CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES (CLAS) IN RHODE ISLAND

Toward a More Inclusive Behavioral Healthcare System

2022

Mental Health Association of Rhode Island
Brown Initiative for Policy

The **Mental Health Association of Rhode Island (MHARI)** operates with the mission of promoting and nourishing mental health through advocacy, education, and policy development. Its guiding values are compassion and altruism, collaboration and cooperation, equality and justice, and innovation. MHARI is an affiliate of Mental Health America.

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Section 1:

Introduction and Review of Literature

1.1: Overview and Background

It is an intuitive fact that each individual who comes in contact with the behavioral healthcare system is unique in socioeconomic circumstance, racial and ethnic background, and lived experience. These facets of identity critically shape an individual's conception of mental illness and behavioral healthcare, how they may present symptomatically, and the care best suited for them. Yet, the provision of behavioral health care too often overlooks or fails to adequately account for these distinctive attributes — a pattern facilitated by systemic factors ranging from understaffing to insufficient training. Such structural shortcomings not only disservice the consumers in question by hindering the effectiveness of behavioral healthcare, but also by contributing to hesitancy surrounding care-seeking in communities and populations that are already underserved and underrepresented.

For these reasons, the provision of culturally and linguistically appropriate services (CLAS) is essential to a thriving, successful behavioral healthcare system. Indeed, various literature has suggested that providing behavioral health treatment sensitive to one's cultural background and experiences facilitates enhanced patient satisfaction and wellbeing.[1,2,3,4] To support the provision of CLAS, the Office of Minority Health within the Unit-ed States Department of Health and Human Services (HHS) introduced the *National Standards for Culturally and Linguistically Appropriate Services (CLAS)* in Health Care in 2000 as part of an ongoing effort to strive for health equity and improved health care quality.[5] In 2013, enhanced National CLAS Standards were released and coupled with the launch of the 2014 National CLAS Standards Implementation Initiative by the Office of Minority Health.[6,7,8]

There are 15 National CLAS Standards, broken into three themes: *Governance, Leadership, and Workforce; Communication and Language Assistance; and Engagement, Continuous Improvement, and Accountability*.[9] Each theme is meant to support the Principal Standard of providing "effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs." Taken together, this blueprint is meant to promote strides toward the elimination of disparities in outcomes attributable to social determinants of health, socioeconomic status, educational level, and accessibility of services.

1.2: Role of Culture and Language in Treatment-Seeking Behaviors

Linguistic Factors: Language Proficiency

Linguistic factors are integral to the provision of both accessible and high-quality behavioral healthcare.

1 Michalopoulou, G., Falzarano, P., Butkus, M., Zeman, L., Vershave, J., & Arfken, C. (2014). Linking Cultural Competence to Functional Life Outcomes in Mental Health Care Settings. Journal of the National Medical Association, 106(1), 42–49. https://doi.org/10.1016/S0027-9684(15)30069-9

2 Heckler MM. Report of the Secretary's Task Force on Black and Minority Health. United States Department of Health and Human Services. 1985 August. https://archive.org/details/reportofsecretar00usde/page/n1/mode/2up?view=theater

3 McGregor B, Belton A, Henry TL, Wrenn G, Holden KB. Improving Behavioral Health Equity through Cultural Competence Training of Health Care Providers. Ethn Dis. 2019 Jun 13;29(Suppl 2):359-364. doi: 10.18865/ed.29.S2.359. PMID: 31308606; PMCID: PMC6604769.

4 Center for Substance Abuse Treatment (US). (2014). Improving Cultural Competence. Substance Abuse and Mental Health Services Administration (US).

5 Office of Minority Health; National Standards on Culturally and Linguistically Appropriate Services (CLAS) in Health Care. (2000). Federal Register. https://www.federalregister.gov/documents/2000/12/22/00-32685/office-of-minority-health-national-standards-on-culturally-and-linguistically-appropriate-services

6 Awareness, Knowledge, Adoption, and Implementation of the National CLAS Standards in Health and Health Care Organizations Evaluation Project. (2018). Office of Minority Health (OMH). https://thinkculturalhealth.hhs.gov/assets/pdfs/clas-ncs-evaluation-project.pdf

7 An Implementation Checklist for National CLAS Standards. (2018). Office of Minority Health. https://thinkculturalhealth.hhs.gov/assets/pdfs/AnImplementationChecklistfortheNationalCLASStandards.pdf

8 National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care. (2013). Office of Minority Health (OMH). https://thinkculturalhealth.hhs.gov/assets/pdfs/EnhancedNationalCLASStandards.pdf

9 Ibid.

More specifically, one's likelihood of accessing treatment is affected by obstacles including linguistic discordance with available providers. Given that descriptions of mental illnesses and their symptoms vary among languages, it is no surprise that cross-sectional analyses have identified limited English proficiency (LEP) as being correlated with lower odds of receiving necessary mental health services. Because minority groups frequently include higher proportions of LEP individuals, this barrier to necessary care often culminates in racial and ethnic disparities.[10,11] Unfortunately, there is a marked shortage of multilingual providers as well as interpreters available in behavioral healthcare. For example, one of the few studies available on language skills in mental health providers reported that 43 percent of school psychologists in the eight states with the highest percentages of Latinos self-identified as English-speaking monolinguals.[12] This suggests that, to bridge the gap in the short term between monolingual providers and individuals whose English skills are limited, interpreters must play an essential role in patient-provider interactions. However, a recent study found that only 16 percent of behavioral healthcare providers reported that professional interpreters were always available when needed at their current workplace.[13] Furthermore, the use of interpretation services does not guarantee the conveyance of nuanced conceptions of mental illness across languages, particularly when cultural differences in such conceptions extend beyond just the words used to describe them.

Cultural Factors: Stigma, Cultural Congruence, and Treatment Preferences

In addition to the logistical obstacles posed by language barriers, cultural nuances in understanding mental illness and behavioral healthcare may affect both the manner in which one seeks treatment and one's treatment experience. Throughout this report, the word culture refers primarily to the shared beliefs, values, and norms of a given racial or ethnic group. Culture operates in tandem with race and ethnicity as individuals sharing the same race and ethnicity may also share cultural beliefs. This may be due, among other factors, to shared histories of cultural practice prior to racialization or because processes of being racialized may result in a unique set of beliefs and norms. Given the heterogeneity of cultures and the difficulty of developing accurate methods to understand conceptions of mental illness, this brief report cannot comprehensively encompass the specificity nor fully reconcile the contradiction that arises from studying mental illness and behavioral healthcare across different demographic groups. However, we hope to convey broad trends in the academic literature that demonstrate the importance of recognizing cultural context in the course of providing behavioral healthcare services, as well as the increased efficacy of care that results from this recognition.

Previous academic research, both in psychiatry and the social sciences, has suggested that mental illness carries distinct connotations in each culture — many of which are fraught with guilt or shame. In the U.S., multiple studies suggest that perceptions of individuals with mental illness as dangerous to themselves and others are widespread among the general public. While the substantial within-group diversity among minority communities in the U.S. means that studies on stigmatization of mental illness are not uniformly applicable, broad trends indicate higher levels of stigma in certain cultural groups in comparison to white Americans. For example, many studies note higher levels of mental illness stigma in primarily first- and second-generation Asian American subjects, often associated with perceived dissonance from hegemonic values of collectivism.[14,15,16] Such stigmatizations may further dissuade individuals identifying with certain cultural groups from wanting to

10 Sentell, T., Shumway, M. & Snowden, L. Access to Mental Health Treatment by English Language Proficiency and Race/Ethnicity. J GEN INTERN MED 22, 289–293 (2007). https://doi.org/10.1007/s11606-007-0345-7

11 Saechao, F., Sharrock, S., Reicherter, D. et al. Stressors and Barriers to Using Mental Health Services Among Diverse Groups of First-Generation Immigrants to the United States. Community Ment Health J 48, 98–106 (2012). https://doi.org/10.1007/s10597-011-9419-4

12 Ochoa, S. H., Powell, M. P., & Robles-Piña, R. (1996). School psychologists' assessment practices with bilingual and limited-English-proficient students. Journal of Psychoeducational Assessment, 14(3), 250:275. https://doi.org/10.1177/073428299601400306

13 Mirza, M., Harrison, E., Bentley, J., et al. (2020). Language Discordance in Mental Health Services: An Exploratory Survey of Mental Health Providers and Interpreters. Societies, 10(66). https://www.mdpi.com/2075-4698/10/3/66/pdf

14 Whaley A. L. (1997). Ethnic and racial differences in perceptions of dangerousness of persons with mental illness. Psychiatric services (Washington, D.C.), 48(10), 1328–1330. https://doi.org/10.1176/ps.48.10.1328

15 Deepa, R., Feinglass, J., Corrigan, P. (2007). Racial and Ethnic Disparities in Mental Illness Stigma. The Journal of Nervous and Mental Disease. 195(12); 1020-1023. doi: 10.1097/NMD.0b013e31815c046e.

16 Parcesepe, A. M., & Cabassa, L. J. (2013). Public stigma of mental illness in the United States: a systematic literature review. Administration and policy in mental health, 40(5), 384–399. https://doi.org/10.1007/s10488-012-0430-z

acknowledge symptoms of mental illness, which may consequently manifest in a greater reluctance to seek treatment.

While such research underscores instances of cultural stigmatization perpetuated by external sources, it is also crucial to consider the prevalence of internalized stigmatization borne of cultural preconceptions. In a 2008 study, investigators from the University of California, San Francisco conducted qualitative interviews with Black mental health consumers and found that over a quarter of interviewees "said they were taught early on that Blacks should be able to handle any adversity, so having mental health problems was incompatible with Black values of strength, resilience, and religious faith."[17] It is no wonder, then, that in this same pool of consumers, 65% of respondents characterized stigma as a barrier to recognition of need for treatment. Importantly, similar focus group studies saw African American participants express the concern that "admitting" to having a mental illness would subject them to an implicit, negative societal label indicative of weakness.[18]

In addition to culture-specific stigmatization of mental illness impacting one's willingness to seek behavioral healthcare, other cultural factors may affect one's likelihood of actually beginning such treatment — including an inability to find providers who share their cultural backgrounds and experiences. Considering that behavioral healthcare treatment entails the vulnerable task of recounting personal experiences and emotions with a provider who is initially a stranger, taking the leap to begin treatment may be an emotionally daunting process. Thus, particularly among populations in which distrust of the healthcare system may be more prevalent, speaking with a provider of one's own race, ethnicity, or cultural background may make this process less intimidating and facilitate feelings of safety, trust, and connectedness. Indeed, prior literature has established that healthcare consumers who see clinicians of their own race report feeling more comfortable with their providers — underscoring the importance of recruiting and retaining a diverse behavioral health workforce.[19] This is especially true considering providers from underrepresented minority (URM) populations are more likely to serve communities who share similar lived experiences.[20]

Moreover, the type of behavioral healthcare sought differs across cultural backgrounds. For example, members of the Native American community are more likely to seek care from (or supplemented by) traditional healers, drawing from tribal practices passed down through generations, than care provided in formal hospital settings.[21,22] Additionally, it has been reported that Asian Americans are more likely to rely upon primary care providers rather than specific mental health services.[23] Given this proclivity and the well-documented and ongoing push for the integration of behavioral health and primary care, it is worth considering the importance of such preferences within consumer populations, both for clinical benefit and patient autonomy.[24,25]

1.3: Cultural and Linguistic Factors Influencing Treatment Experience and Outcome

Beyond impacting one's willingness and ability to pursue care opportunities, culture and language may shape one's treatment experience by playing an integral role in the presentation of symptoms of mental illness. More specifically, there is a wide array of evidence supporting the notion that individuals living with the same

17 Alvidrez, J., Snowden, L.R., Kaiser, D.M. (2008). The Experience of Stigma among Black Mental Health Consumers. Journal of Health Care for the Poor and Underserved, 19(3); 874-893. https://doi.org/10.1353/hpu.0.0058.

18 Mishra, S.I., Lucksted, A., Gioia, D. et al. Needs and Preferences for Receiving Mental Health Information in an African American Focus Group Sample. Community Ment Health J 45, 117 (2009). https://doi.org/10.1007/s10597-008-9157-4

19 Kennedy, B. R., Mathis, C. C., & Woods, A. K. (2007). African Americans and their distrust of the health care system: healthcare for diverse populations. Journal of cultural diversity, 14(2), 56–60.

20 Forstag, EH, Cuff, PA. (2020). Recruiting and Supporting a Diverse Workforce. In Educating Health Professionals to Address the Social Determinants of Mental Health: Proceedings of a Workshop. Washington, D.C. https://www.ncbi.nlm.nih.gov/books/NBK563948/

21 Office of the Surgeon General (US); Center for Mental Health Services (US); National Institute of Mental Health (US). Mental Health: Culture, Race, and Ethnicity: A Supplement to Mental Health: A Report of the Surgeon General. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2001 Aug. Chapter 4 Mental Health Care for American Indians and Alaska Natives. Available from: https://www.ncbi.nlm.nih.gov/books/NBK44242/

22 Bassett, D., Tsosie, U., & Nannauck, S. (2012). "Our culture is medicine": perspectives of Native healers on posttrauma recovery among American Indian and Alaska Native patients. The Permanente journal, 16(1), 19–27. https://doi.org/10.7812/tpp/11-123

23 Appel, H., D. Nguyen, P., & Bang, K. (2021). Eliminating racial and ethnic disparities in behavioral healthcare in the United States. Journal of Health Inequalities, 7(1), 52-56. https://doi.org/10.5114/jhi.2021.107008

24 Funk, M., Saraceno, B., Drew, N., & Faydi, E. (2008). Integrating mental health into primary healthcare. Mental health in family medicine, 5(1), 5–8.

25 Schrager, S. (2021). Integrating Behavioral Health Into Primary Care. Fam Pract Manag. 2021 May-June;28(3):3-4. https://www.aafp.org/fpm/2021/0500/p3.html

mental illness may present symptoms differently based on their respective cultural backgrounds and subsequent normative expectations. To take one example, multiple methods of assessment have suggested that in describing somatic and psychological symptoms of depression, Chinese patients are more likely to focus on the former in comparison to their North American counterparts.[26,27,28] It is also critical to note that certain patterns of behaviors regarded as pathological in one culture may be regarded as expected or even advantageous in another culture, highlighting a need to acknowledge the role of cultural norms when diagnosing mental illness. For example, the same collection of symptoms typically construed as "depression" according to Western psychiatry may be interpreted by Buddhists as a manifestation of life's inevitable strife. For them, this suffering is not an indication of mental illness, but is an unavoidable experience that is necessary to reach ultimate fulfillment.[29] Together, this research illuminates a strong need for CLAS within behavioral healthcare. In order to accurately diagnose individuals with a mental illness, it is critical that behavioral healthcare providers understand the role of culture in symptom presentation, as well as whether symptoms should be considered pathological in the first place.

In addition to impacting the presentation of mental illness symptoms, culture also plays a role in accurate diagnosis due to persistent cultural biases — implicit or otherwise — held by behavioral health providers. For example, academic literature dating back decades has suggested that stereotyped perceptions of African Americans as prone to violence have swayed professional treatment decisions. In the current day, schizophrenia is overdiagnosed in African Americans,[30] while bipolar disorder and depression are underdiagnosed.[31]

It is also important to note that one's culture may inform appropriate courses of treatment. For instance, mounting evidence indicates that individuals from dissimilar ethnic or cultural backgrounds may respond differently to psychotropic medications.[32,33] Another example of culture informing suitable treatment plans is highlighted in a 2007 anthropological paper that compares approaches of eating disorder clinics in the United States and Mexico.[34] The author notes that, in contrast to the American emphasis on self-determination and individualism, Mexican values tend to be based in collectivism and interdependence. Thus, the researcher suggests that it may not be appropriate for eating disorder treatment in Mexico to revolve around "regaining autonomy" as treatment in the United States typically does. This salient example highlights the necessity for behavioral healthcare services to consider one's culture when crafting treatment plans.

1.4: Intersections with Existing Disparities

The provision of CLAS is especially vital considering the multitude of pre-existing racial and ethnic disparities in mental illness treatment access, quality, and uptake. Previous work has found that while the prevalence of specific behavioral health conditions varies among minority groups,[35,36] these individuals are consistently more

26 Zhou, X., Peng, Y., Zhu, X., Yao, S., Dere, J., Chentsova-Dutton, Y. E., & Ryder, A. G. (2016). From culture to symptom: Testing a structural model of "Chinese somatization." Transcultural Psychiatry, 53(1), 3–23. https://doi.org/10.1177/1363461515589708

27 Chang, M., Jetten, J., Cruwys, T., & Haslam, C. (2016). Cultural Identity and the Expression of Depression: A Social Identity Perspective. Journal of Community and Applied Social Psychology, 27, 16-34. doi: 10.1002/casp.2291.

28 Ryder, A.G. & Chentsova-Dutton, Y.E. (2012). Depression in Cultural Context: "Chinese Somatization," Revisited. Psychiatr Clin N Am. 35, 15-36. doi:10.1016/j.psc.2011.11.006.

29 Obeyesekere, G. (1985). 4. Depression, Buddhism, and the Work of Culture in Sri Lanka. In A. Kleinman & B. Good (Ed.), Culture and Depression: Studies in the Anthropology and Cross-Cultural Psychiatry of Affect and Disorder (pp. 134-152). Berkeley: University of California Press. https://doi.org/10.1525/9780520340923-007

30 Schwartz, R. C., & Blankenship, D. M. (2014). Racial disparities in psychotic disorder diagnosis: A review of empirical literature. World journal of psychiatry, 4(4), 133–140. https://doi.org/10.5498/wjp.v4.i4.133

31 Riley, M, Hill-Daniel, J. (2020). What factors lead to the underdiagnosis of depression among African Americans? Evidence-Based Practice, 23(4), 41-42. doi: 10.1097/EBP.0000000000000619.

32 Ramamoorthy, A., Pacanowski, M. A., Bull, J., & Zhang, L. (2015). Racial/ethnic differences in drug disposition and response: review of recently approved drugs. Clinical pharmacology and therapeutics, 97(3), 263–273. https://doi.org/10.1002/cpt.61

33 Keith C. Ferdinand & Miyako Igari (2018) The role of racial/ethnic factors in global clinical trials, Expert Review of Clinical Pharmacology, 11:9, 829-832, DOI: 10.1080/17512433.2018.1510311

34 Lester R. J. (2007). Critical therapeutics: cultural politics and clinical reality in two eating disorder treatment centers. Medical anthropology quarterly, 21(4), 369–387. https://doi.org/10.1525/maq.2007.21.4.369

35 Mental Health Disparities: Diverse Populations. (2017). American Psychiatric Association. https://www.psychiatry.org/psychiatrists/cultural-competency/education/mental-health-facts

36 McGuire, T. G., & Miranda, J. (2008). New evidence regarding racial and ethnic disparities in mental health: policy implications. Health affairs (Project Hope), 27(2), 393–403. https://doi.org/10.1377/hlthaff.27.2.393

likely to encounter access barriers in the course of seeking behavioral health services as compared to their white counterparts.[37] Similarly, a 2015 study found that, among individuals experiencing any major depressive disorder in the prior year, Latino, Asian, and African American individuals were anywhere from 19 to 30 percent more likely than non-Latino white individuals to report not having accessed any mental health treatment in the same time period.[38] Literature has further indicated that, once in treatment, individuals from these same populations are more likely to receive lower-quality mental healthcare than white people.[34,39] Additionally, it has been reported that Black individuals are more likely than white individuals to terminate treatment prematurely.[34] To rectify these inequalities, it is undeniable that government initiatives such as health insurance reform and a robust focus on mental health parity have a critical role to play. However, while continuing to advocate for such initiatives, it is critical to promote CLAS implementation in order to adequately address trends in disparate behavioral health outcomes across racial and ethnic groups.

1.5: This Report

Mental health is an indispensable component of holistic wellbeing, and every Rhode Islander deserves the opportunity to engage with a behavioral healthcare system that accommodates and supports their unique cultural and linguistic needs. This report was driven by a desire to learn more about how healthcare organizations and individual clinicians in Rhode Island implement and support the provision of CLAS, how these groups track the demographics and linguistic capacity of their workforce and patient population, as well as any barriers that may be impeding the fulfillment of National CLAS Standards on a day-to-day basis.

This project was conducted with the principal aims of foregrounding the needs of marginalized communities seeking behavioral healthcare, giving voice to the observations and experiences of providers, clarifying the data collection infrastructure in this space, and drawing attention to the critical importance of CLAS as a policy issue. As part of this effort, we leveraged both qualitative and quantitative approaches to capturing the state of CLAS in Rhode Island in order to integrate as many perspectives as possible. This report was written for consumption by the general public, policymakers, and behavioral healthcare providers alike. By prioritizing a clear, transparent, and consistent dialogue surrounding CLAS, the state of Rhode Island can make enormous strides toward the mitigation of health disparities and the achievement of health equity.

37 Substance Abuse and Mental Health Services Administration, Racial/ Ethnic Differences in Mental Health Service Use among Adults. HHS Publication No. SMA-15-4906. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015.

38 Alegría, M, Chatterji, P, Wells, K, et al. (2015). Disparity in Depression Treatment Among Racial and Ethnic Minority Populations in the United States. Psychiatric Services, 59(11), 1264-1272. https://doi.org/10.1176/ps.2008.59.11.1264

Section 2:

Diversity of the Provider Pool

In order to successfully offer CLAS, it is critical that behavioral healthcare providers understand how culture shapes their patients' needs, communication styles, thought patterns, behaviors, and goals. Since culture is multidimensional and conceptually abstract, one of the soundest ways a provider can develop a nuanced, refined understanding of culture's intersection with mental health is via lived experience.

"[It's] hard to understand what [you] do not experience."
- Licensed mental health counselor at a Rhode Island-based nonprofit health system

The importance of shared cultural identities in providing CLAS is supported by research regarding ethnic matches between behavioral healthcare patients and providers. Indeed, a wide body of literature supports the idea that patient-provider ethnic matches are associated with better treatment experiences for patients belonging to minority populations. For example, a seminal study conducted in 1991 found that among non-English speaking Mexican Americans and Asian Americans, ethnic matching between behavioral healthcare patients and providers was associated with more positive treatment outcomes.[1] The same study also found that, among African American behavioral health patients, patient-provider ethnic match was associated with a lower treatment dropout rate. Similarly, a recent study that investigated the implications of ethnic matching among specific Asian American identities (i.e., Korean, Vietnamese, and Chinese) demonstrated that these more refined ethnic matches predicted both the number of counseling sessions attended and the likelihood of successful treatment completion.[2] Finally, a 2011 meta-analysis of over 150 studies found that patients with behavioral healthcare providers of the same race or ethnicity had more positive perceptions of their providers compared to patients without.[3]

"I know that [certain groups have] a lot of stigma, but if POC are serving POC, then recovery could be more of a reality."
- Clinical health worker and peer recovery specialist at a Rhode Island-based nonprofit

Diversity in the Provider Pool: A Quantitative Snapshot

Given the importance of a diverse provider pool, we sought to establish a quantitative sense of the demographic breakdown of Rhode Island's behavioral healthcare workforce. To do so, we drew from data provided by the RI Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH) Research, Data Evaluation, and Compliance Unit (RDEC). For more information on the figures presented here, see the Methods and Appendices section of this report.

Race and Ethnicity

Between 2018 and 2020, non-Hispanic white individuals accounted for 65.8% of client-facing staff at BHDDH-licensed mental health and substance use disorder (MH/SUD) treatment facilities, while non-Hispanic Black and Hispanic (any race) individuals accounted for 16.0% and 12.7%, respectively (**Fig. 2.1**).

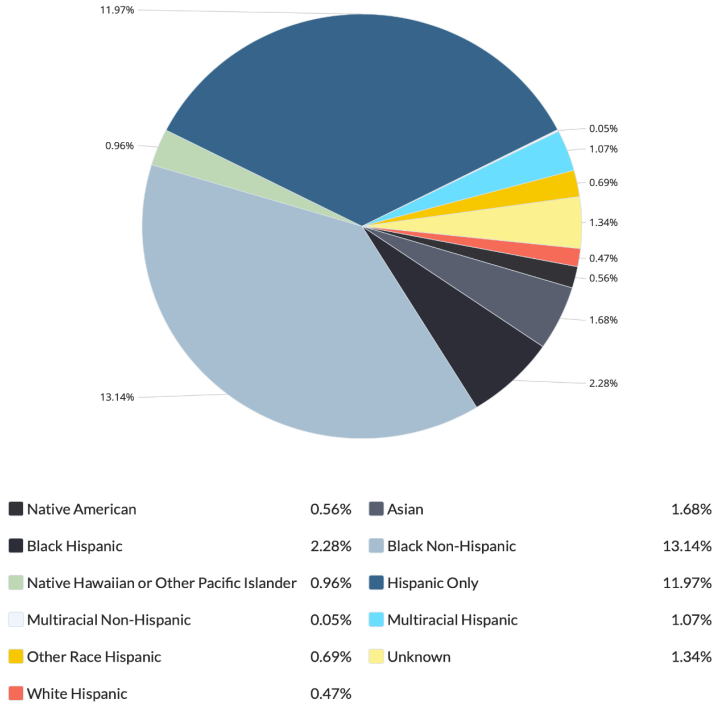
1 Sue, Fujino, D. C., Hu, L., Takeuchi, D. T., & Zane, N. W. S. (1991). Community Mental Health Services for Ethnic Minority Groups: A Test of the Cultural Responsiveness Hypothesis. Journal of Consulting and Clinical Psychology, 59(4), 533–540. https://doi.org/10.1037/0022-006X.59.4.533

2 Presley, & Day, S. X. (2019). Counseling Dropout, Retention, and Ethnic/Language Match for Asian Americans. Psychological Services, 16(3), 491–497. https://doi.org/10.1037/ser0000223

3 Cabral, & Smith, T. B. (2011). Racial/ethnic matching of clients and therapists in mental health services: A meta-analytic review of preferences, perceptions, and outcomes. Journal of Counseling Psychology, 58(4), 537–554. https://doi.org/10.1037/a0025266

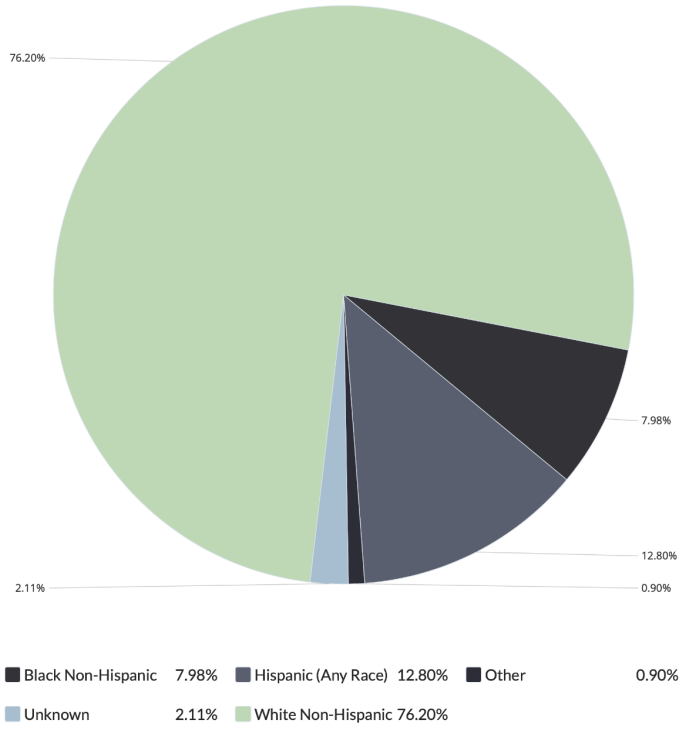
We also obtained a demographic breakdown of clinical supervisors to direct care staff. Between 2018 and 2020, 76.2% of these individuals were non-Hispanic white (**Fig. 2.2**). The most common non-white racial identities among the remaining clinical supervisors were Hispanic only (12.5%) and Black (8%). The least common were Asian (0.6%), white Hispanic (0.3%), and Native American (0.3%).

Fig. 2.1:
Racial Breakdown of MH and SUD Client-Facing Staff, 2018-2020 Average



(i) Data from BHDDH human resources (HR) database.
(ii) "Client-facing staff," per BHDDH, includes the following: Licensed Chemical Dependency Professional (LCDP), Master's Level and Above., Non-Master's Case Manager, Nurse, Peer, and Residential Worker. For more information on each of these positions, see Appendix C.
(iii) See Appendix D for more detail on average calculation.

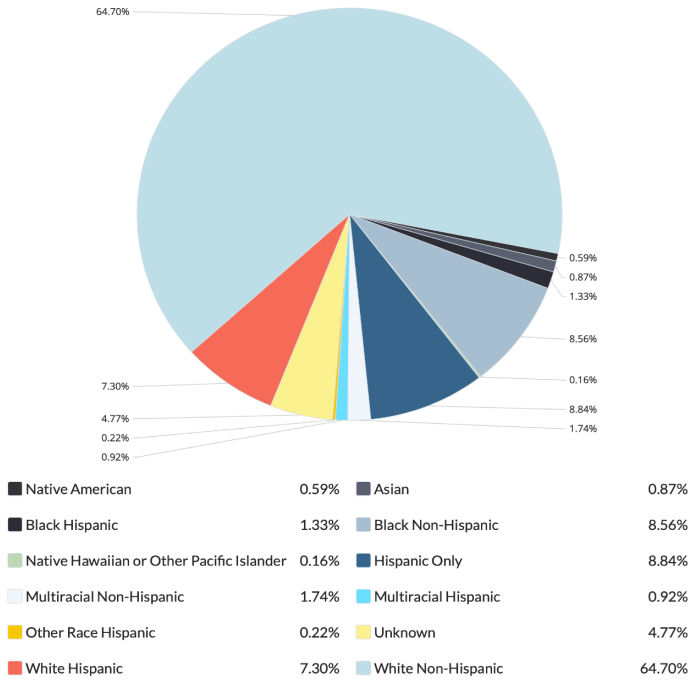
Fig. 2.2:
Racial Breakdown of MH and SUD Clinical Supervisors, 2018-2020 Average



(i) Data from BHDDH human resources (HR) database.
(ii) See Appendix D for more detail on average calculation.

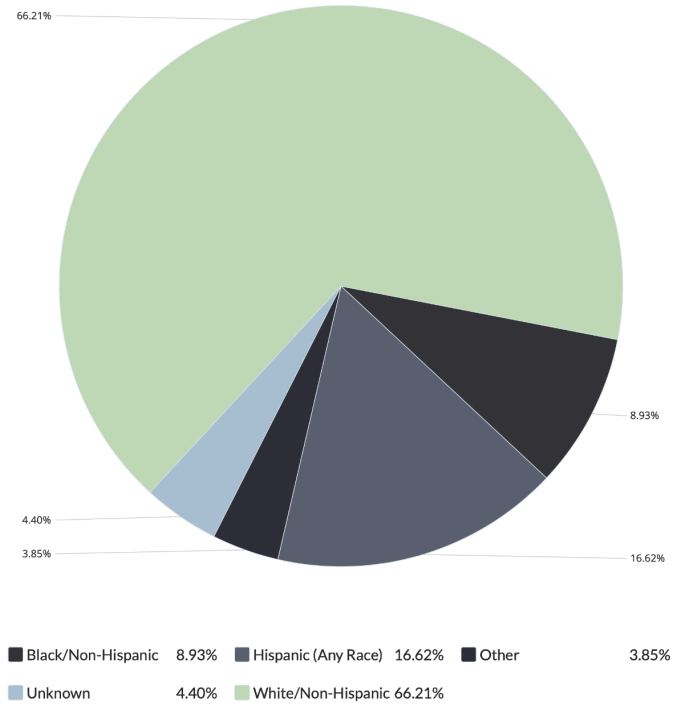
To juxtapose the diversity of behavioral healthcare staff with the state's behavioral health patient population, we additionally reviewed demographic information from the RI Behavioral Health Online Data (RI-BHOLD) system. BHDDH-licensed providers are required to enter client data into this system, regardless of pay source. According to these data, 66.2% of clients served in any BHDDH-licensed MH/SUD facility between 2018 and 2020 (n=135,954) were non-Hispanic white (**Fig. 2.3**). The most common non-white racial identities were Hispanic only (8.84%), Black non-Hispanic (8.56%), and white Hispanic (7.3%). Notably, race data for 4.77% of clients served in this timespan were "unknown." These trends were largely recapitulated in data for clients admitted to BHDDH-licensed MH/SUD facilities in the same time interval (**Fig. 2.4**)

Fig. 2.3:
Racial Breakdown of Clients Served in Any MH or SUD Facility, 2018-2020 Average



(i) Data from RI-BHOLD.
(ii) Clients "served" could be admitted (i.e., begin receiving services) at any time as long as they were in treatment (i.e., receiving any MH/SUD services from a provider at a BHDDH-licensed facility) in the time period indicated.
(iii) For an overview of BHDDH-licensed facilities, see Appendix F.
(iv) See Appendix D for more detail on average calculation.

Fig. 2.4:
Racial Breakdown of Clients Admitted to Any MH or SUD Facility, 2018-2020 Average



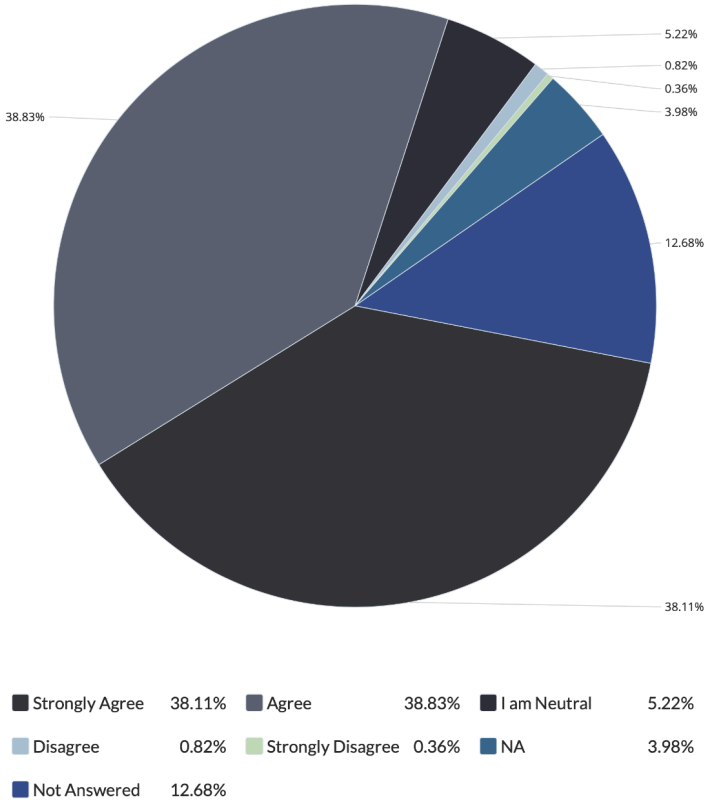
(i) Data from RI-BHOLD.
(ii) Clients "admitted" are those who started a new treatment or transferred to a new BHDDH-licensed program/location at some point in the time period indicated. Clients admitted are included in the count of clients served.
(iii) For an overview of BHDDH-licensed facilities, see Appendix F.
(iv) See Appendix D for more detail on average calculation.

Patient Perceptions of Care

In addition to exploring the quantitative breakdown of behavioral health care providers by race and ethnicity, we sought to gain insight into patient perceptions of care from the standpoint of sensitivity to lived experience. The Outcome Evaluation Instrument (OEI) is a survey administered annually by BHDDH to gauge the performance of the state's behavioral healthcare system. For a more detailed description of the survey's contents, structure, and function, see the Methods and Appendices section of this report.

One question featured on the OEI asks clients to report the degree to which they agree with the statement that "Staff were sensitive to my cultural background (race, religion, language, etc.)." Between 2018 and 2020, an average of 76.9% of respondents either "agreed" or "strongly agreed" with this statement, while fewer than 7% were neutral, "disagreed," or "strongly disagreed" (**Fig. 2.5**). Notably, 16.7% of respondents either responded "NA" or chose against responding to this question. While this is only one of 41 questions in the section of the OEI administered to clients and its results should by no means be broadly generalized, we found it helpful as a rough proxy for client perspectives.

Figure 2.5: OEI Responses to "Staff were sensitive to my cultural background (race, religion, language, etc.), 2018-2020 Average



(i) For more information on how the OEI is administered, see Appendix E.
(ii) See Appendix D for more detail on average calculation.

Diversity in the Provider Pool: Stakeholder Perspectives

To supplement the quantitative data pertaining to the diversity of the provider pool, we solicited the perspectives of behavioral healthcare providers, leaders within health systems, and patient advocates. As part of our discussions, we explored not only the value of a diverse workforce to the provision of CLAS, but also the implications of shortcomings in this realm for patients and clinicians alike.

The overwhelming consensus among interviewees was that Rhode Island's current provider pool lacks diversity. When asked about the biggest obstacles to the provision of CLAS, most conversations began by addressing the challenge of facilitating ethnic matching given the scarcity of providers of color.

"Most clients will tell you they prefer to have a provider … with the same cultural background. The barrier is that they all don't exist."

- Social worker at a non-profit community health center

A recurring theme in our conversations with interviewees was the mention of workforce diversity as a primary driver of shortcomings in culturally appropriate care. They repeatedly invoked both the intangible (e.g., implicit understanding derived from lived experience) and concrete (e.g., increased wait times) ways in which the composition of the provider pool may hinder individuals from minority communities seeking behavioral healthcare. One individual, a licensed clinical social worker and practicing therapist, described the longer wait times often incurred by minority groups seeking care aligned with their lived experience. In a different interview, a social worker from a community health center expressed a sentiment that treatment provided to care-seekers for whom ethnic matches are not available is unlikely to be as effective as it could be, saying,

"They'll come to us and we'll provide services to them, but it's not adequate if it's not culturally appropriate."

It is important to note that some providers, while acknowledging the inherent difficulties that come with ethnic discordance in patient-provider relationships, projected optimism about the ameliorative potential of entering a dialogue with cultural humility (an idea that will be discussed further in the following section). One interviewee, a licensed independent clinical social worker and private practitioner, stated, "There's a lot that I don't know, but it shouldn't stop me [from seeing] people and offer what I can to help with an open mind."

Discussion and Recommendations

Delving further into this issue, we prompted interviewees to discuss their vision for ways in which the barriers to workforce diversity (and their implications for care-seekers) described above may be addressed. Broadly, the responses we received could largely be classified as dealing with financial barriers, licensing requirements, and a need for a larger provider pool.

Financial Barriers

An improvement in behavioral health workforce diversity begins with addressing inequities in opportunities for educational attainment. Because people of color often experience disproportionate financial barriers in the course of pursuing higher education,[4,5] numerous interviewees underscored the critical nature of providing funding for minority populations with the aim of empowering them to pursue their scholastic ambitions. Such financial aid would allow students to avoid delays in program completion because they would not have to work part-time jobs in addition to their coursework in order to support themselves. One interviewee, a licensed independent clinical social worker and educator in social work expressed that, "If I want to get [students'] attention, I really have to offer them a financial break." This interviewee shared examples of the enormous good that can be done by dispensing financial support with no restrictive conditions. At the interviewee's institution, the percentage of students of color was doubled by leveraging federal grant funding from the Obama administration.

Licensing Requirements

Apart from financial barriers to entry, interviewees addressed the testing requirements associated with obtaining a license to practice social work in Rhode Island. Briefly, to become a Licensed Clinical Social Work-er (LCSW) in Rhode Island, one must first hold a Master of Social Work (MSW) or Doctorate of Social Work (DSW) from a program accredited by the Council on Social Work Education (CSWE). After this, one must pass the Association of Social Work Boards' (ASWB) Master's Exam — a test consisting of 170 multiple-choice questions. After 3,000 hours of supervised clinical social work experience, one may take the ASWB Clinical Exam — also consisting of 170 multiple-choice questions — to become a licensed independent clinical social worker (LICSW).[6,7]

Comments from interviewees on the test-heavy licensing requirements included both skepticism about the degree to which a timed examination reflected qualification in the field as well as the linguistic inaccessibility of the ASWB Clinical Exam. Literature spanning decades has described the interplay between education quality, access to resources, and fairness of standardized assessments in communities of color.[8,9] Many scholars assert that what is often cast as an "achievement gap" would be more accurately described as the manifestation of an "opportunity gap" borne of socioeconomic factors including income levels, employment rates, neighbor-

4 Banks, T., & Dohy, J. (2019). Mitigating Barriers to Persistence: A Review of Efforts to Improve Retention and Graduation Rates for Students of Color in Higher Education. Higher Education Studies, 9(1). doi:10.5539/hes.v9n1p118

5 National Academy of Sciences (US), National Academy of Engineering (US), and Institute of Medicine (US) Committee on Underrepresented Groups and the Expansion of the Science and Engineering Workforce Pipeline. Expanding Underrepresented Minority Participation. Washington (DC): National Academies Press (US); 2011. 5, Affordability. Available from: https://www.ncbi.nlm.nih.gov/books/NBK83366/

6 Rhode Island Social Work Licensing Requirements. (2022). Social Work Guide. https://www.socialworkguide.org/licensure/rhode-island/

7 Social Work (Licensing). (2022). State of Rhode Island Department of Health. https://health.ri.gov/licenses/detail.php?id=245

8 Jencks, C., & Phillips, M. (1998). The Black-White Test Score Gap: Why It Persists and What Can Be Done. Brookings. https://www.brookings.edu/articles/the-black-white-test-score-gap-why-it-persists-and-what-can-be-done/

9 Couch, Michael II; Frost, Marquisha; Santiago, J.; and Hilton, Adriel (2021) "Rethinking Standardized Testing From An Access, Equity And Achievement Perspective: Has Anything Changed For African American Students?," Journal of Research Initiatives: Vol. 5 : Iss. 3 , Article 6.

hood crime rates, and housing access.[10,11] In keeping with these findings, interviewees advocated for the removal of the LCSW test, with one wondering aloud why students should be assessed in rote fashion after completing all of the training requirements. Instead of propelling aspiring social workers toward the first phase of their ca-reer, the interviewee explained, "failing the test shakes their confidence."

"[Social work is] one of the most fluid, contextual fields…How can you ever translate behavioral health knowledge into multiple choice?"

- Licensed independent clinical social worker and educator

Beyond their concerns that a reliance on these standardized tests serves as both a reflection and exacerbation of inequity, interviewees mentioned that the exams fail to accommodate individuals who speak English as a second language. Both ASWB licensing exams are offered in English only.[12] While "qualified candidates who use English as a second language may request additional time…and the use of up to two dictionaries," interviewees noted there is a disconnect between the evident need for a culturally and linguistically diverse workforce and this seemingly restrictive policy. For their part, the ASWB states in the ASWB Candidate Handbook that exam questions "are developed from a regularly updated survey of the actual practice of social workers across the United States and Canada who work in a variety of settings and represent demographic diversity," "are written by item writers who have been selected to reflect racial, ethnic, gender, geographic, and practice-setting diversity," that "ASWB ensures that the examinations are fair measures of competency regardless of the race or gender of the test-taker," and that "Results over several years have shown that ASWB exams are statistically free from race and gender bias."[13]

At least one ongoing legislative effort is seeking to modify licensing requirements for social workers in Rhode Island. House Bill No. 7396 ("An Act Relating to Businesses and Professions — License Procedure for Social Workers"), introduced in February 2022, would amend the General Laws to eliminate the examination requirement for LCSW licensing and provide for the administration of the LICSW clinical examination in languages other than English.[14]

Increasing the Size of the Provider Pool

Lastly, interviewees mentioned the overall sparseness of behavioral healthcare providers in Rhode Island, laid bare by rising mental health concerns during the pandemic, and discussed their impressions of its potential drivers. The overwhelming majority of viewpoints from interviewees pertaining to the factors underlying this shortage touched upon financial incentives, or a lack thereof. Several individuals attributed a dearth of candidates — both generally and from underrepresented backgrounds — to subpar compensation and underappreciation, the combination of which contribute to burnout.

"I felt for a long time that organizations like us identify a problem and then you try to say what can we do right now within the organization. But I think you have to start the investment far sooner than that. And that is to make the professions, like becoming a mental health clinician, make that worthwhile for people to do. But it pays so poorly that nobody wants to do that. If you start there, then you could grab a larger population"

- Social worker at a non-profit community health center

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10 Hasan, Sharique and Kumar, Anuj, Digitization and Divergence: Online School Ratings and Segregation in America (July 23, 2019). Available at SSRN: https://ssrn.com/abstract=3265316 or http://dx.doi.org/10.2139/ssrn.3265316

11 Rosales, J., & Walker, T. (2021). The Racist Beginnings of Standardized Testing. National Education Association. https://www.nea.org/advocating-for-change/new-from-nea/racist-beginnings-standardized-testing

12 Requesting English as a second language arrangements. (2022). Association of Social Work Boards (ASWB). https://www.aswb.org/exam/getting-ready-for-the-exam/nonstandard-testing-arrangements/requesting-english-as-a-second-language-arrangements/

13 ASWB Exam Candidate Handbook. (2021). Association of Social Work Boards (ASWB). https://www.aswb.org/wp-content/uploads/2020/11/Candidate-handbook-06-2021.pdf

14 An Act — RELATING TO BUSINESSES AND PROFESSIONS — LICENSE PROCEDURE FOR SOCIAL WORKERS, H7396, 2022 Reg. Session. (RI 2022). http://webserver.rilin.state.ri.us/BillText/BillText22/HouseText22/H7396.pdf

Common among such observations was the view that insurance companies could play a role in leveling the playing field when it comes to reimbursing services. One interviewee stated, "It starts with insurance providers. Insurance has to reimburse you for services so you can pay your staff better." This assessment was echoed by a different interviewee, a professor of counseling and psychology, who told us that "One [reason for the provider shortage] is just the insurance structures…overall, we don't have enough practitioners for the number of clients that are out there." Such reflections are supported by recent literature reporting disparities in Medicaid reimbursement and network coverage between behavioral healthcare providers and primary care physicians.[15,16]

In addition to dissuading potential new mental health clinicians from entering the profession, dissatisfying wages coupled with understaffing place an increased burden on existing providers. Unsurprisingly, interviewees explained that this often leads to burnout driven by a feeling of being underappreciated. The idea that a mental health clinician is "just a therapist" is reductive, one interviewee told us. For providers of color and multilingual providers, this reduction is further exacerbated as the additional work they do is often unrecognized and unsupported. This chronic lack of recognition, she continued, undermines retention rates in behavioral healthcare fields.

Still, some interviewees experienced optimism for the ameliorative potential of workforce growth as it pertains to directing attention to cultural humility. "When the pool is big enough," one interviewee said, "there will be more noise and more training."

15 Mark, T. L., Parish, W., Zarkin, G. A., & Weber, E. (2020). Comparison of Medicaid Reimbursements for Psychiatrists and Primary Care Physicians. Psychiatric services (Washington, D.C.), 71(9), 947–950. https://doi.org/10.1176/appi.ps.202000062.

16 Davenport, S., Gray, T.J., & Melek, S.P. (2019). Addiction and mental health vs. physical health: Widening disparities in network use and provider reimbursement. Milliman. https://www.milliman.com/en/insight/Addiction-and-mental-health-vs-physical-health-Widening-disparities-in-network-use-and-p

Section 3:

Training and Education of Behavioral Healthcare Providers

It may not be feasible in all circumstances to accommodate ethnic matches between patients and behavioral healthcare providers. Thus, it is important for providers to be exposed to concepts underlying CLAS since not all of them will be able to draw from lived experience directly.

Training for Behavioral Healthcare Providers: Existing Models

Behavioral healthcare providers in Rhode Island are required to engage in training and education related to culture and language by various entities, including state legislation, healthcare systems, and insurance companies.

Enacted by license issuers within the Rhode Island Department of Health (RIDOH), RI law sets requirements which behavioral healthcare providers must fulfill in order to obtain or renew their licenses. Initial licensing standards include fulfillment of degree requirements, internship completion, and passing of standardized examinations. Licenses are renewed following the completion of requisite continuing education credits. Specific requirements vary depending on a provider's area of practice — see Appendix A for a summary of RI licensing and renewal requirements for each type of behavioral health practitioner. Notably, explicit mention of CLAS or related concepts is rare in these core requirements.

Private healthcare systems can also require providers to undergo additional training to supplement that which is mandated by RI law. Given the smaller scale on which such training is commonly carried out, it is typically better suited to encompass more specific topics, such as the intersection of culture and health. One interviewee, a social worker at a non-profit community health center, shared that she and other employees are expected to complete a training course consisting of an hour-long informational video regarding the way that culture informs mental health. Another interviewee, a leader within a non-profit health care system, described unconscious bias training that is required of all employees.

Training for Behavioral Healthcare Providers: Stakeholder Perspectives

Assessment of Existing Training

While there are fragmented or organization-specific requirements in place pertaining to culture and language, providers consistently expressed a desire to see more training required, additionally noting that presently available training for these requirements (e.g., continuing education courses) are lacking in quality and quantity. In one interview, a professor in the field of counseling and psychology emphasized that only social workers are required to have a continuing education credit related to culture (a minimum of three hours in the area of "cross-cultural practice"), but other providers are not subjected to the same obligation. For instance, licensed mental health counselors need to take three out of thirty continuing education credits in "social and cultural foundations," but no further action is required of them upon the completion of these credits. If providers would like additional CLAS-related training, they have to seek this out on their own time, using their own resources. Unfortunately, locating such training is easier said than done, particularly if a provider is not affiliated with a larger health care system. "I wish I could find more training," one private practitioner told us.

In commenting on perceived inadequacies within their own organization's treatment of CLAS-related training, interviewees most commonly cited overgeneralization. A social worker at a non-profit community health center shared with us that training videos provided by her employer are not uniformly accessible to behavioral health employees at all levels of the organization and that the information in the videos themselves is too general to reliably encompass the breadth of cultural diversity with which employees will come in con-

tact. This shortcoming in representation was echoed by a private practitioner, who specifically mentioned that she sees a dearth of effort invested in discussing the experience of Asian Americans in behavioral health during trainings.

Limitations of Training

While training can be a worthwhile supplement for providers, it also has limitations. Multiple providers emphasized that the goal of training must not be to confer "expertise" about a certain culture, as such an aim is patently impractical. Even when two individuals share a cultural background, there is extraordinary heterogeneity in life experience and the manner in which certain ideas are expressed and received, especially across geographic, class, and other identity lines. As a private practice provider asserted, "No one can say they know 'enough' [about a culture] because this country is so diverse." Instead, interviewees suggested that training should embrace the approach of learning about and establishing "cultural humility" as opposed to the oft-invoked "cultural competence." In fact, we were encouraged to use "cultural humility" instead of "cultural competence" multiple times during interviews by providers.

While it may seem minute, this distinction carries great significance. In framing training as an effort to achieve "cultural competence," we further a misconception that educational experiences can teach providers everything about a culture such that they can rotely anticipate the ways in which patients' cultural context impacts their mental health. This leads to the misguided application of generalizations or stereotypes to individual patients, thus increasing the risk that reductive assumptions will detract from a more individualized provider-patient relationship. Irrespective of the training that a provider has undergone, a professor in mental health counseling explained to us, "You're always going to have to ask your clients about their personal experiences." An approach grounded in cultural humility encourages this discussion, while the illusory goal of cultural competence can obstruct it. This same interviewee explained that it is better to focus on teaching "strength-based therapy," a therapeutic approach that seeks to capitalize on a client's strengths and values (as opposed to symptoms and weaknesses) and can leverage culturally specific "protective factors" (as opposed to risk factors).[1]

"You cannot be 'culturally competent' in [someone else's] culture."
- A licensed independent clinical social worker and private practitioner

In line with this model, our interviewee emphasized that providers should avoid categorically pathologizing certain behaviors and instead seek to appreciate how normative and desired behaviors across cultures may differ. Many behavioral healthcare textbooks, in the opinion of the interviewee, fall short in this respect and tend to overgeneralize. They address cultural differences, she said, by framing lessons as "How do we work with Group X versus Group Y." She explained that emphasizing "individual and personal reflection" over textbooks that seem to read like a manual for "understanding" different cultures is a much more effective way to teach cultural humility.

Discussion and Recommendations

In the course of conducting our interviews, numerous recommendations for addressing the issues discussed in this section were raised. Here, we summarize the suggestions articulated by providers by breaking them down by the parties which would be responsible for their implementation.

State Legislation

Some interviewees voiced a belief that state requirements would be the most effective means of improving CLAS-related training. One interviewee expressed confidence that having guidance which "came from

1 Rashid, T. (2015). Positive psychotherapy: A strength-based approach. The Journal of Positive Psychology, 10(1), 25–40. https://doi.org/10.1080/17439760.2014.920411

the state down" would go a long way in rectifying the lack of uniformity in the presence and thoroughness of training provided by healthcare systems and hospitals. This may, for example, take the form of legislation that amends the Rhode Island Code of Regulations to include training stipulations for employers in the healthcare sector.

Healthcare Systems and APA-Approved Continuing Education Organizations

Even if the state moves to codify training requirements in law, it will be incumbent upon employers to ensure that the material provided for clinicians is not only compliant with baseline requirements, but also incorporates diversity in content and leadership. This entails intentionally broaching under-discussed topics with practical applications in behavioral healthcare — an aim most reliably achieved by ensuring that those who develop training curricula are those with pertinent lived experience and identities. On a related note, educators must think critically about the manner in which they are building curricula in classrooms. Culture is dynamic and the most pertinent issues to teach aspiring providers fluctuates frequently. "Just when I think I figure it out, it changes," a professor in mental health counseling expressed to us.

A recurring proposal for which numerous interviewees adamantly advocated was the importance of specifically allocating time for providers to complete training and engage thoughtfully with CLAS-related material. Behavioral healthcare providers commonly contend with burnout as is — it is impractical to place the onus on them to complete supplementary training in their scarce time off. Multiple interviewees expressed the sentiment that such an approach would fail to incentivize skill-building that would in turn improve quality of care. Strides in the provision of CLAS, an interviewee from a non-profit community health center stressed, will not be possible without "an institutional investment."

Section 4:

The Role of Language in Behavioral Healthcare

In order to provide CLAS, it is critical that the interplay between language choice and behavioral healthcare be understood. Not only must behavioral healthcare providers working with multilingual clients translate their English-based training in a literal sense, but they must also navigate differences in understanding of feelings and symptoms that manifest through language.

"Nobody can tell me what is the best word to use in Mandarin, it takes me and my own practice to figure that out with my client."
- Licensed independent clinical social worker and private practitioner

Of the multilingual providers we interviewed, almost all noted the difficulties of providing behavioral healthcare in several languages given that their education and training was done almost exclusively in English. One private practitioner who regularly provides therapy in three languages pointed out the difficulty of accurately providing CLAS across languages. One of many difficulties in providing CLAS included the task of translating medical questionnaires that would aid her in assessing patients. Given different connotations and social norms around the word "feel", for example, how would one go about translating a questionnaire in which every question began with "how do you feel?" Dilemmas such as this one, she emphasized, are frequently encountered by multilingual providers. This is particularly true for those who provide care in languages such as Mandarin or Cantonese — languages in which behavioral healthcare training is scarce in the U.S.

Even in languages that are more commonly spoken in the U.S, such as Spanish, several providers noted similar difficulties in conveying emotional nuance as well as challenges navigating varied understandings of the same words with their patients. One multilingual practitioner shared that her Spanish-speaking patients often have different understandings of certain common phrases in Spanish because they come from a range of countries. Translating these phrases literally or with rote uniformity can lead to the misdiagnosis or pathologization of symptoms that may be considered normal in a client's community.

The importance of a provider's ability to communicate fluently with consumers of behavioral healthcare is supported by a wide body of literature. In a qualitative study of bilingual Spanish-English providers, providers noted that switching languages with bilingual clients allowed them to increase client self-understanding and awareness and enabled clients to better communicate with them.[1] Moreover, as discussed in the introduction, difficulty finding a provider who speaks one's language makes it less likely for a care seeker to receive behavioral health treatment at all.

Languages Spoken by Behavioral Health Care Providers in Rhode Island: A Quantitative Snapshot

As previously discussed, an insufficient supply of multilingual behavioral health care providers presents access barriers to treatment for clients and places additional stress on clinicians who do speak languages other than English. Considering this, we sought to gain a sense of the availability of behavioral health care services provided in languages other than English in Rhode Island. To do so, we used staff at BHDDH-licensed facilities as an illustrative example. BHDDH provided the second languages spoken by client-facing staff and clinical supervisors at these facilities for 2018, 2019, and 2020, from which an average was calculated.

1 Santiago-Rivera, A. L., Altarriba, J., Poll, N., Gonzalez-Miller, N., & Cragun, C. (2009). Therapists' views on working with bilingual Spanish–English speaking clients: A qualitative investigation. Professional Psychology: Research and Practice, 40(5), 436–443. https://doi.org/10.1037/a0015933

Between 2018 and 2020, an average of 81.6% of client-facing staff at BHDDH-licensed facilities did not speak any languages other than English (**Fig. 4.1**). The most common second language spoken by client-facing staff in this time interval was Spanish (10.7%), besides which only French (1.3%) and Portuguese (1.03%) were spoken by more than 1% of client-facing staff. A similar trend was evident in data drawn from clinical supervisors between 2018 and 2020: an average of 85.7% spoke only English, while 10.8% spoke Spanish as a second language, 1.05% spoke French, and 0.60% spoke Portuguese (**Fig. 4.2**).

Figure 4.1: Second Language Breakdown of MH and SUD Client-Facing Staff, 2018-2020 Average

Second Language(s) Spoken	*Percentage of Employees*
None	81.61%
Spanish	10.65%
Other Language	4.25%
French	1.31%
Portuguese	1.03%
Spanish and Portuguese	0.44%
ASL	0.35%
Cambodian/Khmer	0.24%
Spanish and ASL	0.12%

(i) Data from BHDDH human resources (HR) database.
(ii) See Fig. 2.1 for the positions included in "client-facing staff."
(iii) See Appendix D for more detail on average calculation.

Figure 4.2: Second Language Breakdown of MH and SUD Clinical Supervisors, 2018-2020 Average

Second Language(s) Spoken	*Percentage of Employees*
None	85.69%
Spanish	10.84%
Other Language	1.81%
French	1.05%
Portuguese	0.60%

(i) Data from BHDDH human resources (HR) database.
(ii) See Appendix D for more detail on average calculation.

Unfortunately, no comparable data were available for the second language breakdown of clients. In the future, it is important for state agencies such as BHDDH or the Executive Office of Health and Human Services (EOHHS) to institute a mechanism for the collection of such information, even if it is simply an additional question on the OEI. It is only by taking such measures that we will be able to more clearly discern the degree to which any disjuncture exists between the languages spoken by those seeking and providing behavioral health care in Rhode Island. Additionally, it is important to note that the figures provided here only reflect data drawn from staff members at BHDDH-licensed facilities, and should not be taken to represent existing trends among private practitioners. Lastly, one important caveat noted by an interviewee is that data on provider language fluency can be difficult to obtain with any degree of accuracy because some providers may become defensive about their fluency when they are not actually trained to speak that language in a medical environment.

Scarcity of Multilingual Providers

Given the importance of concordance in languages spoken for behavioral healthcare efficacy and uptake, it is clear that a linguistically diverse provider pool is as crucial for providing CLAS as a racially diverse one. At present, RI has progress to make in both respects.

Several interviewees noted that this lack of linguistic diversity reflects a large gap between the demand for behavioral health services in non-English languages and the number of providers who speak these languages. Interviewees specifically mentioned deficiencies in Spanish, Portuguese, and American Sign Language (ASL).

"There's such a huge need, not just for Spanish-speaking [providers], but for other languages as well."
- Social worker at a community health center and founder of community initiative related to recruitment of underrepresented communities in behavioral healthcare

When there are not providers available to meet the language needs of patients, clinicians must often resort to in-person or electronic translators. However, several interviewees pointed out that this is a grossly inadequate replacement in several ways. One provider explained, "The more you can get someone to understand a patient, the better you'll be, and a laptop interpreter or language line is not going to make that connection."

With these challenges in mind, interviewees stressed the importance of recruiting and retaining multilingual providers and cited the bias in favor of English monolinguals in the education, exams, and training for mental health care as an obstacle to this end. An educator in social work said that multilingual students at her institution complete coursework in English, take a licensing exam that is in English, but are then expected to help meet the demands for multilingual providers by working with non-English speaking patients. This disjuncture between the needs of the workforce and the training available persists beyond undergraduate and graduate education. A private practitioner who regularly works with non-English speakers noted that all of the courses she had available for continuing education requirements were in English.

Implications of a Linguistically Homogeneous Provider Pool for Non-English-Speaking Providers

The failure to recruit a linguistically diverse behavioral healthcare provider pool places disproportionate demands on multilingual providers. Broadly, when multilingual providers are largely unavailable to clients, the few that are must take on increased roles in order to support their clients. One interviewee described a case in which she had to translate medical documents and act as a guide through the Providence medical system for a client who did not speak English and relied upon her daughter as a translator. The increased burden that multilingual providers must take on in supporting clients while doing independent translation work in the absence of linguistically diverse training leads to elevated rates of burnout. Several interviewees noted the taxing nature of their work given the lack of institutional support they receive in addition to the lack of recognition of this additional work. One interviewee noted that lack of recognition for the work that providers do in behavioral healthcare is a common reason for leaving the field altogether.

"To be a broker of two languages, to be that bridge, takes so much work"
- Licensed mental health counselor at a Rhode Island-based nonprofit health system

Not only does the failure to recruit a linguistically diverse provider pool negatively impact multilingual providers, but it also decreases care quality for clients who do not speak English. Apart from the aforementioned potential for declines in behavioral healthcare utilization by non-English-speaking care-seekers, interviewees mentioned the effect of a paucity of multilingual providers on patient attrition.

One provider at a non-profit community health center noted the importance of having multilingual staff

and providers at clients' first visits in particular. The first step of attending a visit with a new provider can be immensely daunting. Given this, she emphasized the value of having staff that understood a patient's language and culture. As an example, she noted that the lack of Portuguese-speaking providers at her workplace had impacted utilization of services by Portuguese-speaking patients, stating,"That's where you lose people."

"I've had Portuguese speaking people in my office, they often bring a family member in to provide interpretation services. [The patient will] show up and be like, 'No, I'm not going to do it.' I think it could be very different if they had a Portuguese-speaking person running that meeting."

- Social worker at a non-profit community health center

In order to bridge the gap between non-English-speaking clients and English-speaking providers while additional recruitment efforts are ongoing, behavioral healthcare systems may hire translators. However, the pursuit of this strategy is often fraught with several obstacles. First, many behavioral healthcare systems may experience difficulty procuring the requisite funding to hire and retain translators. Several interviewees mentioned that hiring interpreters is not only costly, but that convincing administrators to prioritize them is challenging given that they do not generate additional revenue.

Even when translators are hired, their training is determinative in the accuracy of their translation. One interviewee, a licensed independent clinical social worker, observed that translators hired by healthcare facilities are often trained broadly in medical translation rather than behavioral health specifically. While this may seem like a minute distinction, the lack of specialization resulted in inaccuracies in translation. Returning to the example at the start of this section, we again note the importance of recognizing the provision of behavioral healthcare across languages as fundamentally greater than an issue of literal translation.

"Just because you have interpreter doesn't mean it's culturally adequate"
- Licensed social worker at a community health center

Beyond the practical implications of inaccuracy in translation, the presence of a third party in the provision of behavioral healthcare may negatively impact the efficacy of the treatment. One provider highlighted the difficulty of discussing sensitive or deeply personal topics through a translator as opposed to a patient's own voice. This disruption to the ability to autonomously convey one's own narrative may carry particular significance for patients who may be averse to vulnerability as a result of stigmatization and other community influences.

Recommendations

In addressing ways to improve barriers to the provision of linguistically appropriate care, interviewees unanimously advocated for higher numbers of multilingual providers. Given this, many of the recommendations for providing linguistically appropriate care overlap with recommendations to increase the diversity of the provider pool in Section 2 of this report. Briefly, these include reducing structural barriers — such as the financial burden of graduate education — that disproportionately prevent providers of color from entering the field. Other recommendations that interviewees provided converged to several focus areas.

Tailored Training for Translators in Behavioral Healthcare

Given that the process of educating, training, and recruiting a more diverse pool of behavioral healthcare providers will necessitate the implementation of initiatives over a longer timescale, there remains a need for stop-gap measures to address a large-scale inability to provide language matches for non-English-speaking patients. One short-term solution is a targeted investment in the hiring of more translators. Moreover, drawing

on the experiences shared by our interviewees, it is imperative that such translators be equipped with training that enables them to contribute meaningfully in behavioral healthcare settings.

Increased Linguistic Diversity of Licensing Preparation and Continuing Education of Training for Multilingual Providers

Several interviewees mentioned the difficulty associated with translating concepts learned in English into different languages to make them accessible to patients in a clinical setting. This challenge could be addressed, in part, by ensuring that fundamental coursework, licensing examinations, and continuing education materials are provided in languages other than English.

Section 5:

Accountability and Leadership

In order for lasting structural change to occur, healthcare providers, institutions, and systems alike should be held accountable for upholding CLAS standards. Legislation is an essential avenue to ensure that this takes place at state and local levels, but few states have established formal mechanisms to quantify adherence to CLAS standards, adequacy of CLAS-related training, and the impact of these measures on behavioral health care outcomes and patient satisfaction. In Rhode Island, for example, there is no centralized repository of information that could be used to assess the impact of CLAS-promoting policies over time.

Data Accessibility and Interoperability

Presently, there is little publicly available data pertaining to measures of relevance to CLAS in Rhode Island. This includes languages spoken by behavioral health care clients and outcomes of clients grouped by race and ethnicity (see Methods and Appendices for further discussion of metrics for which we were unable to obtain quantitative data). One interviewee, an administrator at a non-profit healthcare system, mentioned that a number of hospitals in Rhode Island have pioneered internal efforts to systematically track demographics and language proficiency with the aim of increasing the diversity of their staff, complemented in some cases by a standing CLAS committee.

One interviewee familiar with the operations of a CLAS committee at one such hospital described their function in promoting institutional accountability. The committee breaks down patient satisfaction data by race and ethnicity and disseminates the information within the hospital and to other facilities within the same healthcare system. The interviewee mentioned, however, that such diligence and granularity is somewhat of an outlier at the state level — a major obstacle has been mobilizing all healthcare facilities in Rhode Island to collect, tabulate, and assess demographic data of providers and clients consistently and uniformly. While initiatives and innovation within individual organizations is important, a unified data collection effort spearheaded by the state would stand to improve accountability, data interoperability, and, in turn, the probability of successful CLAS implementation.

Selection of Outcome Measures

Another interviewee, a social worker at a non-profit community health center, stressed the importance of selecting clinically meaningful outcome measures. It does no good, she emphasized, to perfunctorily collect data for the sake of having material to report. "There are things we have to report on that I think are not super important. There are outcome measures about mental health…I would want to look at. These are the things that would actually help clients." Specifically, the interviewee mentioned instruments like depression screening tests[1] and detailed data on patient attrition by race.

"If you had data that said, 'Hey, look — all of these Portuguese-speaking patients' treatment lasts 50% less than white non-Hispanic clients', that would be amazing [to have]. Then you would have to do something about that. Would it be another thing for you to do? Yeah. Would it be a helpful thing to do? Yeah."
- Social worker at a non-profit community health center

A commitment to metrics like these would make the tailoring of mental health services more sensitive to and appropriate for the circumstances of diverse patient populations. The interviewee was confident that the will to

1 Spitzer, R.L., Williams, J.B.W, Kroenke, K., et al. (n.d.) Patient Health Questionnaire - 9 (PHQ-9). American Psychiatric Association. https://www.apa.org/depression-guideline/patient-health-questionnaire.pdf

do this analysis exists within her organization's quality department. "I'm sure they would love to do something like this," she said.

Stakeholder Perspectives on Leadership

Interviewees largely echoed one another in their support for government leadership in requiring that organizations routinely collect CLAS-related data according to uniform standards. They supported government action for both practical and symbolic reasons. Interviewees almost unanimously agreed that conditions set by the government would increase the probability of compliance and optimal outcomes. As one provider put it, "It was required, you would have no choice…then you would have to be doing that within your organization." Moreover, visible action by policymakers on this issue would serve to further legitimize its importance and encourage the public to regard it with the urgency it deserves.

Several interviewees discussed what this might look like at the state and national levels. Beyond the provision of grants to broadly collect demographic data in behavioral healthcare, one interviewee floated the idea of a centralized joint commission — a governing body that oversees adherence to CLAS standards throughout the state or country. Irrespective of the ultimate mode of implementation, there was an overarching sentiment among the providers and administrators with whom we spoke that there is a need for state-led efforts in facilitating the provision of behavioral healthcare that is attentive to the lived experience and background of clients. Encouragingly, innovative repositories of information for care improvement are not without precedent in Rhode Island. The Rhode Island Quality Institute (RIQI) is an excellent model for this.

Ultimately, the hope is that CLAS-related initiatives become more widespread absent governmental influence, but partnering with public-sector stakeholders may serve as an important catalyst for this transition. Importantly, a large part of this leadership is ensuring that healthcare systems have the requisite resources to execute CLAS-related programs; several interviewees noted that the departments within their organizations dedicated to the monitoring of care quality are presently understaffed and underfunded.

"It always comes down to a resource issue…[We] have to have a pay source for that. Where is that money coming from? Especially for nonprofits."
- Social worker at a non-profit community health center

Important Considerations in Partnership-Building and Data Collection

There are a number of considerations that must be taken into account when building partnerships to implement policy reform prioritizing culturally appropriate care. First, several interviewees cautioned that, often with the best intentions, healthcare administrators or policy advocates initiate proposals to increase provider diversity but fail to adequately solicit the involvement of the very groups whose perspectives they seek to affirm. It is important, then, that the leadership of CLAS-related initiatives intentionally reflects the diversity and lived experience of the patients they aim to benefit.

When it comes to data collection, overgeneralization is one of the principal barriers to progress. One interviewee, a licensed independent clinical social worker with experience in both patient care and hospital administration, mentioned that patient survey results which cannot be broken down by race and ethnicity may present an incomplete picture of care quality. While a topline number may seem favorable, a more thorough evaluation may expose disparate outcomes across subgroups (e.g., races, ethnicities, speakers of different languages) that may have otherwise been overlooked.

Lastly, a number of interviewees mentioned that acknowledging the importance of one aspect of identity in shaping culturally appropriate behavioral health care need not entail de-emphasizing others. One interview-

ee, a professor of counseling and psychology, emphasized that race is merely one of many "malleable layers of identification." Another educator in social work echoed this point, citing the many complex and interwoven layers (e.g., gender identity, race, language) that comprise an individual's identity. In sum, interviewees were clear-eyed about the perils of rotely categorizing clients in the course of collecting demographic data. This is reflective of an overarching sentiment conveyed to us throughout our interviews: integrating cultural humility into behavioral healthcare is a challenging but worthwhile endeavor precisely because of its complexity and incompatibility with a one-size-fits-all approach.

Methodology

Literature Review

We began this project by performing a thorough literature review during which we explored existing research on the relationships among culture, language, and behavioral health. The blueprint for equitable care provision set forth by the national CLAS standards served as a springboard for our research questions and heavily informed our discussions with interviewees.

Interviews

Between the months of December 2021 and February 2022, we individually contacted 33 stakeholders by email or phone to request interview participation. No incentives, financial or otherwise, were provided. Our outreach list was curated with the aim of soliciting the participation of a group that offered diverse perspectives, came from a range of professions in behavioral healthcare, and worked in a range of care settings.

We ultimately conducted interviews with 11 stakeholders who shared their opinions, experiences, and recommendations on CLAS in behavioral healthcare in Rhode Island. These included licensed social workers, directors, administrators, advocates, and professors at local hospitals, community health centers, health systems, nonprofits, and academic institutions. Interviews were held over Zoom and lasted between 30 and 45 minutes. See Appendix B for sample interview questions.

All statements from interviewees in this report should be interpreted strictly as opinions representative of their individual perspectives.

Quantitative Data

All quantitative data in this report were obtained from the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH). BHDDH facilitates the delivery of safe and accessible health-care services for individuals with differing intellectual/developmental abilities, mental health or substance use disorders, or who are in the care of facilities administered by BHDDH.[1] Under BHDDH, the Licensing Office processes licenses for organizations that provide behavioral healthcare services, services for persons with intellectual/developmental disabilities, and services for persons with cognitive disabilities. The BHDDH licensure period is for two years.[2]

Data provided by BHDDH are drawn from several sources. BHDDH-licensed providers are required to enter data on all clients receiving services into the Rhode Island Behavioral Health On-line Data (RI-BHOLD) system. Treatment data found in RI-BHOLD generally follow the guidelines of the Substance Abuse and Mental Health Services Administration (SAMHSA).[3] Client race, ethnicity, and language data are drawn from RI-BHOLD. Staff and supervisor race and ethnicity data are drawn from the BHDDH human resources database.

Limitations

Sample Size

Because we draw from a relatively small number of stakeholder interviews, our sample is not meant to

1 About BHDDH. (2022). State of Rhode Island Department of Behavioral Healthcare, Disabilities and Hospitals (BHDDH). https://bhddh.ri.gov/about-us.

2 Licensing. (2021). State of Rhode Island Department of Behavioral Healthcare, Disabilities and Hospitals (BHDDH). https://bhddh.ri.gov/developmentaldisabilities/provider/licensing/index.php.

3 Research, Data Evaluation, And Compliance Unit. (2022). State of Rhode Island Department of Behavioral Healthcare, Disabilities and Hospitals (BHDDH). https://bhddh.ri.gov/about-us/research-data-evaluation-and-compliance-unit.

be generalized to the entire RI provider pool. Instead, this report is intended to capture a snapshot of firsthand perspectives from behavioral health workers, bridging the gap between existing research and lived experience. Future reports should seek to build on this model by interviewing more stakeholders, particularly those from underrepresented cultural backgrounds and from a range of occupations.

Lastly, future reports should ideally aim to include interviewees from the RI state government to discuss their outlook on the options available for policy reform and regulation, as well as their feasibility.

Quantitative Data (Scope and Availability)

RI-BHOLD data do not capture the languages of clients and only reach back to 2018. Furthermore, responses to the OEI could not be matched with respondent race, ethnicity, and language. We were also unable to find race, ethnicity, or language benchmarks to which we could compare the demographic breakdowns of staff and clients at BHDDH-licensed facilities.

Our quantitative comparisons were also limited by the fact that few measures exist which we can use to gauge the association between treatment quality or treatment length and patient-provider matches in race, ethnicity, and primary language. Specifically, we were interested in exploring (but were unable to quantify) the following metrics, which we strongly recommend for inclusion in future data collection efforts:

- Patient attrition rates and average length of treatment in behavioral health care settings stratified by race, ethnicity, and English language proficiency
- Continuation rates of clients (i.e., whether they are willing to stay after an initial visit or consultation) stratified by race, ethnicity, and English language proficiency
- Facility-specific provider and client demographic breakdowns (from CMHCs, specific hospitals, etc.)
- Specific CLAS-related training requirements by facility

Appendices

Appendix A: Rhode Island Licensing and Renewal Requirements

We manually curated this information by reading the publicly available Rhode Island Code of Regulations (RICR), looking specifically for mention of requirements relevant to CLAS and the topics discussed in this report. This table is an annotated, abbreviated summary of our findings and is not meant to reflect the totality of formal requirements for each profession cited here.

Psychologists (See 216-RICR-40-05-15):

Title	*License Issuer*	*License Requirements*	*Continuing Education Requirements*
Licensed Psychologist	Board of Psychology within Rhode Island Department of Health (RIDOH)	(i) Doctorate degree (PhD or PsyD) [15.5.1] • Program must be accredited by the APA or meet equivalency requirements set by the Board • Equivalency requirements: requires at least 3 credit hours in "social bases of behavior (e.g., group process, multiculturalism…)," but does not have any requirements specifically related to cultural/linguistic competency (ii) 2 years of supervised experience/internship [15.6.1] • No mention of any requirements related to cultural/linguistic competency (iii) Pass a Board-approved examination [15.8.1] OR receive a temporary permit [15.8.2] OR receive licensure by endorsement in accordance with the provisions set forth in R.I. Gen. Laws § 5-44-11.	Need to renew license every other year To do so, need to complete at least 24 credits of approved continuing education courses "relevant to psychology" [15.9] • Approval can be from many different professional organizations, including APA or RI Medical Society • No specific requirements for the content of CE classes they need to take

Social Workers (See 216-RICR-40-05-7):

Title	*License Issuer*	*License Requirements*	*Continuing Education Requirements*
Licensed Clinical Social Worker (LCSW)	Board of Social Work Examiners within RIDOH	(i) A master's or doctorate degree in clinical social work accredited by the national Council on Social Work Education [7.4.2] (ii) Pass a Board-approved examination OR receive special Board endorsement [7.4.4]	Need to renew license every other year To do so, need to complete at least 30 hours of continuing social work education" [7.4.5] • At least 22 of the hours need to be "contact hours": "hours acquired through attendance or participation at programs that provide for direct interaction between faculty and participants and may include symposia, live teleconferences, or workshops" • "A minimum of 3 contact hours shall be in the area of cross-cultural practice to include the alleviation of oppression"
Licensed Independent Clinical Social Worker (LICSW)	Board of Social Work Examiners within RIDOH	(i) Be a LCSW (see above) (ii) 2 years of board-approved experience as a LCSW (iii) Completion of the CE requirement for the LCSW (iv) Pass Board-approved examination	See LCSW requirements

Counselors/Therapists (See 216-RICR-40-05-11)			
Title	License Issuer	License Requirements	Continuing Education Requirements
Licensed Mental Health Counselor (LMHC)	Board of Mental Health Counselors and Marriage and Family Therapists, within RIDOH	(i) At least a master's degree from a program accredited by Council for Accreditation of Counseling and Related Educational Programs (CACREP) or any other graduate program that meets the "core curriculum" requirements outlined in [11.5.1] Part of the core curriculum states that at least 3 out of the 30 total credits must be in "social and cultural foundations (i.e., multicultural and pluralistic trends including characteristics and concerns of diverse groups; attitudes and behavior based on such factors as age, race, religious preference…)" (ii) Board-approved educational practicum or internship (completed during above education) (see 11.3.1.2) (iii) Board-approved post-grad field experience/case work (iv) Pass board-approved exam (typically the National Clinical Mental Health Counselor Examination of the National Board of Certified Counselors)	Need to renew license every other year To do so, need at least 40 approved credits of "continuing education relevant to the practice of clinical mental health counseling" • Courses can be approved by many different professional organizations, including the APA, AMA, etc. (see 11.3.8.B) • At least 20 credits must be formal continuing ed programs (e.g., online workshops, grad course, etc.) while the other 20 can from research publications • No specific requirements for what CE classes they need to take
Licensed Marriage and Family Therapist (LMFT)	Board of Mental Health Counselors and Marriage and Family Therapists, within RIDOH	(i) At least a master's degree from an educational program that meets the "core curriculum" requirements outlined in [11.5.2] • No requirement specifically on cultural/linguistic competency, although it is broadly stated that Area II and III classes (6 classes and 1 class required, respectively) "will expose all students to issues of ethnicity, race, socioeconomic status and culture as they relate to marriage and family therapy and practice" (ii) Board-approved educational practicum or internship (completed during above education) (see 11.3.2.2) (iii) Board-approved post-grad field e xperience/case work (iv) Pass Board-approved exam (typically the Association of Marital and Family Therapy Regulatory Boards)	See LMHC requirements above

Appendix B: Sample Questions from Interviews

A set of baseline questions was asked to all interviewees. These included questions such as:

1. What does culturally and linguistically appropriate care mean to you, and what role do you see it playing in effective behavioral healthcare?
2. Have you received any training specifically for culturally and linguistically appropriate care?
3. Are there any questions that we haven't asked that you think we should be asking?

We also tailored questions to the role of a given interviewee depending on whether they were organizational leaders in behavioral healthcare settings or providers in public or private practices. Examples of occupation-specific questions are included below.

Leaders

1. Are you familiar with the national culturally and linguistically appropriate services (CLAS) standards?
    a. What policies are [your organization] implementing to uphold the CLAS standards?
    b. How do you evaluate the effectiveness of these policies (e.g., CAHPS surveys[1], C-CAT survey)[2]?
2. How does [your organization] engage/partner with the community to evaluate community health assets and needs?
3. How confident are you that someone (an immigrant, someone who doesn't speak English very well) looking for behavioral health care would find culturally and linguistically appropriate services at your organization?
4. How does [your organization] go about employing interpreters? Are they expensive or difficult to find?

Providers

1. What has been your biggest challenge in providing culturally appropriate care?
2. How often have you worked with an interpreter? Is it easy to get access to one if you need to?
3. What has been your biggest challenge in providing culturally appropriate care?
4. Are you aware of any policies [your organization/system] implements to ensure that patients are receiving culturally and linguistically appropriate care?

We largely sought to make each interview a flexible, intermittently guided discussion. Our follow-up inquiries were frequently spontaneous and derived from the unique lived experiences of the individuals who were generous enough to share their perspectives with us.

1 CAHPS Mental Health Care Surveys. Content last reviewed May 2022. Agency for Healthcare Research and Quality, Rockville, MD. https://www.ahrq.gov/cahps/surveys-guidance/echo/index.html.

2 C-CAT Surveys. University of Colorado Anschutz Medical Campus, Center for Bioethics and Humanities. https://www.cuanschutz.edu/centers/bioethicshumanities/research/c-cat/c-cat-surveys

Appendix C: Client-Facing Staff Positions at BHDDH-Licensed Facilities

Client-Care Staff Position	Explanation of Position
Licensed Chemical Dependency Professional (LCDP)	LCDPs are certified by the Rhode Island Certification Board (RICB) after applying to the Rhode Island Department of Health (RIDOH). This licensure requires the fulfillment of minimum education requirements, supervised experience, and passing of standardized exams. LCDP certifications include Provisional Alcohol and Drug Counselor (PADC), Certified Alcohol and Drug Counselor (CADC), and Certified Advanced Alcohol and Drug Counselor (CAADC).[3]
Master's Level and Above	This categorization includes all staff members who have obtained a master's degree or higher, including those who hold doctorate degrees.
Non-Master's Case Manager	Case managers monitor and assist clients throughout their overall treatment course. This may include facilitating access to medical or educational services, coordinating care, and monitoring progress.[4]
Nurse	This position category encompasses any type of nurse who does not hold a master's degree or above. This may include a medical nurse, psychiatric nurse, or others.
Peer	Peers are staff members who have lived experience with a mental illness, substance use disorder, or both. Peer recovery specialists may be certified or uncertified; this categorization includes both. Peers aid individuals in treatment and recovery by serving as positive role models and developing wellness plans.[5]
Residential Worker	These staff members work in residential care facilities with individuals in treatment for a mental illness, substance use disorder, or co-occurring illnesses. Residential workers often proceed to become case managers and may later work as part of integrated health teams.

Appendix D: Methods for Computing Averages

Several figures throughout the report display an average percentage taken across multiple years. For the metrics in question, these averages were determined by first computing each year's respective percentage, and then averaging these values. For example, in Fig. **2.1**, the 2018-2020 average percentage of client-facing staff identifying with each racial/ethnic category was computed by (1) finding the yearly values of this percentage, and then (2) averaging these three values.

3 Chemical Dependency Profession. (2021). State of Rhode Island Department of Health. https://health.ri.gov/licenses/detail.php?id=282

4 Targeted Case Management: Case Management Defined. (2021). State of Rhode Island Executive Office of Health and Human Services. https://eohhs.ri.gov/ProvidersPartners/ProviderManualsGuidelines/MedicaidProviderManual/RehabilitativeService/TargetedCaseManagement.aspx

5 Peers are staff members who have lived experience with a mental illness, substance use disorder, or both. Peer recovery specialists may be certified or uncertified; this categorization includes both. Peers aid individuals in treatment and recovery by serving as positive role models and developing wellness plans.

Appendix E: BHDDH-Licensed Facilities

Facility Type	Explanation of Services
General MH Outpatient	According to BHDDH, "General MH Outpatient" refers to outpatient services delivered by BHDDH-licensed facilities (such as Community Mental Health Centers), typically for low-acuity mental health conditions. More information can be found in 212-RICR-10-10-1.6.7 under "General Outpatient Programs (GOP)", available publicly on the website of the Rhode Island Department of State.
Outpatient Community Support Program	According to BHDDH, outpatient community support programs deliver services to individuals with serious and persistent mental illnesses (and other higher-acuity mental health conditions) that demand more support than general outpatient services. Offered in Rhode Island's six Community Mental Health Centers (CMHCs), these services include office visits, care coordination, and aid with daily living activities (e.g., grocery shopping).
Mental Health Psychiatric Rehabilitative Residence (MHPRR)	According to the Rhode Island Code of Regulations, a MHPRR "is a congregate licensed residential program with no more than sixteen (16) beds which provides twenty-four (24) hour staffing. This population includes individuals with refractory psychosis; dual diagnosis (individuals with developmental disabilities and mental health issues); addiction and mental health issues (co-occurring disorders), who cannot be treated in the community through outpatient supports." MHPRRs may be supervised apartments or group homes. More information regarding MHPRRs can be found in 212-RICR-10-10-1.6.12, available publicly on the website of the Rhode Island Department of State.
Acute Stabilization Unit/Crisis Stabilization Unit (ASU/CSU)	According to BHDDH, ASU and CSU can be used interchangeably. RI EOHHS defines these facilities as hospital diversion and step-down units for Rhode Island residents aged 18 and older who are experiencing a psychiatric or substance abuse-related crisis.[1] Services dispensed at an ASU/CSU include 24-hour crisis services, psychiatry services, medication services, and discharge planning. More information regarding ASU/CSU can be found in 212-RICR-10-10-1.6.12 under "Behavioral Health Stabilization Unit," available publicly on the website of the Rhode Island Department of State.
Substance Use Disorder Intensive Outpatient Program (SUD IOP)	BHDDH defines SUD IOPs as programs providing nine or more hours of structured counseling per week for SUD. More information regarding IOPs in general can be found in 212-RICR-10-10-1.6.7, available publicly on the website of the Rhode Island Department of State.
Substance Use Disorder Residential (SUD Residential)	According to 212-RICR-10-10-1.3.1, residential services "means a type of service providing twenty-four (24) hour care, treatment, and support in a setting other than a hospital." More information specifically regarding SUD Residential programs can be found in 212-RICR-10-10-1.6.12.

Appendix F: Notes on the Outcome Evaluation Instrument (OEI)

Purpose

The Rhode Island Outcome Evaluation Instrument (OEI) is being administered as part of the BHDDH outcome initiative, which operates with the goal of shifting the emphasis of mental health service provision from process to outcome. The OEI is administered to both staff and clients, and asks clients questions about their life situation, use of services, satisfaction with services, and treatment outcomes.

1 Behavioral Health Acute Stabilization Unit. (n.d.) Rhode Island Executive Office of Health and Human Services. (https://www.google.com/url?q=https://eohhs.ri.gov/sites/g/files/xkgbur226/files/Portals/0/Uploads/Documents/bhasu.PDF&sa=D&source=editors&ust=1622600663291000&usg=AOvVaw2zrOVqnzNQtN-1zlb3WgoLx

Administration

Importantly, the OEI is only administered to clients at Integrated Health Home (IHH) and the Assertive Community Treatment (ACT) programs. Thus, the responses presented here are not representative of the state's entire behavioral health patient population. Clients have the option to refuse to take the survey when offered it.

Structure

The survey administered to clients has 41 questions. Of these, 4 are meant to establish client background (e.g., duration of time receiving services, self-description of health, etc.) and 37 are Likert scale questions that are meant to elicit responses which assess, per the BHDDH manual, "the effectiveness, acceptability, and accessibility of services."

Mental Health Association of Rhode Island
Brown Initiative for Policy