DBHDS Division of Community Services
Position Statement on Racism, Race-based Trauma and Behavioral Health
June 25, 2020

As the state behavioral health and developmental service agency, DBHDS provides state level programmatic oversight, resources, training and technical assistance, subject matter expertise, and a core belief in people's resiliency, ability to live integrated and independent lives, and ability to recover from mental health and substance use disorders. The following statement represents the Division of Community Services, as we are a division with *internal* responsibilities to address systemic racism, as well a division with *external* responsibilities for behavioral health and developmental services across Virginia.

We believe wholeheartedly in our vision statement: *A life of possibilities for all Virginians*. We embrace and exemplify our mission statement: "Supporting individuals by promoting recovery, self-determination, and wellness in all aspects of life". Further, we draw from concepts in DBHDS' *Orientation Manual for Direct Support Professionals (DSP): Supporting People in their Homes and Communities* which states the following Principles of Person-Centered Practices:

- We see a Virginia where individuals of all ages and abilities have the supports we need to enjoy the rights of life, liberty and the pursuit of happiness and the opportunity to have a good life.
- Having a good life means different things to different people. It includes joy and happiness, health and safety, hopes, meaningful activities, intimate relationships with family and friends, having a home, transportation, work, money, and opportunities to contribute to family and community.
- We believe that a good life is best led by the voice of the individual and by following these person-centered principles.

At the same time, there is an extensive body of research on the connection and intersectionality between racism, racial violence and health, behavioral health, and developmental status that our Division cannot ignore. Based on key research findings and the values described above, we highlight the following:

Racial discrimination damages individuals, hurts health (physical and behavioral) and shortens lives. Research on Adverse Childhood Experiences (ACEs) has evolved to include racism and social determinants, known as the "Pair of Aces", and has been linked to shortened life spans as a result of decreased physical, mental and emotional wellness. Racial trauma impacts the behavioral health of victims and witnesses, individuals, and entire communities. Those who have been directly victimized are likely to develop post-traumatic stress disorder (PTSD). Moreover, SAMHSA's Office of Behavioral Health Equity notes, and we affirm: "The burden of being a person of color in America includes the stress from the anticipation of violence in everyday life; diminished access to good health care and education; and, more broadly, socioeconomic differences that might not exist if the individuals were not targeted, marginalized and deprived of the tools to make their lives better." In other words, the behavioral health burden of race-based trauma can be identified and better understood by understanding sub-clinical symptoms, stress, wellbeing, and ability to thrive, more so than rates of diagnosis of specific behavioral health disorders.

There is definitive evidence that Black Americans and People of Color receive lower quality behavioral healthcare as compared to white Americans, including lower access to care (including lack of insurance coverage), direct discrimination from healthcare providers, and decreased efficacy of treatment. Coupled with stigma around mental illness, valid lack of trust for the "system" and Black Americans relying primarily on the faith community for behavioral health support, traditional systems have not adequately addressed the needs of Black Americans (Institute of Medicine, 2003). The report "Mental Health: A Report of the Surgeon General" and its supplement, "Mental Health, Culture, Race and Ethnicity" highlight some examples. After entering care, clients who are Black, Indigenous, and People of Color are less likely than white Americans to receive the best available treatments for depression and anxiety. Among adults with diagnosis-based need for mental health or substance abuse care, 37.6% of whites, but only 22.4% of Latinos and 25.0% of African Americans, receive treatment (McGuire et al., 2008). Research on healthcare disparities in autism spectrum disorder (ASD) from 2017 indicated disparities in access to quality diagnostics and care: Black and Latinx

children are significantly less likely to receive timely diagnoses. Due to the important of early intervention services for ASD, this disparity likely contributes to overall chronicity and severity across development. Further, there is evidence that Black children with ASD are significantly more likely to be misdiagnosed with behavior problems when evaluated (2007 research indicates a five-fold increase in misdiagnoses compared to white children with ASD), and initial misdiagnoses also contribute to delayed services.

Further, health care disparities relate not only to systemic inequities but also dyadic discrimination at the provider-client level. There is evidence that when Black clients receive behavioral health and developmental services from Black providers, they experience improved retention and outcomes. No such finding has been identified for any other racial groups/pairings between clients and clinicians—which underscores the importance of a diverse behavioral health workforce. Systemic barriers to building a diverse workforce include a number of factors, including barrier crimes. Black people have been shown to receive harsher and longer sentences than similarly situated white people for the same offenses (U.S. Sentencing Commission, 2017). Thus, barrier crimes, which keep people out of the behavioral health workforce, are a larger barrier for Black people.

It is critically important to focus on suicide prevention and interventions among Communities of Color and increase upstream youth and family support that is culturally salient and informed. This includes approaching our work implementing behavioral health crisis response diligently and with an equity and trauma-informed lens. Nationally, suicide attempts increased by 73% between 1991-2017 for Black adolescents while injury attempts increased by 122% for adolescent Black boys during that time period (Lindsey, et al., 2019). In Virginia, The number of suicide deaths increased 62% from 2014-2018 among Black or African Americans. Black youth are less likely to report feeling down, anxious, or depressed which can mask risk for behavioral health crisis and/or suicide. Rates of engagement in treatment are also lower in black adolescents compared to white adolescents which may be due to negative perceptions of treatment systems and reluctance to recognize behavioral health symptoms. However, youth and family support and culturally sensitive interventions can buffer youth and adults from risk factors for suicide (personal or family history of suicide, depression and/or other behavioral health concerns, incarceration, easy access to lethal means, alcohol and/or drug use etc.). Protective factors help youth adapt to hardship and protect against suicide risk and may include strong familial support/relationships, religious and spiritual engagement, community and social support, personal feelings of well-being and resilience, and stable housing, income, and employment. It is critical that our efforts increase feelings of value and connectedness among Black youth and families and access to culturally informed treatment and support services in all communities of color. These interventions include the development of a robust crisis response system that functions as a first responder to behavioral health crises. We note both the Crisis Now Model and Sequential Intercept Model (Intercept Zero) as best practice models/frameworks to draw from.

Supporting Anti-Racist Communities (SPARC), issued a national report in 2018 based on data analysis among people experiencing homelessness. The report affirmed that People of Color (specifically, Black and Native American individuals) were dramatically over-represented among people experiencing homelessness in a consistent pattern across communities that could not be explained by poverty rates among these groups. According to the report, "the vast and disproportionate number of people in the homeless population in communities across the United States is a testament to the historic and persistent structural racism that exists in this country." Additionally people with behavioral health disorders are disproportionately likely to experience homelessness in Virginia, as in communities across the country. More work is needed to better understand the racial disparities among individuals with behavioral health disorders who are experiencing homelessness. We believe that ending homelessness is an important part of racial justice work.

The challenge we face before us during this time of local, state, and national events calling for social and racial justice is that often our mission and vision are actually part of a system that has been supported and sustained by structural racism. This can have profound negative effects on the people we serve as well as the people we work with. The Aspen Institute defines structural racism as:

“A system in which public policies, institutional practices, cultural representations, and other norms work in various, often reinforcing ways to perpetuate racial group inequity. It identifies dimensions of our history and culture that have

allowed privileges associated with “whiteness” and disadvantages associated with “color” to endure and adapt over time. Structural racism is not something that a few people or institutions choose to practice. Instead it has been a feature of the social, economic and political systems in which we all exist.”

For these and many other reasons, it is incumbent upon us as a Division to acknowledge that structural racism limits the mental health, safety, health, educational, and other opportunities of Black people and other People of Color we serve and how they participate in and receive services that are part of our organization and systems that our organization touches, and limits our ability to recruit and retain a diverse behavioral health workforce. The individuals, their families, and communities affected by this matter because as a Division we believe that Black Lives Matter and we support the ideals that Black Lives Matter stands for, and cannot claim our values of person-centered, trauma-informed care if we do not analyze our practices from this perspective. Further, we also acknowledge and affirm that, although systemic racism is a longstanding problem that has not been given adequate attention within the behavioral health system in a broader sense, the recent local, state, and national events for racial justice present a test because they show how far we have to go to dismantle and rebuild the systems created by hundreds of years of oppression, racism, and institutional discrimination. Lastly, we acknowledge that the stress and trauma of racism and its manifestation affects victims, individuals, and entire communities, and the burden falls disproportionately on our Black coworkers who have to continue to show up to work and often feel pressure to appear emotionally unaffected, and/or continue to care for others at home, perhaps those they fear may be in harm’s way.

To that end, the Division of Community Services commits to:

- Continue conversations internally related to social disparity and racial bias, accepting feedback with an open heart and mind from staff members related to how we can be more inclusive.
- Conduct anti-bias, anti-racism, and cultural humility trainings that delve into implicit and explicit biases and how we can approach this work both internally and with our external partners.
- Provide educational opportunities to acknowledge, learn and celebrate diverse communities and their accomplishments, including distinguished individuals from these communities that address disparities in behavioral and public health.
- Ensure that all initiatives associated with diversity, equity, and inclusion consider and celebrate all Black, Indigenous, and People of Color, while also considering the specific pervasiveness and impacts of anti-Blackness as well as intersections of racial disparities with other marginalized identities and stigmatized conditions.
- Work within our own Division to ensure diversity at all levels of staffing including having recruitment policies that yield a diverse group of applicants for all hiring positions.
- Ensure that human resources policies on discrimination and harassment are easily accessible by all staff and visitors and have clear systems in place for employees to provide feedback without fear of retaliation.
- Work collaboratively toward improved data collection and analysis to identify disparities within our system of care and to create and promote programming that reflects progressive responses to these identified needs.
- Continue regional training for cultural competence and cultural humility and ensure these trainings are available at every level of service with those in management also encouraged to participate.
- Work with various partners and stakeholders to recommend changes to existing policies, regulations, programmatic, funding, and laws to better support equity and racial justice.
- Ensure diversity and representation is woven into the fabric of all programmatic implementation put forth by our division.
- Be a voice for sustainable change within state government reflecting our vision and mission in all we do.

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