

**DEPARTMENT OF HEALTH AND HUMAN SERVICES  
ADVISORY COMMITTEE ON MINORITY HEALTH (ACMH)**

**Bethesda, MD  
June 20-21, 2016**

**Committee Attendees**

Roderick K. King, MD, MPH, FAAP (Chair)  
Arthur Chen, MD  
B. Ashleigh Guadagnolo, MD, MPH  
Paul Juarez, PhD  
Beverly L. Malone, PhD, RN, FAAN  
Cynthia Mojica, PhD, MPH  
Sela V. Panapasa, PhD  
Rea Pañares, MHS  
Roland J. Thorpe, Jr., PhD

**Federal Staff**

J. Nadine Gracia, MD, MSCE, Deputy Assistant Secretary for Minority Health, U.S. Department of Health and Human Services  
Minh Wendt, PhD, Public Health Advisor, Division of Policy and Data, Office of Minority Health, U.S. Department of Health and Human Services (Designated Federal Officer, ACMH)  
Alexis Bakos, PhD, MPH, RN, Senior Advisor to the Deputy Assistant Secretary for Minority Health, and Acting Director, Division of Policy and Data, Office of Minority Health, U.S. Department of Health and Human Services (Alternate Designated Federal Officer, ACMH)

**Invited Presenters**

James Bell, JD, Founder and Executive Director, W. Haywood Burns Institute  
Arnold Chandler, MS, Co-Founder, Forward Change  
Tahira Cunningham, MBA, Program Officer, California Executives Alliance/Sierra Health Foundation  
Joel Fein, MD, MPH, Professor of Pediatrics and Emergency Medicine, Perelman School of Medicine, University of Pennsylvania; Director, Advocacy and Health Policy, Division of Emergency Medicine, The Children's Hospital of Philadelphia  
Larke Nahme Huang, PhD, Director, Office of Behavioral Health Equity, Administrator's Office of Policy Planning and Innovation, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services  
Kenneth D. Johnson, JD, Section Chief, Office for Civil Rights, U.S. Department of Health and Human Services  
Joan Muir, PhD, Executive Director, Brief Strategic Family Therapy® Institute, University of Miami, Miller School of Medicine  
Kevin Mwata Washington, PhD, Assistant Professor of Counseling Psychology, Howard University; National President, Association of Black Psychologists

## **DAY ONE – Monday, June 20, 2016**

### **Call to Order**

- Roderick K. King, MD, MPH, Chair

Dr. King called the meeting to order, welcomed Committee members and staff, and reviewed the agenda for the meeting.

### **OMH Welcome and Updates**

- J. Nadine Gracia, MD, MSCE, Deputy Assistant Secretary for Minority Health and Director, Office of Minority Health, U.S. Department of Health and Human Services

Dr. Gracia provided an update on activities related to strategic priorities and key initiatives of the Office of Minority Health (OMH). Key points were as follows:

- National Minority Health Month (April 2016): HHS hosted a Health Equity Forum to commemorate the thirtieth anniversary of the establishment of OMH during National Minority Health Month in April. Stakeholders across the country attended in person and online. Messages from the Acting Assistant Secretary for Health and the Surgeon General emphasized the importance of health equity and the need to address the social determinants of health (SDOH). The White House Cabinet Secretary and Assistant to the President, the Secretary of Education, the Assistant Attorney General, and Dr. Gracia participated in a panel discussion regarding the role of the education and justice sectors in promoting health and well-being in communities of color and highlighted the progress of President Obama's My Brother's Keeper Initiative. The Cabinet Secretary read a message from the President to commemorate National Minority Health Month.
- Affordable Care Act: OMH is working with partners to support the implementation of the Affordable Care Act, with a focus on increasing enrollment of racial and ethnic minorities in the health insurance marketplace. In 2015, OMH partners assisted more than 280,000 individuals through on-the-ground activities, and social media and traditional media. Those efforts will continue when open enrollment begins in the fall.
- HHS Disparities Action Plan: OMH is engaged in ongoing work to promote the adoption and implementation of the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (National CLAS Standards). Activities include:
  - A series of webinars to raise awareness and promote adoption of the National CLAS Standards among new partners and stakeholders. The first webinar in March presented the fundamentals of the National CLAS Standards and was attended by participants across the country. The second webinar on June 30 will focus on implementation of the standards, with speakers from an integrated health care system, an academic medical center, and a public health department.
  - The first-ever *Compendium of State-Sponsored National CLAS Standards Implementation Activities* was published in May 2016.
  - A new, interactive map on the Think Cultural Health website to track adoption and implementation of CLAS (<https://www.ThinkCulturalHealth.hhs.gov>).
- National Partnership for Action to End Health Disparities (NPA): Highlights of activities conducted by NPA implementation partners in the past year included:

- Federal Interagency Health Equity Team (FIHET): The FIHET conducted a health equity mapping exercise that helped six federal agencies in different sectors infuse a health equity lens into their mission, programs, and policies. Participating agencies presented the results of this activity at monthly FIHET meetings.
- Regional Health Equity Councils (RHECs): The Southeast RHEC launched a healthy food financing initiative through a partnership with UpLift Solutions. The initiative provides access to capital for small grocery stores and meets the need for healthy, affordable food in underserved communities across the region.
- National Partners: The Association of State and Territorial Health Officers (ASTHO) issued a Presidential Challenge for 2015-2016 of advancing health equity and optimal health for all. OMH assisted ASTHO with strategic mapping to support that process and develop a health equity framework for years to come.
- Hepatitis B and C: The World Health Organization has been moving toward goals to eliminate viral hepatitis. OMH and the Centers for Disease Control and Prevention (CDC) commissioned the National Academy of Science (NAS) to study the feasibility of establishing elimination goals for Hepatitis B and Hepatitis C virus in the U.S. Phase 1 of the study and concluded that setting elimination goals is feasible; the report was released in April. Phase 2 was recently launched and will develop recommended targets. At the kick-off meeting for Phase 2, Dr. Gracia discussed disparities in hepatitis B and C viral infections and emphasized the need to address the SDOH.
- Opioid crisis: OMH is supporting the Surgeon General's new Turn the Tide Rx campaign to address the opioid crisis in the U.S. The Surgeon General and Dr. Gracia will convene Grand Rounds co-hosted by Meharry Medical College and Vanderbilt University regarding the role that providers can play to end the epidemic. Dr. Gracia will emphasize the importance of addressing the needs of communities that are impacted.
- Public health crises:
  - Flint water crisis: OMH has been actively involved in the federal response to this crisis, and Dr. Gracia and OMH staff have been in Flint to support the federal response efforts. Activities include working with stakeholders to understand and meet the diverse needs of communities that are impacted, including African Americans, Arab Americans, Hispanic/Latinos, deaf and hard of hearing, and others. They are helping with ongoing outreach, especially related to the Medicaid expansion. This work further highlights the importance of the CLAS.
  - Zika virus: OMH is engaged in the federal response to Zika. In particular, OMH is creating bilingual (English/Spanish) materials, conducting bilingual outreach and education, and ensuring that multilingual resources are available on the OMH website. OMH is reaching out to stakeholders, such as its Promotores de Salud Steering Committee and others, to raise awareness of and provide education on Zika.
- My Brother's Keeper (MBK): The initiative marked its two-year anniversary this year and has seen a surge of interest. Nearly 250 communities across the country have accepted the MBK Community Challenge, and the private sector has provided nearly \$1 million to support the MBK goals. A fact sheet highlighting the accomplishments was included in the meeting materials. In the two-year MBK progress report, the Minority Youth Violence Prevention Program, a joint OMH and Department of Justice (DOJ) grant program that uses a public health framework to address youth violence, was featured as *Impact in*

*Action*, highlighting one of the grantees in Savannah, Georgia. The grantee's comprehensive approach to reduce gang violence resulted in a 50 percent decline in truancy rates.

- Re-entry: To address re-entry policy, OMH developed a resources page on its website to raise awareness of the health needs of individuals who are formerly incarcerated and are returning to the community. OMH has also commissioned NAS Committee on National Statistics to convene a workshop to identify measures to assess criminal justice involvement as social determinant of health and indicator for health status in population-based health data collections.

### Discussion

- Dr. Guadagnolo expressed appreciation for research on the use of the National CLAS Standards.
- Dr. Chen appreciated the emphasis on implementation of CLAS. He noted that there is a great deal of variability in attempts to provide culturally appropriate services. The National CLAS Standards clearly describe how to provide and measure the effectiveness of those services.
- Dr. King asked if Dr. Gracia saw a clear role for OMH regarding the impact of the opioid epidemic on minority populations.
  - Dr. Gracia said OMH was working side-by-side with the Office of the Surgeon General to identify and conduct outreach to specific communities that are most impacted. They are also looking at disparities in pain management in communities of color. The meeting in Nashville would look at equity as well as prevention.
- Dr. Juarez stated that the link between hepatitis and the opioid crisis was emerging as a critical issue, especially with regard to IV drug use. The discussion should be broadened to include that linkage, as well as the resurgence of HIV with shared needles.
  - Dr. Gracia replied that the link between hepatitis C and opioid use was raised at the White House Briefing on Responding to Viral Hepatitis during Hepatitis Awareness Month in May, as well as co-infection with HIV. OMH partners with the Office of HIV/AIDS and Infectious Disease Policy on the National HIV/AIDS Strategy; they are addressing co-infection with hepatitis C and how that overlaps with the opioid crisis.
- Dr. Thorpe emphasized that racism and immigration are two key SDOH that are rarely discussed in research. He was not aware of any federal dataset that includes racism. The Behavioral Risk Factor Surveillance System (BRFSS) has an optional module, and states are not required to include it. The National Survey of American Life (NSAL) only includes African American men, Afro-Caribbean men, and White men. If researchers are not willing to have meaningful conversations about those issues, there will not be much progress on health equity.
  - Dr. King agreed that it was important to address those issues. He urged the Committee to consider this meeting as the beginning of a discussion.
  - Dr. Panapasa suggested that some consideration should be made to include measures related to racism in the national public health surveys. The NSAL and small community surveys have validated measures.
- Dr. Panapasa commended OMH for its leadership in the Flint water crisis, and she noted that the University of Michigan was involved at all levels. She asked if OMH was looking

at how to expand its partnerships for implementation of the National CLAS Standards to include other racial and ethnic communities that might not be benefitting from that work. She stated that the compendium of state programs would be a valuable resource for disseminating best practices and helping communities build on programs in other states. She appreciated the efforts OMH was making to ensure that population health measures are inclusive as well as the attention it was placing on achieving health equity.

- Dr. Gracia noted that the development of the enhanced National CLAS Standards included an investment in implementation, evaluation, and research. OMH recognizes that this is a critical time to advance the National CLAS Standards, and they are using many levers to focus on policy, programs, research, education/training, and data. Examples of projects include:
  - OMH is evaluating a subset of health and health care organizations that are adopting and implementing the National CLAS Standards. In-depth reviews of those organizations will serve as examples of promising practices.
  - Through an interagency agreement with CDC, OMH is including questions related to the National CLAS Standards in the National Health Interview Survey (NHIS) and in the National Ambulatory Medical Care Survey (NAMCS) to assess provider awareness and implementation of CLAS.
  - OMH is also pursuing the integration of CLAS into the research agenda of specific HHS agencies.

### **A Life Course Framework for Improving the Lives of Boys and Men of Color**

- Arnold Chandler, MS, Co-Founder, Forward Change

Mr. Chandler articulated the case for focusing on boys and men of color (BMOC) and described a holistic life course framework to improve the lives of disadvantaged populations. He began with the following comments about gender disparities:

- Girls are doing better than boys, but that does not mean they are doing well. Girls are treading water, while boys are drowning.
- The lives of males and females are inextricably intertwined.
- Disadvantage operates intergenerationally, in a gender-specific way.

Key points of the presentation were as follows:

- The rationale for focusing on BMOC is supported by:
  - Gross disparities in particular negative outcomes, such as violence (victimization and offending), crime, and incarceration;
  - Negative or stagnant trends in key opportunity outcomes relative to females, including employment and earnings, high school graduation, and college enrollment and completion; and
  - A vicious cycle of intergenerational male disadvantage.
- Employment and earnings among BMOC have declined due to demand-side shifts and mass incarceration, with significant gaps among those who do not attend college.
  - Demand-side shifts include technological change, suburbanization of low-skilled jobs, and legal discrimination against felons.
  - Imprisonment increased by 430 percent between 1973 and 2010. Felony conviction and/or imprisonment reduce lifetime earnings and employment by 10 to 30

percent. The risk of incarceration is three times higher for males who do not complete high school or receive a GED.

- Single-parent families have increased in Black communities due to the decline in “working class” families and the class divide in family formation; the decline of “marriageable males” and imbalanced ratios of men to women; and reduced male parental involvement following incarceration.
- Family disadvantage has gender-specific effects on educational attainment and income.
  - Boys who grow up in a single-parent family are less likely than girls to attend college and more likely to exhibit behavior problems and/or juvenile delinquency.
  - Behavioral and academic outcomes between boys and girls begin to diverge in kindergarten.
  - Boys raised in single-parent families work less than girls as adults.
- Concentrated poverty and jobless ghettos have increased since the early 1970s, coinciding with the onset of the war on drugs and mass incarceration. High-poverty neighborhoods are increasingly hostile to formation of families that are supportive of children.
- Education attainment among males has stagnated. The persistent gap in high school graduation rates between girls and boys of color has not changed, despite increasing rates of graduation overall.
- The combination of declining employment and earnings, the growth of single-parent families, stagnant education attainment, and mass incarceration creates a vicious cycle. This cycle is intergenerational because education attainment shapes the employment prospects of the next generation.

The life course framework is a holistic approach to interrupt the cycle and improve the lives of disadvantaged populations. It has three components:

- Dimensions of human development (e.g., physical health, cognitive development, mental health, socio-emotional skills):
  - There is increasing evidence of the impact of early exposure to toxic stress and trauma.
  - Different aspects of who we are become important at different times.
- Life course outcomes (e.g., school readiness, high school graduation, incarceration, stable full-time employment, homelessness):
  - Risk factors and protective factors impact whether an individual is “on track” or “off track” in each dimension of human development.
  - The life course model includes “on track” and “off track” indicators for each age range (0-5, 6-11, 12-18, 19-25, 26-35) that reflect factors that are most predictive of long-term outcomes (e.g., birth weight, attachment, school readiness, proficiency in fourth grade math, reading, and socio-emotional skills, etc.).
- Ecological and contextual factors that shape human development and life course outcomes (e.g., family, neighborhoods, schools, public systems):
  - Social determinants of health give rise to the health determinants of social outcomes.

The life course framework reflects several key concepts:

- Earlier life outcomes affect later ones.

- Interventions are needed across the life course. Early intervention is necessary, but not sufficient.
- There are “sensitive” developmental periods for intervention.
- Everything is related to everything else (“causal density”); siloed approaches are ineffective.

The life course framework adopts a two-generation approach, recognizing that the life courses of parents and children are linked, and interventions that target a parent have early life course implications for the next generation.

Key takeaway messages for the Committee’s consideration:

- Change conditions and remove barriers confronting BMOC through policy and systems changes.
- Help children become more resilient to bad conditions by applying programs, services, and practices that are proven to work for BMOC.

### **Questions and Answers**

- Dr. Juarez thanked Mr. Chandler for demonstrating the complexity of the issues, taking a lifespan approach, and focusing on the impact of transgenerational exposures. He noted that it is important to develop a common language across disciplines and look at multilevel interventions.
- Dr. Mojica asked if Mr. Chandler had a list of effective dual-generation interventions.
  - Mr. Chandler stated that he was compiling a list of interventions. He noted that dual-generation interventions are most often found in early childhood programs, and the most effective models provide a full array of services, including legal services. Most dual-generation interventions are at the local level, although the approach is becoming a theme of policy reform. Examples include giving fathers credit toward child support arrears for spending time with their children or for attending co-parenting mediation with the mother of their children.
- Dr. Panapasa appreciated Mr. Chandler’s holistic approach to a complex issue. She asked whether he looked at the impact of factors on premature mortality, the impact of health on social outcomes, and the role of caregivers.
  - Mr. Chandler replied that those issues are addressed in the section on ecological factors. Time constraints prevented him from discussing them during this presentation.

### **Incarceration and Health**

- James Bell, JD, Founder and Executive Director, W. Haywood Burns Institute (by videoconference)

Mr. Bell discussed the intersection of the SDOH and the administration of justice for communities of color. Key points of his presentation were as follows:

- Expenditures for incarceration tripled between 1971 and today. Nearly nine million individuals are currently under supervision or parole. Administration of justice consumes 40 to 60 percent of county budgets. National recidivism rates of more than 60 percent underscore the need to rethink what we are doing to achieve safety.

- Demographics across the country are shifting toward people of color, and the general population is becoming younger.
- Society has an obligation to provide support so that young people can reach their full potential, regardless of skin color, gender, religion, sexual orientation, income, or ability. The intersection of youth, crime, and race is a powerful place where society often acts from fear.
- The W. Haywood Burns Institute has worked with more than 140 counties across the country to establish an equitable, humane approach for youth and adults in trouble with the law. It promotes a system of positive interventions and consequences that maintains public safety and encourages school participation and healthy habits.
- Fear-based policies in many communities have criminalized age-appropriate behaviors of risk taking and challenging limits. This promotes a racialized conceptualization that subordinates and criminalizes youth of color on a de facto presumption of impulsivity and violence. A 2014 study found that police officers saw Black boys as less childlike, older, and more culpable than their White peers.
- False perceptions that young people of color are inherently more dangerous and require a firmer hand than White youth trick the public into demanding justice in the form of custody. That response is fed by an addiction to incarceration as a primary tool of social control. Professionals compound the problem by referring young boys to the justice system for social problems, when they are not a danger to public safety.
- The justice system is not a cohesive entity. It consists of autonomous agencies that have no accountability to each other and no central locus of authority.
- Placing youth in secure confinement does not reduce harm. Detention has a negative impact on physical and mental well-being and life outcomes, it does not work as a deterrent, and it is not an effective conduit to services.
- When faced with a mental or conduct disorder, White youth are referred to treatment, while youth of color are referred to the justice system. Differential treatment also occurs in the realm of physical health.
- “Trauma-informed” care is the new buzzword. Institutions are learning about trauma, but they are not changing their practices.
- The notion of “benign detention” is misguided. The primary interest of the justice system is public safety, not the best interest of the child. True public safety consists of applying a strengths-based approach to address the needs of children.
- There are two conflicting approaches to achieve public safety. The prevailing, deficit-based approach uses custody, control, and suppression. The alternative, mastery-based approach begins with a concept of well-being and uses a range of positive interventions and services that allow youth to make autonomous decisions.
- Systems should be transformative, not merely transactional. Communities need an alternative vision of what will keep them safe. We must stop the mere processing of young people that creates a treadmill between the courts and the streets, and push back against mandates for justice that are not therapeutic.

### Questions and Answers

- Dr. Malone asked how Mr. Bell would distinguish “suppression” from “oppression.”
  - Mr. Bell replied that “suppression” refers to the training in tools of control that most justice officers receive. “Oppression” is a philosophy.



- Dr. Juarez noted that Memphis is under a federal consent decree for disproportionate arrest of African American males. A major cause for juvenile arrest is domestic violence, but no other tools or interventions are available. He asked if different options were available in other communities.
  - Mr. Bell noted that he would be working with Shelby County to address the situation. He reiterated that a justice solution to a social problem, such as putting a child in detention, does not resolve the social problem. Communities such as Pima County, Arizona, and Multnomah County, Oregon, created domestic violence centers that offer an array of services to the family. Rather than criminalizing the problem, law enforcement is responsible for ensuring that no further violence occurs and services are delivered. Unfortunately, most of the funding is allocated to the justice system. When a situation is defined as a crime, other systems no longer have jurisdiction. Some communities have specialty courts (e.g., drug courts, women’s court), which increase racial and ethnic disparities.
- Dr. Panapasa called attention to the lack of data regarding Native Hawaiian and Pacific Islander (NHPI) populations in this area. She expressed concern that a community in California sent staff to Tonga to learn about cultural factors, rather than consulting with the local Tongan community. She asked if it would be helpful to have interventions that address structural barriers and law enforcement that reflects communities of color.
  - Mr. Bell replied that bringing diversity to an organization with a toxic culture without changing the mission of that organization results in culturally competent oppression. He noted that Hawaii infused the “Aloha spirit” into the juvenile justice system, which had a significant positive impact.
- Dr. Chen requested examples of effective approaches for mission change.
  - Mr. Bell replied that organizations have begun to gather data and base decisions upon the data; some justice systems partner with organizations that provide treatment; and judges in some jurisdictions are beginning to share power and engage community organizations. Positive changes have been made in Santa Cruz, California; Pierce County, Washington; Lucas County, Ohio; Indianapolis, Indiana; and Cook County, Illinois. Mr. Bell expressed concern that judges in treatment courts dictate the type and duration of therapy to physicians and therapists.
- Dr. Mojica asked if there were any coordinated efforts to highlight this issue and change public perception.
  - Mr. Bell stated that it would require the public to recognize and question the disparate nature of law enforcement. Once people are educated at the local level, they begin to make the types of changes that give prosecutors more flexibility. Positive responses have occurred in isolated locations. It is important to change the conversation about how we achieve public safety because we have 300 years of evidence that the existing system does not work. The justice system has disparate components that do not work together. As a result, it is difficult to reform the system in a unified, sustainable way.
- Dr. King stated that it is difficult to find providers to meet the mental health needs of young men of color before they end up in the juvenile justice system. He asked what recommendations the Committee could make to address that issue.

- Mr. Bell replied that justice is administered at the county level, but most innovation is funded at the federal level. DOJ and HHS should work together and use federal funds to create incentives for positive approaches. Collaboration would create momentum to change the mission.
- Mr. Chandler noted that data disaggregation is a major challenge. Mr. Bell agreed that there are many challenges related to criminal justice data.

## **Addressing Their Real Concerns: Mental Health Treatment and Family Dynamics for Black Men and Boys**

### Challenges and Resilience in African American Families

- Joan Muir, PhD, Executive Director, Brief Strategic Family Therapy® Institute, University of Miami, Miller School of Medicine

Key points of Dr. Muir's presentation were as follows:

- Families are systems that operate within larger, institutional systems. Systems resist change and are designed to maintain the status quo.
- People of African descent living in the U.S. and the Caribbean bear the legacy of legalized oppression.
  - Slavery entailed the loss of basic human rights, language, culture, and family of origin.
  - During the Jim Crow era, African Americans were exposed to legal injustice, violence, and restrictions of movement and travel.
  - Discrimination by race or sex was legal prior to the Civil Rights Act of 1964. State and local barriers to voting were legal prior to the Voting Rights Act of 1965.
- African American families face numerous challenges:
  - African American men have the highest rate of unemployment in the U.S.
  - African Americans are disproportionately involved in the criminal justice system and the child welfare system. The criminalization of African American males creates imbalance in families.
  - Stereotypes detract from the emotional and cognitive resources required for performance. Efforts to overcome stereotypes often confirm them. Negative stereotypes about Black fathers and the image of the strong, Black woman create burdens for African American families.
  - Challenges in family relationships include low marriage rates, high divorce rates, and single-parent households. Those patterns are related to the marginalization of the African American male.
  - Racism, racial oppression, and racial socialization impact parenting in African American families. Nurturing has been superseded by overprotection and rigid, punitive parenting, especially for African American males.
- African Americans have always found a way to survive and thrive. Spiritual strength and strong kinship and nonblood kinship bonds are important sources of resilience for African Americans. Those factors must be taken into account in any mental health intervention.
- Only 15 percent of the work that is being done in mental health in the U.S. is supported by federal funding. Additional funding would help practitioners develop evidence-based treatment approaches for BMOC.

## Effective Mental Health Interventions with Black Males: The Power of Ubuntu Psychotherapy

- Kevin Mwata Washington, PhD, Assistant Professor of Counseling Psychology, Howard University; National President, Association of Black Psychologists

Dr. Washington discussed mental health interventions for African American males that more directly address their challenges, including treatment modalities for cultural and historical trauma among Black males. Key points were as follows:

- African American males have important mental health needs, but they are less likely to seek or receive treatment.
  - Adult Blacks are 20 percent more likely to report serious psychological distress than adult Whites. Those living below poverty level are two to three times more likely to report serious psychological distress than those living above poverty level.
  - Adult Blacks are more likely to have feelings of sadness, hopelessness, and worthlessness than are adult Whites.
  - Black teenagers are less likely than Whites to die from suicide, but they are more likely to attempt suicide.
  - Less than 10 percent of African American and Hispanic adolescents make use of outpatient mental health services, and African Americans are less likely to receive outpatient and inpatient mental health treatment.
- Discrimination results in a sense of internalized inferiority that has a deleterious effect on African American men. Rage, anger, frustration, bitterness, resentment, grief, and despair over time place them at a disproportionately higher risk of mental health outcomes and stress-related health outcomes, such as heart disease and chronic diseases.
- A sense of self-mastery has been associated with positive outcomes for African American men, including life satisfaction, educational attainment, occupational status, and improved mental health and psychological well-being. Many systems undermine that sense.
- Prevention programs to improve the health of African American men should consider the social construction of manhood, empower young men to care for their health, and provide access to health care services. Middle-adulthood prevention should focus on the collective and individual impact of racism.
- Research evidence is only one component of evidence-based practice. Clinical expertise and patient values and preferences comprise two-thirds of the model. An exclusive focus on research evidence overlooks many effective interventions.
- It is important to look at the context in which a population is described. Can Western conceptualizations of trauma accurately describe the African experience of torture, rape, dehumanization, degradation, and despiritualization?
- A focus on challenges overlooks positive contributions. Black males do not have opportunities to see their ancestors elevated. Internalized oppression results in a devalued sense of self.
- The concept of continuous traumatic stress recognizes that a diagnosis of post-traumatic stress disorder (PTSD) is not relevant to people who experience trauma on a daily basis.
- Ubuntu psychotherapy is an African-centered model that is based on the Zulu concept of collective humanity. It reflects an understanding that all humanity is interrelated, and the actions of anyone in the community will impact everyone in the community. The paradigm incorporates the following principles:

- The value of the collective is the most salient element of existence.
- Communal self-knowledge is the key to total health.
- The spirit is the primary source of health, healing, and holism.
- Healing the spirit is healing the body.

## Questions and Answers

- Dr. Guadagnolo asked how the speakers’ concepts could be implemented when the justice system does not include a mental health infrastructure.
  - Dr. Muir replied that most therapeutic interventions are funded at the federal level. More support is needed for emerging interventions that are specifically tailored to African American males.
  - Dr. Washington stated that the conversation must address the core issues in ways that can be understood at multiple levels. Policy must look at the health markers that are residual expressions of racism and oppression, such as elevated cortisol levels. Support for grassroots programs is important to advance new treatment models.
- Dr. Juarez noted that county budgets are already overtaxed and asked if there are any community interventions that would not require new federal dollars.
  - Dr. Washington stated that the Association of Black Psychologists is promoting creative approaches, such as “Men’s Monday” informal conversations in barbershops. However, grassroots programs still need funding. The federal system must be held accountable for addressing problems that are the result of legalized, institutional racism.
  - Dr. Muir added that programs that receive federal funding gain visibility and are accountable for their outcomes. Funding to develop evidence-based treatment models for youths and families would cost less than 10 percent of what is allocated for juvenile justice.
- Ms. Pañares asked if there was an age at which an intervention to address the “internalized inferiority” described by Dr. Washington would be effective.
  - Dr. Washington stated that mental health programs must address identity, purpose, and direction, and they must talk about racism as a real issue that operates on both the individual and the collective level.
- Dr. Malone asked how interventions can link the “I” and the “we.”
  - Dr. Muir replied that mental health interventions focus on the “I,” but most African cultures focus on the “we.” Effective interventions help individuals strengthen their relationships with others.
  - Dr. Washington added that the African worldview and family therapy both acknowledge the communal context of identity. Programs must reflect the social and cultural reality of the population. He is working with the Alameda County African American steering committee for mental health to develop programming that incorporates identity, purpose, and direction, and examines the impact of racism on both the collective and individual level.
- Dr. Panapasa noted that the federal government is not the only source of funding for those programs; foundations provide important support. Accountability must apply to all sources of funding. She emphasized that researchers should recognize the wisdom and power of

the community and should value their contributions. She thanked the speakers for acknowledging the importance of the spiritual aspect of mental health.

### **Youth Violence and Trauma-Informed Care**

- Joel Fein, MD, MPH, Professor, Pediatrics and Emergency Medicine, Perelman School of Medicine, University of Pennsylvania; Director, Advocacy and Health Policy, Division of Emergency Medicine, The Children's Hospital of Philadelphia (CHOP)

Dr. Fein addressed violence and child development; the current state of trauma science; what trauma and violence mean for young boys of color; expanding the definition of adverse childhood experiences (ACEs); and applying trauma-informed care. Key points were as follows:

- The effects of violence over time escalate in stages. They can manifest as attachment problems as an infant to anxiety, PTSD, and somatic symptoms as a toddler, aggression and depression as a child, risk taking and unsafe relationships as an adolescent, and a lifestyle of violence as an adult.
- Positive stress is brief, infrequent, and of mild to moderate intensity (e.g., a child's first day of school). Most normative child stress leads to resiliency.
- There are two forms of stress:
  - Tolerable stress is a physiologic state that could potentially disrupt brain architecture, but it is buffered by supportive relationships that facilitate adaptive coping. It is time limited, so physiologic responses can return to baseline.
  - Toxic stress is excessive or prolonged activation of physiologic stress-response systems that disrupts brain architecture. It lowers the threshold for physiologic responses over the lifespan and increases risk for stress-related disease and cognitive impairment.
- Mediators such as environment, neurobiology, immunology, and epigenetics can determine whether ACEs result in toxic stress.
- Structural and functional changes in the brain disrupt balance. Activation of the amygdala can trigger fight, flight, or freeze responses.
- Stress increases cortisol, which suppresses immunity, increases inflammation, and reduces immunity to infection. Factors in the prenatal environment (e.g., maternal poverty, life stress, and community violence) can alter neonatal immunity.
- Parental stress affects cortisol receptors in offspring, and changes can persist over generations.
- Children who are exposed to violence and toxic stress are incapable of escaping and are more likely to get PTSD, and trauma has a greater impact on the developing brain. However, children's brains have more plasticity.
- The CHOP Emergency Department Behavioral Health Screen includes a safety screen for patients who have been assaulted. Responses that raise concerns lead to an in-depth assessment that may result in referral to the Violence Intervention Program.
- The Philadelphia ACE study was formed to develop and implement research, practice, and policies in urban pediatric settings based on the Kaiser ACE study. Responses to the household survey led the researchers to expand the list of ACEs to include witnessing violence, living in unsafe neighborhoods, experiencing racism, living in foster care, and experiencing bullying.

- The Philadelphia ACE study found that young Black males were eight times more likely to have lost someone to violence; buffers to trauma or stress may be absent; and violence and oppression led to cultural adaptations in masculinity and parenting. Systems issues included stressed neighborhood support agencies and unconscious bias in medical, legal, and education institutions. Behavioral health care was not available in the community, and Black males were unlikely to seek it due to cultural stigma.
- CHOP took steps to become a trauma-informed hospital, adopting an approach that avoids blame or shame. Clinicians are trained to identify the key stressors by asking, “What happened to you?” not, “What’s wrong with you?” or “What did you do?” They are also trained to identify acute stress symptoms and to be sensitive to triggers (e.g., facial cues/eye contact, body language/touching, verbal triggers).

### **Questions and Answers**

- Dr. Juarez expressed appreciation for expanding the concept of ACEs to include exposure to community violence. Prior research focused exclusively on violence in the home.
  - Dr. Fein stated that childhood experience is generally limited to the home for the first three years. However, the impacts of domestic violence can begin in infancy. It is important to know what is happening, even if we cannot fix it.
- Dr. Chen commended Dr. Fein for integrating behavioral and physical health and acknowledging the importance of social determinants and systems change. He asked if Dr. Fein was familiar with Peter Levine’s Somatic Experiencing approach that integrates body and mind to reprogram and moderate dysregulation.
  - Dr. Fein replied that CHOP uses yoga and trauma education in its groups.
  - Dr. Muir stated that the University of Miami conducted a pilot study using a mindfulness technique for youth. She noted that increasing awareness of mind and body can be a critical component of treatment.
  - Dr. Washington stated that his program incorporates awareness and regulation of emotional and physical responses to stress. He emphasized that trauma-informed interventions must be conducted in a cultural context that acknowledges the reality of continuous exposure to stress.
  - Dr. Fein acknowledged the work of Dr. John Rich regarding men of color and police. He stated that children need to use their bodies, rather than cognitive concepts, and said he would look into Dr. Levine’s work.

### **Investing in Boys and Men of Color: Challenges and Opportunities**

- Tahira Cunningham, MBA, Program Officer, California Executives Alliance/Sierra Health Foundation (by videoconference)

Ms. Cunningham provided an overview of the California Executives Alliance (CEA) and its work to address disparities that impact boys and young men of color. Key points of her presentation were as follows:

#### **Overview**

- The CEA is an alliance of about 20 family and community foundations in California. The goal of the CEA is to expand the percentage of boys and young men of color in California who achieve stable, full-time employment with earnings sufficient to support a family.

- CEA draws upon a number of tools and resources for this work:
  - Alliance for Boys and Men of Color: A statewide alliance of more than 200 community organizations and advocacy groups working on policy and systems change in education, workforce development, juvenile justice, and health
  - Select Committee on BMOC: A committee in the California state legislature that was formed to develop and promote policy and systems changes to improve the health and well-being of BMOC.
  - Community partners: Organizations across the state that work with BMOC.
  - Investments in BMOC: A mapping exercise conducted by CEA identified \$133 million in investments that target BMOC in California. CEA is using the map to identify gaps in funding and opportunities for collaboration.
- To support the implementation of Proposition 47, which reduced low-level offenses to misdemeanors, CEA developed a rapid-response fund to help individuals reintegrate into the community when they were released from jail.
- CEA foundations collaborated to ensure that funds allocated through the Local Control Funding Formula would benefit children from low-income families or with limited-English proficiency.

#### My Brother's Keeper

- CEA is focusing its work on My Brother's Keeper, using the intergenerational approach and life course framework developed by Mr. Chandler. It developed a communications strategy and a place-based strategy for that work.
- The goal of the communications strategy is to build support for investments and solutions that can dismantle the "rules" limiting opportunities for BMOC across the issues identified in the life course framework.
  - CEA conducted interviews, focus groups, and a statewide survey to inform the communications strategy. The survey found that voters see BMOC as assets, recognize that they face challenges, and feel a responsibility to help.
- The purpose of the place-based strategy is to align, amplify, and accelerate existing successful models for policy and systems changes rooted in the community. CEA will do this by:
  - Advancing policy and system changes;
  - Leveraging philanthropic relationships, investments, and influences;
  - Deepening organization capacities of communities;
  - Ensuring measurable population-level outcomes; and
  - Connecting the CEA communications strategy.
- CEA adopted a regional approach to achieve statewide impact. The first year will support local capacity for policy and systems change and provide philanthropic leadership in Oakland, Los Angeles County, and Sacramento. The five-year goal is to implement MBK in nine cities, with ongoing community engagement and sustained support. After the first five years, CEA expects to see:
  - Measurable progress in local population-level outcomes,
  - Increase and repositioning of public resources,
  - Increase in partners working together to advance a policy and systems change agenda,
  - Development of a statewide community of practice sharing promising models,

- Sharing of research and expertise to broaden the advocacy for BMOC, and
- Greater awareness and support for BMOC issues.
- CEA established a “Pyramid of Action” to implement its MBK strategies:
  - Regional Action Committees (networking and idea sharing);
  - Communications and place-based workgroups (strategy development; recommendations; alignment of grant agreements, outcomes, and evaluation); and
  - Funder collaboratives/workgroups (collaboration among investors, pooled and/or direct investments).

### **Questions and Answers**

- Dr. Malone asked what age group the MBK strategies would target.
  - Ms. Cunningham replied that the age range would depend on the issue. It would most likely go up to age 25 or 26 for issues such as juvenile justice, health care, and education. CEA will focus on investment to build capacity and infrastructure. They will hold conversations to select a primary issue for each of the three regions.
- Dr. Malone asked if the amount of the investment would be based on specific issues.
  - Ms. Cunningham said that CEA established a baseline investment for each region, based on existing capacity. CEA’s investment will be designed to build the long-term capacity of organizations to focus on any issue.
- Dr. King noted that there is a significant interest in these issues in Florida, but the capacity and infrastructure to address them is missing. He asked if that was common in other communities in California or across the country.
  - Ms. Cunningham stated that Mark Philpart at PolicyLink could provide a national perspective on capacity and infrastructure. She noted that organizations in Oakland and Los Angeles have extensive experience working with and advocating for communities of color. That work is more difficult in Sacramento and the Central Valley because community organizations do see themselves as advocates. Building capacity must begin by helping organizations learn that they can own an issue and take a stand.
  - Dr. King noted that activists and professionals in this field often grew up with a history of advocacy. People in many communities do not hear those stories, so that skill is missing. Learning to hold themselves and the system accountable is a challenging first step.
  - Ms. Cunningham emphasized that it is important to trust the youth and give them an opportunity to take action so they can experience themselves as advocates.
- Dr. Chen noted that systems and policy changes are often rescinded. He asked if CEA had a strategy to sustain its efforts beyond the period of its investments.
  - Ms. Cunningham replied that CEA sees this initiative as a 20-year effort and is committed to BMOC for the long term. It recognizes that its investment will not be sustainable without policy change, and it recognizes that gains in Sacramento must be implemented at the community level.



## CHOP Experience in Violence Prevention

- Joel Fein, MD, MPH

Dr. Fein discussed efforts of CHOP and other institutions in Philadelphia to address violence prevention. He began by building on Ms. Cunningham's remarks regarding education and practice:

- Education: People know what the problem is. At this stage, the focus should be on determining why and what to do about it.
- Practice: We want to do what is best, but we often have to do what is "good enough." When we do not know what is good enough, we end up doing what is "not bad" (i.e., it does not do harm). If we find an intervention that does not do harm, we should promote it and research it.

Dr. Fein stressed that research outcomes need to be chosen carefully. CHOP no longer uses outcomes imposed by others and is beginning to use outcomes that reflect what is important to end users. CHOP studied programs conducted by hospitals participating in the National Network of Hospital-Based Violence Intervention Programs. It identified 17 priority outcomes and found validated measures for each of those outcomes. It is now promoting the use of those measures for all programs in the network.

CHOP does place-based work at the neighborhood level, but policy change needs to take place at the city level in order to have an impact. CHOP is now looking at what levers are needed to change policies at the state level.

The ACEs Task Force spent a year talking about what it should be doing and created four committees to implement specific aspects of its plan (Community Education, Professional Education, Research, and Practice in the Environment). That structure proved an effective way to engage disparate groups of stakeholders and develop a shared agenda.

## Discussion

- Ms. Cunningham agreed that it can be challenging to develop a shared agenda. CEA gave the foundations in each region the freedom to choose a focus area, while identifying a common thread across the state. California has done a significant amount of work on the issue of school push-out. The issue was identified through a youth caucus in Los Angeles convened by the CEA's Education Workgroup; it expanded from advocacy at the city level to an initiative to create a statewide policy. Funders and advocates need to be flexible and listen to what the youth say they need.
- Dr. Juarez described two situations in which unfunded activities led to the establishment of community coalitions (the Violence Prevention Coalition of Greater Los Angeles in the 1990s and a CDC-funded youth violence prevention research center in Nashville). In both cases, staff were willing to do work that went beyond the scope of the funding.
  - Ms. Cunningham stated that the CEA's general infrastructure grants are designed to support activities that organizations are doing without funding.
- Dr. Chen asked for examples of funding streams to address re-entry for young men of color.
  - Ms. Cunningham replied that CEA's rapid response in 2015 to support Proposition 47 implementation generated a \$2.5 million donation from Google. Member

foundations have also issued individual grants pertaining to juvenile justice. CEA is currently focused on what is holding young men back and on opportunities in workforce development and post-secondary education. They are conducting community discussions through July and will identify key issues that emerge from those discussions in August.

- Dr. King asked Ms. Cunningham to suggest issues for the Committee to address in its recommendations.
  - Ms. Cunningham replied that CEA would be interested in seeing HHS and OMH infuse BMOC more intentionally into its agenda.
  - Dr. King noted that Dr. Gracia's update highlighted ways in which OMH was doing that, including support for MBK. The Committee may provide recommendations to move that work forward.

### **Public Comment**

- Marian Smithey (Division of Nursing and Public Health, Health Resources and Services Administration, HHS) asked what types of careers CEA was developing for BMOC.
  - Ms. Cunningham stated that CEA was focusing on preparing young men to be successful over the life course, rather than preparing them for specific careers. However, they are developing strategies to connect some young men with jobs in the technology and health care industries.
- Ms. Smithey observed that the speakers did not discuss lesbian/gay/bisexual/transgender youth of color, who are at increased risk for suicide.
  - Dr. King thanked Ms. Smithey for highlighting this issue. He expressed regret that there was not sufficient time to address it at this meeting and stated that the Committee would consider it for discussion in the future.

### **Wrap-Up**

Committee members shared reflections on the day:

- Dr. Juarez was struck by the categorical response regarding the need for federal funding, despite the crosscutting nature of the issues that the Committee addresses.
- Dr. Malone noted that several speakers recommended joint funding between HHS and DOJ and asked what needs to happen for that to occur.
- Dr. Panapasa said she hoped that the diversity of populations would not get lost in discussions of "boys and men of color." It is not possible to develop a "one size fits all" intervention because what is culturally relevant for one group does not meet the needs of another.
- Dr. King agreed that it is important to know the diversity within the community when developing a strategy in order to understand the root causes.
- Dr. Thorpe added that it is important to understand the history of a population group and the history of the community.
- Dr. Malone stated that every community has a narrative, which often gives rise to counter-narratives. She noted that a colleague of hers was creating spaces where a corrective narrative can be developed.
- Dr. Juarez stated that practitioners can identify the core elements of an intervention over time and tailor them to specific communities.

- Dr. Chen stated that the process of an intervention is as important as the outcomes, and it is important to look at each patient as an individual. He noted that discussions during the day covered everything from intervention with an individual to policy-level changes, and highlighted the role of youth as drivers of change.

The meeting was adjourned for the day at 4:36 p.m.

## **DAY TWO – Tuesday, June 21, 2016**

### **Call to Order and Remarks**

- Roderick K. King, MD, MPH, Chair

Dr. King called the meeting to order and reviewed the agenda for the second day.

### **Reflections on Day One**

Committee members reflected on the presentations of the previous day:

- Dr. Guadagnolo remarked that this was one of the most interesting and informative meetings she had ever attended due to the compelling speakers. Actionable items included data collection, mental health care for children (funding, disparities across agencies, cross-sector issues), and the need to base messaging on assets rather than deficits.
- Dr. Pañares appreciated the comprehensive nature of the presentations. The Committee should look at how to link the recommendations to MBK.
- Dr. Mojica said she would like to know more about the role of ACMH in MBK. She appreciated the wealth of experience that the speakers brought and noted that their presentations reflected her experience.
- Dr. Juarez stated that the presentations echoed issues discussed by the advisory committee for the National Institute for Minority Health and Health Disparities (NIMHD). He highlighted the need to develop a common conceptual model for a life course approach to address health equity, and he suggested that the ACMH could take a leadership role in setting the agenda for that approach.
- Dr. Malone stated that the speakers presented a panoramic view of issues that demand a response, and she thanked the leadership team for assembling such a powerful group of speakers. She noted that some groups emphasize interventions that target early childhood, while others focus on adolescents, and she stated that the most important thing is to start somewhere. She also expressed concern that some African American mothers would rather have their young boy identified as a criminal than someone who needs mental health support. Young men of color are running toward a cliff. Those who know about the cliff and are in a position to intervene are responsible for doing something.
- Dr. Panapasa appreciated the flow of the presentations, which moved from the general to the specific. She noted that OMH could play an important role in addressing the lack of good data, in collaboration with other agencies. She was struck by Dr. Bell's comment regarding the need for a major paradigm shift to change the mission of the criminal justice system.
- Dr. Chen stated that the presentations were impressive, and the complexity of the issue was clear. It will be important to compile more information to validate what is happening

at each point in the life course. He noted that the health care delivery sector has a wide range of interpretations of population health that differ from how it is understood in public health. The presentations showed how to use a population health perspective to address the needs of specific groups. Sustainability requires good people and public will. The question is how to change the mission to reflect a deeper understanding of complex social problems, so issues remain on the agenda.

- Dr. Thorpe said he was struck by the extent to which efforts to address BMOC are siloed. There is no strategic plan or coordinated effort because researchers, advocates, practitioners, and policymakers do not talk to each other, and no one wants to talk about racism. However, those conversations are essential. Dr. Thorpe expressed concern about the lack of evidence-based interventions for BMOC because they are not represented in the data. It is important to find ways to recruit boys and young men of color to participate in surveys. The recruitment methodologies that the federal government uses for the National Health Interview Survey (NHIS) are not appropriate for all racial and ethnic groups. Dr. Thorpe expressed concern about the impact and sustainability of MBK when the President leaves office. Dr. Thorpe suggested that the ACMH should encourage more interagency work between DOJ, HHS, and the Census Bureau to address BMOC and should consider a recommendation to have a senior advisor on men's health at HHS.
- Dr. King noted that an executive alliance had been formed to transition the MBK initiative to the private sector, similar to the Clinton Global Health Initiative.
- Dr. Juarez stated that the timing was right for ACMH to develop a conceptual framework that would serve as a road map for MBK going forward.
- Dr. King stated that when a president leaves office, aspects of initiatives such as MBK might remain within federal agencies to maintain momentum, depending on who takes office. This meeting was designed to help the Committee think about complex issues in a broader, more interconnected way. Dr. King noted that shared accountability emerged as a key issue in the presentations. It is difficult to get all parts of the system to recognize that they have a role to play. However, sustainability requires a paradigm shift in which everyone sees the work as part of what they do to build healthy communities. It is also impossible to tackle any population health issue or achieve restorative justice without conversations that address the historical context of how communities have been treated. Dr. King hoped that the Committee's recommendations would move in the direction of supporting cross-sector collaboration and coordination.
- Dr. Malone stated that shared accountability requires shared leadership. Leaders are accustomed to being in charge, and it can be challenging to step back and acknowledge that someone else needs to run some aspect of the work. The Committee's recommendations should emphasize shared leadership as an adult behavior.
- Dr. Thorpe added that a recommendation on shared leadership should address the politics around determining who will lead and who will step back.
- Dr. Juarez noted that Alameda County was trying to incorporate a health in all policies approach, in which each department is required to identify its responsibility and develop a specific plan to address health.
- Dr. Panapasa emphasized that change needs to come from the community. The Committee's recommendations should discuss the need to invest in communities and build their capacity to do the work.

- Dr. King commented that the philanthropic sector would rather invest in interventions than do the hard work of capacity building.
- Dr. Thorpe observed that NIMHD committed funds to community-based participatory research and asked how that effort could be sustained.
- Dr. Panapasa observed that community-based participatory research is often conducted by people who are not part of the community. Researchers gain an understanding of the community, but the assessments do not reflect the community voice.
- Dr. King said the concept of community needs assessment is good, but the implementation had been problematic. Health care and public health are beginning to value community input due to the rise of consumerism. However, that shift requires leadership to surrender power and admit that they are not the experts. There has not been a national convening of people working on BMOC across the country.
- Dr. Juarez suggested that the OMH webinar series could bring together speakers from different sectors. He noted that webinars offer flexibility.
- Dr. Panapasa supported the suggestion of webinars and observed that a summit could put the issue on the radar of the next president.
- Dr. Juarez encouraged the Committee to use the vehicles that are already available, such as the OMH newsletter and webinars.
- Dr. Chen suggested that the Committee's recommendations should emphasize resources that are required for a mission change, including shared accountability, shared leadership, and listening to the community. There is a growing literature on place-based strategies for capacity building, such as the recent report by The California Endowment. The California Department of Public Health published a document on health in all policies that is a model for shared leadership, with strategies to engage various departments and to help them see the role they play in improving health.

### **Committee Business**

- Minh Wendt, PhD, Public Health Advisor, Division of Policy and Data, Office of Minority Health, U.S. Department of Health and Human Services (Designated Federal Officer, ACMH)

Dr. Wendt reviewed a number of administrative matters pertaining to the Committee:

### Nomination Process

- OMH issued a call for nominations for five candidates to represent the American Indian/Alaska Native (AI/AN) and Asian American/Native Hawaiian/Pacific Islander (AANHPI) populations. Two positions to represent the AI/AN population are currently open, and one position to represent the AI/AN population will be open as of November 2016. One position to represent the AANHPI population will be open in July 2016, and one will be open in November 2016. Candidates for those positions are being cleared at the Department level.
- OMH issued a call for nominations for two positions to represent the Black/African American population that will be open in July and November 2016. Applications are due by September 8, 2016.

### Committee Chair

- OMH is undertaking a process to identify a new chair.

#### Status of ACMH Reports

- All Committee reports and memos are available on the OMH website.

#### **Questions and Answers**

- Dr. Juarez noted that his work on a Hepatitis C vaccine and pre-exposure prophylaxis for HIV identified a lack of cultural awareness among providers, particularly regarding the LGBT population. He asked if OMH was conducting any information campaigns to address that issue.
  - Dr. Wendt replied that she would forward that question to the OMHRC and would share its response with the Committee.
- Dr. Panapasa requested an update on the Health Equity blog.
  - Dr. Wendt stated that she would share that information following the meeting.
- Dr. King encouraged Committee members to share information about the nomination announcements.
- Dr. Chen asked how the activities cited by Dr. Wendt support the Committee's recommendations.
  - Dr. Wendt replied that her update included examples of HHS activities in response to the Committee's recommendations. She also reported on ways in which OMH is sharing the recommendations with agencies across HHS.
  - Dr. Chen said it would be helpful for OMH to provide an update on a regular basis so the Committee could see the full impact of its recommendations. He suggested adding an update as a standing agenda item for future meetings.
- Dr. Panapasa suggested expanding the update to describe how other agencies are responding to or implementing the Committee's recommendation letters. That list would also help to document the effectiveness of OMH.
  - Dr. Wendt stated that she was developing a database to track the impact of the Committee's products.
- Dr. Mojica said it would be helpful to inform Committee members of the full range of OMH activities and publications on a regular basis, in addition to updates at the meetings.
  - Dr. Wendt said OMH was working on that.
- Dr. Malone requested information on the content of the training on African immigrant health beliefs at the University of Pittsburgh. She noted that there is a difference between understanding a belief and supporting beliefs that are contrary to health, such as female genital mutilation.
  - Dr. Juarez said it would be helpful to provide information on the curriculum so that the benefits of the funding could be shared more broadly.

## **An Overview of Behavioral Health for Asian American, Native Hawaiian, and Pacific Islander (AANHPI) Boys and Men**

- Larke Nahme Huang, PhD, Director, Office of Behavioral Health Equity, Administrator's Office of Policy Planning and Innovation, Substance Abuse and Mental Health Services Administration (SAMHSA)

Dr. Huang prefaced her presentation by noting that the Affordable Care Act extended coverage for mental health services and treatment to millions of people. However, more disparities will be created in states that did not expand Medicaid. SAMHSA is looking at data to identify communities that are affected and is also looking at how its funding can be used for services and support that are not covered by the Affordable Care Act or Medicaid.

Dr. Huang provided an overview of mental health and substance abuse issues of AANHPI men and how resources can be mobilized to support this diverse population and increase their access to culture-specific services. Key points were as follows:

- The AANHPI population will triple in the next several decades. It includes diverse groups with very different acculturation experiences.
- Several factors justify a focus on men's behavioral health:
  - Male focus group participants described symptoms of depression without realizing they are depressed and did not connect their mental health and physical symptoms such as headaches, digestive problems, and physical pain.
  - Somatization of symptoms in men and behaviors such as hostility and irritability, verbal violence and abusiveness, drinking to excess, or womanizing may be rooted in depression.
  - Men do not recognize, acknowledge, or seek help for their mental health concerns. The utilization of services by AANHPI men is the lowest among all racial minority men.
- Mental illness among AANHPI men
  - About six percent of Asian American (AA) men reported a lifetime presence of a psychiatric disorder.
  - AA men born and raised in the U.S. are more likely to report a psychiatric disorder than AA immigrant men.
  - AA male college students are more likely to suffer from depression than their female counterparts.
  - AA men who endorse masculine gender role norms report higher levels of depressive symptoms.
- Substance use among AANHPI men and boys is less prevalent than in the general population, but first generation and adolescents appear to be at greatest risk.
  - U.S.-born AA men are significantly more likely to have a substance use disorder than foreign-born AA men.
  - Pacific Islander (PI) middle and high school males in California had the highest rate of lifetime and past-month cigarette smoking and lifetime and past-month methamphetamine use compared to all other racial groups.
  - AANHPI middle and high school males in California had the highest rates of marijuana use (same rate as African Americans) and binge alcohol use compared to all other racial and ethnic groups.

- Gay and bisexual AANHPIs who use substances are more likely to engage in risky sexual behaviors than those who do not use substances.
- There is significant variability within AANHPI groups in terms of behavioral health disorders and conditions (e.g., NHPs have a higher rate of binge alcohol use).
- The prevalence of mental disorders among AANHPI groups is slightly lower than the general population, but the burden of disease may be greater due to the stigma of mental health disorders.
  - AANHPIs are less likely to seek mental health care, and they use fewer services per capita than other groups.
  - AANHPIs do not seek or engage in services in a timely manner, and those who get into services are more severely ill.
  - The onset of mental disorders among AANHPIs occurs earlier in life.
- AANHPI males are particularly vulnerable to stigma surrounding mental health. Stigma for men include stereotypes about strength, endurance, pride, and courage. AANHPI men also face stereotypes about intellect, work ethic, and resolve, and cultural values emphasize reliance on the family system, faith, and conformity to norms.
- Health insurance enrollment rates among AANHPIs are similar to those of non-Hispanic Whites. Koreans and Vietnamese have the highest rate of uninsurance among AAPIs (25.5 percent and 20 percent, respectively, compared to the national average of 15.7 percent). This may be due to the fact that many Koreans and Vietnamese are small business owners.
- AANHPIs have strong beliefs that a person with mental illness can eventually recover and can lead a normal life with treatment. However, there is a strong perception that people with mental illness experience high levels of prejudice and discrimination.
- SAMHSA recently developed a Disparity Impact Strategy (DIS) framework that requires all grantees to submit a statement outlining how they will address disparities in access to, use of, and outcomes of their programs. Grantees are doing a better job of finding, enrolling, and serving diverse populations, and SAMHSA is beginning to see broader inclusion of underserved and vulnerable populations in the programs it funds.
- SAMHSA supported the formation of the National Network to Eliminate Disparities in Behavioral Health (NNED, [nned.net](http://nned.net)). NNED is linking community-based organizations that have developed effective programs to reduce disparities and promote behavioral health equity.
- Tangible steps to support AANHPIs include:
  - Research on culturally sensitive interventions for working within the diverse ethnic groups that compose this population,
  - Identifying resources and programs that specialize in work with AANHPIs,
  - More research-informed policymaking that recognizes the marginalized status of AANHPIs in the U.S., and
  - Greater collaboration between programs and organizations serving this population and SAMHSA.

## Questions and Answers

- Dr. Juarez asked how Native Hawaiians are defined.
  - Dr. Huang stated that this population is defined by ancestral lineage, as opposed to blood content. The Native Hawaiian population is quite dispersed, with significant populations along the west coast of the U.S. They are trying to develop more treaty



arrangements with the U.S. government, similar to those that are in place for the Pacific jurisdictions and tribes.

- Dr. Chen asked about SAMHSA’s experiences and challenges promoting the National CLAS Standards.
  - Dr. Huang stated that SAMHSA developed a blueprint for behavioral health providers to implement CLAS, but they did not actively promote the standards until they developed the DIS. The blueprint is based on the law and provides guidance to document quality improvement. SAMHSA is encouraging its grantees to implement the standards incrementally. Grantees are beginning to recognize their responsibilities, particularly in the area of language access, and have been very responsive. A grantee in Vermont identified many newcomer populations through the process of preparing their DIS. They have taken major steps to align their organization with CLAS, including hiring newcomers to conduct outreach and including them on the board.
- Dr. Panapasa said it would be helpful to have disaggregated data for the different NHPI populations, given emerging evidence of significant disparities among some subgroups.
  - Dr. Huang stated that SAMHSA’s national household survey is one of the few instruments for which data can be disaggregated among subgroups of Asian Americans. It collects data on ethnic identity, but it does not oversample for any population and it cannot do nationally representative sampling. It disaggregates data to the extent that it can, but it requires combining data over several years. However, individual researchers can access the data and do their own analysis.
- Dr. Chen asked if SAMHSA had considered collaborating with PI jurisdictions to fund oversampling when the survey is implemented.
  - Dr. Huang replied that SAMHSA PI populations are sampled on the continent and in Hawaii; it does not conduct the survey in the Pacific jurisdictions. SAMHSA has funded epidata and prevention projects in PI jurisdictions, but the data from those studies are not part of the national dataset.
- Dr. Panapasa asked if SAMHSA would consider conducting its national household survey in the Pacific jurisdictions if funding could be found.
  - Dr. Huang stated that Congresswoman Judy Chu had introduced a bill regarding data collection. She encouraged Dr. Panapasa to follow up with her.

#### **Office for Civil Rights Section 1557 Final Rule**

- Kenneth D. Johnson, JD, Section Chief, Office for Civil Rights (OCR), U.S. Department of Health and Human Services

Mr. Johnson provided an overview of the final rule of Section 1557 of the Affordable Care Act, which is the nondiscrimination provision of the law. Key points were as follows:

- The process of developing the rule began in 2010. The final rule was issued in May 2016.
- Section 1557 prohibits discrimination based on race, color, national origin, sex, age, or disability in certain health programs and activities. It has been in effect since the Affordable Care Act was signed in March 2010. The final rule aims to educate consumers about their rights and help covered entities understand their obligations.
- Section 1557 builds on prior federal civil rights laws, including Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972; Section 504 of the Rehabilitation Act of 1973; and the Age Discrimination Act of 1975.

- Section 1557 extends protection to populations that have been most vulnerable to discrimination in health care and health coverage, including women, members of the LGBT community, individuals with disabilities, and individuals with limited-English proficiency. It is the first federal civil rights law to broadly prohibit sex discrimination in health programs and activities.
- Section 1557 applies to all health programs and activities that receive federal financial assistance from HHS, all health programs and activities administered by state-based and federally facilitated health insurance marketplaces, and all health programs and activities administered by HHS.
- The final rule clearly specifies what a covered entity may not do and what it must do in order to comply with all aspects of the law. For example, Section 1557:
  - Strengthens long-standing provisions to ensure language access for individuals with LEP, and encourages covered entities to develop and implement a language access plan.
  - Extends protections to ensure access for individuals with disabilities, including communication assistance.
  - Requires equal access to health care and insurance coverage regardless of an individual's sex, including gender identity and sex stereotypes, and it prohibits exclusions or limitations in coverage for all health care services related to gender transition.
  - Prohibits insurance plans from denying, limiting, or canceling coverage based on race, color, national origin, or disability.
- The inclusion of health research in the definition of health programs or activities is not intended to alter the fundamental manner in which research projects are designed, conducted, or funded. Health research was covered by existing federal laws that prohibit discrimination on the basis of race, color, national origin, disability, or age in all health programs and activities that receive federal financial assistance. Sex discrimination has been prohibited in health research by Title IX. OCR recognizes that health research is designed to answer scientific questions to improve health and advance knowledge; it is not designed to result in direct health benefits to participants. Research projects are often limited in scope for many reasons, including the principal investigator's scientific interests, funding limitations, recruitment requirements, and other nondiscriminatory considerations. Criteria and research protocols that exclude certain populations are warranted where nondiscriminatory justifications establish that such criteria are appropriate.
- More information, including a link to the final rule, is available at [www.hhs.gov/ocr](http://www.hhs.gov/ocr).

### Discussion

- Dr. Panapasa noted that the NHIS is not administered in Pacific Island jurisdictions and asked if this constitutes discrimination.
  - Mr. Johnson replied that discrimination in this case was not as clear as it would be if an American Samoan were denied service at a health center. Section 1557 marks the first time that prohibitions of discrimination based on race, color, and national origins will be applied to federally conducted programs. That distinction could potentially address Dr. Panapasa's concern.

- Dr. Thorpe asked whether the definition of health programs or activities includes surveys or human research.
  - Mr. Johnson replied that Section 1557 applies to all health programs and activities that receive federal assistance from HHS. Research entities that provide health services, such as the National Institutes of Health (NIH) Clinical Center, are clearly covered. A physician who limits the population for a study must demonstrate that the limitation is based on scientific considerations and is not discriminatory. An example of a nondiscriminatory limitation would be research to determine the effects of a drug on a specific population.
- Dr. Juarez noted that the criteria for NIH-funded research require a scientific justification for exclusion of women, children, or minorities. He asked if the lack of a bilingual investigator or resources to provide language assistance would constitute a scientific justification.
  - Mr. Johnson stated that this issue is discussed in the preamble to the rule, which is available in the Federal Register. It is not permissible for clinical researchers to consider the cost of accommodating participants with disabilities as a reason to exclude them from participation. The researcher would have to demonstrate that the study was focused on the effect of a treatment on a particular population.
- A Committee member asked what would happen when federal law and state laws were in conflict, such as the laws in Virginia and North Carolina limiting access to restrooms based on gender identity.
  - Mr. Johnson stated that those cases were still being litigated. The Department's position is that covered institutions must treat individuals in a manner that is consistent with their gender identity, including access to facilities, such as restrooms and locker rooms.
- Dr. Panapasa noted that the rule applies to marketing practices of covered entities and asked if it would also cover discrimination in hiring practices.
  - Mr. Johnson replied that hiring practices are covered by Equal Employment Opportunity legislation. OCR would be involved in cases that entail employer-provided health coverage.
- Dr. Malone asked if the complaints regarding language access services indicated that there were systematic issues in certain states.
  - Mr. Johnson stated that hospitals in some states are having difficulty making a transition to the new standards. Some safety net hospitals are facing severe financial constraints. OCR is working with the American Hospital Association to help hospitals find cost-effective ways to comply with the law, such as forming a consortium to purchase language line services.
- Dr. Juarez asked if OCR used the National CLAS Standards when it works with hospitals.
  - Mr. Johnson replied that OCR used CLAS when it worked with critical access hospitals to develop language access policies and services. He noted that he was planning to develop a crosswalk between CLAS and Section 1557.
- Dr. Mojica asked about the process for filing a complaint.
  - Mr. Johnson replied that OCR created an online portal, which increased the number of complaints. Complaints can also be filed by mail or in person. Some hospitals include information about the rule and the complaint process in the materials they provide regarding patients' rights and responsibilities.

- Dr. Malone asked if states that did not participate in the Medicaid expansion had a higher volume of complaints.
  - Mr. Johnson said he had not seen a geographic correlation.
- Dr. Panapasa asked if the policy would apply to U.S. territories and compact states and whether information was provided in those locations.
  - Mr. Johnson stated that Section 1557 applies to U.S. territories, and a number of complaints had been filed in Puerto Rico. The relationship with compact states might be different.

### **Committee Business**

Committee members discussed potential recommendations to HHS OMH. Dr. King presented a preliminary list of ideas for recommendations that had emerged through discussions:

- National summit on boys and men of color
- Webinar
- Data (Data Subcommittee)
  - Data collection: Provide feedback on national surveys that are changing elements (request from OMH), and
  - Disaggregation.
- Integration of federal RFPs and services
  - National health equity network,
  - DOJ, etc., and
  - Funding to incentivize integration and innovation.
- Changing the messaging
  - Mastery versus deficit model.

Committee members discussed potential recommendations:

- Dr. Juarez suggested that the Data Subcommittee could address the recommendation on data collection. Dr. Thorpe supported that suggestion.
- Dr. Panapasa stated the need to improve data on crime victimization and to improve data on the topic at the national level for different subpopulations. The primary data source is the National Criminal Victimization Survey (NCVS), produced by the Bureau of Justice Statistics at the Department of Justice. That survey does not currently include measures related to SDOH. A potential recommendation would be for the National Center for Health Statistics (NCHS) to include a supplement to the NHIS with measures related to crime and victimization. Another recommendation would be for the Census Bureau to incorporate a module or supplement as part of the American Community Survey (ACS). The challenge is the sample size; a more robust sample would provide more granular data. The sample for the NCVS includes age 12 and above; the Committee may wish to recommend lowering the age range. Another consideration would be to adopt Mr. Chandler's recommendation to develop rich datasets by linking administrative records across agencies (e.g., environmental, justice, and health).

- Dr. Juarez asked if OMH was looking for ways to improve specific surveys or a broader principle regarding how to integrate existing surveys.
  - Dr. Panapasa replied that OMH was looking for recommendations on both levels. However, she thought they were leaning toward an opportunity to build links across agencies and develop cost-effective ways to make rich data available.
- Dr. Thorpe asked if this issue would be relevant for the HHS Data Council.
  - Dr. Wendt stated that the Data Council focuses on high-level issues. They recently requested input regarding revision of the NHIS child and adult models and the rotation of supplements.
- Dr. Thorpe asked if federal agencies outside HHS could participate in the Data Council.
  - Dr. Wendt stated that the Data Council has invited representatives of DOJ, the Census Bureau, and other departments for presentations on various data policies and issues.
- Dr. Thorpe requested clarification regarding the role of the Data Council.
  - Dr. Panapasa noted that the Data Council recently discussed issues pertaining to the ACS, such as race and ethnicity categories and questions pertaining to gender identity. Decisions about the types of data the Census Bureau collects affect data collection at all other agencies. This would be an opportunity to introduce questions that could be incorporated into the ACS questionnaire or the Bureau of Justice survey. The Committee could make a recommendation to begin this process, with the ultimate goal of having rich data on victimization, BMOC, and SDOH.
- Dr. Malone proposed that the Committee develop an overall letter of recommendation, beginning with an introduction outlining principles that frame the recommendations (e.g., shared accountability, shared leadership, community participation, and place-based approach).
- Dr. Juarez outlined two potential approaches: 1) look at existing survey instruments and determine what is needed to obtain a bigger picture to ensure continuity across the lifespan; and 2) move beyond national data, use smaller surveys to capture place-based data, and obtain a temporal dimension. The question is how to incorporate additional elements to have a more nuanced understanding, given the existing structure.
- Dr. King said there were two considerations: how to leverage what currently exists and how to raise awareness of what currently exists.
- Dr. Malone said the recommendation should not prescribe details in order to provide Dr. Gracia with as much flexibility as possible.
- Dr. Juarez proposed that the Committee develop a report that would provide guidance for federal agencies and state and local governments to implement a life course approach to BMOC without specifying which agencies would be responsible.
  - Dr. Panapasa noted that when MBK was launched, several agencies, including HHS and the Department of Education, were asked to develop reports regarding the status of BMOC. The Committee should consider how to improve upon what has been done and maximize existing programs.
  - Dr. Juarez said he envisioned a conceptual model to create a framework. ACMH plays a leadership role in that process.
- Dr. Chen was in favor of a letter that would express the Committee's concern regarding the complexity of the issue and propose a different approach. HHS could start the

conversation regarding the cost-effective nature of cross-sector collaboration that would make use of existing survey instruments.

- Dr. Malone noted that a report would require considerable work and might be more effective if it were a collaborative effort. A letter proposing collaboration on data would be the first step.
- Dr. Juarez noted that a letter would reach a limited audience, while a report could be submitted to a journal.
- Dr. Thorpe asked if the Data Subcommittee would submit a separate letter or memo regarding data collection.
  - Dr. Juarez said that a letter or memo would be the best format for recommendations.
  - Dr. Guadagnolo said the recommendations should come from the entire committee for greater impact.

Dr. King outlined the types of products the Committee could deliver. A report is a relatively long, formal document (25 pages) that needs to be approved by every agency that is referenced. A letter or memo is shorter (3-5 pages) and does not include background data to support the recommendations.

Committee members agreed to develop a letter of recommendation with an introduction that outlines principles, followed by specific recommendations to OMH regarding BMOC. The content and format of the recommendations would be developed through a series of conference calls with the ACMH writing team (members to be determined), OMH staff, and a technical writer.

### **Public Comment**

Dr. King opened the floor for public comment.

- Ms. Smithey noted that Mr. Chandler cited pre-term birth status and parents' educational status as strong predictors of life outcomes. She asked if it would be feasible to recommend that vital statistics departments across the country collect uniform data as part of birth records.
  - Dr. Panapasa stated that most states already collect that data because there is funding attached.
- Lilliane Smothers (Academy of Nutrition and Dietetics) urged the Committee to consider the impact of food access and nutrition on health outcomes in minority populations.
  - Dr. King thanked Ms. Smothers for raising an important issue and stated that the Committee would consider it in future discussions.

### **Wrap Up**

Dr. Chen stated that it had been a pleasure and a privilege to serve on the Committee.

Dr. King echoed Dr. Chen's remarks and said it had been an honor to serve as Chair. He noted that important work remained to be done, together and individually. He would take insights from conversations with Committee members into his work going forward.

The meeting was adjourned at 12:41 p.m.