

Mental Health Transformation - State Incentive Grant

Workgroup #3 - Disparities in Mental Health Services Are Eliminated Convener: José Ortiz, Director, DMHAS Office of Multicultural Affairs

I. INTRODUCTION

“The unintentional institutional racism that permeates the American mental health care system is perpetuated by behaviors that can be divided into three distinct categories: no initiatives, misguided initiatives, and mismanaged initiatives. All of these categories are behavioral in nature and fit the definition of racism as the systematic denial of access and opportunities to members of minority groups coupled with the perpetuation of access and opportunities for members of the majority group” (Ridley, 2005).

Background and Literature

Institutional and individual racism has contributed significantly to the creation and maintenance of a dual healthcare system in which health disparities among racial and ethnic minority groups are pervasive and pernicious. Numerous federal reports and studies have documented striking mental health and substance abuse inequities in access, service quality and treatment outcomes. Studies have shown, for instance, that individuals of African and Latino origin experience greater unmet need for care among those with alcohol, drug or mental health needs and Latinos experience poorer quality of care for mental health and substance abuse conditions (Wells, Klap, Koike, Sherbourne, 2001). Further, Snowden (1999) found that African Americans were less likely than White Americans to receive regular, on-going care from a private therapist or at a mental health center, and were more likely to have sought help on an emergency basis. Disparities have additionally been demonstrated in medication prescribing patterns. Kuno & Rothbard, 2002, in their study based on a sample of individuals receiving Medicaid, found that African Americans were less likely than White Americans to receive atypical antipsychotics, and were more likely to receive older antipsychotic medications. Similar findings have been cited throughout the behavioral health literature (Fleck, Hendricks et al 2002).

The presence of disparities in behavioral health services suggests that populations of color experience numerous unmet behavioral health needs, and as a result may live with a greater disability burden (DHHS, 2001). Given that population projections suggest that individuals of color will comprise nearly 48% of the U.S. population by the year 2050, if left unaddressed, one may expect disparities in care to increase with increasing population numbers. Given this, throughout healthcare, numerous reports, initiatives and funding streams for eliminating disparities have been generated. Most recently at the federal level, the *2003 President's New Freedom Commission on Mental Health Report, Achieving the Promise: Transforming Mental Health Care in America*, set the national goal of eliminating disparities through the development of more recovery oriented and culturally competent systems of care at the local, state and federal levels. Further, in response to this report, the Substance Abuse and Mental Health Services

Administration awarded seven grants to state mental health departments in an effort to assist states in transforming their systems of care to be more recovery oriented and culturally competent.

As a SAMHSA transformation grantee, the State of CT Department of Mental Health and Addiction Services is currently in the initial needs assessment and planning phase of carrying out their systems transformation work. As part of this process, workgroups have been formed to coincide with the content areas addressed within each of the Transformation Report goals. Further, workgroups have been charged with developing recommendations for bringing about systems change related to their specified goal. This document outlines interventions generated from Workgroup # 3 whose task was to create recommendations for eliminating behavioral health disparities within the State of CT.

II. DISCUSSION

Objectives

Recommendations developed by Workgroup # 3 addressed Goal 3 of the President's New Freedom Commission report. In particular, objective areas of this goal addressed by Workgroup # 3 included the following:

Improve access to quality care that is culturally competent.
Improve access to quality care in rural and geographically remote areas.

Discussion and the work of the group focused on recommendations that would establish strategies to meet the stated goal and objectives.

Workgroup Membership and Process

The workgroup consisted of members from diverse backgrounds who actively participated in the group process. Members represented the following:

- Service consumers
- State Departments and the Judicial Branch (Department of Children and Families, Department of Corrections, Department of Mental Health and Addiction Services, Department of Mental Retardation, Department of Public Health, Department of Social Services, Judicial Branch – Court Support Services Division, Juvenile Branch)
- State-Operated facilities (Cedarcrest Hospital, Capitol Region Mental Health Center)
- Advocacy and non-profit organizations (Connecticut Commission on Aging, Connecticut Hospital Association, Catholic Charities/Institute for the Hispanic Family, Khmer Health Advocates, Hartford Behavioral Health, Clifford Beers Clinic)
- Yale University

A collaborative consensus-building approach was used to develop the recommendations. The workgroup met biweekly for 3-hour meetings beginning March 9, 2006, and ending June 8, 2006. The workgroup process was divided into three phases: orientation and generation of preliminary ideas (Meetings 1-2), deepening understanding of disparities and further developing the recommendations (Meetings 3- 4), and the final consensus building process for approving the phrasing of the present document (Meetings 5-8). There was a collaborative approach to the process, with all workgroup members participating in the discussion and the final document.

The first two meetings were aimed at introductions, orienting workgroup members to the transformation grant and the goals of the workgroup, and generating preliminary ideas and solutions regarding healthcare disparities. Ground rules were established, and additional members were suggested. Workgroup members read literature relating to the transformation grant and behavioral health disparities including the *Executive Summary* of the President's New Freedom Commission on Mental Health. They also participated in an informational research-based Power Point presentation that outlined the definition, causes, and solutions for behavioral health disparities. A detailed timeline for the completion of successive steps towards the end goal of the present document was introduced, agreed upon, and maintained.

To begin developing recommendations, during the first meeting the workgroup divided into four breakout groups that discussed statewide disparities and generated a preliminary list of suggestions. There was an emphasis on disparities identified throughout the state of Connecticut and across the complex intersections of state systems. During the discussion members considered disparities across the lifespan, issues of multicultural diversity (including sex, race, ethnicity, language, socio-economic status, religion, sexual orientation, etc.), as well as disparities related to geographical or rural areas and other underserved groups.

The suggestions generated at the first meeting by the four breakout groups were compiled into a master document that was further refined during successive meetings and resulted in the present document. The four breakout groups were collapsed into two breakout groups that discussed, modified, and amended the master list of ideas during the third and fourth meetings. Between each meeting, staff from the Department of Mental Health and Addiction Services typed and edited the document for clarity and re-distributed it to the workgroup members via e-mail.

During the middle phase of the process, other activities during the meetings were conducted that helped enhance and deepen members' understanding of disparities. Representatives from different state and non-profit agencies provided 10-15 minute presentations regarding the disparities discovered within their respective agencies or systems, and initiatives and efforts made to address these. Additionally, representatives from the transformation grant provided presentations to the workgroup regarding the ongoing statewide needs assessment process, the Review of State Reports document, and the steps by which the different workgroup products will be compiled into the final state recommendations to be submitted to SAMHSA. Consumers provided examples of challenges they faced navigating through the different provider systems.

At the final four meetings, the entire workgroup worked to refine the list of recommendations. The master document of recommendations was projected onto a screen using Power Point, and revised in real time. Members discussed the structure, organization, and specific phrasing of the recommendations and the strategies associated with each recommendation. There was a democratic process, with no phrasing accepted without consensus. The recommendations were organized into five overriding subject areas with several "sub-recommendations" or strategies listed under each one. Workgroup members moreover proposed ideas for information that should be included in the sections of the present document preceding the actual recommendations; these were also reviewed and revised with member agreement.

III. PREAMBLE

A culturally competent service system is based upon a person-centered approach. This definition of cultural competency recognizes and promotes recovery and resiliency through individualized

care, viewing these concepts as critical to effective and sustainable positive outcomes for people in Connecticut with mental and behavioral health needs.

Culturally competent care strategies, including policies, funding mechanisms, approaches and decisions, physical structures, service types/array and practices, must be cognizant, respectful of and responsive to the State's diversity and statuses of "race" and ethnicity, language, gender, sexual orientation, physical abilities, immigration, age, and residence.

Connecticut's transformation efforts, particularly as it pertains to eliminating disparities, must also be responsive to the whole person and their family, espousing a concept and definition of family and spirituality as set forth by the individual seeking care. These efforts must also promote an environment of systemic access and equal opportunities to members of minority groups and engender the systemic prevention of racism.

Moreover, disparities elimination requires a commitment to ensuring, at a minimum, that all persons' basic needs are met. This means that issues of institutional racism, poverty, self-sufficiency, housing and educational/vocational opportunities must be prominent components of Connecticut's transformation dialogue. Therefore, the recommendations to facilitate parity in care, quality and outcomes set forth below are to be applied to the Offices, Divisions, Commissions and Departments of all the Executive and Judicial Branch Agencies, and Agencies/Organizations across the state of Connecticut addressing behavioral health issues.

IV. THE RECOMMENDATIONS

1. State Office of Multicultural Affairs

***Need:** Not all state agencies have an office of multicultural affairs. A central entity is needed to support the establishment and monitoring of consistent standards, practices, policies and training that can eliminate disparities. This entity is needed to ensure that culturally competent care is delivered to all persons in the State.*

Recommendation

The State should establish a permanent Office of Multicultural Affairs that promotes quality assurance, develops, oversees and coordinates cultural competence initiatives across State agencies and State funded service providers.

Strategies

An essential initial task of this Office will be to establish core values and standards across state agencies through a collaborative process.

The Office will facilitate and coordinate technical assistance and training.

This Statewide Office should be adequately funded with necessary resources.

This Office should be staffed by culturally and linguistically competent individuals representative of the diverse populations of Connecticut.

The Office should collect and distribute information about local, state, and national efforts to eliminate mental health disparities and promote the delivery of culturally competent care.

The Office should develop, collect and distribute reports detailing the State's progress related to access, engagement and retention, service quality and outcomes for culturally diverse populations.

Each state agency will be allocated at least one FTE to oversee cultural competency efforts of that agency and coordinate and liaison with the State Office of Multicultural Affairs.

In collaboration with the Office of Multicultural Affairs all agencies will develop, implement and regularly update cultural competence plans to ensure the provision of effective service delivery.

Standard language regarding cultural competency should be developed and required for all state contracts. Common core quality indicators that result in effectively tracking and monitoring performance should also be created and applied.

This Office should establish a set of common cultural competence standards that would be applied across all state agencies.

2. Racism Prevention and Intervention Model

***Need:** Populations of color consistently fare less well than their majority counterparts across United States legal, political, educational, economic, employment, and healthcare systems. Racism and bias due to stereotyping has been found to contribute significantly to these inequities. Educational curricula and systems interventions designed to eliminate racism and stereotyping biases are critically needed so that populations of color may experience parity within behavioral health and other relevant Connecticut service systems.*

Recommendation:

The State should be responsible for developing and implementing a system wide racism prevention program for the prevention, intervention and elimination of practices that contribute to racism throughout the behavioral health services system.

Strategies

Develop a racism prevention curriculum.

Mandate the implementation of this curriculum.

3. Health Disparities Data

***Need:** State agencies, providers and service recipients must have easy access to centralized, accurate data about utilization, satisfaction and outcomes. This data should allow for basic comparability across service providing systems through the use of uniform, core data variables. Readily available data supports a culture of accountability and aids in determining service systems effectiveness.*

Recommendation

The State should establish a uniform data collection system across agencies and the judicial branch that facilitates identification, monitoring and elimination of behavioral health disparities related to race/ethnicity and culture.

Strategies

Agencies should collaboratively establish and use common variables and data definitions related to cultural competency and health disparities. These variables should include, but not be limited to, the following:

- race
- age
- housing status
- income source
- insurance
- ethnicity
- religion/spirituality
- employment
- disability status
- gender
- language
- income
- educational level
- literacy
- sexual orientation
- acculturation

Agencies should actively engage in the analysis of their data to assess for parity in access, engagement and retention, service quality and outcomes and make needed adjustments to facilitate improved services across populations.

The Office of Multicultural Affairs will respond with targeted interventions when discriminatory trends are identified.

State and funded agencies should establish and enforce, through an interagency collaboration, uniform standards regarding data for the purpose of improving service quality as it relates to health disparities.

Create a statewide report, at established intervals, that identifies current and projected trends related to behavioral health disparities.

4. Workforce Development Related to Behavioral Healthcare Disparities

Need: *Communication and engagement between care seekers and care providers are critical elements in producing positive, sustainable outcomes. A competent, well trained, culturally and linguistically diverse workforce is essential to creating the level of trust and service quality necessary to improve access to and satisfaction with care.*

Recommendation

Connecticut should ensure that its health and human services workforce is culturally competent and aware of health disparities through training, performance monitoring, recruitment, retention, and enhancements to certification and licensure.

Strategies

To create a mental health services provider workforce development model based on the PACCT model (Program for Addictions Cultural Competency Training) that will recruit people of color (including bilingual/bi-cultural individuals), train them in at least entry level skills and provide actual work experience (e.g., agency based practica) in order to increase the number of minorities and people in recovery or consumers in human service agencies across the state.

Fund, develop and implement a leadership development training model that provides additional leadership education and training for PACCT model graduates and other staff within the behavioral health service system in order to affect upward mobility for people of color in key leadership positions.

The State of Connecticut should expand scholarship programs that support the education of diverse individuals to increase the capacity of the multicultural workforce in Connecticut.

The State of Connecticut should establish cultural and linguistic competence standards for its workforce to ensure a level of skills that meets the needs of the populations that they serve.

The State of Connecticut should enact legislation that requires cultural competency training related to the receipt and maintenance of certification and licensing for health and human services professionals.

The State of Connecticut should establish training to promote culturally competent care and effective clinical supervision.

5. Access to Quality Culturally Competent Care

Need: Service system gridlock and lack of sufficient local care access thwarts a person's ability to receive care in a timely manner. Delays in treatment could result in unnecessary or otherwise preventable exacerbations of health care issues. Such postponement can result in increased service systems cost and enhanced negative impact on persons needing care and their families. Ensuring that the people of Connecticut receive access to care in their communities that is culturally and linguistically responsive should assist with positively influencing and facilitating receipt of treatment.

Recommendation:

The state should ensure availability, access and quality of culturally competent behavioral healthcare in rural and remote geographical areas, and among populations for whom barriers impede access to care.

Strategies

Utilize innovative technologies such as telemedicine and mobile health vans to increase access of underserved populations or rural and geographically remote areas.

Expand current reimbursements to include telemedicine, interpreters, and non-traditional services such as outreach provided by community health workers to underserved populations.

Incentives such as loan forgiveness programs should be implemented to ensure that rural communities and designated Health Professional Shortage Areas have sufficient qualified staffing to facilitate individual access to and receipt of quality care.

Regularly perform a network analysis of the system of services in the state of Connecticut to determine if adequate resources are in place to meet the behavioral health needs of all persons to be served.

A strategic initiative to improve the transportation system statewide should be developed.

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