Addressing Behavioral Health Disparities and Improving Cultural Competence within a Statewide System of Care

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Session overview

- What is DMHAS and what challenges do we face as CTs public sector behavioral health authority?

- What are some of the health disparities we're seeing?

- What are the characteristics of a culturally competent system of care?

- What initial steps have we taken toward developing culturally relevant programs?

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Who are we? -- We're DMHAS

- Department of Mental Health and Addiction Services
  - CT's public sector behavioral health authority
- Substance abuse and mental health services
  - administrator
  - payer
  - provider
- 3,600 employees, two hospitals, 15 LMHAs
- $560 million/year operating expenses
- Contract with 250 private non-profit agencies

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What are the public sector challenges?

- Attend to the most clinically complex cases
- Address full spectrum of client needs
  - Housing, medical, financial, transportation
- Client involvement in multiple systems
  - Family and Social Services, Criminal Justice
- Provider system is under intense pressure
  - Under-staffed, under- resourced, best staff recruited away, need for improved quality
  - Changes in private sector care are increasing demand
- Recent layoffs and funding reductions

What do we need to do to meet these challenges?

- Maintain "Safety Net" responsibility
- Improve care quality within limited resources
- Provide holistic care
- Address increased client acuity/chronicity
- Build and maintain a culturally competent system of care
- Reduce health disparities
- Improve client outcomes

How significant is the problem of mental illness in the U.S.? 44 Million
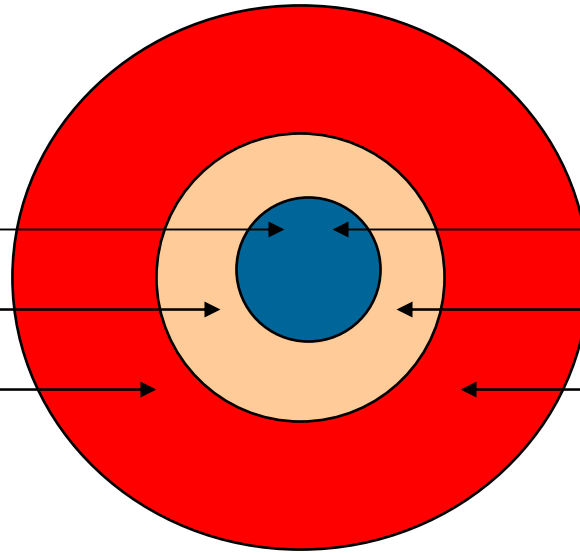
Annual prevalence, adults only

Percent of Adult Population				Number of Adults	
SPMI	2.6%			SPMI	4.8 Million
SMI	5.4%			SMI	10.0 Million
MI	23.9%			MI	44.2 Million

SPMI = Severe and Persistent Mental Illness

SMI = Serious Mental Illness

MI = Any form of Mental Illness

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Source: Kessler et al, 1996

How does mental illness rank among disabling diseases?

- ## WHO - "Global Burden of Disease Study"

Disease burden by selected illness in established market economies

	Percent of DALYs
All cardiovascular conditions	18.6
All mental illnesses (includes suicide)	15.4
All malignant diseases (cancer)	15.0
All respiratory diseases	4.8
All alcohol use	4.7
All infectious and parasitic diseases	2.8
All drug use	1.5

*Disability Adjusted Life Year: a measure of years of life lost to premature death and years lived with disability of a specified severity and duration.

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How are Public Sector Behavioral Health Clients doing in Treatment?
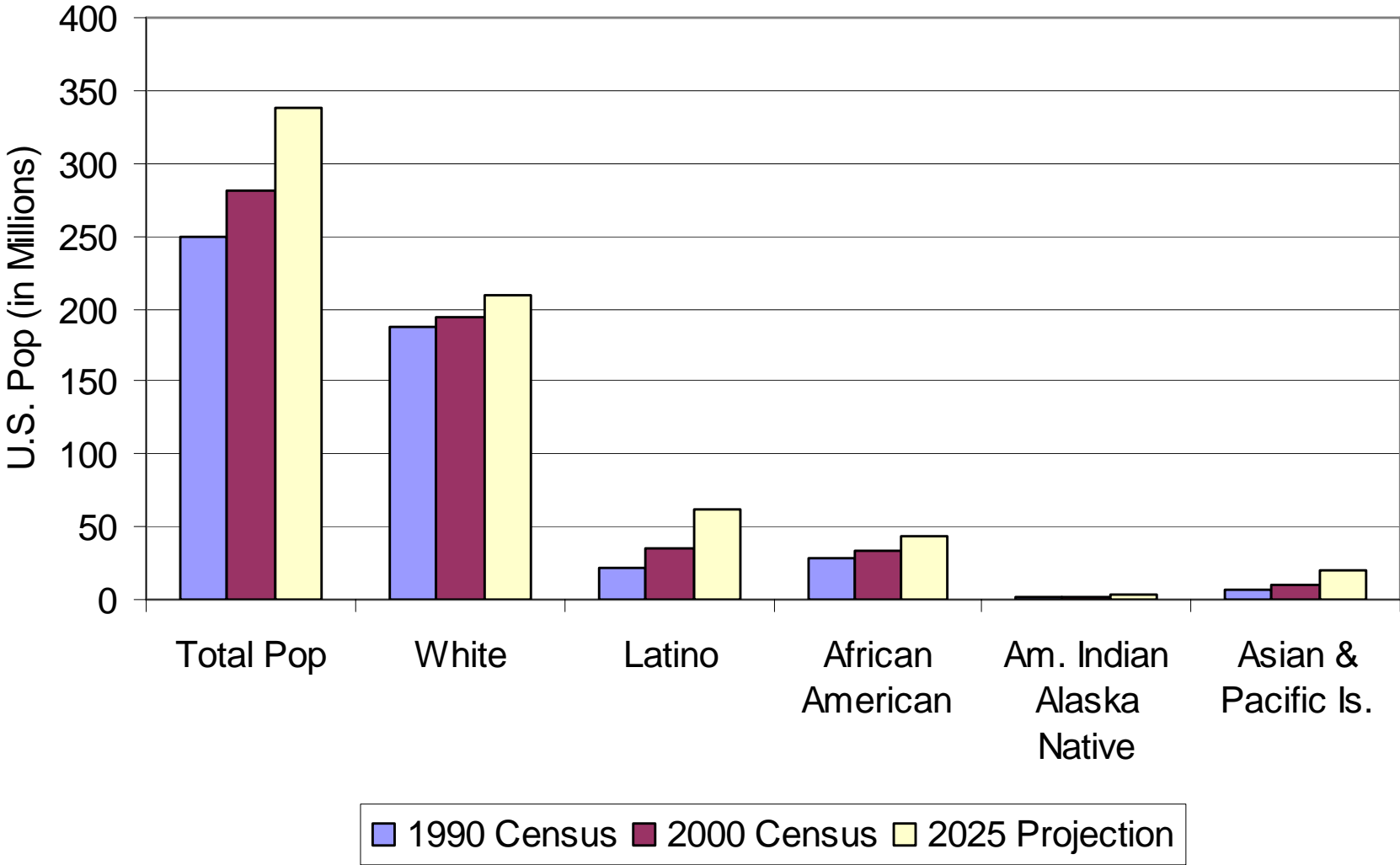
General Impression

1/3 Doing Well

1/3 Doing Fair

1/3 Doing Poorly

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Behavioral Health Disparities: What did the Surgeon General find?

- **Ethnic and racial minorities:**
  - Less access to, and availability of, mental health services
  - Less likely to receive needed mental health services
  - Those in treatment often receive a poorer quality of mental health care
  - Underrepresented in mental health research
  - Experience a greater burden of disability

Mental Health: Culture, Race and Ethnicity: A Supplement to Mental Health: A Report of the Surgeon General (2001)
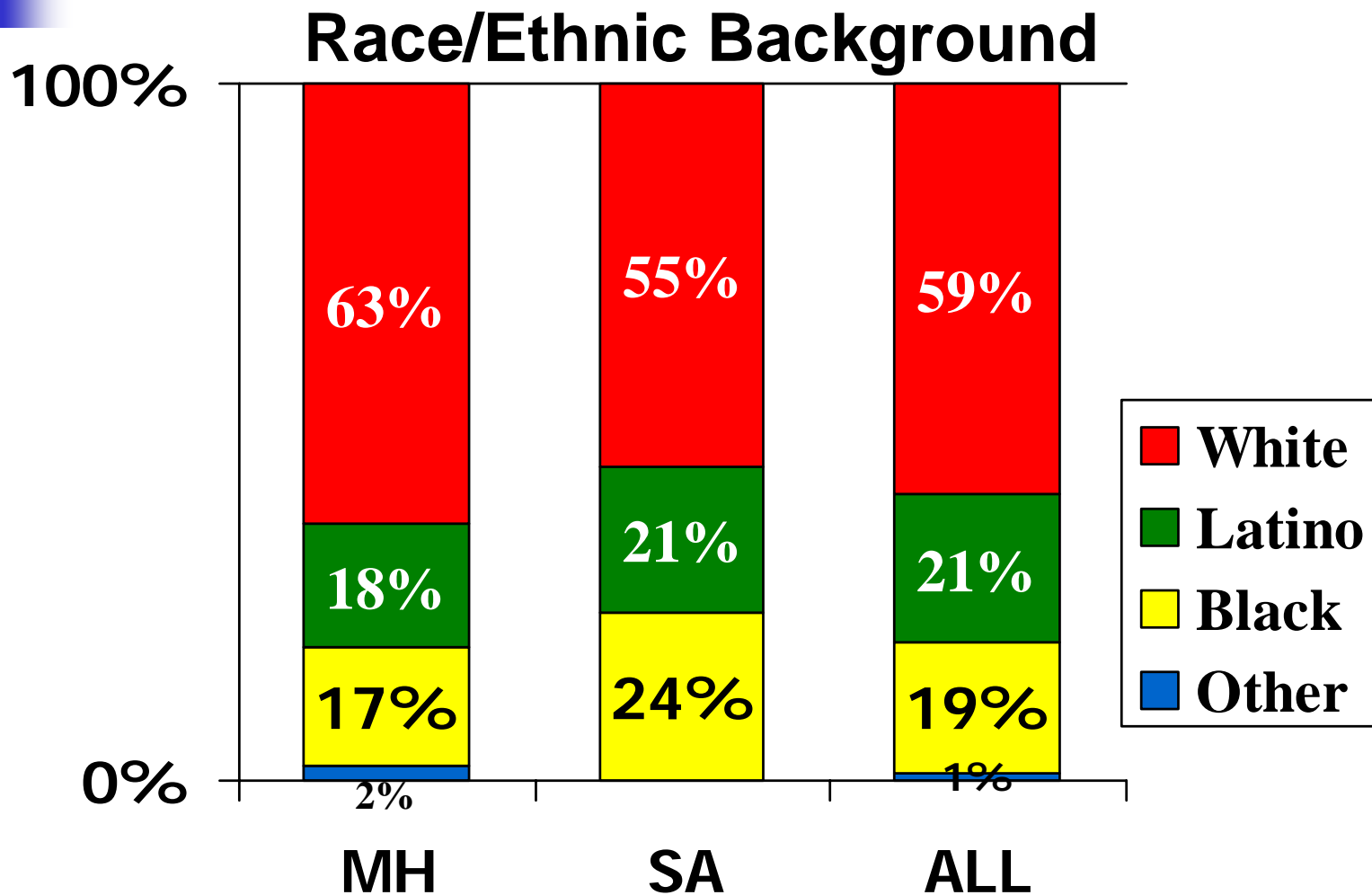
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U.S. Population by Race and Hispanic Origin

U.S. Pop (in Millions)

Categories: Total Pop, White, Latino, African American, Am. Indian Alaska Native, Asian & Pacific Is.

Legend: ☐ 1990 Census ■ 2000 Census ☐ 2025 Projection

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What demographic changes can we expect in Connecticut?

Connecticut demography in 2000 and in 2025

CT Population in Thousands	July 2000	July 2025	% Change
Latino*	288	574	99.3
African Amercian	324	490	51.2
Am Indian, Eskimo, Aleut	8	11	37.5
Asian & Pacific Islander	80	171	113.8
White	2873	3065	6.7
TOTAL	3285	3737	13.8

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Who used DMHAS services during FY02?

Race/Ethnic Background

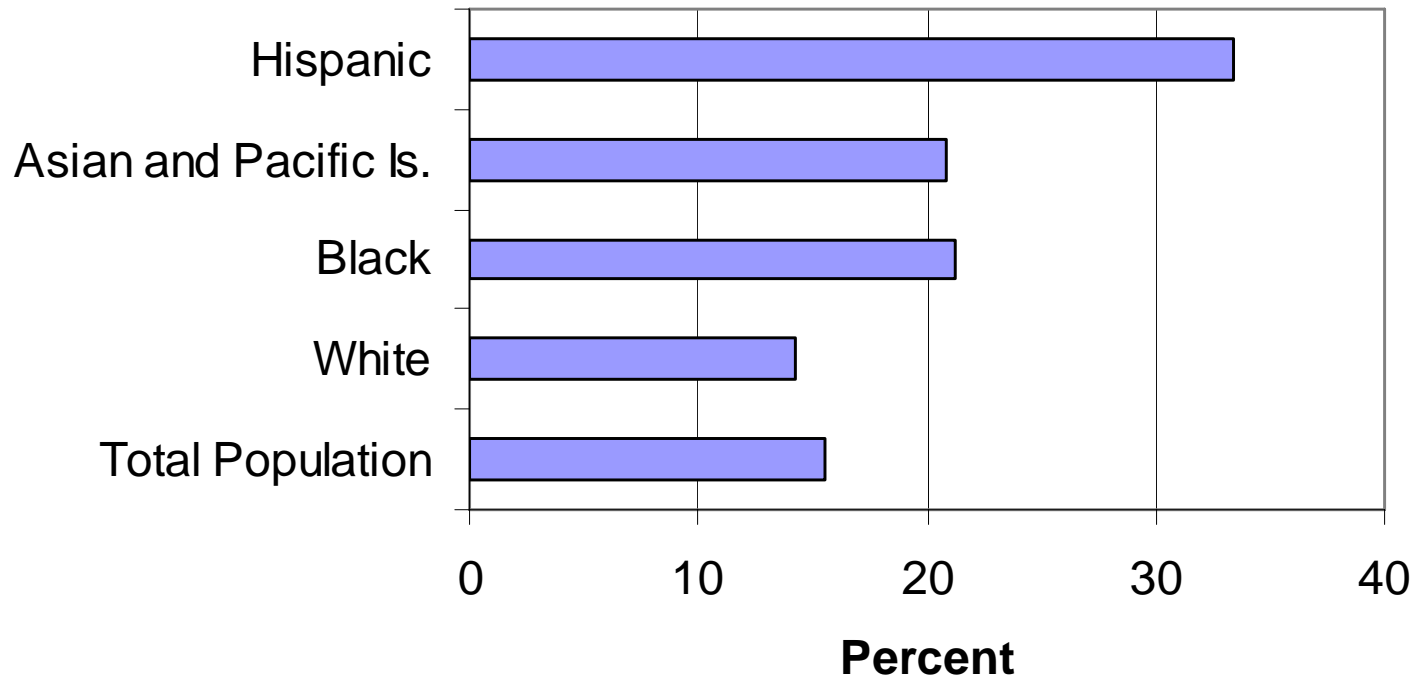|	MH	SA	ALL
White	63%	55%	59%
Latino	18%	21%	21%
Black	17%	24%	19%
Other	2%		1%

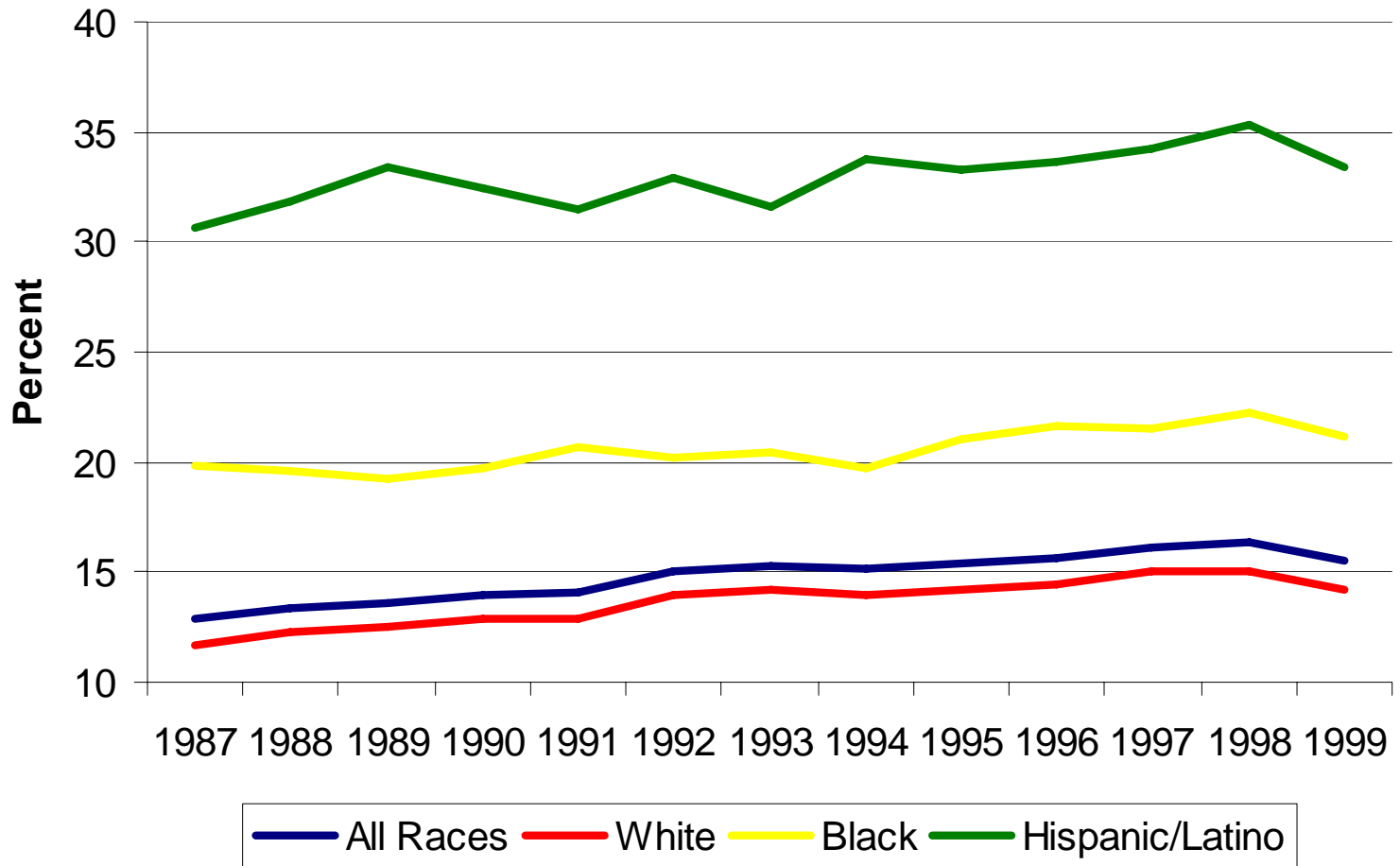**Legend:** White, Latino, Black, Other

Who is uninsured?

U.S. Population Without Health Insurance During the Entire Year 1999

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Uninsured gradually increasing

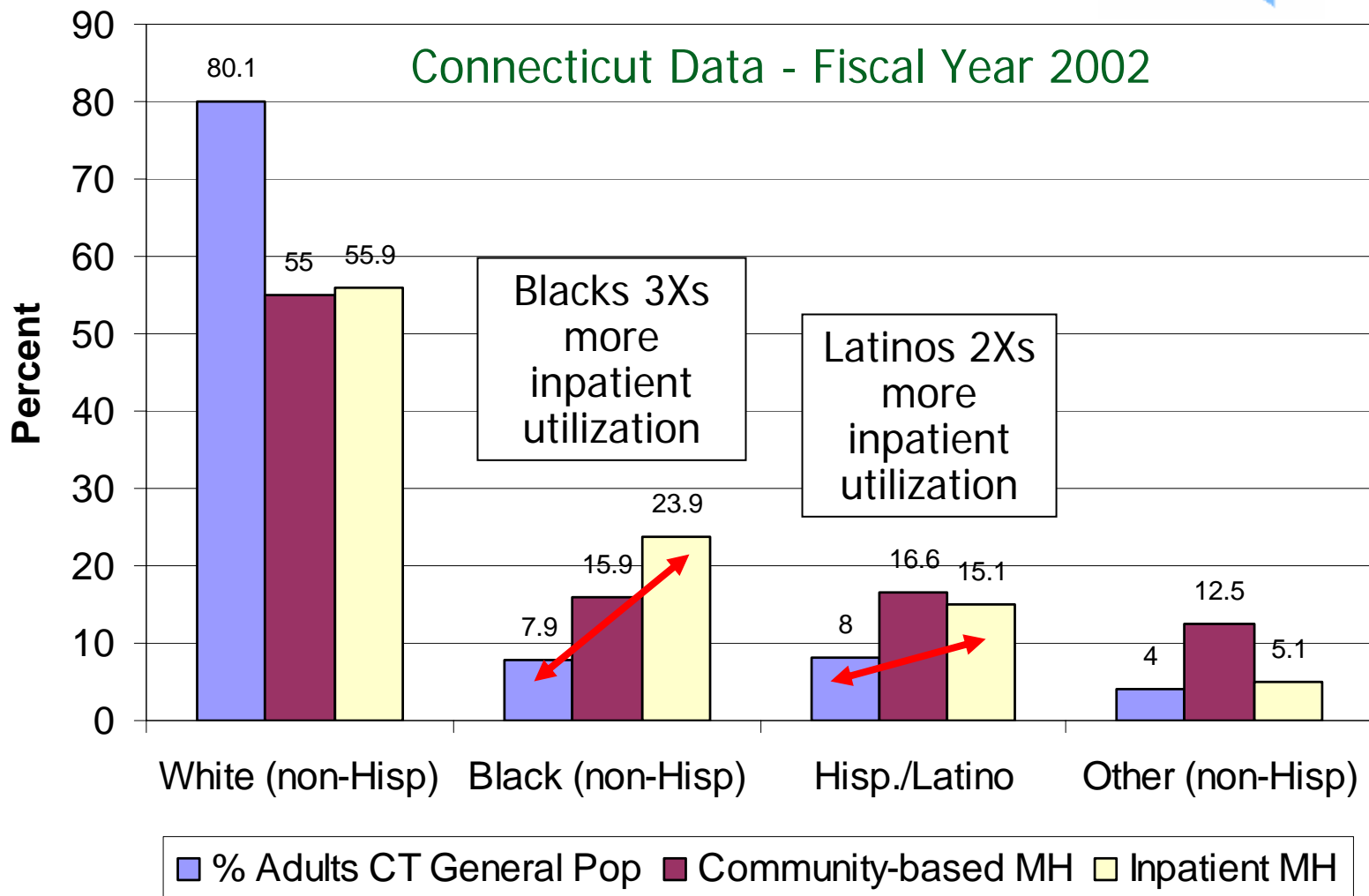**Uninsured People in the U.S. 1987 to 1999**

Who uses psychiatric emergency services and why?

- <u>Lonnie Snowden Ph.D., UC Berkeley</u>: More African Americans using PES than expected based on % in community population
- Why?
  - Substitution
  - Untreated illness
  - Economic stress
  - Intolerance

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Who gets hospitalized?

Connecticut Data - Fiscal Year 2002

Blacks 3Xs more inpatient utilization

Latinos 2Xs more inpatient utilization

White (non-Hisp): 80.1, 55, 55.9
Black (non-Hisp): 7.9, 15.9, 23.9
Hisp./Latino: 8, 16.6, 15.1
Other (non-Hisp): 4, 12.5, 5.1

Percent

☐ % Adults CT General Pop   ☐ Community-based MH   ☐ Inpatient MH

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Who gets overmedicated or is denied medications they need?

- Schizophrenia (PORT) Patient Outcome Research Team
  - Most treatment not consistent with Evidence-based Practice
    - 1/3 were over-medicated and 1/3 were under-medicated
  - Antidepressants were prescribed to only 1/2 despite known suicide risk in this population
    - 15% of people with schizophrenia commit suicide
  - African Americans were twice as likely to be over-medicated and twice as likely to be denied antidepressants as Whites

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Who gets "New Generation" antipsychotics?

- V. Ganju and L. Schacht (2002) looked at 32,000 episode of inpatient care

- Half of clients served had psychotic disorder diagnoses

- 49% - 82% received antipsychotic meds

- Whites with schizophrenia and "other psychotic disorders" were more likely to receive new generation meds than Black/African American and Hispanic clients

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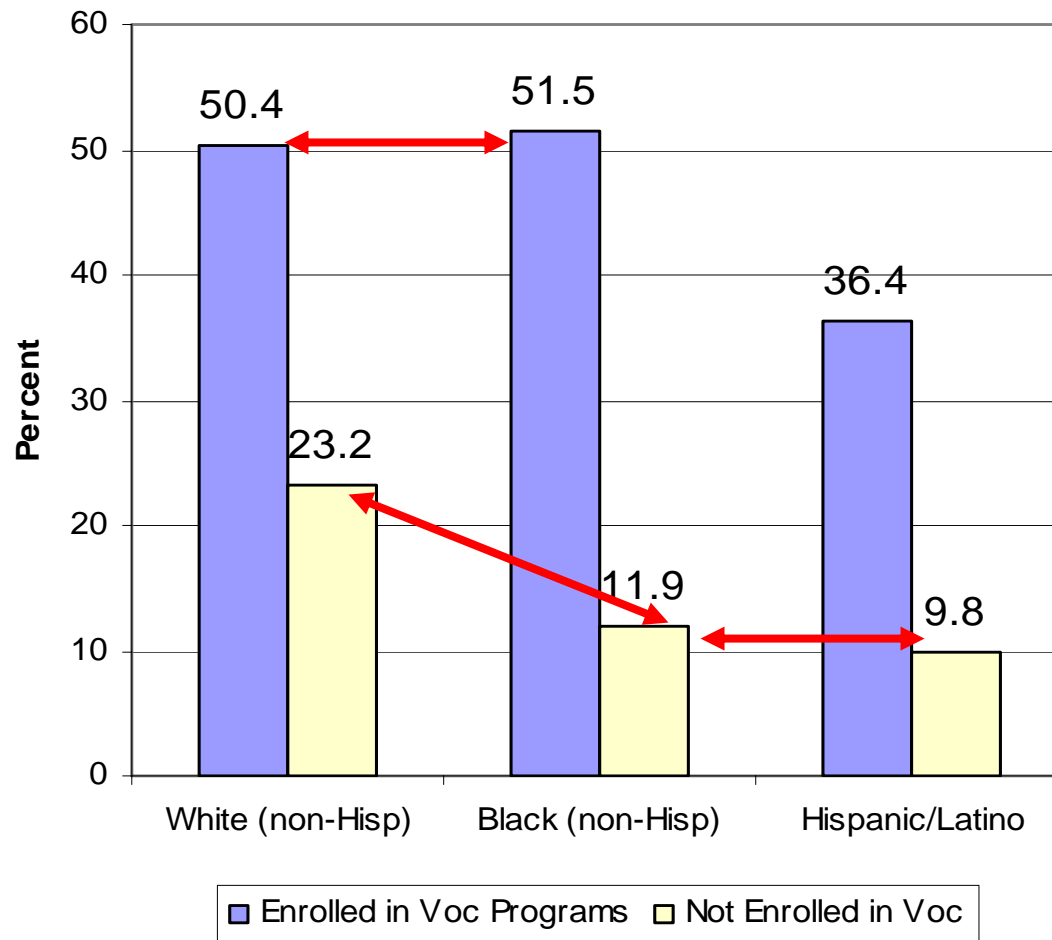# What about use of "New Generation" antipsychotics meds in a Connecticut state hospital?

- Patients receiving new generation antipsychotic meds increased significantly: 80% in FY99 to 87% in CY01

- <u>During FY99</u>: Significantly fewer African American patients received atypical meds (72% African American versus 82% among all other patients)

- <u>But During CY01</u>: Gap in use of newer meds closes (85% African Americans versus 87% among all other patients)

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Who gets vocational services and a paid job?

Results from the "Voice Your Opinion 2000-2001" Connecticut Consumer Survey

Legend: ■ Enrolled in Voc Programs □ Not Enrolled in Voc

Data values shown:
- White (non-Hisp): 50.4 (Enrolled), 23.2 (Not Enrolled)
- Black (non-Hisp): 51.5 (Enrolled), 11.9 (Not Enrolled)
- Hispanic/Latino: 36.4 (Enrolled), 9.8 (Not Enrolled)

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What about continuity of care?

Transition from acute substance detox to rehab services
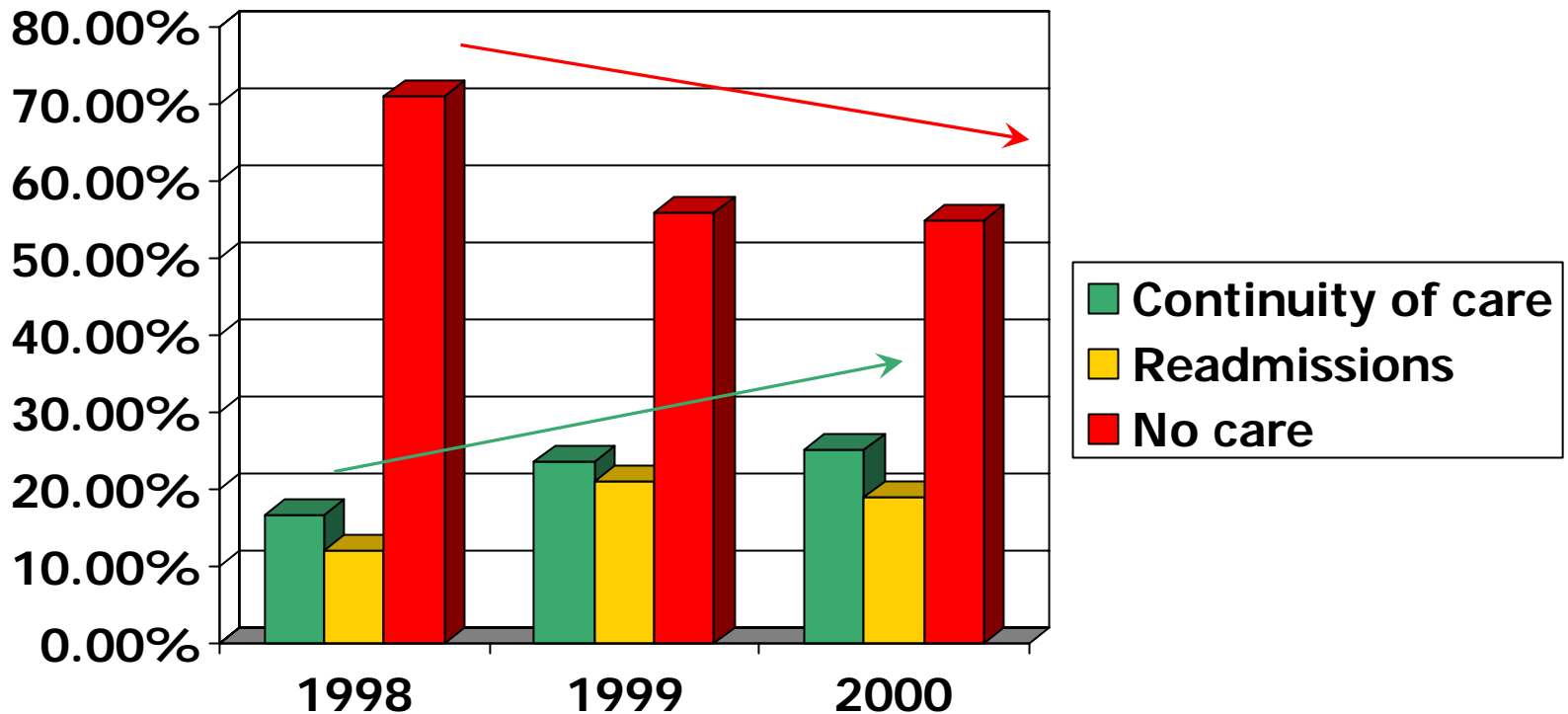
Source: Connecticut Data

Do aggregate data masks important differences among groups?

Who makes the transition from acute substance detox to rehab services in Connecticut?

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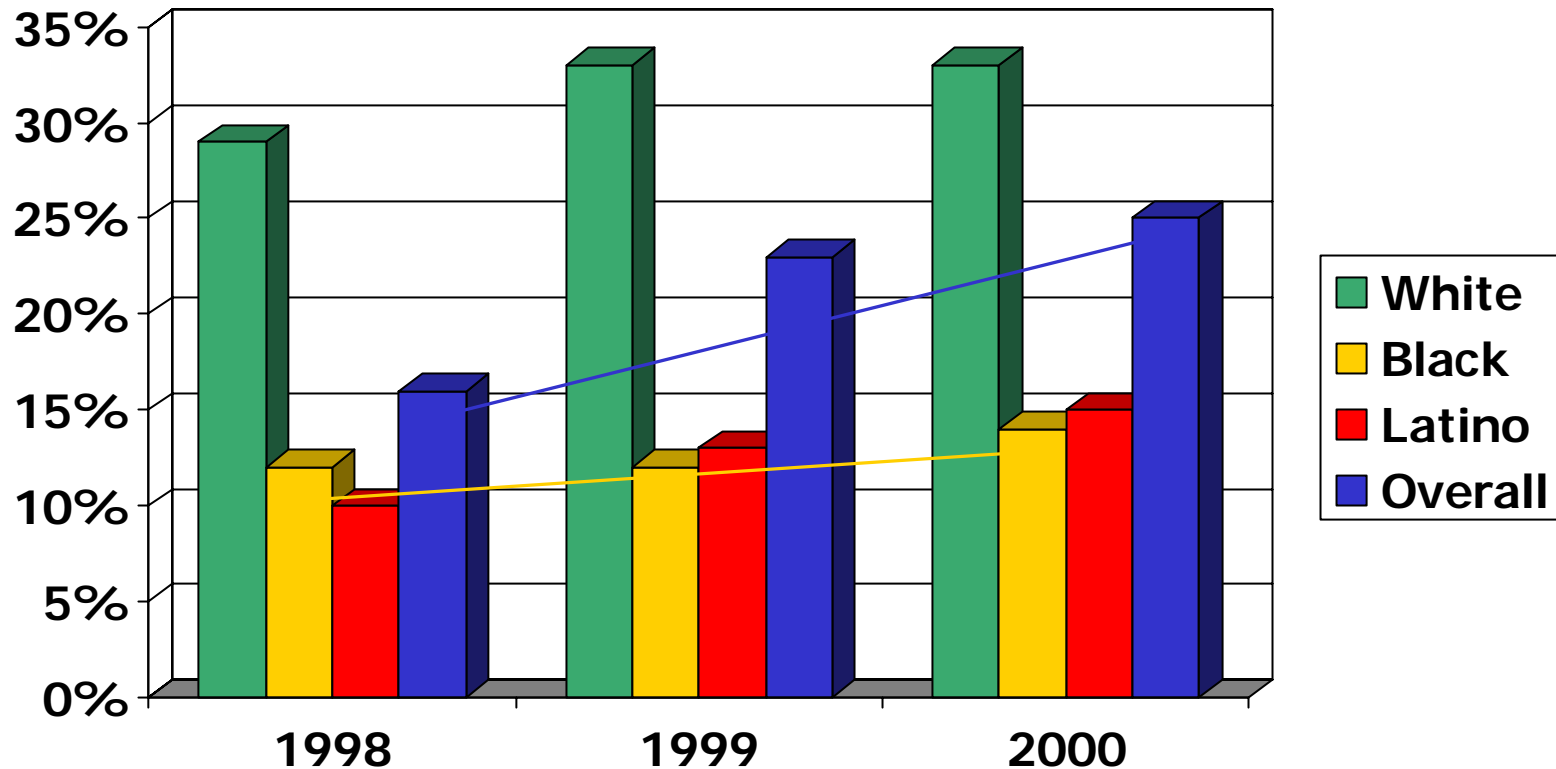
What causes health disparities?

- Factors that co-vary with race/ethnicity
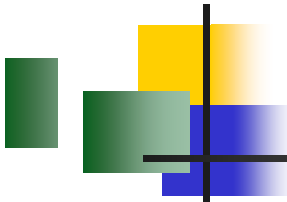 - Income, education and environment
- Still some important relationships

What are some of the other causes?

- Service fragmentation

- Absence of qualified service provider(s)

- Culturally specific needs of clients

- Language barrier + meaning barrier

- Societal stigma

- Racism and discrimination

- Mistrust, fear of treatment, relevance of treatment

- Absence of holistic approach

- Cost (absence of health insurance)

Treatment Access

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What are some of the institutional barriers?

- Client racial and ethnic groups perceive that behavioral health services are:
    - fragmented - not well organized
    - not set up to address their needs
    - not relevant
- Clients believe they're not going to be able to communicate
    - U.S. Surgeon General's Report on Mental Health

What's our approach to addressing behavioral health disparities?

- Develop a Culturally Competent System of Care (CCSC)

What's our approach to addressing behavioral health disparities?

- Develop a Culturally Competent System of Care (CCSC)

$$CCP^n \neq CCSC$$

What is Cultural Competency?

- A culturally competent mental health system incorporates skills, attitudes, and policies to ensure that it is effectively addressing the treatment and psychosocial needs of consumers and families with diverse values, beliefs, and sexual orientations, in addition to backgrounds that vary by race, ethnicity, religion, and/or language.

- The extent to which programs provide effective services to members of various cultural backgrounds.
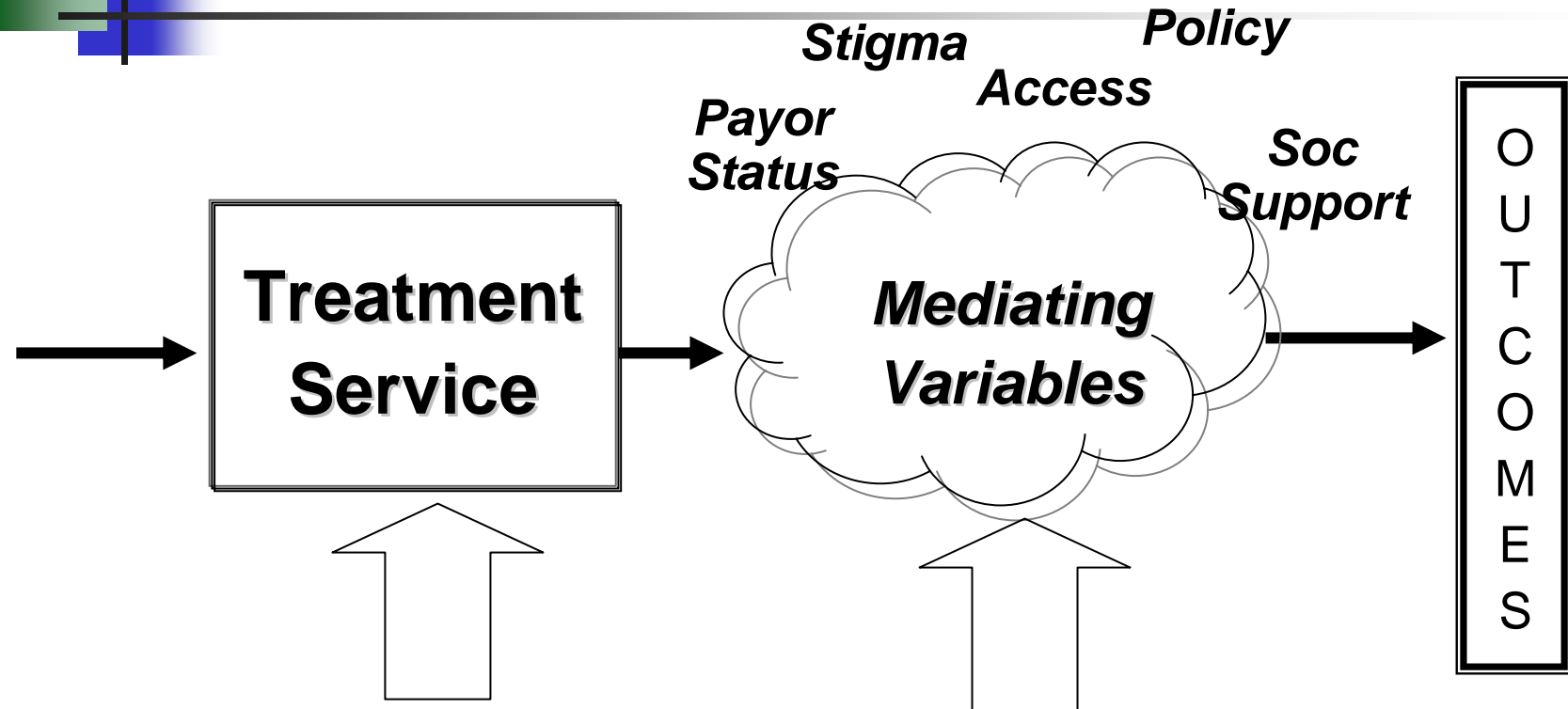
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What are the characteristics of a CCSC?

- Encompasses a complex understanding of clients and systems

What are the characteristics of a CCSC?
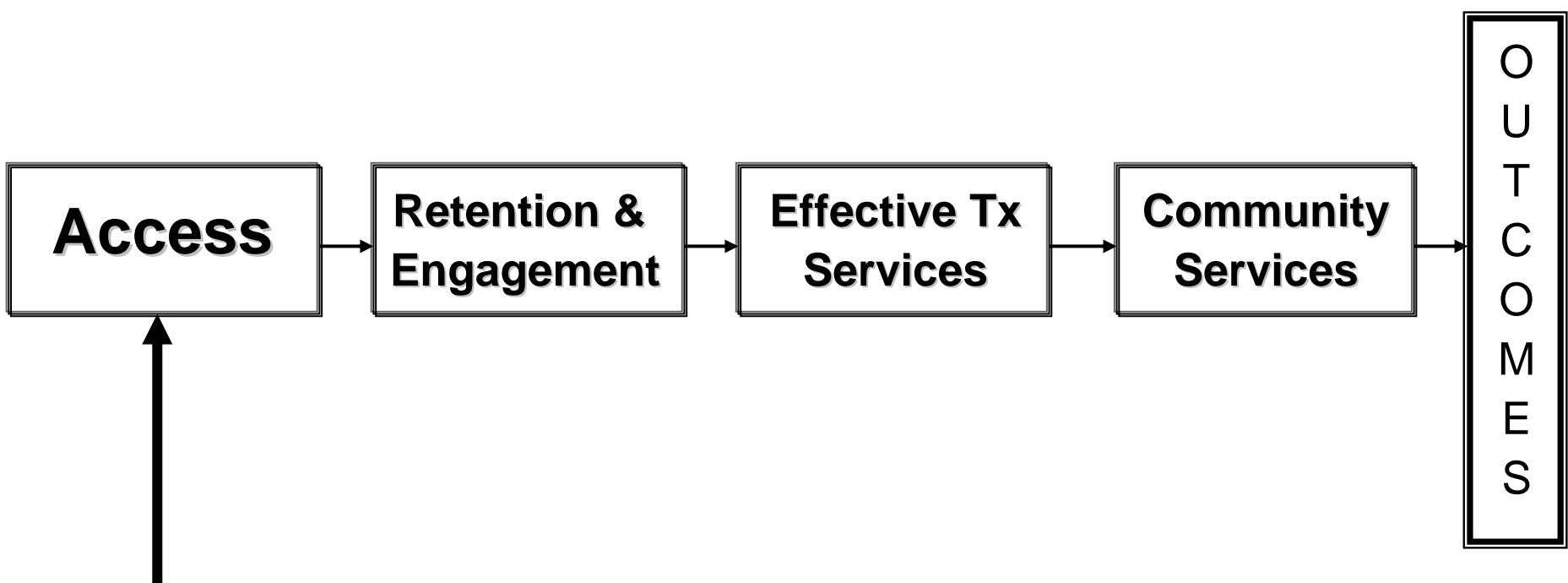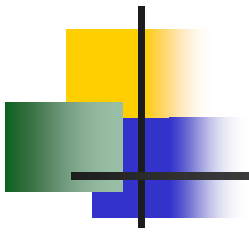
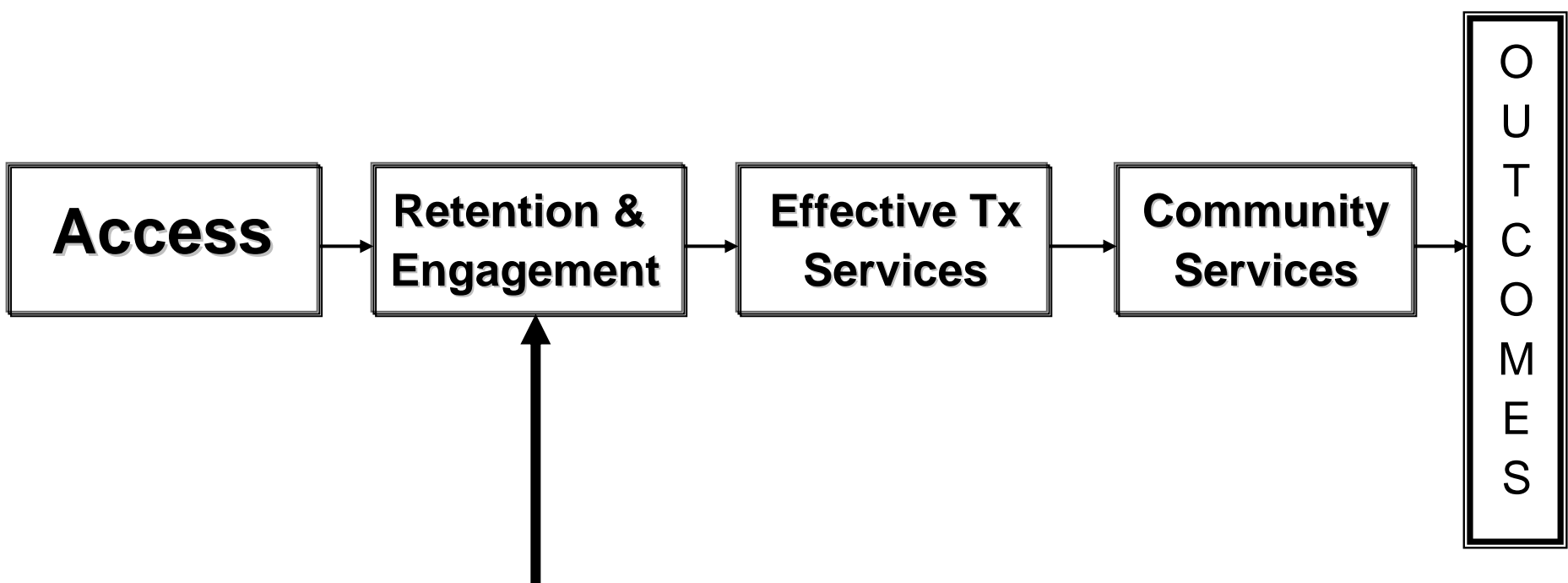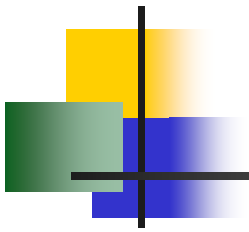- Encompasses a complex understanding of clients and systems

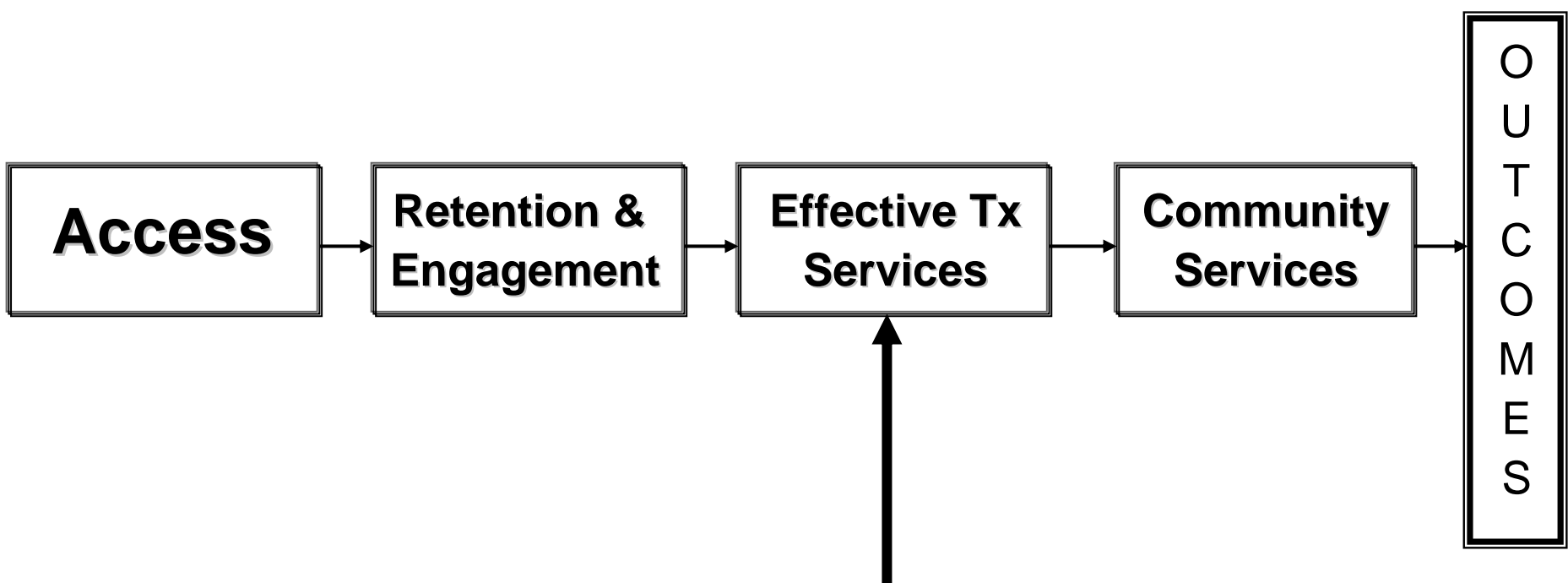Treatment Service → OUTCOMES
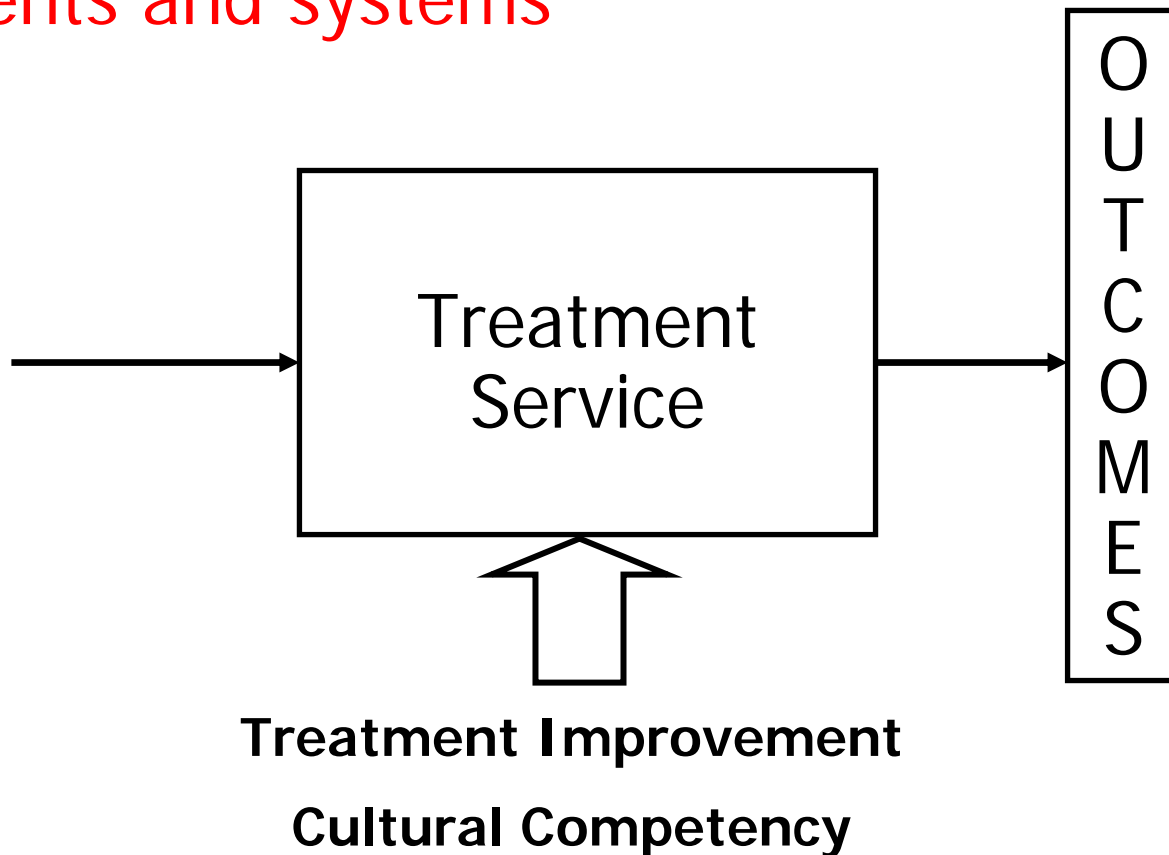
Treatment Improvement

Cultural Competency

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Access → **Retention & Engagement** → **Effective Tx Services** → **Community Services** → **OUTCOMES**

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Access → **Retention & Engagement** → **Effective Tx Services** → **Community Services** → **OUTCOMES**

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Access → **Retention & Engagement** → **Effective Tx Services** → **Community Services** → **OUTCOMES**

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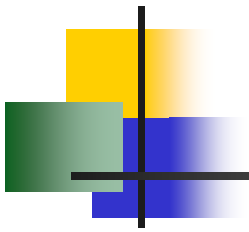
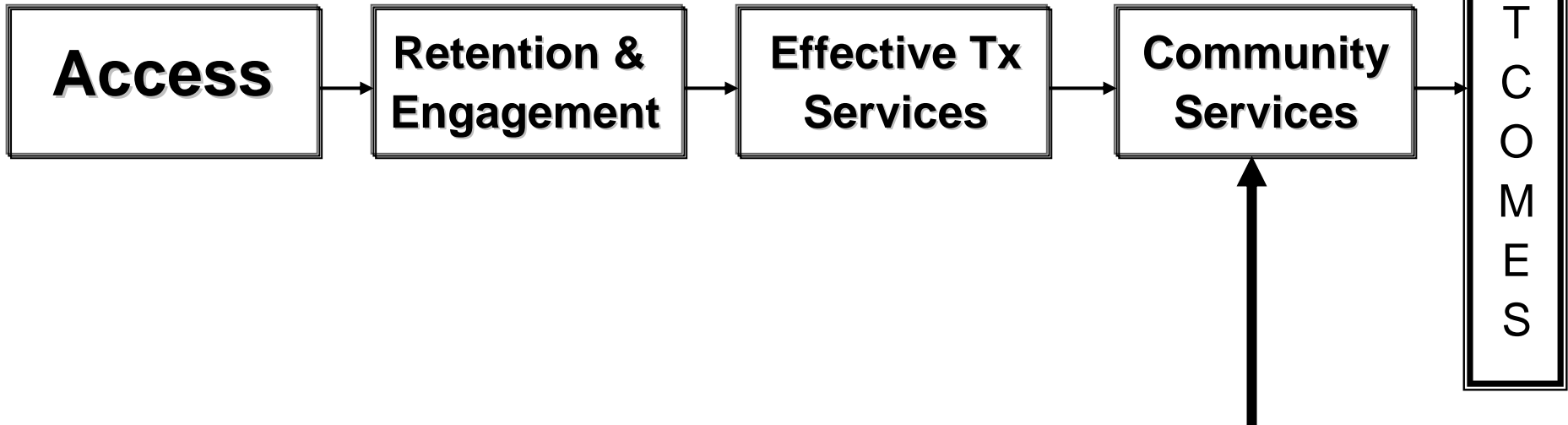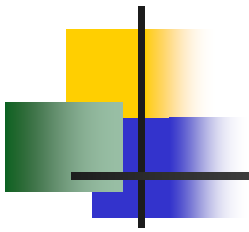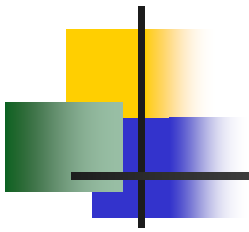**Geographical**
Psychological
Physical
Insurance Coverage

Tx Participation
Admission Process
Establishment of Trust
Therapeutic Relationship

Therapeutic Relationship
Quality Treatment

Indigenous Healers
Ecological Perspective
of clients
Community
Relationships

Access	→	**Retention & Engagement**	→	**Effective Tx Services**	→	**Community Services**	→	**O U T C O M E S**

Penetration Rates
Geo Mapping
Proportion in LOC

Length of Stay
Frequency of Visits

Clinical Outcomes
Treatment Completion
Quality of Life Measure

Relapse/Recidivism
Rates

Addressing Payor Issues
Geographical Access
Inviting Environment
Staff Selection

Culturally Specific
Programs
Motivational
Enhancement
Therapy

Culturally Specific
Programs

Urban Initiative
Self-Help Groups

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What are the characteristics of a CCSC? (Cont'd.)

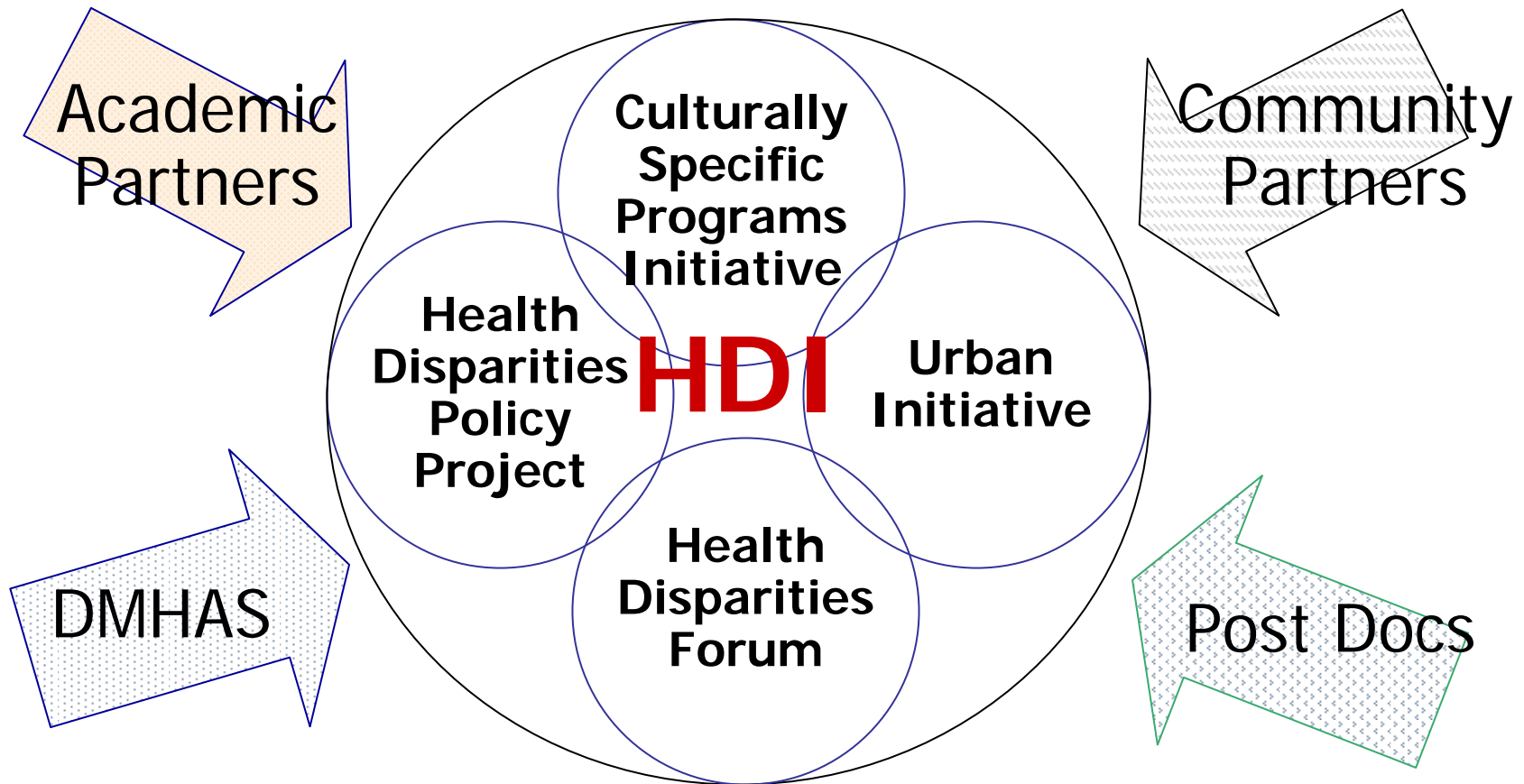## Uses a Multi level - Multi-dimensional Approach

- Clinical (Practitioner)
- Program (Provider)
- System (Policy)

- Training
- Standard Setting
- Contracting
- Data systems/MIS
- Quality Management
- Clinical/Systems Policy
- Consumer Advocacy/ Input/Satisfaction
- Evaluating care

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What are the characteristics of a CCSC? (Cont'd.)

Involves simultaneous initiatives

Academic Partners

Community Partners

Culturally Specific Programs Initiative

Health Disparities Policy Project

HDI

Urban Initiative

Health Disparities Forum
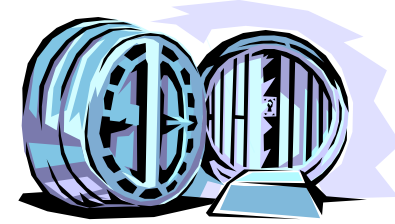
DMHAS

Post Docs

Health Disparities Initiative (HDI)

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What is the CT Health Disparities Initiative?

Goals:

- Identify and reduce behavioral health disparities
- Improve quality of care by enhancing cultural competence
- Create sustained *Systems Change*
- Contribute to the body of scientific knowledge

D

What are the characteristics of a CCSC? (Cont'd.)

Involves many different partners

Academic Partners	DMHAS	Community Partners

UConn

Center for Trauma Response/ Recovery & Preparedness

Dept. of Psychiatry

Yale

The Consultation Center

Dept. of Psychiatry

Center Urban Health, Poverty and Disability

Postdoctoral Fellows

Senior Leadership

Office of Multicultural Affairs

Health Disparities Forum

CT Institute for Cultural Literacy and Wellness

Urban Initiatives

Faith Community Initiatives

Asian Family Services & Khmer Advocates

CT Psychological Association, Diversity Taskforce

Hartford Call to Action

Connecticut Association for United Spanish Action

New Haven Family Alliance

Recovery Communities

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What are the characteristics of a CCSC? (Cont'd.)

Promotes consumer and community empowerment and includes outreach to the community

- **New Haven Family Alliance**
  - Sought consumer and provider's perspectives
  - Provided consultation
  - Empowerment
  - Reciprocal relationship

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What are the characteristics of a CCSC? (Cont'd.)

- Uses a Data Driven approach
- Promotes use of "Evidence-based Practices"
  - Evidence-based
  - Evidence-supported
  - Evidence-informed
  - Evidence- suggested
- Focused on outcomes

What are the characteristics of a CCSC?

- **Supported by policy and financial resources**

  - Change language in contracts
  - Training initiatives
  - Medicaid
  - Augment services through Grants

What are the characteristics of a CCSC? (Cont'd.)

- **Provides culturally competent treatment based on understanding of:**
  - Language, history, tradition, beliefs and values
  - Nuances of communication
    - understanding the meaning of words and idioms
    - non-verbal - human and environmental communication
  - Building trust between client and clinician
  - Understanding the role of:
    - Racial identity, spirituality/religion, family, alternative healing practitioners/methods

- **Is based on collaborative planning of treatments and supports :**
  - Involving clients, families and spiritual/faith resources

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Enhancing the Cultural Relevance of Treatment Programs

The Challenge:

- To assess the ways culturally specific programs are qualitatively different from traditional approaches

- To determine in what ways the culturally relevant approaches influence outcomes

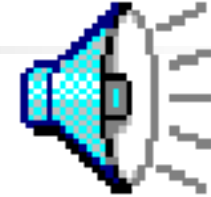- To operationalize cultural competence

Enhancing the Cultural Relevance of Treatment Programs (cont'd.)

The Approach:

- Draw on the literature and existing programs to:
  - Isolate critical factors in programs
  - Develop treatment models
  - Test the models
- Use outcome results to inform policy

Identifying the critical components of cultural competence

- Literature Review
- Qualitative Research

  Case Study: The Amistad Village Project
  - Focus Groups
  - Ethnographic observation
  - Interviews
  - Analysis of policies and procedures
- Consumer Surveys

Summary

Use cultural competence as a vehicle to address health disparities

Characteristic	BH	PH	Characteristic	BH	PH
Complex understanding of clients and systems	X	X	**Data driven approach**	X	X
Multi-level approach	X	X	**Evidence-based practices**	X	X
Multi-dimensional approach	X	X	**Focused on outcomes**	X	X
Simultaneous initiative	X	X	**Culturally relevant treatment**	X	X
Multiple partnerships	X	X	**Collaborative planning of treatments and supports**	X	X
Consumer and community empowerment/outreach	X	X	**Supported by policy and financial resources**	X	X

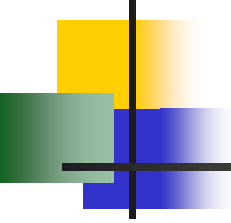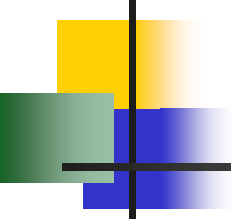BH = Behavioral Healthcare   PH = Primary Healthcare

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Questions for you

How can this framework be used to address health disparities for physical illnesses?

Characteristic	BH	PH	Characteristic	BH	PH
Complex understanding of clients and systems	X	X	Data driven approach	X	X
Multi-level approach	X	X	Evidence-based practices	X	X
Multi-dimensional approach	X	X	Focused on outcomes	X	X
Simultaneous initiative	X	X	Culturally relevant treatment	X	X
Multiple partnerships	X	X	Collaborative planning of treatments and supports	X	X
Consumer and community empowerment/outreach	X	X	Supported by policy and financial resources	X	X

BH = Behavioral Healthcare   PH = Primary Healthcare

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- What experiences can you share about effective ways to use culturally-based approaches to reduce health disparities?

- What role does institutional racism and discrimination play in creating and perpetuating health disparities?

Need for Behavioral Health Care

- <u>African Americans:</u>
  - Overall rates of mental illness similar to non-Hispanic whites
  - Differences in prevalence of specific illnesses
  - Suicide rates lower but on the rise
  - Environmental, economic and social factors
    - Exposure to violence, homelessness, incarceration, social welfare involvement
  - Less access to behavioral health services

Need for Behavioral Health Care

- <u>Latinos/Hispanic Americans:</u>
    - Overall rates of MI similar to non-Hispanic whites
    - Higher rates of some disorders
        - Anxiety-related and delinquency behaviors, depression and drug use, more common among Latino youth
        - Higher rates of depression among elderly Latinos
    - Culture-bound syndromes:
        - Susto (fright), nervios (nerves), mal de ojo (evil eye), and ataque de nervios
    - Access to behavioral health services is limited

Need for Behavioral Health Care

- **<u>Asian Americans/Pacific Islanders</u>**
  - Limited data on prevalence of MI
    - Existing data suggests overall rates similar to whites
    - Higher rates of depression, PTSD
    - Somatic complaints of depression
    - Culture-bound syndromes
    - Lower suicide rates - except elderly women who have the highest suicide rates in U.S.
  - Refugees with PTSD
  - Language barrier limits access to services

Need for Behavioral Health Care

- <u>**American Indians and Alaska Natives**</u>
  - Limited data on prevalence of MI
    - One small study with 20 year follow-up found 70% lifetime prevalence of MI
    - Increase rise of depression among older adults
    - Suicide rate 1.5xs national average with young males accounting for 2/3 of suicides
    - 2nd decade of life has highest mortality rate
    - Alcohol dependence, alcohol related deaths
  - Little information on service utilization patterns

The Impact of Cultural differences on the treatment process

Cultural differences affect how people:

- ❖ Label and communicate pain or problems
- ❖ Label symptoms or indicators
- ❖ Determine the causes of behavioral health problems
- ❖ Perceive health care providers
- ❖ Respond to or utilize treatment or assistance
- ❖ View personal involvement and responsibility

Other ways cultural variation impacts treatment

- ❖ Behavioral health problems are viewed differently by different cultures
- ❖ Substance abuse as sin, will or morality; disease model not accepted by some cultures
- ❖ Notions of family vary by culture
- ❖ Racism must be acknowledge as part of the recovery process, can't ignore trauma such as sexual abuse, nor discrimination against experienced by culturally diverse groups.

The role of culture in behavioral healthcare?

- Etiology and Course of Behavioral Health Problems
  - Studies show that ethnicity plays major role
  - For example, a study examining HIV risk behaviors in youth concluded that: *"Ethnicity plays a larger role than gender or cognitive measures in predicting sexual activity as well as substance use."*

    (Faryna and Morales, 2000)