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

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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
- $500 million/year operating expenses
- Contract with 250 private non-profit agencies
- 60,000 people served annually

What are the public sector challenges?

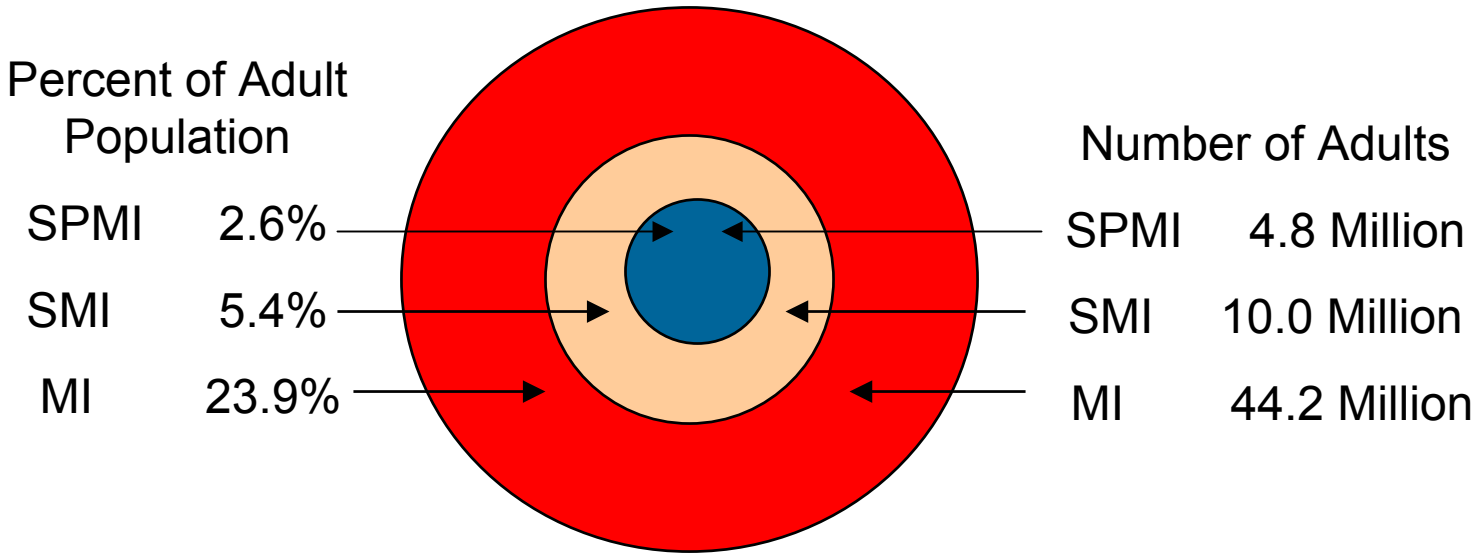
- Attend to the most clinically complex cases
- Address full spectrum of client needs
  - Housing, medical, financial, transportation
- Client involvement in multiple systems
  - Family and Social Services, Criminal Justice
- Provider system is under intense pressure
  - Under-staffed, under- resourced, 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



SPMI = Severe and Persistent Mental Illness

SMI = Serious Mental Illness

MI = Any form of Mental Illness

A

Source: Kessler et al, 1996

How does mental illness rank among disabling diseases?

- WHO - "Global Burden of Disease Study"

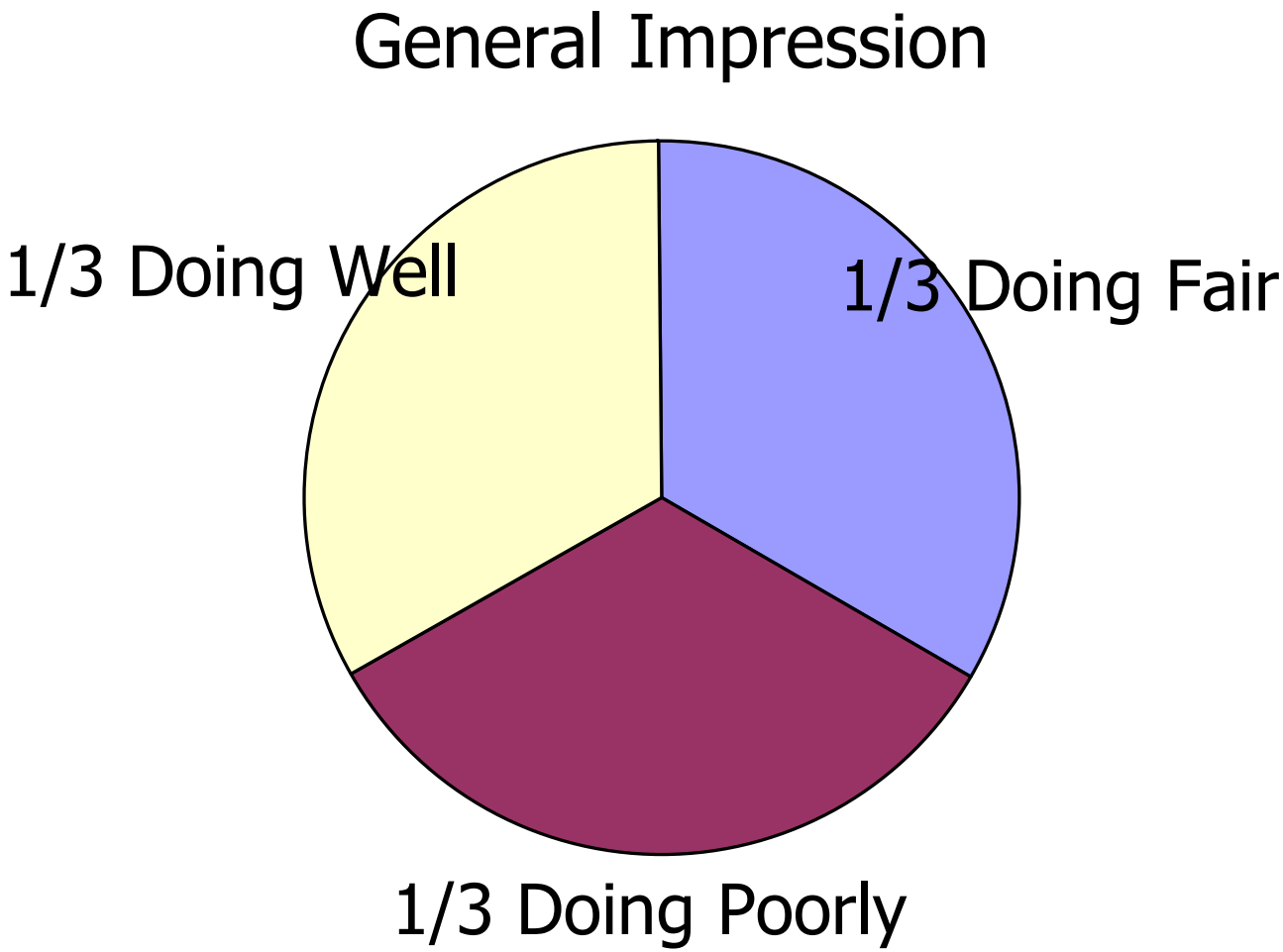
Disease burden by selected illness in established market economies

	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.

Source: Murray & Lopez, 1996

How are Public Sector Behavioral Health Clients doing in Treatment?

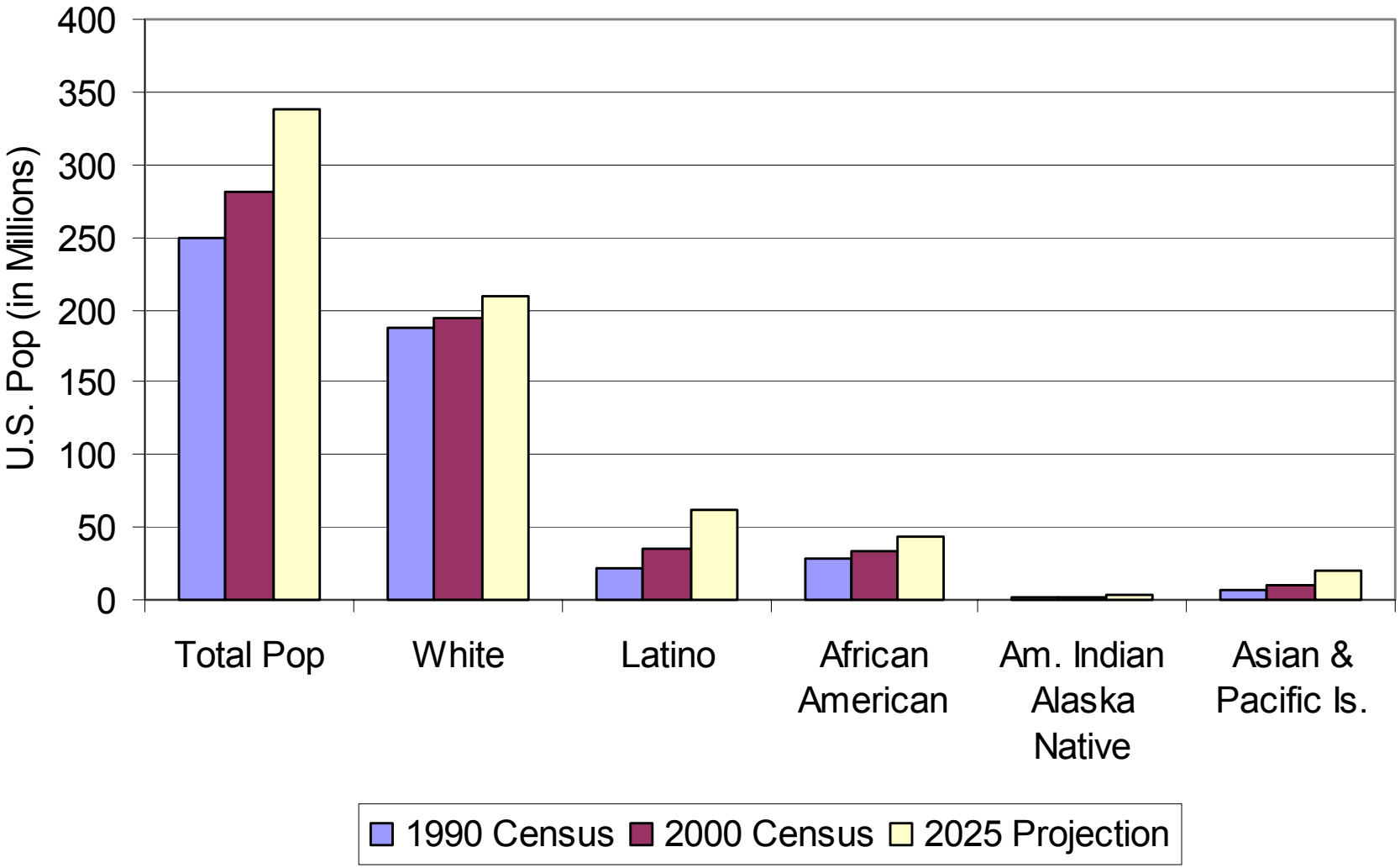


Behavioral Health Disparities: What did the Surgeon General find?

- 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)

U.S. Population by Race and Hispanic Origin



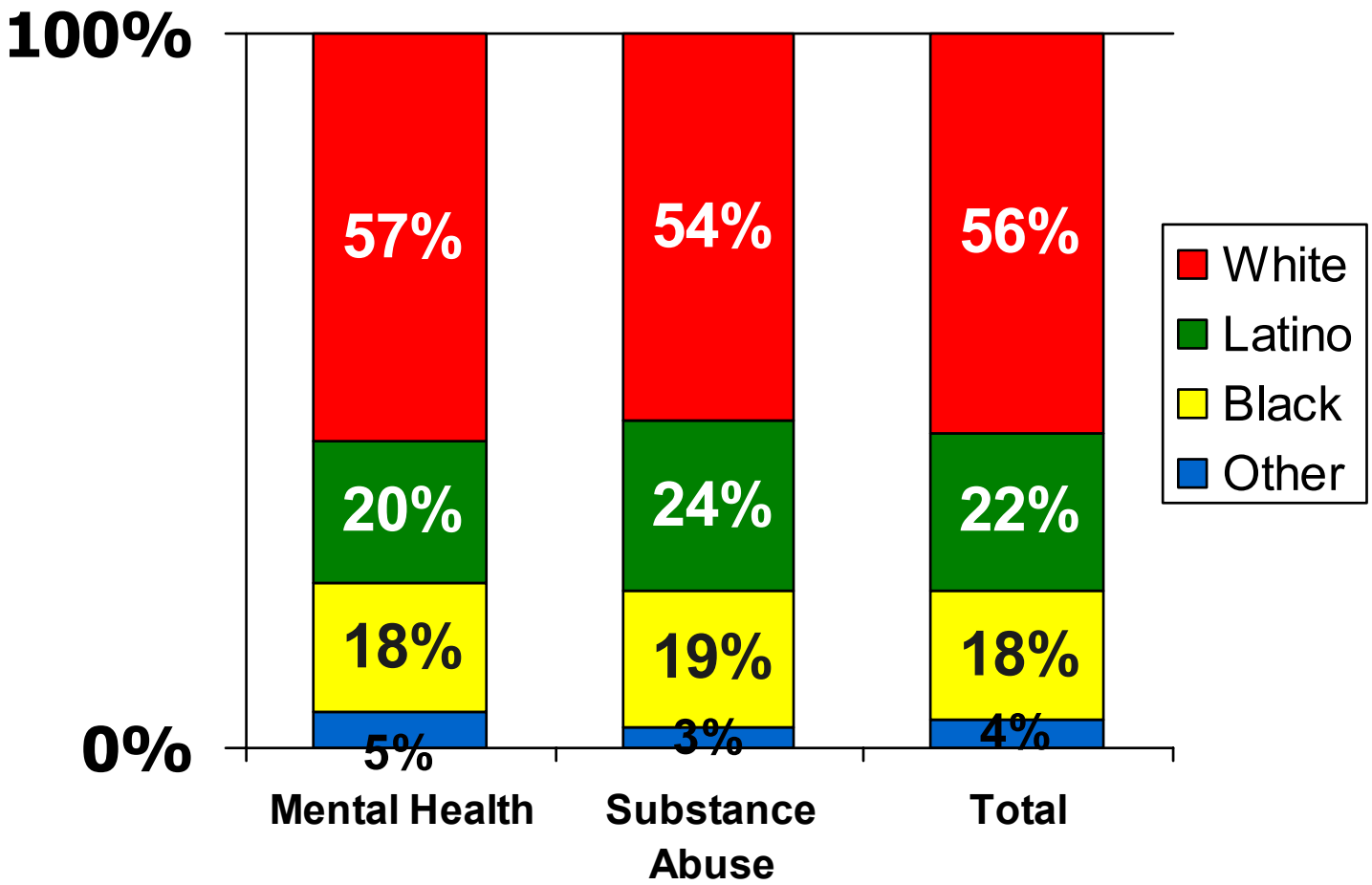
What demographic changes can we expect in Connecticut?

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

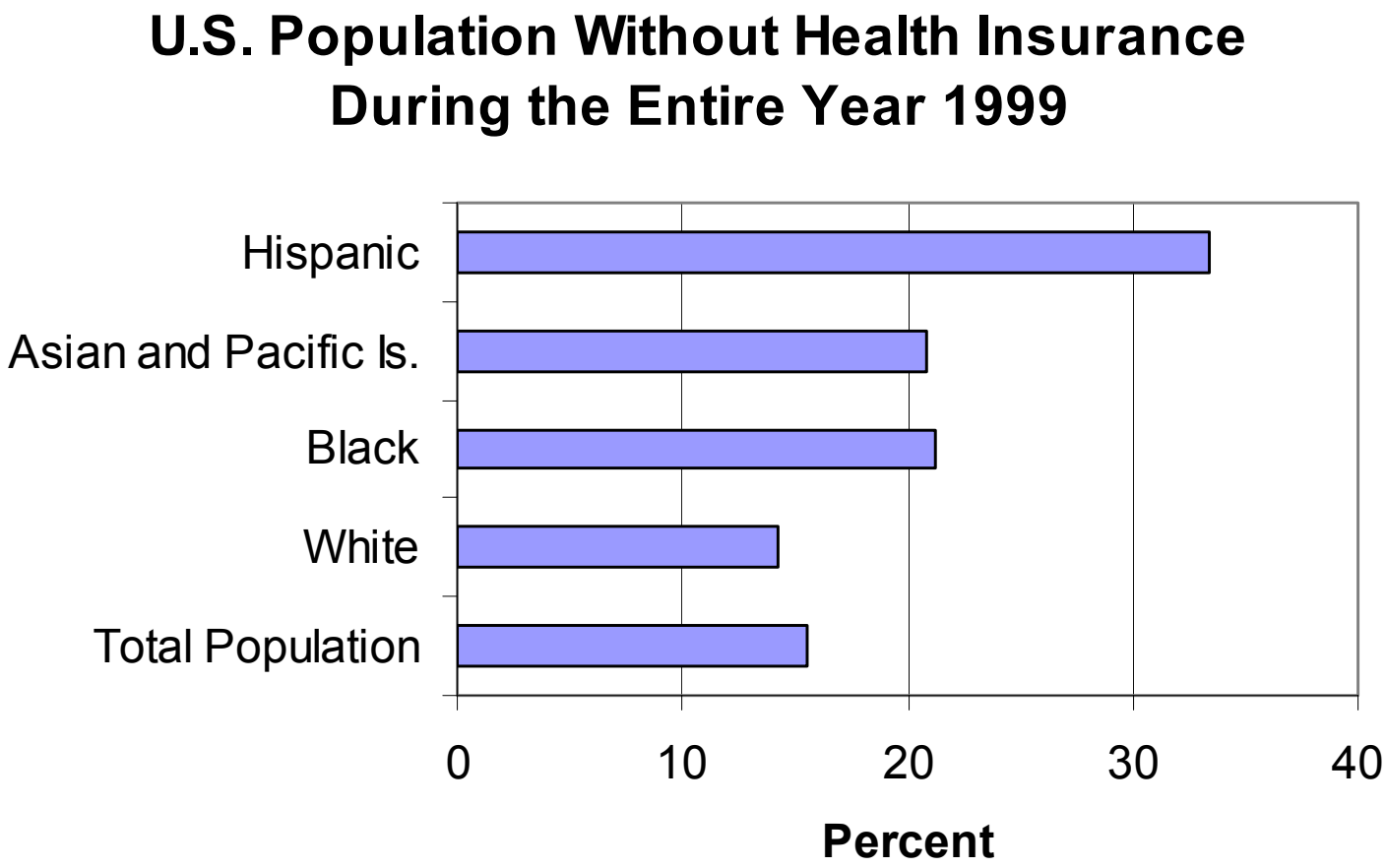
Who's using public sector services?

DMHAS Fiscal Year 2003 Data

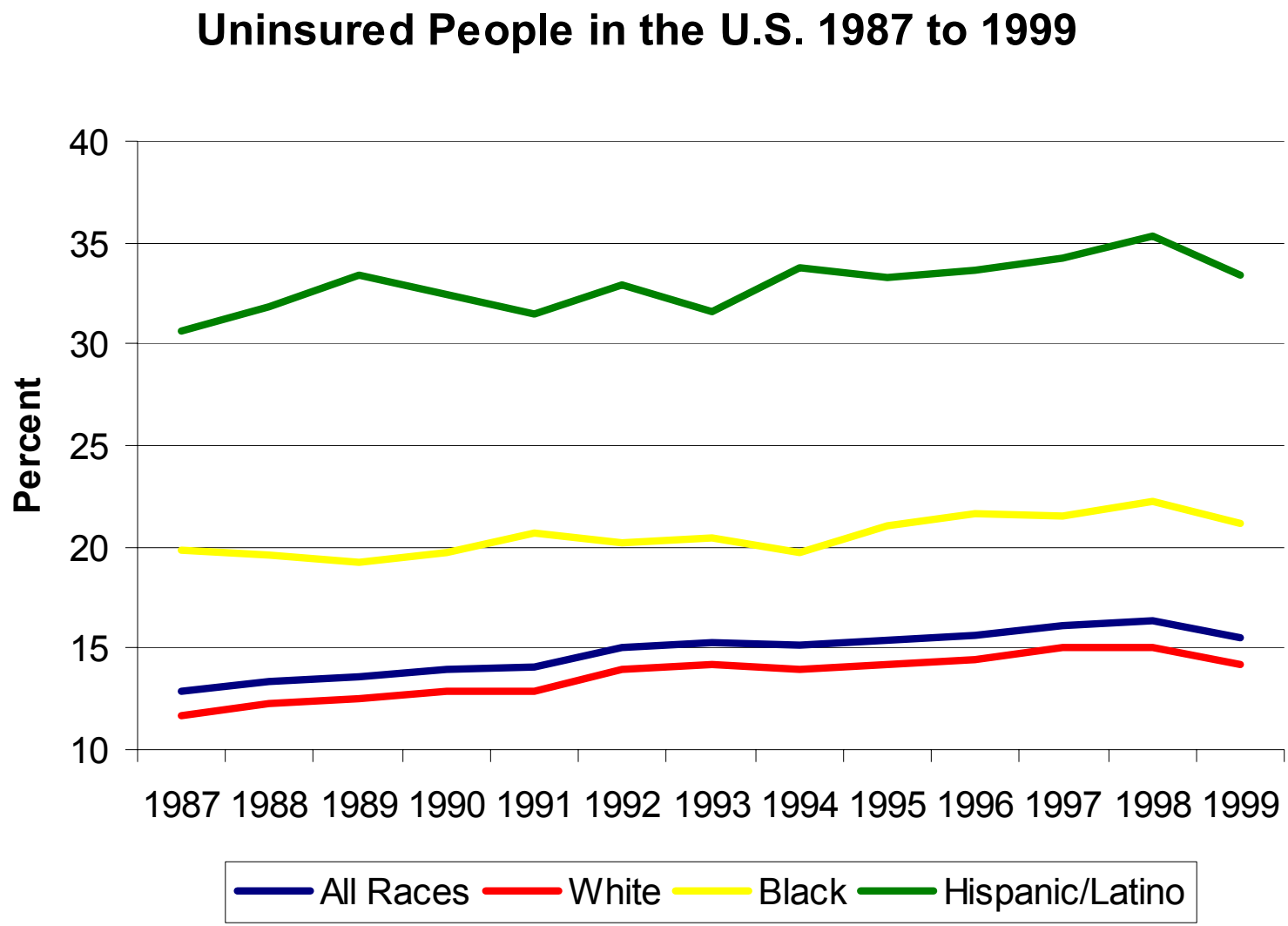


Source: CT DMHAS eCura

Who is uninsured?



Uninsured gradually increasing



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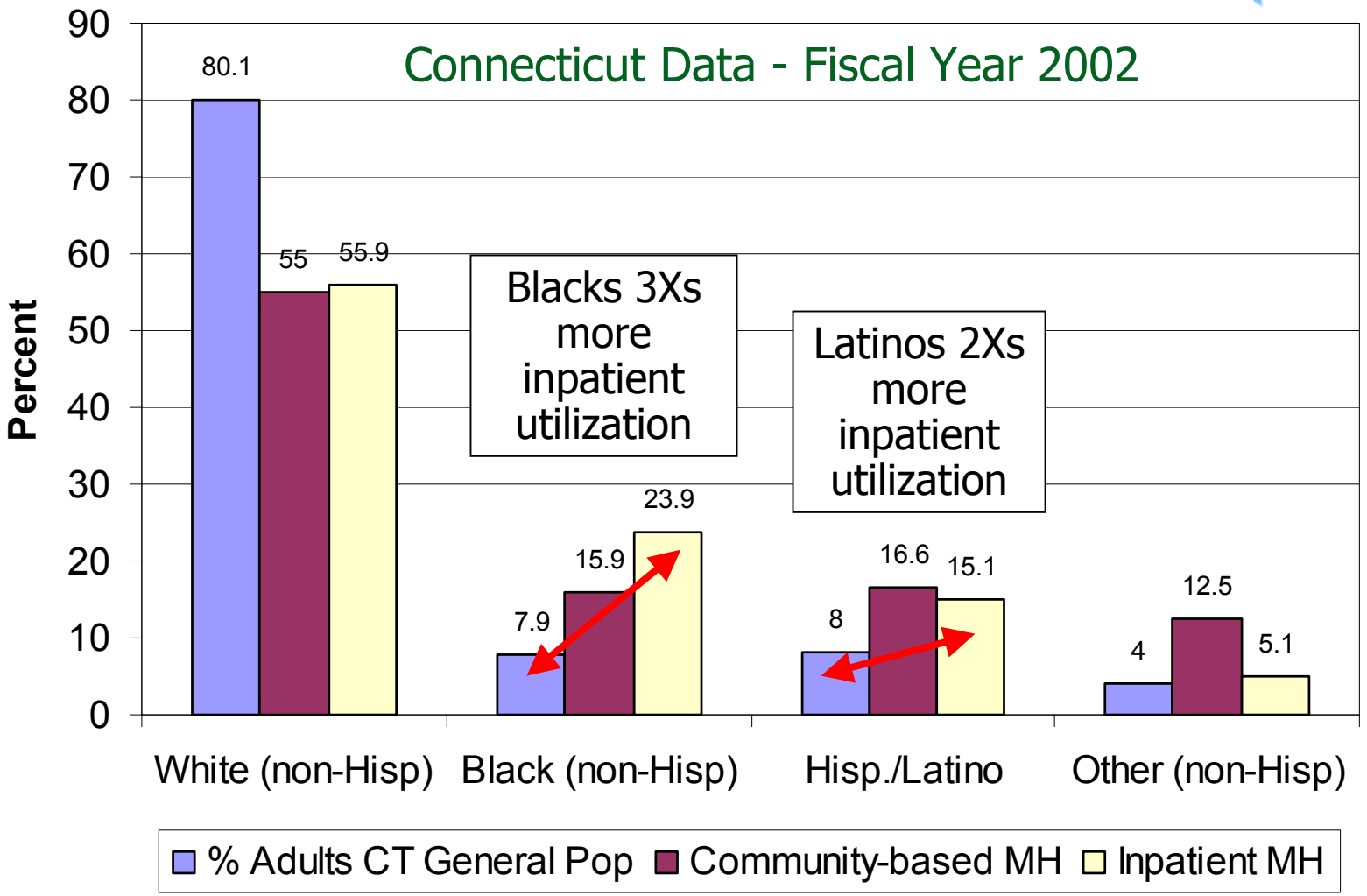
Who uses psychiatric emergency services and why?

- 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?



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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

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

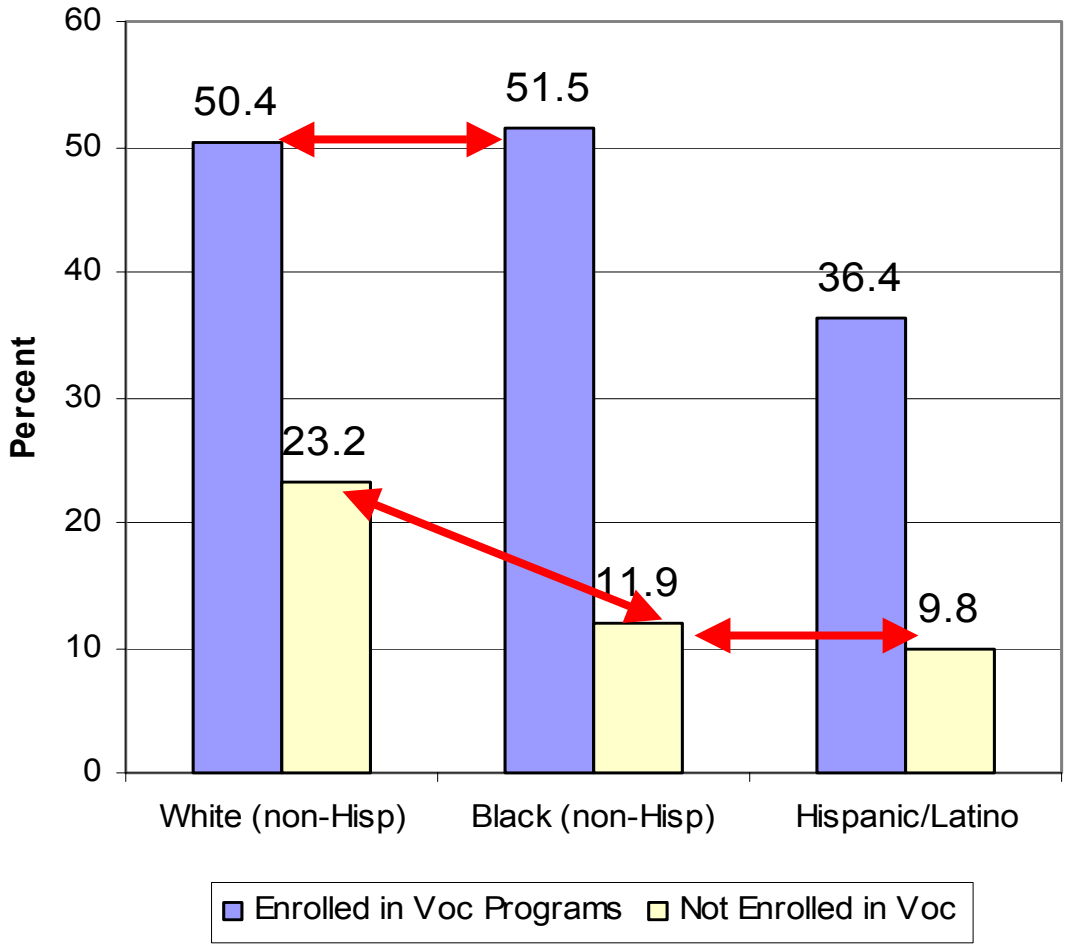
What about use of "New Generation" antipsychotics meds in a Connecticut state hospital?

- 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



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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)

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?

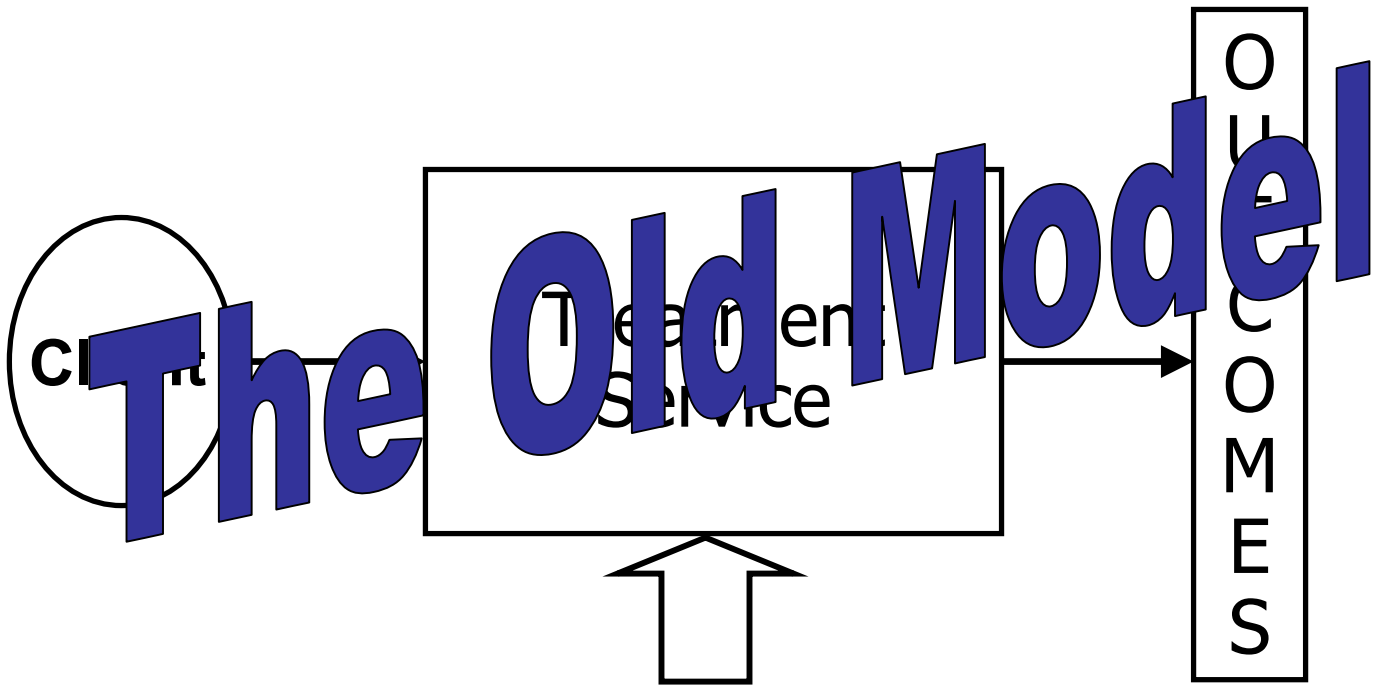
- Develop a Culturally Competent System of Care (CCSC)

$$CCP^{n} \neq CCSC$$

What is Cultural Competency?

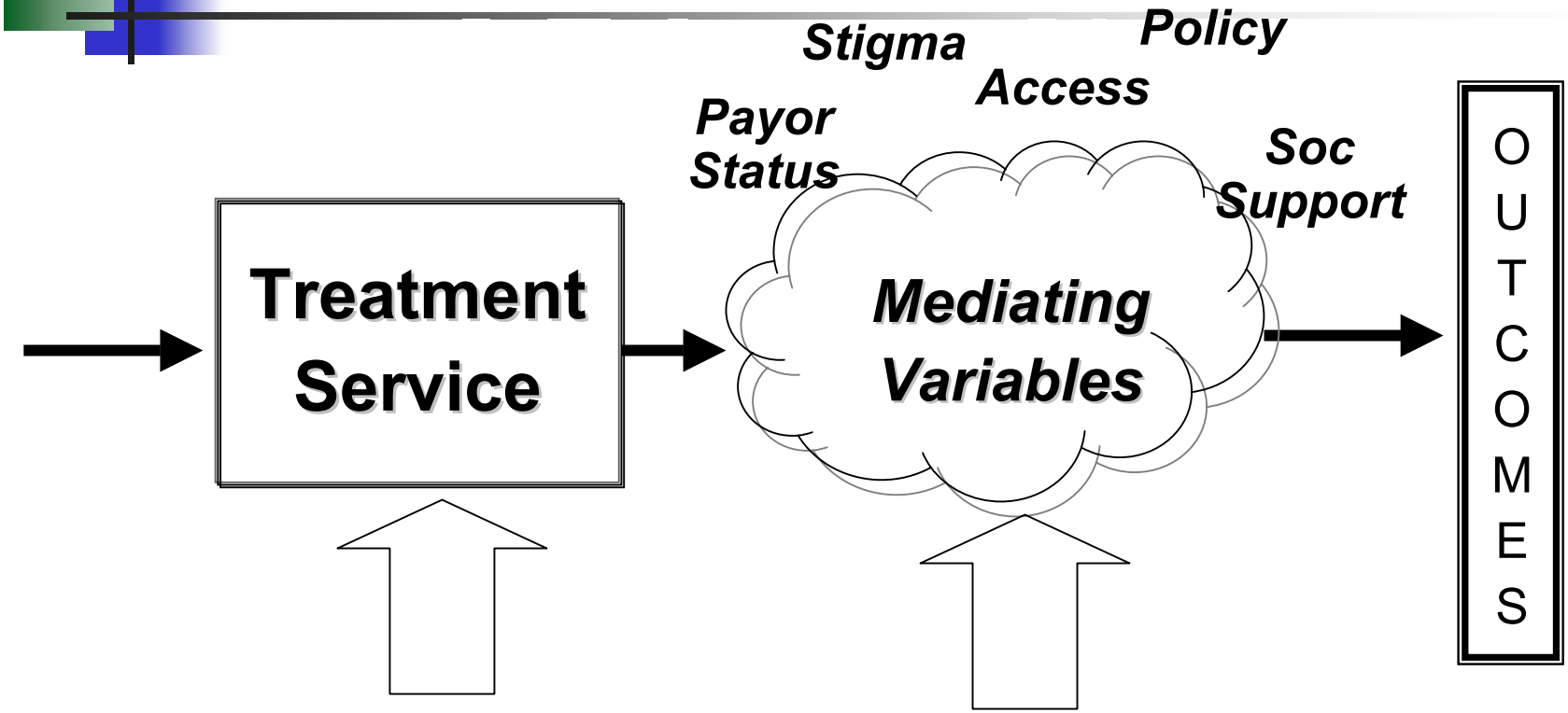
- A culturally competent mental health system incorporates skills, attitudes, and policies to ensure that it is effectively addressing the treatment and psychosocial needs of consumers and families with diverse values, beliefs, and sexual orientations, in addition to backgrounds that vary by race, ethnicity,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

What's been the discussion about how treatment works?



Treatment Improvement

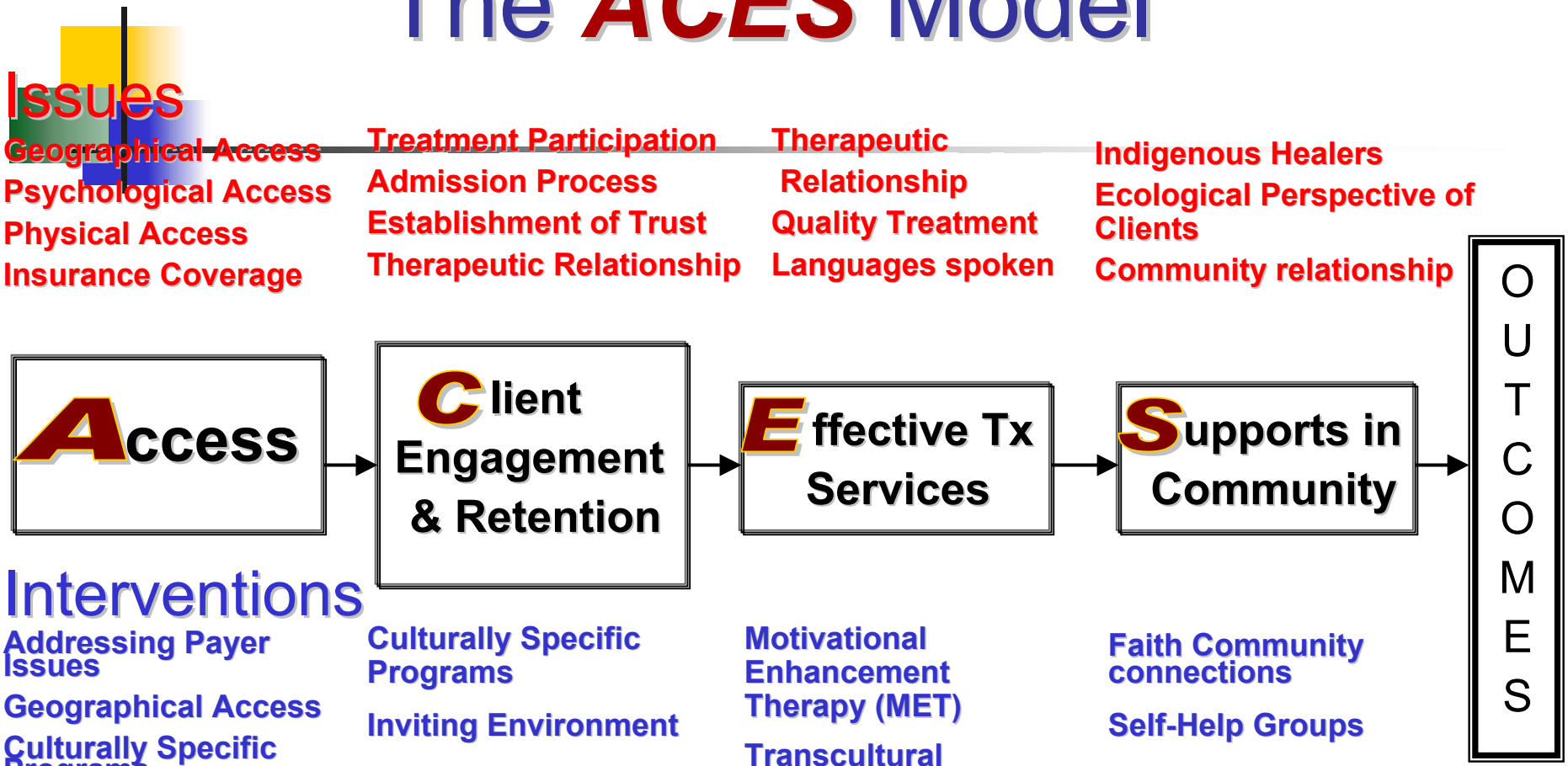
Cultural Competency



Treatment Improvement Cultural Competency

- ✓ ***Need to Understand***
- ✓ ***Include in Our Conceptualizations***
- ✓ ***Intervene***

The *ACES* Model



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

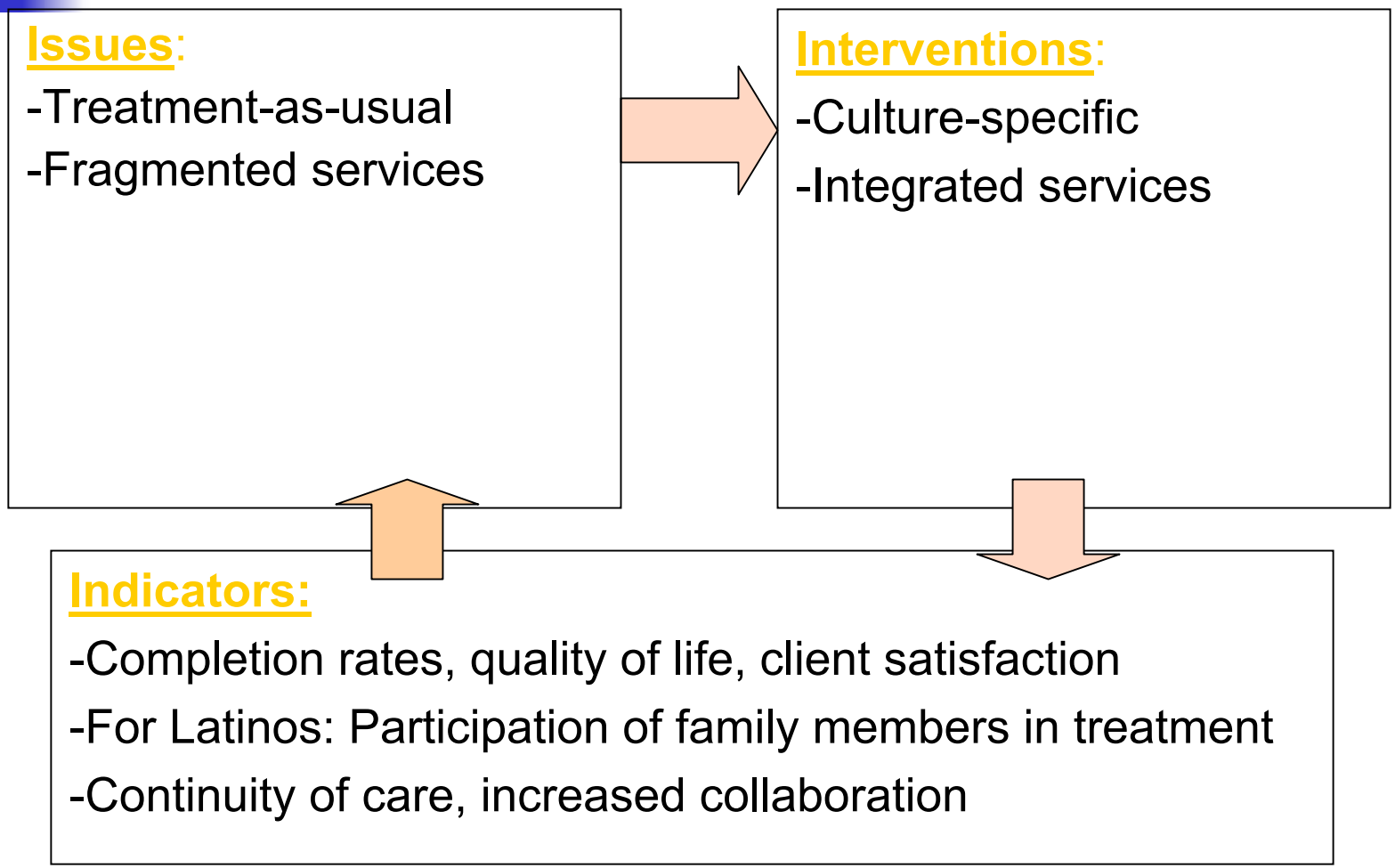
Indicators:

-Length of stay, frequency of visits, early treatment dropout

-Number of outreach referrals and people leaving treatment AMA

-Treatment Completion Rates

Effective Treatments



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?

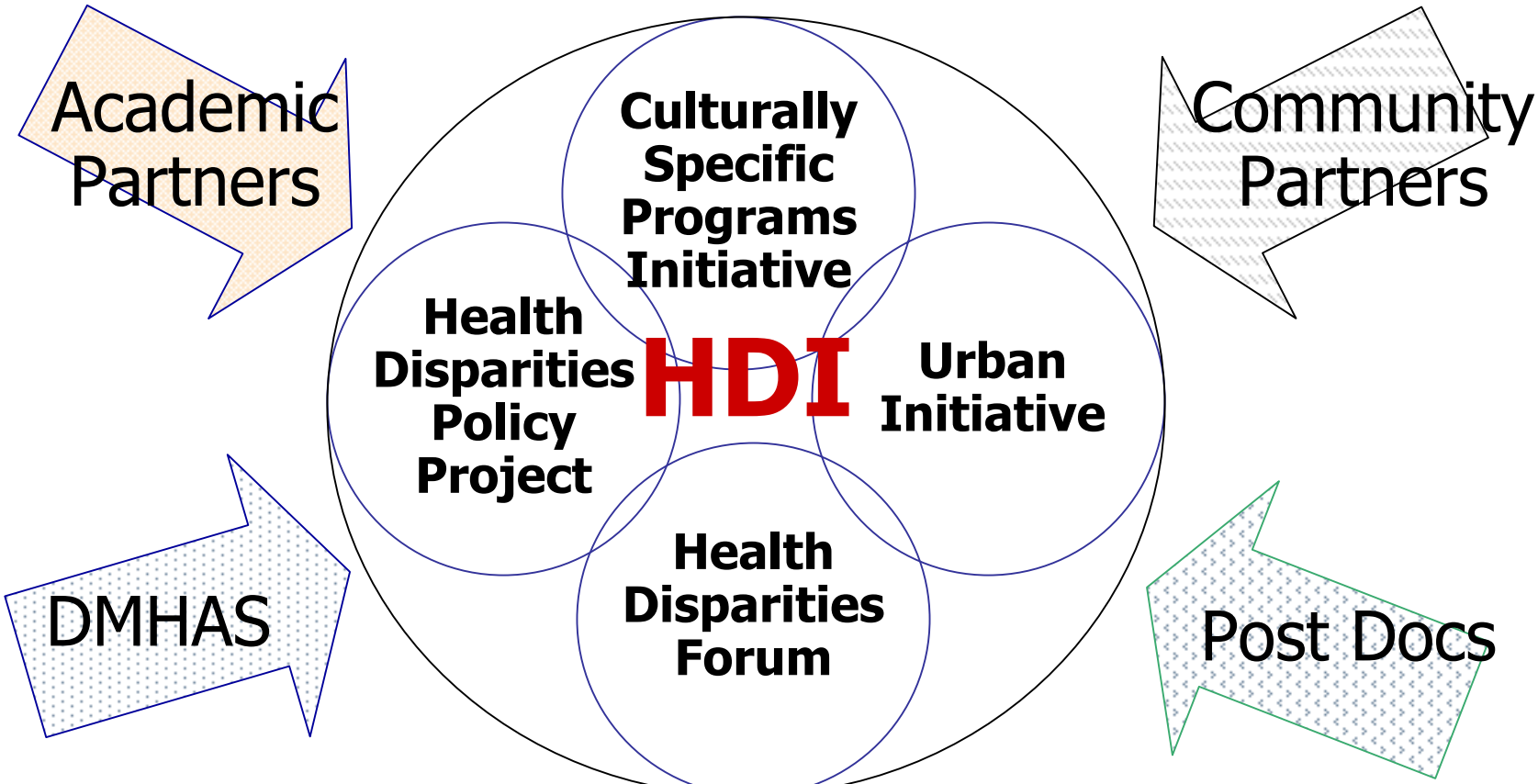
Uses a Multi level - Multi-dimensional Approach

- 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

Academic Partners

UConn

Center for Trauma Response/ Recovery & Preparedness

Dept. of Psychiatry

Yale

The Consultation Center

Dept. of Psychiatry

Center Urban Health, Poverty and Disability

DMHAS

Senior Leadership

Office of Multicultural Affairs

Health Disparities Forum

Postdoctoral Fellows

Community Partners

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

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:

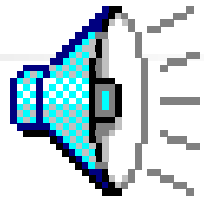
- To assess the ways culturally specific programs are qualitatively different from traditional approaches
- To determine in what ways the culturally relevant approaches influence outcomes
- To operationalize cultural competence

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

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
    - 2nd decade of life has highest mortality rate
    - Alcohol dependence, alcohol related deaths
  - Little information on service utilization patterns