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

Arthur C. Evans, PhD, Deputy Commissioner
Wayne F. Dailey, PhD, Senior Policy Advisor
Connecticut Department of Mental Health and Addiction Services
Dietra Hawkins, PsyD and Ijeoma Achara-Abrahams, PsyD, and Raquel Andres, Ph.D.
Post Doctoral Fellows
Yale University School of Medicine
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
- $500 million/year operating expenses
- Contract with 250 private non-profit agencies
- 60,000 people served annually
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

- SPMI: 2.6%
- SMI: 5.4%
- MI: 23.9%

Number of Adults

- SPMI: 4.8 Million
- SMI: 10.0 Million
- MI: 44.2 Million

SPMI = Severe and Persistent Mental Illness
SMI = Serious Mental Illness
MI = Any form of Mental Illness

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

<table>
<thead>
<tr>
<th>Condition</th>
<th>Percent of DALYs</th>
</tr>
</thead>
<tbody>
<tr>
<td>All cardiovascular conditions</td>
<td>18.6</td>
</tr>
<tr>
<td>All mental illnesses (includes suicide)</td>
<td>15.4</td>
</tr>
<tr>
<td>All malignant diseases (cancer)</td>
<td>15.0</td>
</tr>
<tr>
<td>All respiratory diseases</td>
<td>4.8</td>
</tr>
<tr>
<td>All alcohol use</td>
<td>4.7</td>
</tr>
<tr>
<td>All infectious and parasitic diseases</td>
<td>2.8</td>
</tr>
<tr>
<td>All drug use</td>
<td>1.5</td>
</tr>
</tbody>
</table>

*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.

Source: Murray & Lopez, 1996
How are Public Sector Behavioral Health Clients doing in Treatment?

General Impression

1/3 Doing Well
1/3 Doing Fair
1/3 Doing Poorly
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

What demographic changes can we expect in Connecticut?

Connecticut demography in 2000 and in 2025

<table>
<thead>
<tr>
<th>CT Population in Thousands</th>
<th>July 2000</th>
<th>July 2025</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Latino*</td>
<td>288</td>
<td>574</td>
<td>99.3</td>
</tr>
<tr>
<td>African American</td>
<td>324</td>
<td>490</td>
<td>51.2</td>
</tr>
<tr>
<td>Am Indian, Eskimo, Aleut</td>
<td>8</td>
<td>11</td>
<td>37.5</td>
</tr>
<tr>
<td>Asian &amp; Pacific Islander</td>
<td>80</td>
<td>171</td>
<td>113.8</td>
</tr>
<tr>
<td>White</td>
<td>2873</td>
<td>3065</td>
<td>6.7</td>
</tr>
<tr>
<td>TOTAL</td>
<td>3285</td>
<td>3737</td>
<td>13.8</td>
</tr>
</tbody>
</table>
Who’s using public sector services?
DMHAS Fiscal Year 2003 Data

Source: CT DMHAS eCura
Who is uninsured?

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

- Hispanic
- Asian and Pacific Is.
- Black
- White
- Total Population

Percent
Uninsured gradually increasing

Uninsured People in the U.S. 1987 to 1999

Percent


All Races  White  Black  Hispanic/Latino
Who uses psychiatric emergency services and why?

- **Lonnie Snowden Ph.D., UC Berkeley**: More African Americans using PES than expected based on % in community population

- **Why?**
  - Substitution
  - Untreated illness
  - Economic stress
  - Intolerance
Who gets hospitalized?

Connecticut Data - Fiscal Year 2002

- Blacks 3Xs more inpatient utilization
- Latinos 2Xs more inpatient utilization

<table>
<thead>
<tr>
<th>Group</th>
<th>% Adults CT General Pop</th>
<th>Community-based MH</th>
<th>Inpatient MH</th>
</tr>
</thead>
<tbody>
<tr>
<td>White (non-Hisp)</td>
<td>80.1</td>
<td>55</td>
<td>55.9</td>
</tr>
<tr>
<td>Black (non-Hisp)</td>
<td></td>
<td>7.9</td>
<td>15.9</td>
</tr>
<tr>
<td>Hisp./Latino</td>
<td></td>
<td>8</td>
<td>16.6</td>
</tr>
<tr>
<td>Other (non-Hisp)</td>
<td></td>
<td>4</td>
<td>12.5</td>
</tr>
</tbody>
</table>

Legend:
- % Adults CT General Pop
- Community-based MH
- Inpatient MH
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
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
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

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

- But During CY01: Gap in use of newer meds closes (85% African Americans versus 87% among all other patients)
Who gets vocational services and a paid job?

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

Culturally competent care wipes out health disparities
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)
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)

\[ \text{CCP}^n \neq \text{CCSC} \]
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.
What’s been the discussion about how treatment works?

The Old Model

Treatment Improvement

Cultural Competency

Outcome
Treatment Improvement

Cultural Competency

Need to Understand

Include in Our Conceptualizations

Intervene

Policy

Stigma

Access

Soc Support

Mediating Variables

Payor Status

Outcomes
The ACES Model

**Issues**
- Geographical Access
- Psychological Access
- Physical Access
- Insurance Coverage

**Interventions**
- Addressing Payer Issues
- Geographical Access
- Culturally Specific Programs
- Staff Selection

**Indicators**
- Penetration Rates
- Geo Mapping
- Proportion in LOC

**Access** → **Client Engagement & Retention** → **Effective Tx Services** → **Supports in Community**

**Treatment Participation**
- Admission Process
- Establishment of Trust
- Therapeutic Relationship

**Therapeutic Relationship**
- Quality Treatment
- Languages spoken

**Indigenous Healers**
- Ecological Perspective of Clients
- Community relationship

**Culturally Specific Programs**
- Inviting Environment

**Motivational Enhancement Therapy (MET)**
- Transcultural Approaches
- Hire bilingual therapists

**Faith Community connections**
- Self-Help Groups

**Clinical Outcomes**
- Treatment Completion
- Quality of Life Measure

**Relapse/Recidivism Rates**
- Length of Stay
- Frequency of Visits

**Penetration Rates**
- Geo Mapping
- Proportion in LOC
Access

**Issues:**
- Lack of awareness of community resources
- Geographic location/access
- Language barriers

**Interventions:**
- Increase awareness thru. collaboration & community activism
- Neighborhood clinic
- Provide services/forms in language of preference

**Indicators:**
- Level of interagency communication/collaboration.
- Proximity, % of target group in region, walk-ins
- % bilingual staff, penetration rates of monolingual groups
## Engagement and Retention

### Issues:
- Lack of cultural referent in physical environment
- Insufficient outreach efforts
- Higher Drop out Rates for people of color

### Interventions:
- Create a culturally welcoming environment
- Reform outreach efforts, solicit support of advocates
- Motivational Interviewing

### Indicators:
- Length of stay, frequency of visits, early treatment dropout
- Number of outreach referrals and people leaving treatment AMA
- Treatment Completion Rates
Effective Treatments

**Issues:**
- Treatment-as-usual
- Fragmented services

**Interventions:**
- Culture-specific
- Integrated services

**Indicators:**
- Completion rates, quality of life, client satisfaction
- For Latinos: Participation of family members in treatment
- Continuity of care, increased collaboration
Supports in the Community

**Issues:**
- Lack of links to natural/community supports
- Lack of community resources

**Interventions:**
-- Integrate natural/community supports in treatment
- Develop community resources/programs

**Indicators:**
- Level of involvement of family/spiritual leader in treatment
- Number of community culture-specific programs and relapse/recidivism rates
What is the DMHAS 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
What are the characteristics of a Culturally Competent System of Care?

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
What are the characteristics of a Culturally Competent System of Care?

Involves simultaneous initiatives

Health Disparities Initiative (HDI)
What are the characteristics of a Culturally Competent System of Care?

Involves many different partners

<table>
<thead>
<tr>
<th>Academic Partners</th>
<th>DMHAS</th>
<th>Community Partners</th>
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<tbody>
<tr>
<td>UConn</td>
<td>DMHAS</td>
<td>CT Institute for Cultural Literacy and Wellness</td>
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<tr>
<td>Center for Trauma Response/Recovery &amp; Preparedness</td>
<td>Senior Leadership</td>
<td>Urban Initiatives</td>
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<tr>
<td>Dept. of Psychiatry</td>
<td>Office of Multicultural Affairs</td>
<td>Faith Community Initiatives</td>
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<tr>
<td>Yale</td>
<td>Health Disparities Forum</td>
<td>Asian Family Services &amp; Khmer Advocates</td>
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<tr>
<td>The Consultation Center</td>
<td></td>
<td>CT Psychological Association, Diversity Taskforce</td>
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<tr>
<td>Dept. of Psychiatry</td>
<td></td>
<td>Hartford Call to Action</td>
</tr>
<tr>
<td>Center Urban Health, Poverty and Disability</td>
<td>Postdoctoral Fellows</td>
<td>Connecticut Association for United Spanish Action</td>
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</table>

New Haven Family Alliance

Recovery Communities

D
What are the characteristics of a Culturally Competent System of Care?

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
What are the characteristics of a Culturally Competent System of Care?

- 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 Culturally Competent System of Care?

- Supported by policy and financial resources
  - Change language in contracts
  - Training initiatives
  - Medicaid
  - Augment services through Grants
What are the characteristics of a Culturally Competent System of Care?

- 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
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
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
Use cultural competence as a vehicle to address health disparities

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

BH = Behavioral Healthcare  PH = Primary Healthcare
Need for Behavioral Health Care

- African Americans:
  - 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

- **Latinos/Hispanic Americans:**
  - 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

- **Asian Americans/Pacific Islanders**
  - 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

- **American Indians and Alaska Natives**
  - 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
    - 2\textsuperscript{nd} decade of life has highest mortality rate
    - Alcohol dependence, alcohol related deaths
  - Little information on service utilization patterns