The Equity Tracer

A TOOL TO HELP US UNDERSTAND THE LIVED EXPERIENCE OF THOSE WE SERVE.

ORGANIZATIONAL PERFORMANCE DEPARTMENT

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Overview

Objective: Research demonstrates that behavioral health and health care organizations achieve worse outcomes for minoritized populations when compared to majority groups (Nelson, 2002; Drwecki, 2011). These outcomes are often linked to service professionals' or systems level bias (Goddu et al., 2018). This tracer identifies areas of potential bias or inequitable treatment that may be evident within a person's treatment or case records. We encourage providers to identify and discuss these discrepancies so that they can make the necessary changes required to provide equitable treatment.

Who are these minoritized populations?: Anyone who is treated differently from a majority population due to the presence of one or more demographic characteristics. Common demographic indicators include race, ethnicity, sexual preferences, gender identity and expression, age, religion, ability, socioeconomic status, and more (Adams & Miller, 2022).

How to use the tracer: This tracer includes seven broad categories of evidence commonly found in service records. Review a person's file for evidence of bias or inequitable treatment in each category. To locate the evidence, search the person's record thoroughly and consult with their chief service providers or partners for more evidence and context. After reviewing the evidence, determine how much evidence exists within each category and select the appropriate option: *no evidence*, *some evidence*, *partial evidence*, or *unable to rate*. After selecting the appropriate option, briefly provide a narrative summary of the evidence identified for each category to help with service planning.

Areas of Potential Bias: Definitions

Definitions for each of the seven common areas of bias follow. Review these definitions prior to using the tracer tool to assist with locating evidence.

1. Systems Framing: There is a large gap between the mental health service system's approaches towards serving minoritized individuals and the negative expectations often found in other institutions (e.g., juvenile justice) (Alegria et al., 2010). Many systems do not exhibit ecosystemic views, instead focusing on individual maladies or blameful characterizations. These systems often rely on punishment as a means of addressing behavior as opposed to preventative care. *Ex: Individual is referred to a higher level of care than records indicate*

2. Family Involvement: When minoritized parents feel as if they are treated differently, there is an increased likelihood that they will not enroll, actively participate, or remain in services for their full duration (Hackworth et al., 2018). Parental anxiety about being judged or feeling unwelcome is associated with decreased help-seeking and lower service uptake and continued attendance (Cortis et al. 2009). *Ex: Family members are not invited to treatment team meetings*

3. Language. Stigmatizing or stereotypical language may be found in an individual's personal and clinical records. This language may reflect implicit bias and negative attitudes on behalf of the

service provider (Goddu et al., 2018). Stigmatizing language often includes one or more of three key linguistic features (O'Conor et al., 2016):

a. Casting doubt on the individual's pain, symptoms, or life stressors (" he insists that his pain is 'still a 10'" vs. "still has 10/10 pain");
b. Portraying the individual negatively, often with irrelevant or unnecessary indicators regarding minoritized status ("the client is Bisexual, and his behavior is unacceptable");
c. Implying individual responsibility instead of a systems approach; often with references to uncooperativeness ("she got herself into this situation" vs. "the behavior is likely influenced by a recorded history of trauma").

4. Access and Service Utilization: Service access is also limited for minoritized groups due to many other factors, such as lack of transportation, childcare, or ability to take time off of work; communication and language barriers; cultural differences between patients and providers; and historical and current discrimination in healthcare systems (Institute of Medicine, 2002; Mirza & Rooney, 2018). *Ex: Doctor's office refuses to treat same-sex couples*

5. Treatment Type: Evidence shows systematic differences in the receipt of a broad spectrum of therapeutic interventions. Minoritized indiviudals are less likely to receive a diverse range of procedures, ranging from high-technology interventions to basic diagnostic and treatment procedures, and they experience poorer quality medical care than majority groups (Institute of Medicine, 2003; Mizra & Rooney, 2018). *Ex: Staff restrain non-White youth at a higher rate*

6. Termination of Services. Evidence suggests that minoritized groups discharge to more intensive levels of care than majority groups, are less likely to discharge to their homes, and more likely to have services ended prematurely (Perzichilli, 2020). *Ex: Service provider advocates for continued treatment, but courts terminate services.*

7. Working Alliance. The working alliance, or relationship between those in the helping professions and the individuals they serve, is an important facilitator of success regardless of service type. Some research shows that white individuals have more favorable working alliances with their providers than individuals who are not white (Eliacin et al., 2016; Walling et al., 2012). Other research demonstrates that health care professionals have implicit preferences that favor heterosexual patients (Sabin et al., 2015). Ex: Frequent staffing changes or records indicate strained relationships between staff members and minoritized individuals.

Indicators of Bias or Inequitable Treatment	No Evidence	Some Evidence	Significant Evidence	Unable to rate
	0	1	2	--
1. Systems Framing: Why was the person referred or adjudicated to treatment? Did the person's behavior or needs reflect the assigned level of care? How did previous stakeholders view the person and discuss their case history? *Notes:*				
2. Family Involvement: Did the program make significant effort to include family members into the treatment process? Did staff exclude family members for any reason? Did any family members express feelings of mistrust or complain about unequal treatment? *Notes:*				
3. Language: Do case notes and documents reflect biased views or stigmatize the youth in any way? *Notes:*				
4. Access and Service Utilization: Did the client experience interruptions in service (why)? Was the client unable to access or receive services? Was the length of stay in line with program expectations? *Notes:*				

5. Treatment Type: Did the client receive different services or interventions when compared to other people? Was the client involved in an atypical number of incidents, including restraints, medication errors, complaints, allegations, etc.? Were certain treatment options not considered or withheld for any reason? *Notes:*				
6. Termination of Services: Did the client discharge to home, or a more restrictive setting? Did the client and service provider agree about the timing and reason(s) for service termination? *Notes:*				
7. Working Alliance: Did the client have ongoing conflicts with service providers? Did the client not agree with the goals and tasks of the treatment plan? Did staff actively seek input from the client as to the direction of services or care? *Notes:*				

Race: ☐ White ☐ Black or African American ☐ Hispanic or Latino ☐ Asian ☐ Native American ☐ Bi- Multi-racial
☐ Missing/Unknown ☐ Other (please explain)

Gender Identity: ☐ Female ☐ Male ☐ Transgender Female ☐ Transgender Male ☐ Non-binary ☐ Genderfluid ☐ Questioning
☐ Missing/Unknown ☐ Other (please explain)

Sexual Orientation: ☐ Straight ☐ Gay ☐ Lesbian ☐ Bisexual ☐ Allosexual ☐ Aromantic ☐ Asexual ☐ Pansexual ☐ Questioning
☐ Missing/Unknow ☐ Other (please explain)

Additional Identity Notes (if any):

Category	No Evidence	Some Evidence	Significant Evidence
Systems Framing	Previous records indicate that client is now in the appropriate level of care. Intake documents advocate for the client's best interests.	Client may not be in the appropriate level of care. At times, existing records negatively characterize the client.	Client is referred to a more restrictive level of care than records suggest. Documents from previous placements frequently speak negatively of the client.
Family Involvement	Families are considered vital members of the treatment team. They are listed as treatment team members and are frequently contacted by program staff.	Families are occasionally included in treatment planning, but at other times they are excluded. Contact with the family is sporadic and unscheduled.	Families are often not included in treatment planning or decisions. There is little evidence that families are contacted by staff. Families complain about treatment by program staff.
Language	Records always use person first language and avoids stereotypical framing. *"Carl suffers from substance abuse disorder"*	Records occasionally mention stereotypes or language that places blame on the individual. *"Carl drinks too much and won't change his behavior"*	Records frequently mention stereotypes or language that places blame on the individual. Negative language used throughout documentation. *"Carl drinks too much and won't change his behavior. He is ignorant of his behavior and is very disrespectful!"*
Access and Service Utilization	Program makes a consistent effort to help connect client to services despite access issues (transportation, scheduling, timing, etc.). Accommodations are made for differences in culture, lifestyle, and language.	Client has missed some treatment due to access issues. Program has provided some accommodations to help with access issues, but could have done more.	Client frequently misses treatment opportunities with no attempts to reschedule or accommodate. Programs do not provide supports or accommodations when necessary.
Treatment Type	Interventions, treatments and strategies are typical for the program or service. Every treatment option was available to client.	Certain helpful interventions may not have been considered. Interventions were not implemented as designed.	Client receives less intensive or more intensive services than they require. Client receives services that most other clients in the program with similar challenges did not. Staff default to punitive or intensive treatment options when more positive, agreeable options exist. Client outcomes are worse than similar clients.
Termination of Services	Length of stay is consistent with program expectations. Client discharges to the appropriate level of care and living setting.	Length of stay may be somewhat short or long. It is unclear if the client discharged to the appropriate level of care or living setting.	Client's length of stay is abnormally short or long. Client and/or family disagrees with discharge plan or reason for discharge. Client did not discharge to home, but should have. Client discharges to a restrictive setting, despite recommendations to the contrary.
Working Alliance	Staff and staff members get along well and there is evidence of a trusting relationship. Staff actively solicit feedback from the client and integrate client desires into treatment. Client-staff pairings are held as consistent as possible during treatment.	Occasional disagreements between client and staff members. Evidence that the client's thoughts on treatment goals and tasks are not always solicited. There are only a few staffing changes during treatment.	There are frequent disagreements and/or conflict between the client and primary staff members. Client does not trust staff members or feels as if staff do not listen to feedback. Client asks to be reassigned, or there are frequent staffing changes during treatment.

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