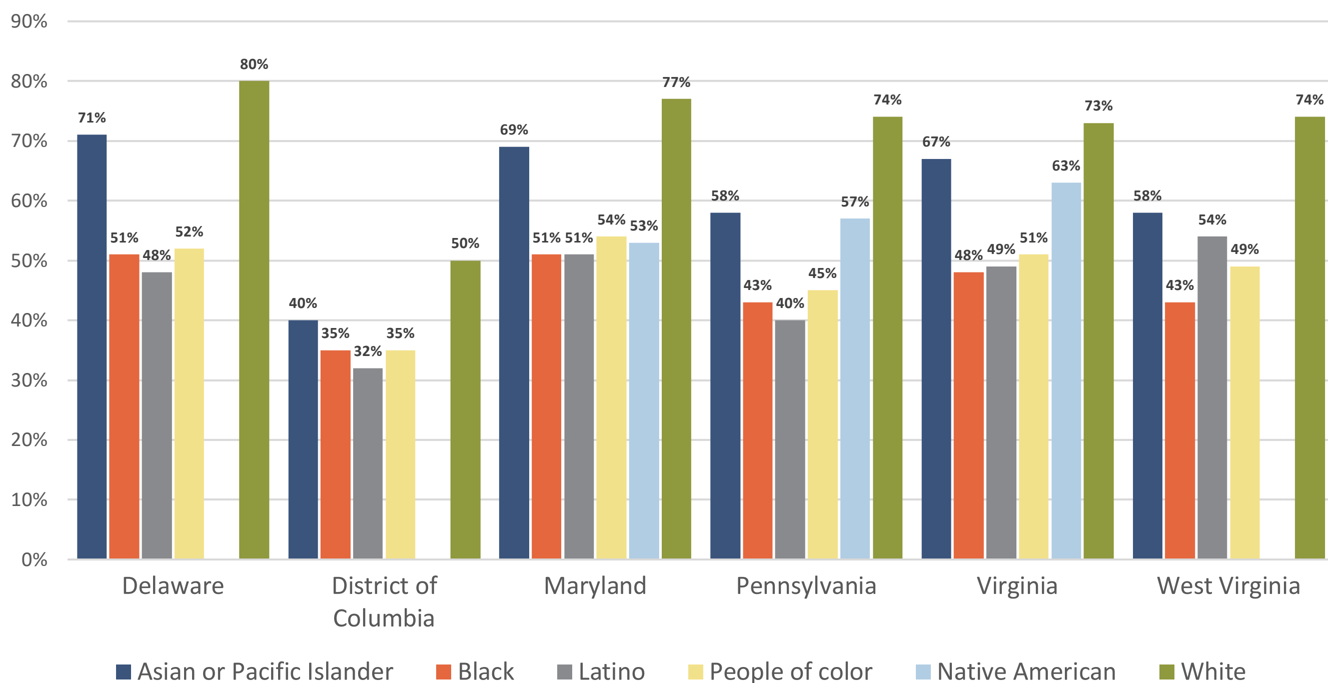
Lack of sufficient income has multiple negative consequences on health, well-being, and economic success. Source: National Equity Atlas Indicators. https://nationalequityatlas.org/indicators

Exhibit 7: Health Equity Indicator: Percent of People with at Least Some College, by Race and Ethnicity, 2019



Educational equity is necessary to build a strong workforce. Good jobs require ever-higher levels of skills and education, but the education system is not adequately preparing young people of color to succeed in the knowledge-driven economy. Source: National Equity Atlas Indicators. https://nationalequityatlas.org/indicators

Exhibit 8: Health Equity Indicator: Percent of People Who Own a Home, by Race and Ethnicity, 2019



Health Equity Home ownership can be a critical pathway to economic security and mobility. Source: National Equity Atlas Indicators. https://nationalequityatlas.org/indicators

State Profiles

Delaware

Delaware has a population of 973,764, with Wilmington City as its largest city. Nearly two-thirds (61.7%) of the population is non-Hispanic White and one-quarter (23.2%) is Black. About 90% of the overall population 25 years or older have attained a high school degree or higher education. The poverty rate is 11.3%, and 5.7% of the overall population does not have health insurance. Nearly one in ten living in Delaware were born in a foreign country.

Black and Latino residents of Delaware were more than twice as likely to live in poverty compared to White or Asian/Pacific Islander residents.

According to the National Equity Atlas, higher poverty rates exist among Latino (24%), Black (19%), and Native American (14%) communities relative to the overall population. Latinos in Delaware were least likely to have attended at least some college (34%). The lowest rates of home ownership were among Latinos (48%) or Black (51%) residents of Delaware.

In all of Delaware, Wilmington City Council is the only reported municipality to declare racism a public health crisis.[16]

District of Columbia

The District of Columbia has a population of 705,749. Nearly half the population (46%) is Black and more than one-third (37.5%) of the population is non-Hispanic White. The District of Columbia has the highest proportion of Hispanic or Latino residents at 11.3% of the population. About 91% of the overall population 25 years or older have attained a high school degree or higher education. The poverty rate in the District of Columbia is second highest in the region at 13.5%. However, they have the lowest uninsured rate, with 3.7% of the overall population without health insurance. Nearly 14% of the population living in the District of Columbia were born in a foreign country, the second highest rate in the region.

Black and Latino residents of the District of Columbia were nearly half as likely to have some college education compared to White residents.

According to the National Equity Atlas, higher poverty rates exist among Black communities (25%) relative to the overall population. Black and Latino residents of the District of Columbia were least likely to have attended at least some college (56% and 58% respectively). Home ownership rates were low across all racial and ethnic groups in the District of Columbia, but lowest among Latino (32%) and Black (35%) residents.

In the District of Columbia, the Council of the District of Columbia is the only reported municipality to declare racism a public health crisis.

Maryland

Maryland has a population of 6,045,680, with Baltimore as its largest city. Half of the population (50%) is non-Hispanic White and nearly one-third (31.1%) of the population is Black or African American. About 90% of the overall population 25 years or older have attained a high school degree or higher education. The poverty rate in Maryland is lowest in the region at 9%. Maryland has 6.1% of the overall population without health insurance. More than 15% of the population living in Maryland were born in a foreign country, the highest rate in the region.

Latino residents of Maryland were half as likely to have some college education compared to White residents.

According to the National Equity Atlas, the highest poverty rates were among Latino and Native American communities (14% each) relative to the overall population. Latino residents of Maryland were

least likely to have attended at least some college (41%). Home ownership rates were lowest among Black and Latino (51% each) and Native American (53%) residents.

In Maryland, the Anne Arundel County Executive and Health Officer, the County Council of Prince George's County, Fredrick County, and Montgomery County Council have all declared racism a public health crisis.

Pennsylvania

Pennsylvania is the most populated state in the region with 12,801,989 residents, with Philadelphia as its largest city. More than three out of four Pennsylvanians are non-Hispanic White (75.7%), 12% are Black or African American, and 7.8% are Hispanic or Latino. About 91% of the population 25 years or older have attained a high school degree or higher education. The poverty rate in Pennsylvania is 12%, and the uninsured rate is 5.7%. Nearly 7% of the population living in Pennsylvania were born in a foreign country, the second lowest rate in the region.

Black, Latino, and Native American residents of Pennsylvania are three times more likely to live in poverty than White residents.

According to the National Equity Atlas, the highest poverty rates in Pennsylvania were among Native American (31%), Latino (28%), and Black (26%) residents of Pennsylvania relative to the overall population. By comparison, the poverty rate for non-Hispanic White residents was 9%. Latino residents of Pennsylvania were least likely to have attended at least some college (40%). Home ownership rates were lowest among Latino (40%) and Black (43%) residents.

In Pennsylvania, the Allegheny County Council, the Erie County Council, the Philadelphia Board of Health, and the Pittsburgh City Council have all declared racism a public health crisis.

Virginia

Virginia is the second most populated state in the region with 8,535,519 residents. Overall, Virginia is largely rural with the second lowest population density in the region. Virginia is the only state in the region with Federal and State recognized tribes—seven total.[17] More than three out of five Virginians are non-Hispanic White (61.2%), 19.9% are Black or African American, and 9.8% are Hispanic or Latino. Virginia has the highest proportion of Asian residents at 6.9% of the population. About 90% of the overall population 25 years or older have attained a high school degree or higher education. The poverty rate in Virginia is 9.9%, the second lowest in the region, and the uninsured rate is highest in the region at 8.6%. More than 12% of the population living in Virginia were born in a foreign country.

Three out of four White residents of Virginia own a home, compared to two out of four people of color.

According to the National Equity Atlas, the highest poverty rates in Virginia were among Black (18%) and Latino (14%) residents, nearly double relative to Native Americans (9%) and non-Hispanic White (8%) residents. Black (53%) and Latino (56%) residents of Virginia were least likely to have attended at least some college. Home ownership rates were lowest among Latino (49%) and Black (48%) residents.

In Virginia, the Virginia General Assembly has declared racism a public health crisis.

West Virginia

West Virginia has a population of 1,792,147 residents. West Virginia is largely rural with the lowest population density in the region. West Virginia residents are predominantly non-Hispanic White (92%). About 87% of the overall population 25 years or older have attained a high school degree or higher education—the lowest rate in the region. The poverty rate in West Virginia is highest in the region at 16%, and the uninsured rate is 6%. Only 1.7% of the population living in West Virginia were born in a foreign country—the lowest foreign-born population in the region.

Despite lower rates of at least some college attendance, White residents of West Virginia were more likely to own a home than people of color.

According to the National Equity Atlas, the highest poverty rates in West Virginia were among Black (27%) and Native American (27%) compared to the population overall. Non-Hispanic White residents of West Virginia were least likely to have attended at least some college (48%). Home ownership rates were lowest among Black (43%) residents.

In West Virginia, the Wheeling mayor has declared racism a public health crisis.

APPENDIX B

Lived Experience

Survey of HHS Region 3 Leaders

A survey was developed and disseminated to reach HHS Region 3 leaders. Authors used mailing lists, email lists, and direct invitations. The survey assessed respondent characteristics, organizational perceptions, and community perceptions. The survey contained 32 questions and on average took five minutes to complete. Respondents were given the option to skip questions. The survey was open for 18 days, and had 201 respondents. Survey summary response data and respondent characteristics are detailed in Exhibit 9.

Exhibit 9: Geographic, Demographic, and Leadership Characteristics of Region 3 Survey Respondents

	Number	%
Race		
White	123	61.2
Asian	2	1.0
Black or African American	27	13.4
American Indian or Alaskan Native	4	2.0
More than one race	12	5.8
Prefer not to answer or skipped	33	16.4
Ethnicity		
Hispanic or Latino	9	4.5
Non-Hispanic or Latino	133	66.2
More than one ethnicity	15	7.5
Other	11	5.5
Prefer not to answer or skipped	33	16.4
Gender or Gender Identity		
Male	47	23.4
Female	130	64.7
Trans Male, Trans Female, Nonbinary	2	1.0
Not reported	22	10.9

LGBTQ+ Identification		
Yes	13	6.5
No	157	78.1
Prefer not to answer or skipped	31	15.4
Current Age Group		
25–44 years	50	24.9
45–64 years	110	54.7
65+ years	16	8.0
Prefer not to answer or skipped	25	12.4
State or District (Work)		
Delaware	2	1.0
District of Columbia	8	4.0
Maryland	28	13.9
Pennsylvania	56	27.9
Virginia	11	5.5
West Virginia	33	16.4
Other or skipped	63	31.3
Years of Leadership Experience		
>20 years	41	20.4
16–20 years	24	11.9
11–15 years	23	11.4
8–10 years	21	10.5
4–7 years	22	10.9
<4 years	22	10.9
Not in a leadership role	26	12.9
Skipped	22	10.9

Part 1 explores perceptions of equity and leadership within their organization, and included 13 statements. Respondents were able to select *Strongly Agree, Agree, Neutral, Disagree, Strongly Disagree,* and *I Don't Know*. Exhibit 10 presents as summaries of responses; *Neutral* and *I Don't Know* responses are not reflected.

Exhibit 10: Survey Questions and Responses, Organizational Perceptions

	Strongly Agree or Agree (%)	Strongly Disagree or Disagree (%)
Question 1: My organization encourages belonging.	83.9	6.5
Question 2: My organization is diverse.	66.3	12.1
Question 3: The people in my organization appreciate others whose backgrounds, beliefs, and experiences are different from their own.	76.8	5.1
Question 4: The leaders in my organization are diverse and representative of staff within the organization.	55.1	20.7
Question 5: The leaders in my organization are diverse and representative of the population we serve.	53.3	21.8
Question 6: My organization's policies and procedures promote diversity, equity, and inclusion.	75.6	11.7
Question 7: I feel safe to challenge the status quo at my organization.	64.1	15.7
Question 8: There is a career development path for all employees at my organization.	49.7	22.3
Question 9: Employees in different demographic groups (ex: race, LGBTQ+, differently abled, age) are provided a fair opportunity to apply and be considered for leadership positions.	72.9	9.7
Question 10: The process of promoting individuals into leadership positions is fair.	62.4	18.3
Question 11: My organization provides training programs that promote an understanding of various dimensions of diversity.	71.1	13.2
Question 12: Leaders are provided with diversity, equity, and inclusion training prior to assuming their roles.	44.4	25.8
Question 13: Leaders in my organization lead from a foundation of equity.	64.8	15.1

Exhibit 11: Competencies to Advance Health Equity within Organizations and Survey Question Alignment to Just Health Collective, 2021

Competency and Definition	Survey Question Number
Career development/paths to leadership: Organizations have various paths to leadership roles that take into consideration the diversity of employees. Diversity includes educational requirements, but also past experiences and backgrounds that might not be captured through formal education.	1, 8, 11, 12
Diversity and representation in the leadership pool: Organizations have diverse employees and leadership representative of employees and the populations served.	2, 4, 5
Fairness and equal opportunities to advance: Organizational policies and procedures promote fair and equal opportunities for employees of all races, ethnicities, gender identities, and/or other marginalized groups to advance.	6, 9, 10
Psychological safety and well-being: Individual employees within an organization feel comfortable bringing one's full self to the workplace. This includes asking questions, challenging the status quo, contributing, and/or feeling they belong.	3, 7, 13

Part 2 explores perceptions of equity and leadership within their community or region, and included nine statements (Exhibit 12). Respondents were able to select *Strongly Agree, Agree, Neutral, Disagree, Strongly Disagree,* and *I Don't Know*. Respondents were also given the opportunity to provide comments related to equity as an essential foundation of leadership at the end of this section.

Exhibit 12: Survey Questions and Responses, Community Perceptions

	Strongly Agree or Agree (%)	Strongly Disagree or Disagree (%)
Question 14: Behavioral health leaders in my community or region are diverse.	43.71	30.60
Question 15: The behavioral health workforce in my community or region is diverse.	49.18	26.80
Question 16: Behavioral health leaders in my community or region are representative of the populations they serve.	41.21	30.80

Question 17: The behavioral health workforce in my community or region is representative of the populations they serve.	48.08	21.90
Question 18: Diversity among behavioral health leaders in my community or region can improve.	79.67	3.90
Question 19: Diversity among the behavioral health workforce in my community or region can improve.	74.87	5.50
Question 20: Behavioral health leaders in my community or region appreciate others whose backgrounds, beliefs, and experiences are different from their own.	58.47	8.20
Question 21: Community partnerships or collaboratives formed to address behavioral health needs in my community or region are representative of the population(s) served.	47.00	19.70
Question 22: I feel safe to challenge the status quo when working with partners in my community or region to address behavioral health needs.	54.39	15.40

Key Informant Interviews

Fourteen key informant interviews were conducted via Zoom, lasting approximately 45 minutes each. Interviewers described the purpose of the interview and told participants that all information shared would remain confidential; comments and emerging themes would not be attributed to any person, organization, or state. Key informants were identified based upon the recommendation of The Danya Institute and through national partners of CBHL. Despite our best efforts to ensure key informants were identified for interview from all HHS Region 3 states, we were unable to find representation for Delaware. Of the 14 key informants, four were from the District of Columbia, two from Maryland, two from Pennsylvania, four from Virginia, and two from West Virginia. Key informants represented various sectors (e.g., behavioral health, addiction, direct service, community engagement, policy, evaluation, technical assistance) from both public and private sector organizations. Titles of key informants ranged from Project Manager to Commissioner. Exhibit 13 lists questions used during the key informant interviews.

Exhibit 13: Key Informant Interview Questions

Describe the journey to your current leadership position.
What has been your toughest challenge? Do you attribute this or any other challenges to your race?
How can the next generation of leaders be better supported? Does this differ for leaders of color?
How would you describe equity-grounded leadership?
How has your lived experience contributed to your leadership priorities?
Why is equity important as a foundation for leaders and for the communities they serve?
What tools, training, or resources do you think are necessary for leaders to be successful?

Focus Groups

Two focus groups were conducted via Zoom, lasting approximately 90 minutes each. Interviewers described the purpose of the interview and told participants that all information shared would remain confidential; comments and emerging themes would not be attributed to any person, organization, or state. Participants were identified via the survey, where respondents were given the opportunity to self-identify to participate in an interview or focus group. Six leaders participated in the focus groups. Participants were diverse demographically but leaned toward early- to mid-careerists. Focus Group questions are presented in Exhibit 14.

Exhibit 14: Focus Group Questions

Do you feel psychologically safe in a leadership role within your organization? Why or why not?
What does your company do to ensure a culture that is inclusive?
As a leader in behavioral health, how do you address language, cultural, or social barriers that exist among the population you serve?
Is mentorship a challenge in your organization? Why or why not?
Do you have a formal mentorship program in your organization? If not, why don't you have one? If yes, does it add value? Has it helped to advance leaders of color? How do you know?
What does the path to leadership look like at your organization? Do you feel career development differs based on race, ethnicity, or any other diversity dimension?
How would you describe equity-grounded leadership?
How would you define equity-grounded leadership?
From your perspective, what is one aspect required to lead from an equity lens? What support is needed for a leader to learn how to lead from an equity lens?
Do you feel it is important for leaders to reflect the communities they serve? Why or why not?

APPENDIX C

Supplementary Information

Definitions

Often, terms are used interchangeably despite the nuances that exist with their meanings. Terms like *diversity, inclusion, equity,* and *equality* will be used in the vernacular when working within organizations or communities, while the processes and systems in place may hold people back.[18]

The importance of use of language and how words are defined was a common theme among Region 3 leaders. According to one leader,

> We have so much jargon in behavioral health. We have lots of different words. When talking to people who are not as familiar with the behavioral health field, they don't know what we are talking about. If we wear this hat in the context of racial tensions *and* cultural appropriations, it makes good sense to have clear definitions. Not everyone is saying the same thing when we talk about equity. We have too many words, and we don't always say the same thing—even when we say the same words.

What is the difference between these terms? Exhibit 15 visualized the information break down of the meaning of diversity, equity, and inclusion and sets a framework for making strides toward DEI maturity.[19]

Exhibit 15: What Diversity, Equity, and Inclusion Really Mean

DI•VER•SI•TY

All the ways in which people differ.

EQ•UI•TY

Fair treatment, access, opportunity, and advancement for all people. One's identity cannot predict the outcome.

IN•CLU•SION

A variety of people have power, a voice, and decision-making authority.

Definitions sourced from City of Portland Office of Equity and Human Rights, The Independent Sector, and UC Berkeley

Source: Gensler. Inclusion by design: Insights from design week Portland. https://ideal.com/diversity-equity-inclusion/

Diversity

Diversity represents the unique characteristics that each person brings to the organization or community, including but not limited to national origin, language, race, color, disability, ethnicity, gender, age, religion, sexual orientation, gender identity, socioeconomic status, veteran status, and family structures. In broad terms, diversity is any dimension that can be used to differentiate groups and people from one another.[20] People have diverse perspectives, work experiences, lifestyles, and cultures. When diversity is valued and respected, people are more likely to develop social connections to others and a sense of belonging in the workplace or to their community, which is especially important to behavioral health and well-being.

Inclusion

Inclusion is a state of being valued, respected, and supported. It is the outcome to ensure those who are "different" and underrepresented feel welcomed and valued. Inclusion is about focusing on the needs of every individual and ensuring the right conditions are in place for each person to achieve his or her full potential. As a set of behaviors (culture), inclusion encourages people to feel valued for their unique qualities and experience a sense of belonging.

Belonging

Belonging is the intersection of diversity, equity, and inclusion. Without belonging embedded in the culture of health, healthcare organizations, and community, health equity will never be achieved. Belonging and health equity are separate and distinct fields of study and practice but are inextricably related. Transforming organizations to impact health equity starts with addressing internal knowledge, awareness, and capacity of the healthcare workforce. This, in turn, enables the advancement of healthcare equity and health equity.[21]

Equity

Equity is the consistent and systematic fair, just, and impartial treatment of all individuals, including individuals who belong to underserved communities that have been denied such treatment, such as Blacks, Latinos, and Indigenous and Native Americans, Asian Americans/Pacific Islanders, and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality.[22]

Health Equity

Health equity means that everyone has a fair and just opportunity to be healthy. This requires removing obstacles to health such as poverty, discrimination, and their consequences—including powerlessness and lack of access to good jobs, education, housing, environments, and healthcare. Fairness requires dedicated efforts to remove these obstacles to health. The concept of health equity focuses attention on the distribution of resources and other processes that drive a particular kind of health inequality—that is, a systematic inequality in health (or in its social determinants) between more and less advantaged social groups—in other words, a health inequality that is unjust or unfair.[23]

A *system of health equity* is a way of organizing and structuring relationships, innovation, learning, and advocacy for coherent and interrelated practices—within the foundation, government, private sector, and community—to attain health equity across the population.[24]

Equity Is an Important Foundation for Leadership

Differing concepts of equity in behavioral health and more broadly in conversations related to policy, place, and practice often create tension. Although definitions of equity are offered in a broad sense, different concepts of equity—historical and present disadvantages, geographic or place-based, and access to services, for example—come with different strategies. With so many definitions and potential strategies, leaders must consider first why the focus is on equity, how equity is linked to racial justice, and from a leadership perspective, where to place focus to remove systemic injustices and prioritize equity in organizations, systems, and communities.

"In its majestic equality, the law forbids rich and poor alike to sleep under bridges, beg in the streets and steal loaves of bread."
—Anatole France

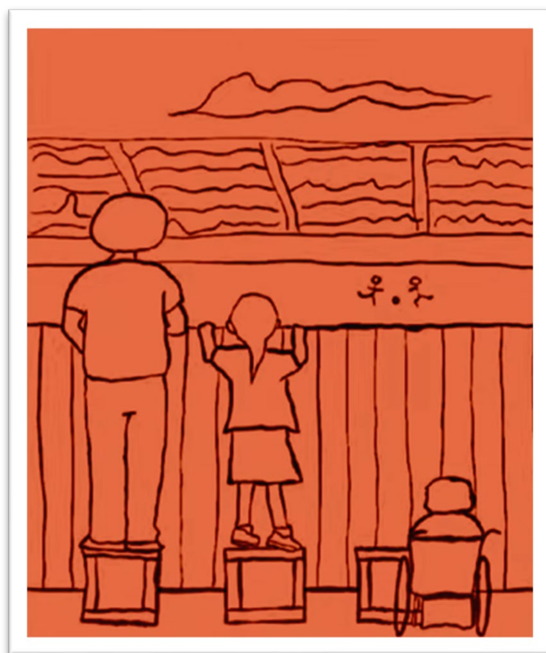
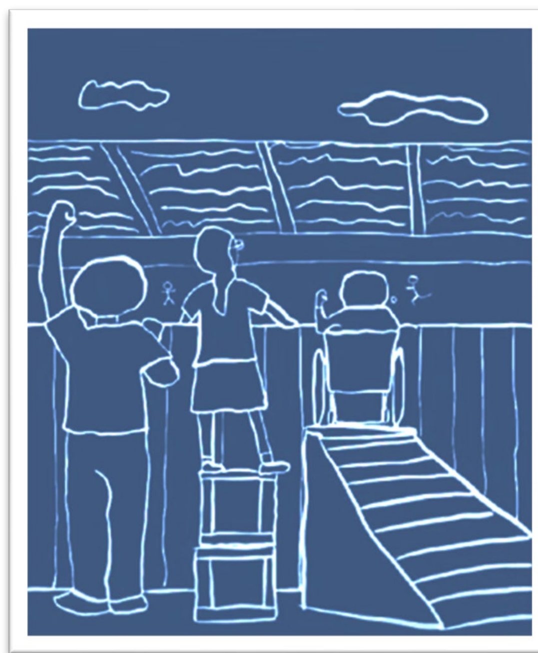
Shifting Focus from Equality to Equity

While the terms *equity* and *equality* may sound similar, the implementation of one versus the other can lead to dramatically different outcomes for marginalized people.

Equality means each individual or group of people is given the same resources or opportunities. *Equity* recognizes that each person has different circumstances and allocates the exact resources and opportunities needed to reach an equal outcome.

In other words, a difference exists in equal opportunity and equal outcomes. Having equal opportunity will not necessarily allow for equal outcomes depending on the disadvantage and challenges people have faced to get them to the place where they are. Exhibit 16 is an image taken from a video differentiating equity from equality.

Exhibit 16: Differentiating Equity from Equality

EQUALITY **EQUITY**

Source: Beyer High YouTube, 2020

Equity Is Linked to Racial Justice

On the most basic level, the relationship between health equity and racial justice is evidenced by data demonstrating a striking pattern of health inequities among the diverse racial and ethnic groups in the United States. These inequities are evident across a multitude of health conditions inside and outside the healthcare system, persist regardless of economic strata, and are not tied to inherent differences in genetics. A look across numerous data sets has demonstrated over time how Blacks, Latinos, Native Americans, and specific groups of Asian Americans/Pacific Islanders have suffered the health, safety, and mental well-being consequences associated with policies, practices, and procedures that have unfairly and unjustly denied these groups the fair opportunity to experience good health, safety, and well-being.[25]

The intersection of health equity and racial justice reflects the profound impact of racism on the persistence and the depth of disparities in health outcomes experienced by people of color. Working to narrow gaps in health outcomes without intentionally addressing racism and the multiple forms of discrimination associated with it thwarts successful outcomes on both fronts.[26] The parameters of health equity and racial justice described below reinforce the imperative of focusing on and elevating racial justice in any effort to ensure that everyone has fair and equal opportunities for good health, safety, and well-being, and that those opportunities systematically produce equitable outcomes for all.

Health equity, as previously described, means that everyone has a fair and just opportunity to attain their full health potential and that no one is disadvantaged, excluded, or dismissed from achieving this potential. Many people live at the intersection of identities like race or ethnicity, disability, immigration

status, or socioeconomic status. Across these many factors, race and ethnicity often exert the greatest and most consistent measurable impact on the unfair and unjust health outcomes. Health equity emphasizes shifts in power and systems and requires the removal of systemic obstacles to health. For example, addressing poverty as a determinant of health inequities would mean addressing the downstream consequences of poverty, including powerlessness and lack of access to good jobs, education, housing, healthcare, and health-promoting environments.[27],[28],[29]

Racial justice would be attained if racial factors (skin color and appearance are often a proxy for this) no longer served as reliable predictors of health, safety, economic stability, educational attainment, or other important societal outcomes. This would entail the elimination or reversal of the policies, practices, norms, and messages that reinforce differential outcomes by race (as a social construct) as well as a transformation of the systems and structures that uphold and reinforce persistent—and sometimes widening—inequities between Whites and non-Whites, with Latinos, Blacks, and Native Americans typically receiving the least and worst access to resources, opportunities, and conditions for thriving. Achieving racial equity means closing gaps between racially defined groups and engaging in processes that lead toward truth and reconciliation, justice, and fairness—as well as redistribution and sharing of power and resources—to rectify the compounding effects of race-based policies and practices rooted in discrimination, exclusion, and dominance.

Efforts to concurrently align and advance health equity and racial justice recognize that:

- Leaders must go beyond documenting disparities. Acknowledging the array of inequities, disparities, and injustices on their own is insufficient to simultaneously achieve health equity and racial justice.
- Not everyone starts from the same place when it comes to understanding the intersection of health equity and racial justice, given differences in lived experience, knowledge of historic and present-day practices, and skill level engaging with these macro-social issues, among other factors.
- Simultaneously advancing health equity and racial justice necessitates a process with actionable strategies and clear milestones that embed equity and justice from the start.
- Achieving health equity and racial justice outcomes requires a strong focus on centering the experiences, perspectives, and approaches of people of color in articulating the problems and securing solutions.[30]

Equity Is an Important Public Health Priority

A growing number of public health professionals consider the pursuit of health equity to be central to the practice of public health. Public health professionals are increasingly embracing the idea that eliminating inequities requires understanding and acting upon the underlying reasons for persistent and systemic gaps in health outcomes. An increasing number of health departments and their professional associations are explicitly naming issues like economic inequality, racism and discrimination, and voter exclusion, to name a few, as central to achieving lasting improvements in health and safety for children, families, and the communities in which they live.

The inclusion of health equity in Healthy People 2020 as one of four overarching goals, along with publications like the World Health Organization's (WHO) *Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health* and Centers for Disease Control and Prevention's (CDC) *A Practitioner's Guide for Advancing Health Equity*, have strengthened awareness and understanding that public health must go beyond documenting disparities in health and toward developing programs that focus on populations experiencing inequities.

Typically, health departments engaged in the practice of addressing health equity systemically are focused on shifting structural, political, and institutional policies and practices that deny resources and opportunities to marginalized and excluded groups while affording other groups (disproportionately White, wealthy, and heterosexual) greater access to resources, power, and decision making needed to achieve optimal health and well-being. The health departments on the leading edge of this work are demonstrating how to be effective in improving health outcomes by eliminating inequities based on race, social status, or economic position in society. Most of the time, they are accomplishing this through deep and embedded partnerships.

As momentum increases to reorient public health toward racial and health equity, the field is looking for "models" of practice and partnership with groups working at the community and grassroots levels. Where public health has traditionally focused on behavior and outcome data, health education, and access to services to reduce chronic illness and injury, an equity-focused practice includes broader efforts to address inequitable community environments—places in which the surrounding conditions are designed to make illness and injury inevitable—and taking on the decisions, decision makers, policies, and practices that are responsible for these conditions. Equity-focused advocates and practitioners work on addressing power imbalances, social and political hierarchies, and norms and values that perpetuate racism, discrimination, and exclusion.

Over recent decades, a growing number of health departments have been transforming their own practices and influencing the field. Increasingly, these departments approach the communities they work in as equal partners, seeing residents and community groups as bearers of solutions, ingenuity, and power, rather than as "consumers" of safety-net care, recipients of services, or clients in health education. In this work, public health rarely sees itself "at the center" of health efforts, but increasingly views itself as lending its resources, skills, and capacity to advance community-defined priorities and strengthen social-justice efforts that take root in (and are defined by) community residents and the groups that collaborate closely with residents.

Understanding that change cannot be accomplished through government alone, these health departments are seeking out deeper connections with social-justice organizations and leaders in their communities. Health departments working toward transforming their policies and practices don't abdicate their responsibility to improving health outcomes but recognize that important and valid ways exist for working with community groups and other governmental departments to make durable, systems-level changes in the institutions and practices that produce health inequities.[31]

Considerations for Equity When Leading Systems Change

Equity is not just a vision or an outcome. It is a process that runs through the everyday work of individuals, organizations, and governments. When leading systems changes, consider three important dimensions of implementation[32] to ensure the change is grounded in equity and does not perpetuate status quo:

1. **Past disadvantage:** Close historical gaps to improve health and economic opportunities in vulnerable communities. This approach recognizes the lasting impact of historical injustices and promotes efforts to reconcile these legacies.
2. **Contemporary participation:** Incorporate perspectives of impacted communities and support community-based participation, resulting in shifts in power and shared decision making, while strengthening collective capacity for action. This approach stresses both process and outcome, particularly focusing on grassroots participation in planning and throughout implementation.
3. **Future consequences:** Adjust as inequities emerge by leveraging funding for long-term community health and organizational capacity, and incorporate metrics and evaluation to enable course correction when initiatives are not successfully closing gaps. This approach looks to the consequences of decisions made today and emphasizes adaptability as these decisions emerge

Achieving equity when leading major systems changes can be further defined and described into three objectives. This equity framework can help leaders assess whether agencies are acting in a just and fair manner when it comes to delivering services, addressing health-related issues, and more.[33]

1. **Procedural equity** refers to transparent, fair, and inclusive processes that provide additional opportunities for participation by those who are disproportionately impacted. Transparency, fairness, and inclusion are values that should be applied to who participates, how participants are engaged, and how input is valued. Procedural equity requires systems and activities that increase trust and reduce imbalances in power and technical expertise between historically marginalized communities, funders, and policy makers in decision making.
2. **Distributional equity** means the fair distribution of resources, benefits, and burdens. Distributional equity is often the first thing people think about when they think about equity because it is the most quantifiable or tangible. Distributional equity is guided by quantitative and qualitative data and allocates goods, services, and other resources in a manner that creates fair opportunities for health and well-being for all. In many communities, making changes in how resources are distributed may require prioritizing communities with the greatest inequities as a part of grant making and contracting awards.
3. **Structural equity** addresses underlying structural factors and policies that gave rise to inequities. Achieving structural equity requires a commitment to correcting past harms and preventing future unintended consequences. Although more difficult to measure than the other types of equity, structural equity is no less important. Structural equity exposes deep factors related to power that perpetuate disadvantage within systems and then reverses these inequities through some combination of new norms, policies, and/or representation.

Central East (HHS Region 3) ATTC
Addiction Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

Notes

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