

# Behavioral Health Disparities: Current Status and Future Directions

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# Overview

- Health Disparities Research
- Causes of Disparities
- Cultural Competence as a Strategy for Eliminating Disparities
- Future Directions

# A National Vision for the Future

- The President's New Freedom Commission on Mental Health (2003)
- Institute of Medicine: Unequal Treatment (2002)
- Mental Health: Culture, Race and Ethnicity, Supplement to the Surgeon General's Report (2001)



# Commission Findings

- The Commission declared “...the mental health delivery system is fragmented and in disarray ... lead[ing] to unnecessary and costly disability, homelessness, school failure and incarceration.”
- “Striking disparities in mental health care are found for racial and ethnic minorities.”

# Commission Findings

- “The system has neglected to incorporate respect or understanding of the histories, traditions, beliefs, languages and value systems of culturally diverse groups.”
- “The system is not oriented to the single most important goal of the people it serves – the hope of recovery”

# Black and White Differences in Specialty Procedure Utilization Among Medicare Beneficiaries Age 65 and Older, 1993

	Black	White
Angioplasty (procedures per 1,000 beneficiaries per year)	2.5	5.4
Coronary Artery Bypass Graft Surgery (procedures per 1,000 beneficiaries per year)	1.9	4.8
Mammography (procedures per 100 women per year)	17.1	26.0
Hip Fracture Repair (procedures per 100 women per year)	2.9	7.0
Amputation of All or Part of Limb (procedures per 1,000 beneficiaries per year)	6.7	1.9
Bilateral Orchiectomy (procedures per 1,000 beneficiaries per year)	2.0	0.8

Source: Gornick et al., 1996

# Media Response to *Unequal Treatment*

*New York Times*, March 22, “Subtle Racism in Medicine”

“ . . . a disturbing new study by the Institute of Medicine has concluded that even when members of minority groups have the same incomes, insurance coverage and medical conditions as whites, they receive notably poorer care. Biases, prejudices and negative racial stereotypes, the panel concludes, may be misleading doctors and other health professionals.”

*The Washington Post*, March 23, “The Health Care Gap”

“Race-based inequities are a sad fact in more than one facet of American life. History has shown how hard they are to overcome. But this week's report paints a picture that cannot be ignored.”

# Media Responses to *Unequal Treatment*

*USA Today*, March 22 “Racial Bias in Health Care”

“In unassailable terms, the report found that even when their insurance and income are the same as those of whites, minorities often receive fewer tests and less sophisticated treatment for a panoply of ailments, including heart disease, cancer, diabetes and HIV/AIDS. By stripping away the pretense that the differences can be explained by minorities' lack of access to timely care, the report should spur doctors and patients to question why racial disparities are tolerated in medicine.”

# Behavioral Health Disparities: Findings of the Surgeon General

## Ethnic & Racial Minorities:

- Less access to, & availability of, behavioral health services
- Less likely to receive needed behavioral health services
- Less likely to receive high quality behavioral health care
- Underrepresented in behavioral health research
- Experience a greater burden of disability

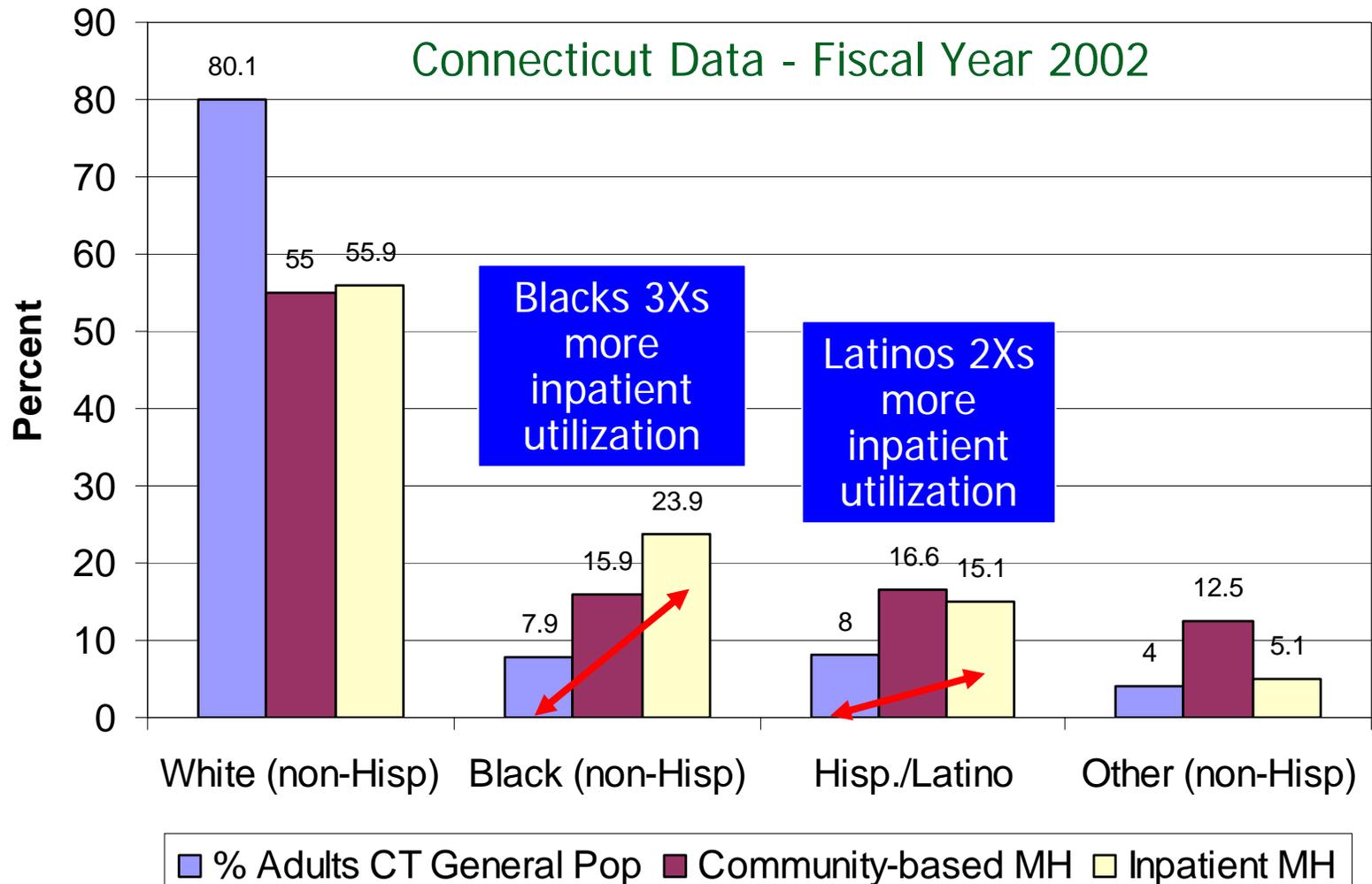
# Health Disparities Defined

- “...systematic differences in healthcare practices and service utilization patterns related to race, culture or gender and not due to a health condition.”

# Access and Utilization

- Few clinicians of color (e.g. APA 96% Caucasian, 1% Latino, 3% other)
- Few bi-lingual/bi-cultural providers
- Geographic location of minority providers
- Seen more in ER and inpatient settings, less likely to use community based care
- Insurance rates do not explain disparities

# Who gets hospitalized?



# Quality of Care

- African American and Latinos are more likely to be overdiagnosed and misdiagnosed with SMI, and underdiagnosed with affective disorders.
  - Analogue studies show diagnostic bias
  - Delayed help-seeking
  - Cultural distance between client and the clinician

# Quality of Care

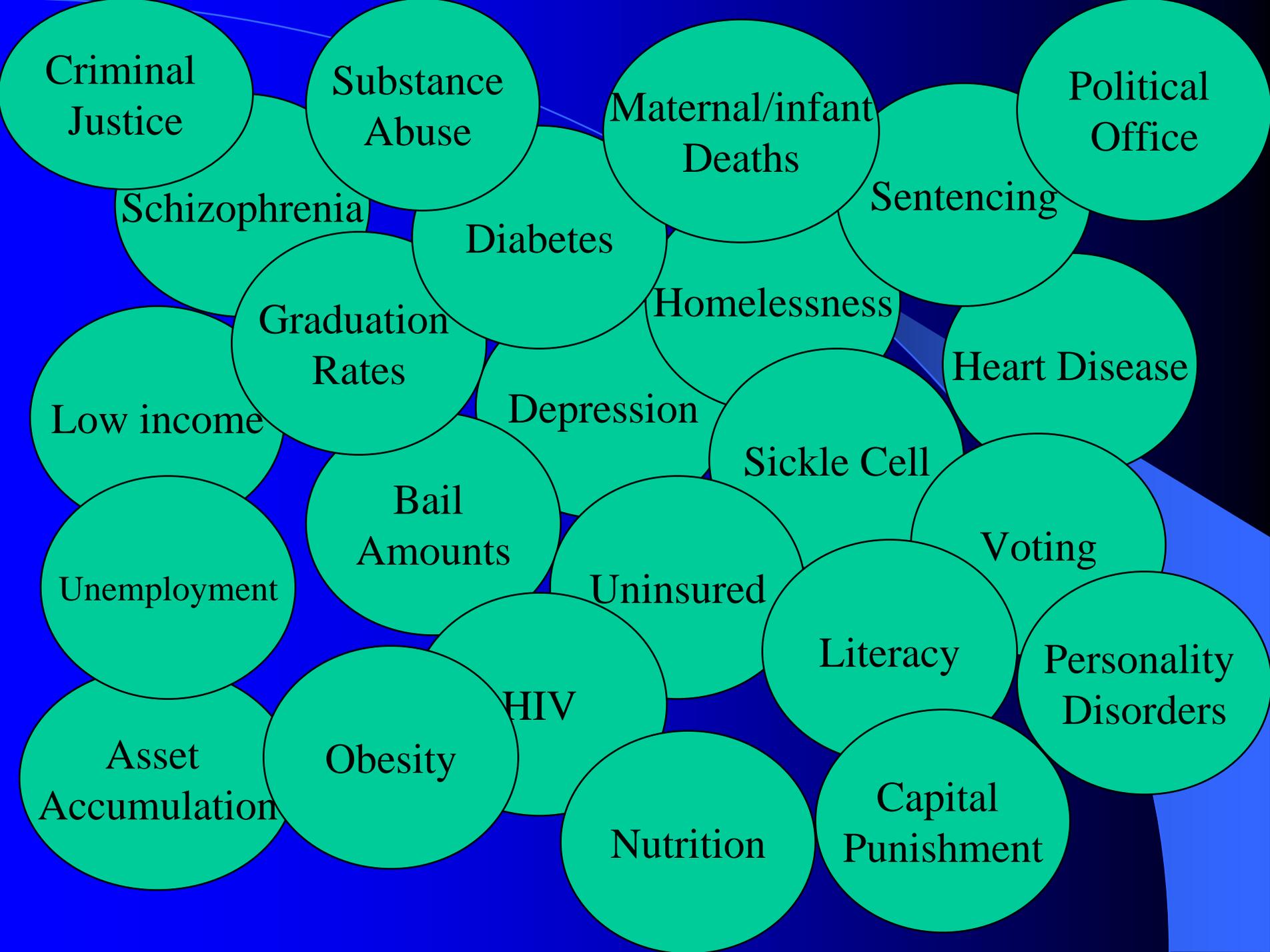
- AA less likely to be prescribed atypicals
- Are prescribed higher doses of antipsychotic medications
- AA and Latinos more likely to be prescribed antipsychotics as maintenance medication for bipolar illness
- CT has seen some change in prescribing patterns

# Treatment Outcomes

- Outcome research is limited
- Higher levels of recidivism
- Lower retention rates
- Don't respond as well to some traditional treatment approaches (e.g. Spanish speaking families and highly structured family therapy)

# Causes of Behavioral Health Disparities?

- Cultural mistrust
- Psychological access
- Socioeconomic differences
- Differences in help seeking norms
- Language barriers
- Stereotyping
- Cultural distance between the client and clinician
- Oppression, racism, and discrimination



Criminal  
Justice

Substance  
Abuse

Maternal/infant  
Deaths

Political  
Office

Schizophrenia

Diabetes

Sentencing

Graduation  
Rates

Homelessness

Heart Disease

Low income

Depression

Sickle Cell

Unemployment

Bail  
Amounts

Uninsured

Voting

Asset  
Accumulation

Obesity

HIV

Nutrition

Literacy

Personality  
Disorders

Capital  
Punishment

# Re-institutionalization

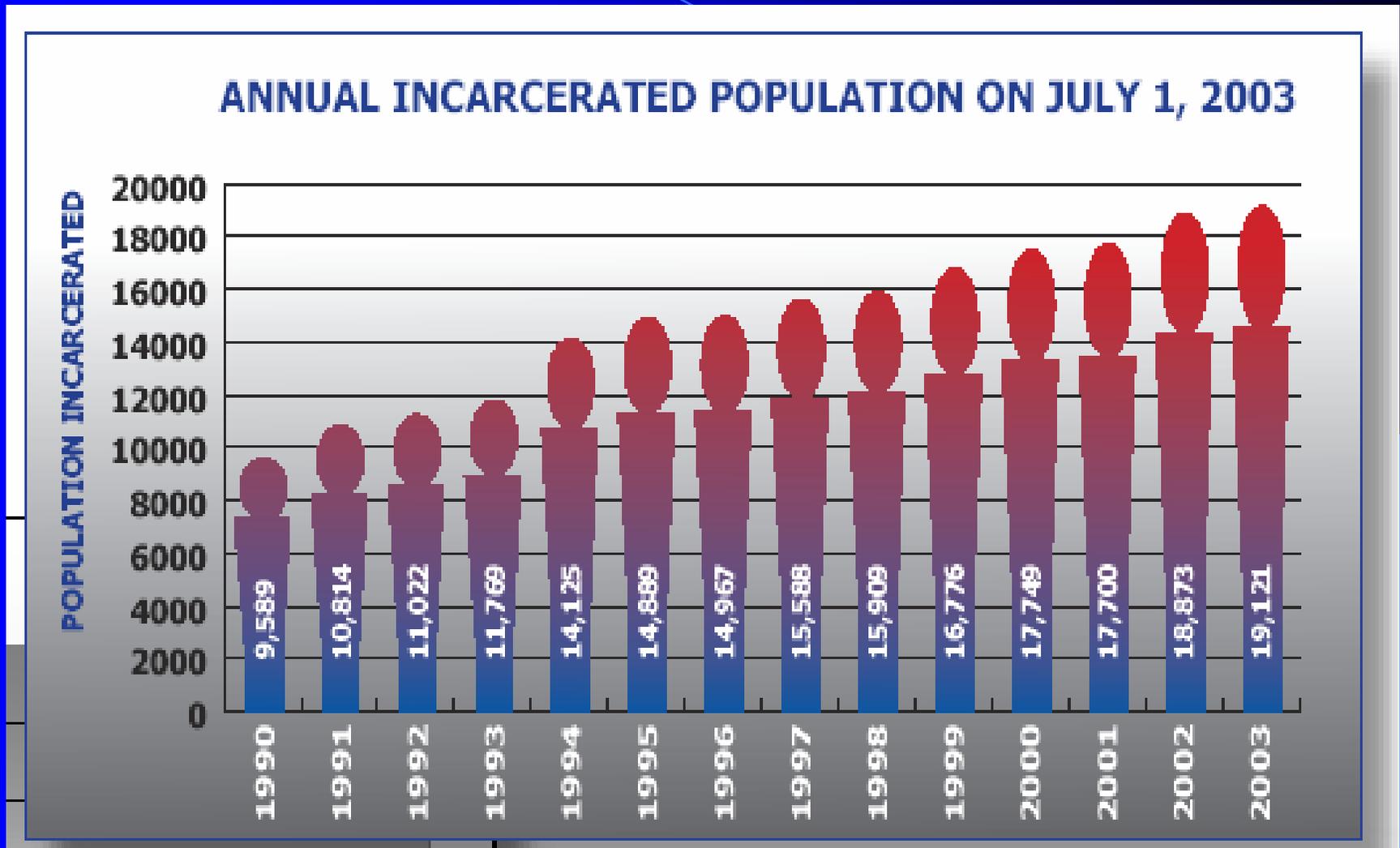
Increase during 7 decades:

- From 1910 to 1980 inmates increased by 462,006

Increase during the last decade:

- In 1990's alone, inmates increased by 816,965

# Incarcerated Population in Connecticut 1990-2003



1985 = 5,813

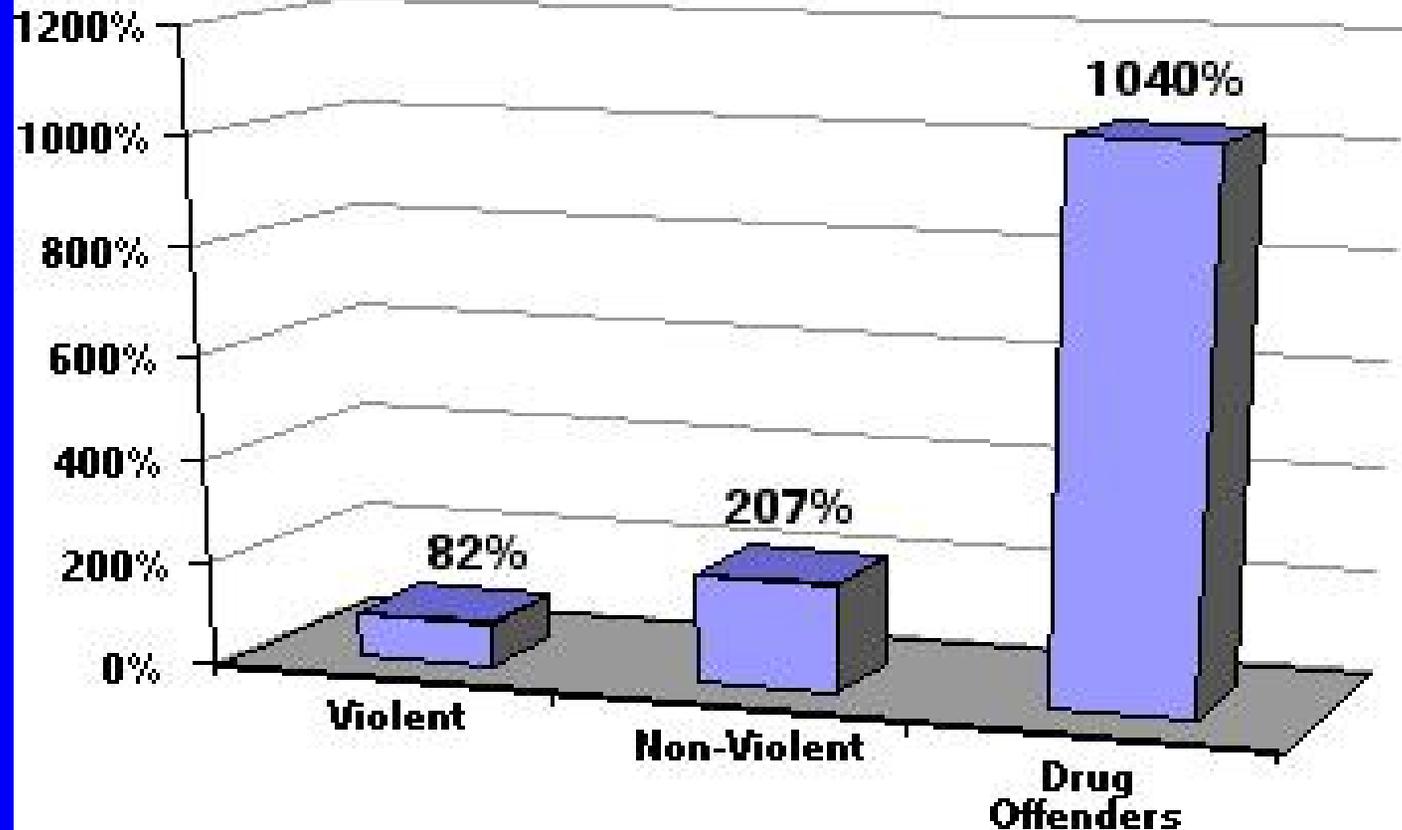
# Which groups are overrepresented?

- From 1978 to 1996, increase in arrests were due primarily to a 76% increase in nonviolent drug offenses

Center on Juvenile and Criminal Justice, 2002

# Admissions for Violent versus Non-Violent Offenses

**Graph 4: From 1980-1997 the number of people entering prison for violent offenses doubled, while non-violent offenses tripled and drug offenses increased 11-fold**

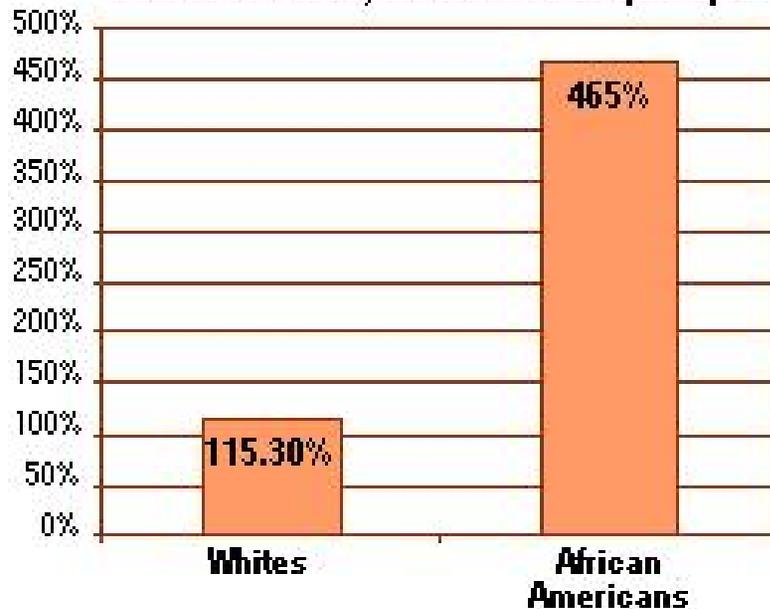


*Source: Gillard, Darrel K. Trends in U.S. Correctional Populations, 1992. Washington, D.C.: U.S. Department of Justice, Bureau of Justice Statistics, 1992, and Mumola, Christopher J. and Beck, Alan. Trends in U.S. Correctional Population, 1997. Washington, DC: U.S. Department of Justice, Bureau of Justice Statistics, in press.*

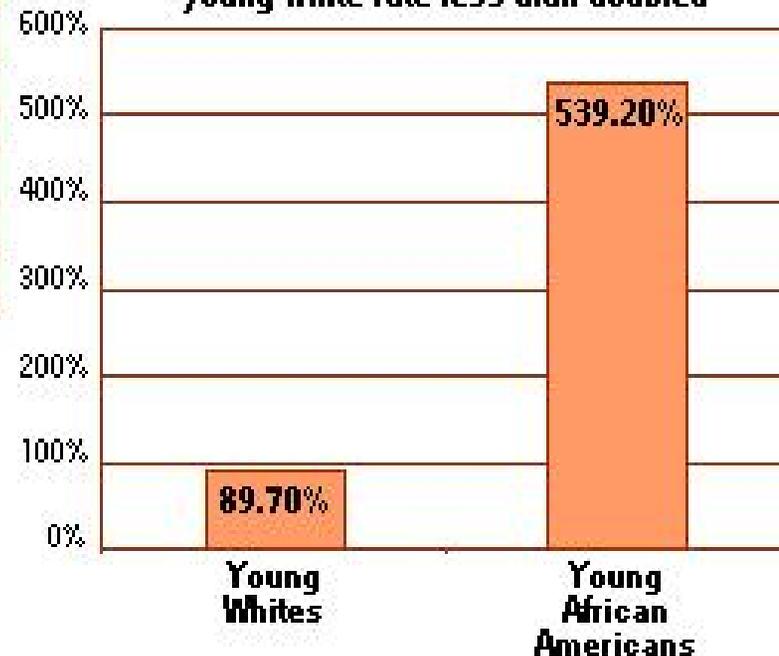
# Incarceration for Drug Offenses

Graph 6

While white commitments for drugs doubled from 1986 - 1996, the black rates quintupled



That disparity was even starker for young blacks, six times as many of whom were incarcerated for drug offenses, while the young white rate less than doubled



# Increase In Individuals Imprisoned With Behavioral Health Disorders

- Staggering number of persons with behavioral health problems in jails and prisons
  - 5% of U.S. populations suffers from MI
  - 16.2% of state prisoners nationally have MI
  - In CT, 17.3% of inmates receiving Tx
- The New Asylums (PBS special)

# Forensic Disparities

“The hammer of incarceration for drug offenses has by no means fallen equally across race of age categories, with young African American men suffering unprecedented rates of incarceration for drug offenses.”

- While there are 5 times as many white drug users as black, black men are admitted to state prison at a rate 13.4 times greater than white men
- AA men represent 13% of regular drug users, but 62.7% of drug offenders admitted to prison.

Source: Center for Juvenile and Criminal Justice, 2002

# Causes

- In addition to sentencing policies, lack of access to high quality treatment consistently cited as one of the reasons for this phenomena
- Even when they do access tx, minorities have poor retention in treatment, and poorer treatment outcomes.
- Community based treatment is either not accessible or not working for many people of color
- Need culturally competent care!!!!

# Culture Mediates How We.....

- Communicate pain or problems
- Label symptoms or indicators
- Determine the causes of problems
- Perceive health care providers
- Utilize & respond to treatment or assistance

# Cultural Competence

A Congruent Set of:

- Behaviors                      Attitudes                      Skills
- Policy                              Procedures

that come together in a system, agency, or among individual professionals to enable them to work effectively in cross cultural situations.

(Cross, Brazon & Issacs, 1989)

# Cultural Competence

*Knowledge  
Information and Data  
From and About  
Individuals and  
Groups*



INTO

*Clinical Standards  
Skills  
Service Approaches  
Techniques  
Marketing Programs*

*Integrated &  
Transformed*

*that match the individual's culture and increase both the quality and appropriateness of health care and health outcomes. (King Davis, 2003)*

# Developing a Culturally Competent System of Care

Multi-dimensional/multi-leveled process

- State Level
- Organization Level
- Program Level
- Individual Level

# Cultural Competence at the State Level

- Workforce Development
- Standard Setting
- Data Systems, (identifying disparities, developing & assessing interventions for effectiveness)
- Fiscal Alignment
- Policy Alignment
- Contracting
- Consumer Input & Direction
- Support of Community Development, Grassroots Providers, and Natural Supports

# Cultural Competence at the Organizational Level

- Cultural competence plans
  - (development and integration)
- Executive level responsibility
- Culturally diverse staffing
- Staff training, supervision
- Advisory board
- Connections to natural supports
- Linguistic Competence
- Monitor utilization + outcomes by race/ethnicity
- Client satisfaction surveys

# Cultural Competence at the Program Level

- Access — decentralized, flexible hours, natural supports, peer mentors, linguistic competence
- Inclusion of family members as preferred
- Holistic Programming
  - Beyond symptom reduction!!!!
  - employment, housing, health, spirituality, purpose
- Strength Based Approach
- Consumer Driven
- Culture Specific Approaches

# Cultural Competence at the Individual Level

- Multidimensional, culturally relevant assessment
- Flexible roles and boundaries
- Questioning Stance
- Awareness of differences in cultural norms
  - individualism vs. collectivism
- Non-hierarchical, reciprocal relationships
- Willingness to relinquish control and foster consumer direction

# Other Strategies For Eliminating Behavioral Health Disparities

- Linking primary care with behavioral health care
- Creating more integrative, wrap around systems of care
- Creative use of media for information dissemination purposes
- Cross-system, cross agency initiatives

# Questions

Are there specific disparities within societal or institutional systems that impact behavioral health disparities?

What cross system, cross agency initiatives or interventions can be developed to reduce disparities within intersecting systems?