The CENTER for VICTIMS of TORTURE GEORGIA

To: Dr. Brenda Fitzgerald, Chair
Behavioral Health Reform & Innovation Commission
Subcommittee on Hospital and Short-Term Care

From: Darlene C. Lynch, Esq., Center for Victims of Torture Georgia

Date: May 27, 2022

Re: Recommendations from *Expanding Access to Care: Meeting the Needs of Georgia's Increasingly Diverse Population* (presented April 28, 2022)

On April 28, 2022, I presented to the Hospital and Short-Term Care Subcommittee of the Georgia Behavioral Health Reform & Innovation Commission (BHRIC) on *Expanding Access to Care: Meeting the Needs of Georgia's Increasingly Diverse Population*. At the request of the Chair, Dr. Brenda Fitzgerald, I respectfully submit key recommendations from the presentation with additional data and state comparisons for inclusion in the Subcommittee's Year Two Report.

INTRODUCTION

Georgia's Increasingly Diverse Population

Georgia is one of the most diverse states in the nation, consistently ranking in the top ten for ethnic and racial diversity,[1] and its population is growing increasingly diverse each year. The April presentation highlighted the following demographics:

- Today, one in ten Georgians – or more than one million people -- are foreign-born.[2]
- In the last 20 years, the state's foreign-born population has grown by almost 90% compared to just 25% for the state's U.S. born population.[3]
- The 2020 census confirmed the trend of a rapidly diversifying population, revealing a surge in growth among Georgia's Asian (53% increase) and Hispanic (32% increase) communities over the past decade.[4]
- Georgia's leading role in the U.S. refugee resettlement program contributes to its diversity. It is a top ten state for refugee resettlement and has successfully welcomed tens of thousands of refugees from countries around the world over the past four decades. Its refugee program is now a model for the nation, with approximately 90% of refugees economically self-sufficient within just six months.[5]

- With the current crises in Afghanistan and Ukraine, Georgia is poised to welcome more individuals in need of refuge than ever before. These new Georgians have endured severely traumatic experiences, and mental health services will help them to heal, integrate and thrive in their new communities.[6]
- Nearly half of all of refugees and immigrants in Georgia are naturalized U.S. citizens.[7]
- Yet, many of these Georgians are still working toward English proficiency. It can take years to master a second language to engage effectively in mental health counseling.
- An estimated 5% or a half-million Georgians are estimated to have limited English proficiency (LEP) that prevents them from accessing mental health care. In certain parts of the state, the percentage is significantly higher: 15% in Gwinnett County and 40% in the City of Clarkston, home to the state's refugee community and widely considered the "most diverse square mile in America."[8]

Tackling cultural and language barriers is essential to ensuring access to mental health care for this large and growing segment of Georgia's population. Indeed, federally-funded entities, such as the Department of Behavioral Health and Developmental Disabilities (DBHDD), risk losing federal funds if they fail to take adequate steps to extend services to individuals with limited English proficiency. [9]

Addressing these barriers is not only necessary to protecting the mental health and well-being of Georgians, but to preserving the economic health and continued prosperity of the state. For while foreign-born Georgians make up 10% of the state's population, they comprise 14% of the state's total workforce, including 20% of doctors & health aides, 30% of small business owners, 40% of agriculture workers, and 12% of our frontline workers during the COVID-19 pandemic.[10]

Access to Culturally & Linguistically Responsive Care in Georgia: Areas for Improvement

DBHDD has recognized the rapidly growing diversity of the state[11] and listed the shortage of culturally and linguistically appropriate services as a principal "unmet need" in applications for federal block grants: "DBHDD noted an increase in the ethnic and racial diversity of the state and of the consumers served by DBHDD providers. There is a need to . . . assist providers with becoming more culturally competent." [12]

Yet, compared to similarly diverse states, Georgia lags far behind in addressing the needs of the state's diverse communities. While other states have invested for years in innovative programs to ensure mental health equity[13] for their changing populations, Georgia has not done the same. As a result, DBHDD has no good means of data collection, no dedicated office, no comprehensive strategic plan, and no coordinated effort to ensure access to care for the more than one million foreign-born Georgians in the state. Specifically:

- DBHDD has no division of cultural competence or mental health equity, unlike the majority of states in the nation.[14]
- DBHDD has not identified ethnic and racial minorities as a "priority group" for collecting data and assessing access to care. Currently, priority groups include deaf individuals, youth, older adults, adults in need of supported housing, criminal justice-involved adults and homeless adults.[15]
- DBHD has drafted but not finalized nor funded a Cultural Competency Plan. [16]
- DBHDD offers a variety of cultural competence trainings but acknowledges the need to do more.[17]

- DBHDD has no method for searching its provider database by cultural and linguistic competencies, unlike other health insurer provider databases in Georgia.[18]
- DBHDD receives no state funds "allocated to identifying and remediating disparities in mental health and substance use disorder care." [19]

While DBHDD has strengthened Georgia's mental health care system in critical ways since 2010, Georgia still finds itself ranked 48th in access to mental health care, with access to culturally competent care limited to non-existent. The following recommendations, based on feedback from mental health professionals, advocates and community members, would address this gap and substantially improve access to care for Georgia's increasingly diverse population.

1. Establish and fully fund a DBHDD Division of Cultural Competence
2. Incentivize professionals to provide culturally-competent care in underserved communities
3. Implement National CLAS Standards
4. Provide regular provider training & assessment
5. Improve coordination between CSBs, state refugee programs & trusted community providers
6. Ensure crisis services are culturally-responsive

RECOMMENDATIONS

1. Establish and fully fund a DBHDD Division of Cultural Competence

The first step to ensuring equitable access to care for all Georgians is to establish a DBHDD Division of Cultural Competence or Division of Mental Health Equity and Disparity Prevention, similar to other states. This division would:

- Lead the Department's efforts to develop statewide policies, programs, and practices that are culturally informed, including finalization of a Cultural Competence Strategic Plan.[20]
- Create and engage with a cultural and linguistic competence advisory council, including members drawn from impacted immigrant communities.[21]
- Develop appropriate internal policies and guidelines to improve access to treatment and community recovery support services and eliminate behavioral health disparities.
- Implement a reliable data collection process and establish annual goals, objectives, strategies and performance indicators to guide the division's work and continually improve its performance.
- Participate in workforce development initiatives to increase the number of bilingual and bi-cultural clinicians and support personnel, including facilitating re-licensure of foreign-born clinicians.
- Shepherd the implementation of the National Culturally and Linguistically Appropriate Services (CLAS) Standards.
- Provide needs assessments, training and research to help existing providers develop and deliver services for speakers of other languages and individuals with different cultural understandings of behavioral health.

Most US states already have a cultural competence division or something similar embedded in their health departments. This includes all of the states – except Georgia – that are ranked in the top ten for ethnic and racial diversity: Arizona, California, Florida, Maryland, New Jersey, New Mexico, New York,

Nevada, Texas and Virginia. [22] Nevada's Health Equity program in its Division of Public and Behavioral Health received a $32 million federal grant last year to address health disparities among its diverse populations.[23]

In addition to these state models, DBHDD can draw upon its own Office of Deaf Services as an example of a division designed to expand access to care for individuals impacted by language and cultural barriers.[24] The Office of Deaf Services is led by a member of DBHDD's leadership team, who has access to the Deaf Service Data Management system to identify the number of Georgians eligible for services with American Sign Language (ASL) interpretation and the number who actually access those services. The Office strives to meet annual performance indicators, increasing the number of Georgians who access services with interpretation year over year.[25]

By some estimates, 3.2% of Georgia's population is deaf or hard of hearing.[26] Georgia refugees and immigrants make up 10% of Georgia's population and face similar barriers due to culture and language. A DBHDD division dedicated to serving these individuals would help ensure that they, too, have equitable access to mental health care in the state,[27] and BHRIC is urged to make this recommendation.

2. Incentivize professionals to provide culturally-competent care in underserved communities

To ensure equitable access to care for Georgians, it is also necessary to develop the state's culturally competent workforce.

While the much-welcomed Mental Health Parity Act passed earlier this year will help address shortages through better data collection and cancellable student loans, Georgia should also implement a streamlined pathway for internationally-trained behavioral health professionals to re-enter practice here. These professionals are an untapped resource, bringing needed bilingual and bicultural skills to the state. They could be particularly valuable in providing care in underserved immigrant communities.

Yet, licensing restrictions leave many of these professionals on the sidelines when the state needs them most. Legislation, similar to legislation introduced in the Georgia General Assembly in 2008,[28] should be enacted to provide a temporary license to foreign counselors whose education and experience can be confirmed by an independent third party. While holding a temporary license, these counselors would acquire the necessary clinical linguistic skills, provide care under clinical supervision, and prepare to take the general licensing exams.

Georgia has shown a willingness to draw on skilled mental health professionals from other states to strengthen its workforce, and it could do the same for professionals from other countries.[29] Indeed, there is a growing nationwide movement, prompted in part by the COVID pandemic, to integrate foreign-trained doctors, nurses and other medical professionals into state healthcare workforces. States have taken a variety of approaches, from allowing foreign-trained doctors to work as "assistant physicians" under the supervision of a licensed physician until they are ready to go out on their own, to offering specialized academic, technical and financial assistance programs for international medical graduates.[30] In fact, Georgia has lost a number of qualified doctors who came to the state as Cuban refugees but chose to move to Miami to take advantage of a streamlined pathway to practice there.[31]

Vermont, a Republican-led state with similar mental health care shortages, just passed legislation this year to study ways to integrate foreign-trained mental health professionals into its workforce. Under the new law, the state licensing office will conduct a study into "streamlining the licensure of mental health professionals practicing in the State" in collaboration with the state's Health Equity Advisory Commission, mental health professional licensing boards, the commissioner of mental health, and other nonprofit and community representatives.[32]

Here in Georgia, Republican leadership in the House has been leading a bipartisan initiative to strengthen Georgia's workforce by tapping into the deep pool of global talent in the state. Healthcare has been a particular area of focus, and last year, the House Study Committee on Innovative Ways to Maximize Global Talent heard compelling testimony from refugee and immigrant health care professionals seeking to practice in the state.[33] The Study Committee's final report recommended that the state streamline requirements for experienced foreign-trained professionals, including by making assistance available for navigating the licensing process and funding staff to coordinate that work.[34]

Now is an excellent time to introduce innovative legislation to strengthen the mental health care workforce by addressing licensing barriers, expanding access to experienced bilingual and bicultural clinicians and providing much-needed services in underserved immigrant communities.

3. Implement National CLAS Standards

In addition to building a culturally competent workforce, Georgia should join other states in implementing the National CLAS Standards in ways that best suit its increasingly diverse population.

Culturally and linguistically appropriate services are an essential part of any effort to address disparities in access to care for Georgia's ethnic and racial minorities.[35] The U.S. Department of Health and Human Services Office of Minority Health promulgated the National CLAS Standards in 2000 and released the enhanced Standards in 2013. These standards include action steps to advance health equity, improve quality, and eliminate health care disparities and provide a blueprint for implementing culturally and linguistically appropriate services.[36] They are grounded in respect and responsiveness to the mental health needs, beliefs and practices of diverse patients. Tailoring services to an individual's culture and language preferences can close the gap in health outcomes, so vividly highlighted by the COVID crisis.[37]

At least thirty-two states, including southern states such as Florida, Kentucky, Louisiana, and Texas, have taken some steps toward incorporating these standards into their delivery of mental health services and training.[38] Ten states have fully implemented the standards, including those with high rates of ethnic and racial diversity similar to Georgia, such as Arizona and New Mexico.[39]

DBHDD has already taken some steps toward integrating cultural competence standards through a working group called the System of Care Cultural and Linguistic Interagency Directors' Team. Yet, while a welcome initiative, this group lacks sufficient capacity to make the kind of progress Georgia needs. If Georgia is to keep pace with its diversifying population and truly commit to providing equitable access to care in the state, it must provide adequate and directed funding for CLAS implementation.

4. Provide regular provider training & assessment

A commitment to rigorous cultural competence training and certification for Georgia mental health providers is another key component to ensuring equitable access to care.

DBHDD has already made provider training a priority area for use of its federal block grants, which includes some training on cultural competence.[40] Comprehensive cultural competence trainings, however, are not mandatory and most trainings are offered as "one-off" opportunities for providers. There is no way to ensure mastery of cultural competency skills or to measure how effective trainings are in expanding access to culturally competent care in underserved immigrant communities.

The U.S. Department of Health and Human Services offers resources to help states develop a training and certification program on cultural competence.[41] Some states, such as New Jersey, have created their own Cultural Competence Training Center to ensure consistent training for providers based on current best practices.[42]

DBHDD is already required to provide cultural competence training and certification for a small but growing number of providers that are federally-funded as Certified Community Behavioral Health Clinics (CCBHCs). CCBHCs are specially-designated clinics that provide an integrated and comprehensive range of mental health and substance use services. To receive federal funding, these clinics must demonstrate "cultural competence, especially when treating people with limited English proficiency (LEP);" training must occur at orientation and at reasonable intervals afterward; and the training must address diversity within the service population.[43] The DBHDD provider network include several CCBHC's, including two community service boards, New Horizons Behavioral Health in Columbus and River Edge Behavioral Health in Macon,[44] and these providers must meet cultural competence training and certification requirements to retain their federal funding.

With an additional state investment, DBHDD could require similar trainings and certification for all providers contracted to provide care in Georgia's immigrant communities and make the programs available on an optional basis to other providers in its network.

5. Improve coordination between CSBs, state refugee programs & trusted community providers

Any plan to ensure access to equitable mental health care must also consider Georgia's unique role as a national leader in refugee resettlement and its incredibly diverse and rapidly growing refugee population. The City of Clarkston, the center of the state's refugee community, is home to residents from over 50 countries who speak more than 60 languages and dialects and is known as "the Ellis Island of the South" or "the most diverse square mile in America."[45]

Georgia's Departments of Human Services (DHS) and Public Health (DPH) work with community partners in Clarkston and other parts of the state to resettle an average of 2,500 to 3,000 refugees each year. These individuals have been carefully selected, vetted and approved by the U.S. government to be resettled here and are eligible to receive federal and state services, including DBHDD safety net care.

With the current crises in Afghanistan and Ukraine, Georgia has seen a sharp increase in the number of refugees coming to the state, with nearly 2,000 Afghan allies resettled here since the Taliban takeover and more expected to arrive from Ukraine.[46]

Refugees have fled war and other deeply traumatic experiences, and community providers are on the frontlines of providing mental health services to this population and helping them regain healthy and productive lives. These providers are reporting a surge in demand for culturally competent and trauma informed mental health services, with long wait lists and many individuals being turned away.

Currently, there is virtually no connection between DBHDD and the state refugee programs run by DHS and DPH. Moreover, because the state often refers refugee clients directly to community providers, bypassing the CSBs, the department has little understanding of the extent of the mental health needs. Better coordination is needed to ensure that refugees can access the mental health services and support they need to build successful lives in the state – and Georgia continues to have one of the most successful resettlement programs in the nation.

Toward this end, DBHDD should:

- Take part in the regular refugee stakeholder meetings led by DHS and DPH in order better understand refugee arrivals and mental health needs.
- Improve access to CSBs for refugees, by ensuring staff are trained in cultural competency, coordinating with trusted community providers, engaging in community outreach, expanding transportation, employing specialized community navigators, and enhancing the offering of multicultural, multilingual resources.
- Support community mental health providers who are filling the gap in care for refugees resettled by the state, including by creating a new Tier 3 specialty category to streamline the process for these providers to join its provider network.
- Collaborate with Georgia State University's Prevention Research Center in Clarkston, the center of Georgia's refugee community, (1) to train community-based peer counselors in refugee-specific counseling techniques; and (2) to embed masters-level psychology students in refugee resettlement agencies and health providers to provide additional support. (GSU's April 28 presentation attached).

6. Ensure crisis services are culturally-responsive

Finally, as the state rolls out the 9-8-8 emergency number and new co-response teams, now is the time to ensure that Georgia's growing refugee and immigrant communities have access to these services. When individuals from these communities experience crisis, culture and language barriers can exponentially increase the dangers to all involved and result in needless death and traumatization.[47] Incorporating culturally and linguistically appropriate approaches to crisis services is life-saving.

With respect to the 9-8-8 number, DBHDD has already taken steps to engage a broad range of stakeholders, including refugee and immigrant service providers, in regular meetings. These stakeholders are providing advice on addressing stigma, crafting effective messaging and outreach, and improving accessibility, as well as sharing connections to community leaders and other resources.

Yet, without an office of cultural competence, DBHDD's 9-8-8 team is at a disadvantage compared to similar teams working across the nation. New York's Office of Mental Health, for example, has an Office on Diversity and Inclusion that has been able to partner with their 9-8-8 team to share key learnings and recommendations.[48] For example, all New York 9-8-8 call centers are required to demonstrate that they have:

- A commitment to equity and the reduction of disparities in access, quality, and treatment outcomes for marginalized populations;
- Training activities and topics related to cultural competence and the reduction of disparities in access, quality, and treatment outcomes for marginalized/underserved populations
- Language access for limited English proficient clients served by the 988 number. Specifically, the state will require that the centers use data to identify the most prevalent language access needs, availability of direct care staff who speak the most prevalent languages, and the provision of best practice approaches to provide language access services (i.e., phone, video interpretation). Centers must also provide information about efforts to ensure all staff with direct contact with clients are knowledgeable about using these resources, as well as a plan to provide key documents in the languages most prevalent in their communities, including consent forms, releases of information, medication information, rights, and grievances procedures.

These recommendations could be adapted for Georgia and applied, with similar stakeholder consultations, to the rollout of the co-responder teams as well. It is essential that all co-responders serving in Georgia's immigrant communities have specialized and regular cultural sensitivity training, access to qualified interpreters when needed, and resources available in the languages spoken in the communities being served.[49]

CONCLUSION

In sum, the Subcommittee is encouraged to include these and other recommendations from the *Expanding Access to Care: Meeting the Needs of Georgia's Increasingly Diverse Population* presentation on April 28 in its Year Two Report. Other recommendations include investing in certified mental health interpreters and expanding access to Medicaid with coverage for the kind of holistic services (case management, interpretation) that immigrant Georgians need to successfully heal and integrate.

For more information on any of these recommendations, including estimated costs, please contact Darlene C. Lynch, Esq., Center for Victims of Torture Georgia, Clarkston, Georgia, dlynch@cvt.org, 404-402-1764.

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[1] https://www.census.gov/library/visualizations/interactive/racial-and-ethnic-diversity-in-the-united-states-2010-and-2020-census

[2] https://www.migrationpolicy.org/data/state-profiles/state/demographics/GA (hereafter, Migration Policy)

[3] Migration Policy

[4] https://www.ajc.com/news/2020-census-georgias-minority-populations-have-surged/SLZIWRHNE5CMDJR2EDMRD42ZDY/

[5]https://crsageorgia.wordpress.com/

[6] Research shows that up to 44% of all U.S. refugees and asylum seekers are torture survivors. Virtually all have endured trauma due to war and conflict. https://www.acf.hhs.gov/orr/programs/refugees/services-survivors-torture.

[7] Migration Policy

[8] https://www.census.gov/acs/www/about/why-we-ask-each-question/language/

[9] Entities that receive federal funding, such DBHDD, must take reasonable steps to ensure access to services for people with limited English proficiency, such as creating a language access plan, ensuring interpretation and recruiting bilingual staff. https://www.samhsa.gov/section-223/cultural-competency/lep-services. While some of Georgia's federally-funded departments, such as the Department of Human Services and Department of Community Affairs, have LEP plans on their websites, DBHDD currently does not.

[10] https://crsageorgia.files.wordpress.com/2021/02/crsa-2020-annual-report.pdf
[11] On Mental Health Day at the Capitol on January 19, 2021, DBHDD's Commissioner, Judy Fitzgerald, also noted the increasing diversity of mental health consumers in Georgia and the need to address disparities in access to mental health care. She expressed a commitment to expand culturally and linguistically appropriate services.
[12] DBHDD Proposal to SAMHSA for Community Health Block Grant, accessible at https://bgas.samhsa.gov/Module/BGAS/Users (hereafter, DBHDD Proposal)
[13] Behavioral health equity is often defined as "the right to access quality health care for all populations regardless of the individual's race, ethnicity, gender, socioeconomic status, sexual orientation, or geographical location**."** https://www.samhsa.gov/behavioral-health-equity.
[14] DBHDD's Director of the Office of Behavioral Health Prevention and Federal Grants oversees cultural competency trainings for providers among a very long and varied list of other duties. While she used to also have "Cultural and Linguistic Competency" in her title, that part of her title seems to have been removed.
[15] DBHDD Proposal
[16] DBHDD Proposal
[17] DBHDD Proposal
[18]https://www.georgiacollaborative.com/#:~:text=Working%20with%20the%20Georgia%20Department,and%20their%20families%20throughout%20the
[19] DBHDD Proposal
[20] Mental health departments in Maryland, New York, Pennsylvania and Washington, for example, published similar strategic plans: https://health.maryland.gov/bha/Documents/CLCSP%20Final%20Plan%20-%20TA%2004.25.19.pdf; https://omh.ny.gov/omhweb/cultural_competence/cc_strategicplan.pdf; www.dhs.pa.gov/docs/For-Providers/Documents/Behavioral%20Health%20Services/OMHSAS%20Strategic%20Plan%20for%20Cultural%20Competence.pdf; https://www.dshs.wa.gov/sites/default/files/odi/documents/CultCompGuidebook22-1470.pdf
[21] Ohio, New Jersey and Colorado are examples of states where the department of mental health works engages with an advisory group to address disparities and advance culturally competent care. DBHDD currently takes part in an Interagency Directors' Team workgroup on culturally competent care, which could potentially continue and accelerate its work with the support and coordination of a funded and dedicated DBHDD division. See, e.g., www.naminj.org/programs/multicultural/; https://cdhs.colorado.gov/behavioral-health/culturally-informed-inclusive-services; https://mha.ohio.gov/community-partners/advisory-groups/dacc/disparities-and-cultural-competence.
[22] See, e.g.,www.nasmhpd.org/sites/default/files/Updated_State_CLC_Network_2-8-19_0. States use a variety of names for these divisions, including Texas' Office for the Elimination of Health Disparities in the Dept. of Health and Human Services, Florida's Office of Minority Health and Health Equity in Dept. of Health; Arizona's Health Disparities Center in Dept. of Health Services; Maryland's Office of Minority Health & Health Disparities in the Dept. of Health & Mental Hygiene; New Mexico's Office of Health Equity in the Dept. of Health; Virginia's Office of Health Equity Advancement in the Dept. of Behavioral Health and Developmental Services.
[23] https://dpbh.nv.gov/Programs/Health_Equity_Program/Health_Equity_Program/
[24]https://dbhdd.georgia.gov/be-dbhdd/deaf-services, linking to http://www.nad.org/issues/health-care/mental-health-services/position-statement ("People who are deaf or hard of hearing are an underserved cultural and linguistic population within the nation's mental health system" and the "should be included, alongside other ethnic and cultural groups, in efforts to eliminate disparities in mental health care.")
[25] DBHDD Proposal
[26] www.statista.com/statistics/794291/hearing-disabled-population-us-by-state/
[27] In 2008, Georgia's Department of Community Health (DCH) led a Health Equity Initiative and published a Georgia Health Disparities Report that examined health disparities across counties and the availability of culturally competent care. The Department worked with a Minority Health Advisory Council. There appears to have been an Office of Minority Health, or at least a coordinator, at DCH or the Department of Public Health, but the department's websites no longer list this division and no subsequent reports on health disparities appear.
[28]https://www.legis.ga.gov/legislation/23281.
[29]Georgia joined the Psychology Interjurisdictional Compact in 2019[29] and the Professional Counselors Licensure Compact in 2021 to strengthen the workforce by drawing on skilled professionals from other states. Georgia law

permits licenses for certain mental health professionals to be issued without examination to applicants who are already licensed in other jurisdictions with substantially equal requirements. https://law.justia.com/codes/georgia/2010/title-43/chapter-10a/43-10a-10/

[30] For example, Missouri and New Hampshire have adopted an associate/assistant physician model so that international medical graduates (IMGs) can practice under a licensed physician while they prepare to practice independently.[30] Minnesota has sponsored residency spots specifically for IMGs, and this year, Colorado passed legislation to create an IMG assistance program that helps integrate IMGs into the state's health-care workforce and a clinical readiness program that helps them prepare for residency. www.wes.org/partners/gtb-blog/moving-forward-with-licensure-for-internationally-trained-health-professionals/; http://leg.colorado.gov/bills/hb22-1050 (See also, www.ama-assn.org/education/international-medical-education/physicians-call-clarity-img-credentialing-licensure, describing AMA's call on state medical boards to examine and remove barriers to licensing for foreign-trained physicians.)

[31] www.ncbi.nlm.nih.gov/pmc/articles/PMC3904828/pdf/jmdh-7-051.pdf

[32] https://legislature.vermont.gov/bill/status/2022/H.661

[33] See, House Resolution 11 creating a House Study Committee on Innovative Ways to Maximize Global Talent, which passed unanimously in the 2021 legislative session. www.legis.ga.gov/legislation/58868

[34] https://www.house.ga.gov/Documents/CommitteeDocuments/2021/Global_Talent/HR_11-Global_Talent_FINAL.pdf

[35] See, e.g., https://jamanetwork.com/journals/jama/fullarticle/2767308 (70% of Black and 67% of Hispanic adults with mental illness during the pandemic reported receiving no treatment compared to 57% of the population as a whole.)

[36] https://thinkculturalhealth.hhs.gov/clas/standards

[37] https://thinkculturalhealth.hhs.gov/clas/what-is-clas

[38] https://thinkculturalhealth.hhs.gov/assets/pdfs/CLASCompendium.pdf

[39] https://thinkculturalhealth.hhs.gov/clas/clas-tracking-map

[40] DBHDD's stated objective for use of block grant funds for provider training is to "increase access to training focused on supporting the behavioral health of diverse populations." It tracks the number of its provider's staff that it trains and strives to increase that number each year. DBHDD Proposal

[41] https://thinkculturalhealth.hhs.gov/education/behavioral-health

[42] https://www.centerffs.org/cultural-competence-training-center

[43] https://www.samhsa.gov/section-223/cultural-competency (Cultural and Linguistic Competence is defined as "culturally and linguistically appropriate services are respectful of and responsive to the health beliefs, practices, and needs of diverse consumers." General requirements of cultural competence include that "the needs assessment includes "cultural, linguistic and treatment needs;" "the CCBHC uses culturally and linguistically appropriate screening tools, and tools/approaches that accommodate disabilities. . . when appropriate;" and "treatment planning components that states might consider requiring as part of certification include accommodations to ensure cultural and linguistically competent services."

[44] https://dbhdd.georgia.gov/document/network-news/december-2021/download. Other DBHDD providers who are CCBHCs are Advantage Behavioral Health Systems, Athens; GA Recovery Consultants of Atlanta, Inc. – Decatur; and Georgia Pineland Community Service Board – Statesboro, GA.

[45] https://www.atlantamagazine.com/great-reads/ellis-island-south-welcome-diverse-square-mile-america/

[46] https://crsageorgia.wordpress.com/

[47] https://www.ajc.com/news/crime--law/who-was-shukri-ali-said-how-did-she-end-dead-hands-police/x7DjMMkK36FMdZITUxHxQP/

[48] https://omh.ny.gov/omhweb/statistics/988-report-to-legislature.pdf

[49] With respect to co-response teams, advocates sought to include language in Senate Bill 403 that would have required CSBs to engage culturally and linguistically trained personnel and materials when providing co-responder services in immigrant communities. That change was not made, in part because there is a belief that CSB personnel are adequately trained in cultural sensitivity, but as noted above, that training is limited.