Minority Fellowship Program
Health Disparities Overview Webinar Part 1
Disparities in Mental Health and Addiction Services

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SAMHSA
Substance Abuse and Mental Health Services Administration

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Injustice Persists

“Of all forms of inequity, injustice in health care is the most shocking and inhumane”

Martin Luther King Jr.

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Introduction

- After decades of disparities research, racial/ethnic disparities in mental healthcare persist.
- Health Reform and the Mental Health Parity Act propelled the expansion of improved access to mental healthcare and addiction services.
- Disparities reduction initiatives must reflect diversity and the changing demographics. Yet, many initiatives fail to consider the whole patient.

AGENDA Overview - Mental Health & Addiction Service Disparities

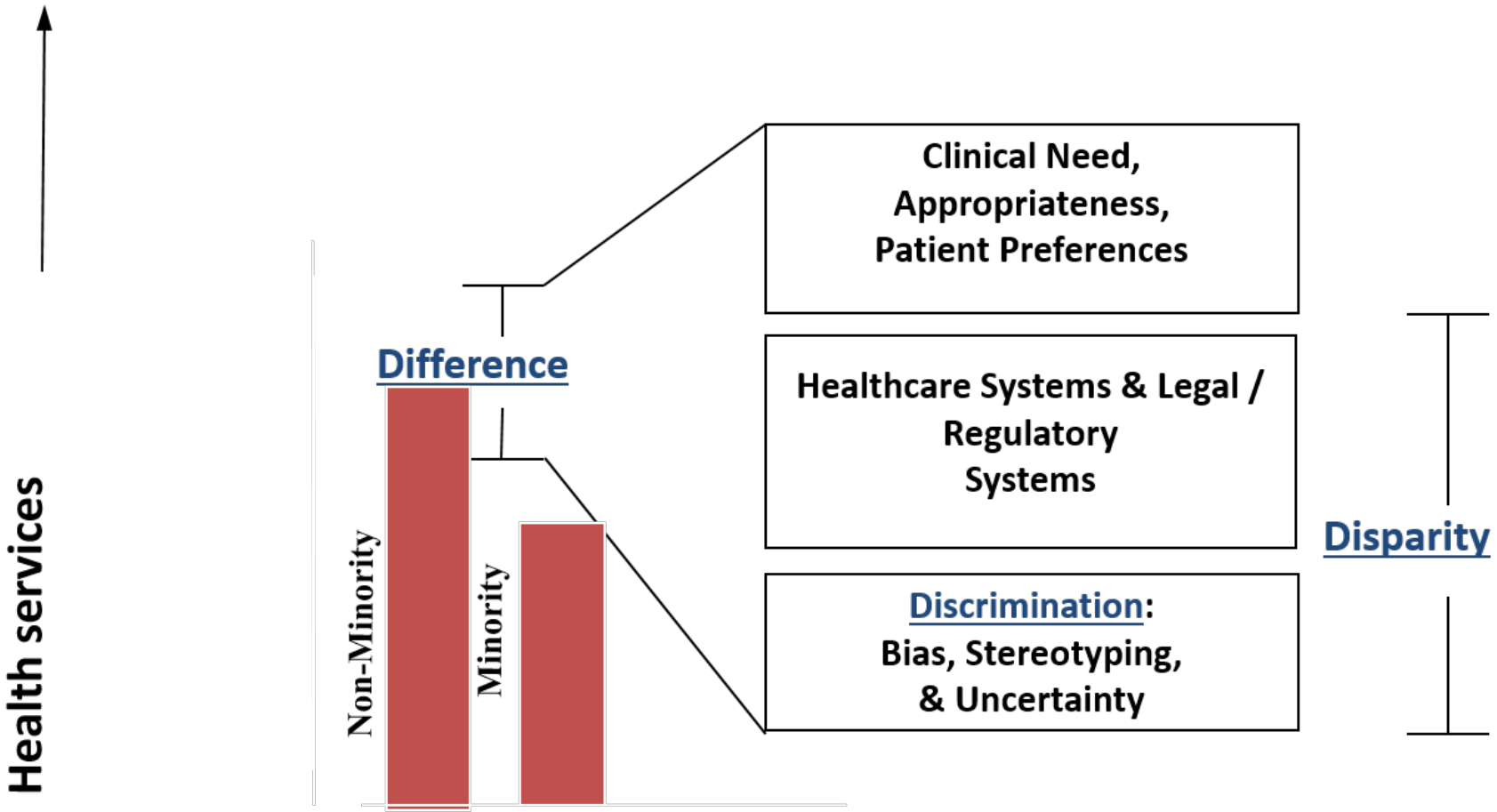
- Defining Mental Health Disparities for the underserved
- Know the numbers: Racial and ethnic minority populations
- Overview of findings from key national reports and research
- How social determinants contribute to mental health and addiction services disparities and unequal access to evidence based and quality behavioral healthcare
- Cultural competence, humility and responsiveness.
- Brief discussion of how certain practices and policies might contribute to mental health and addiction services disparities
- Presentation of several frameworks that explain Mental Health Disparities

Important Definitions

- **Healthcare disparities** refer to differences in access to or availability of facilities and services.
- **Health disparities** are differences in health or in the key determinants of health, such as social, economic, and environmental disadvantage, and are often driven by the social conditions in which individuals live, learn, work and play.
- **Health Equity** means that everyone has a fair and just opportunity to be healthier. This requires removing obstacles to health such as poverty, discrimination, and their consequences, includes powerlessness and lack of access to good jobs with fair pay; attaining quality education and housing, safe environments, and quality health care.

Source: NICHSR, 2009; RWJF, 2017

Differences, Disparities & Discrimination



Source: Institute of Medicine. 2003. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Washington, DC: The National Academies Press. https://doi.org/10.17226/10260

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Definitions (Con't)

- **Mental Health Disparities**: Differences in presence of mental health disease, outcomes, or access to mental healthcare. Example: higher persistence of mental health conditions along with higher rates of mortality and poorer mental health outcomes in racial/ethnic minorities, when compared with the white population.

- **Mental Health/Behavioral Healthcare Disparities:** Unequal access and provision of mental healthcare across different groups determined by race, ethnicity, sex, sexual identity, age, disability, socioeconomic status, or geographic location.

- **Healthy People 2020 --U.S. Dept of Health and Human Services**: A health disparity is a type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.

- **World Health Organization:** Health inequities are avoidable inequalities in health between groups of people within countries and between countries. These inequities arise from inequalities within and between societies. Social and economic conditions and their effects on people's lives determine their risk of illness and the actions taken to prevent them becoming ill or treat illness when it occurs.

In Conclusion – Disparity Definitions

A common nomenclature and lexicon used in describing mental health and substance use disparities allows us to:

- Establish a common ‘working’ language
- Create a framework for understanding disparities and possible interventions
- Conduct disparities research and evaluation
- Design service delivery approaches that strive to eliminate disparities

Know the Numbers: Our Changing Demographics in the United States

Over the next four decades:

- The U.S. population is projected to grow from 326 million to 404 million.
- Non-Hispanic white population remain the largest, although projected to decline as a result of falling birth rates and rising death rates.
- Racial/ethnic minority populations continue to grow- becoming more than 50% of total population.

Source: U.S. Census 2018

U.S. Population Distribution by Race/Ethnicity

In 2018, 61 percent non-Hispanic White and 39 percent racial/ethnic minority (rounding).

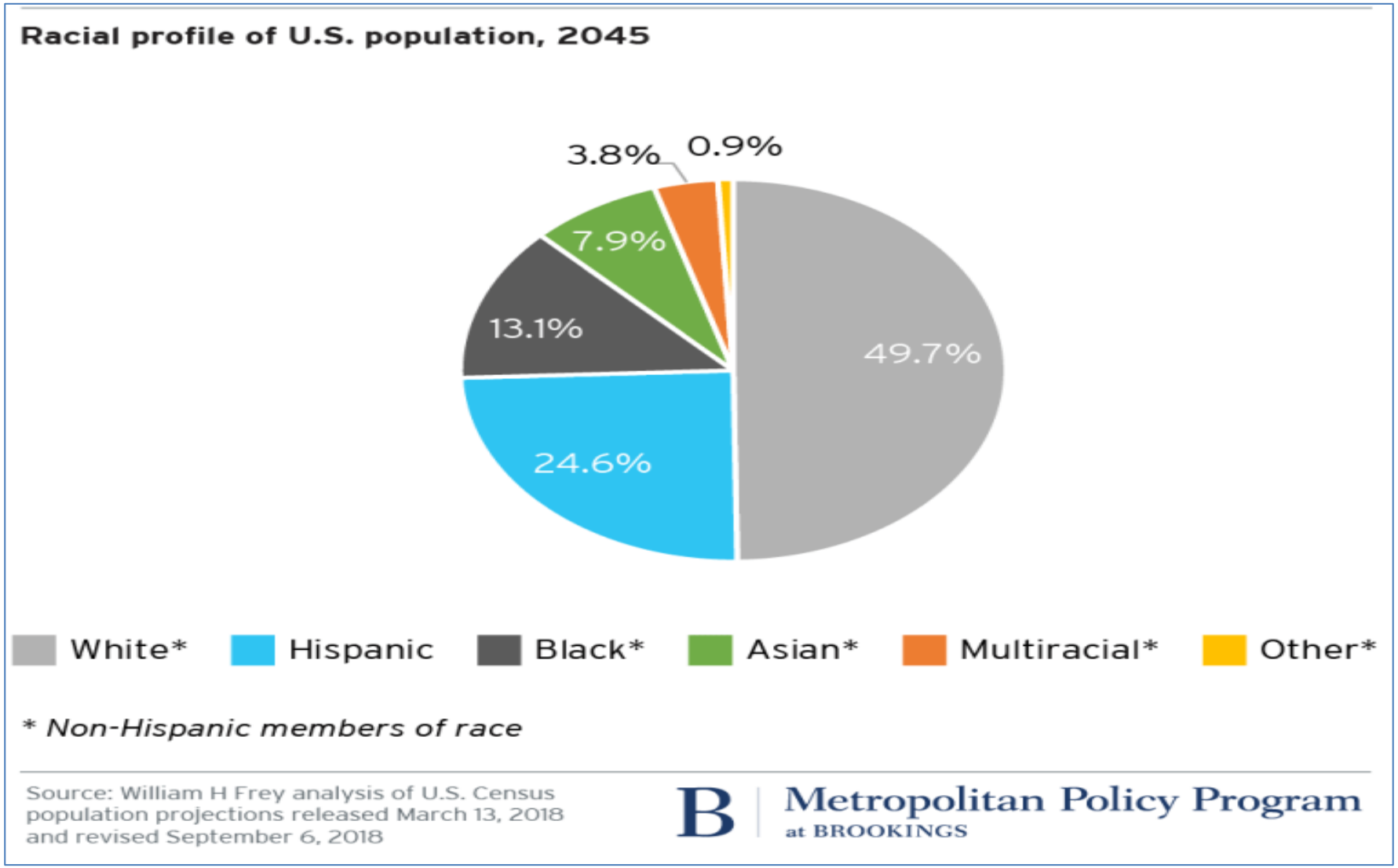
- Latinos represent 18% of the US population and represent the nation's largest ethnic/racial minority group.
- In 2016, the U.S. admitted 84,995 refugees. 49% of those refugees were from the Dominican Republic, Congo, Syria, and Burma.
- The black immigrant population has increased five-fold:
  - 1980: 816,000
  - 2016: 4.2 Million

- The Asian American population grew 72% between 2000 and 2015 (from 11.9 million to 20.4 million), the fastest growth rate of any major racial or ethnic group.

Race	Percent
White	62
Black	12
Hispanic	18
Asian	6
American Indian/Alaska Native	1
Multiracial	2

Source: US Census Bureau, 2018; Pew Research Center, 2017 and 2018.

U.S. Population Projections 2045



Source: https://www.brookings.edu/blog/the-avenue/2018/03/14/the-us-will-become-minority-white-in-2045-census-projects/

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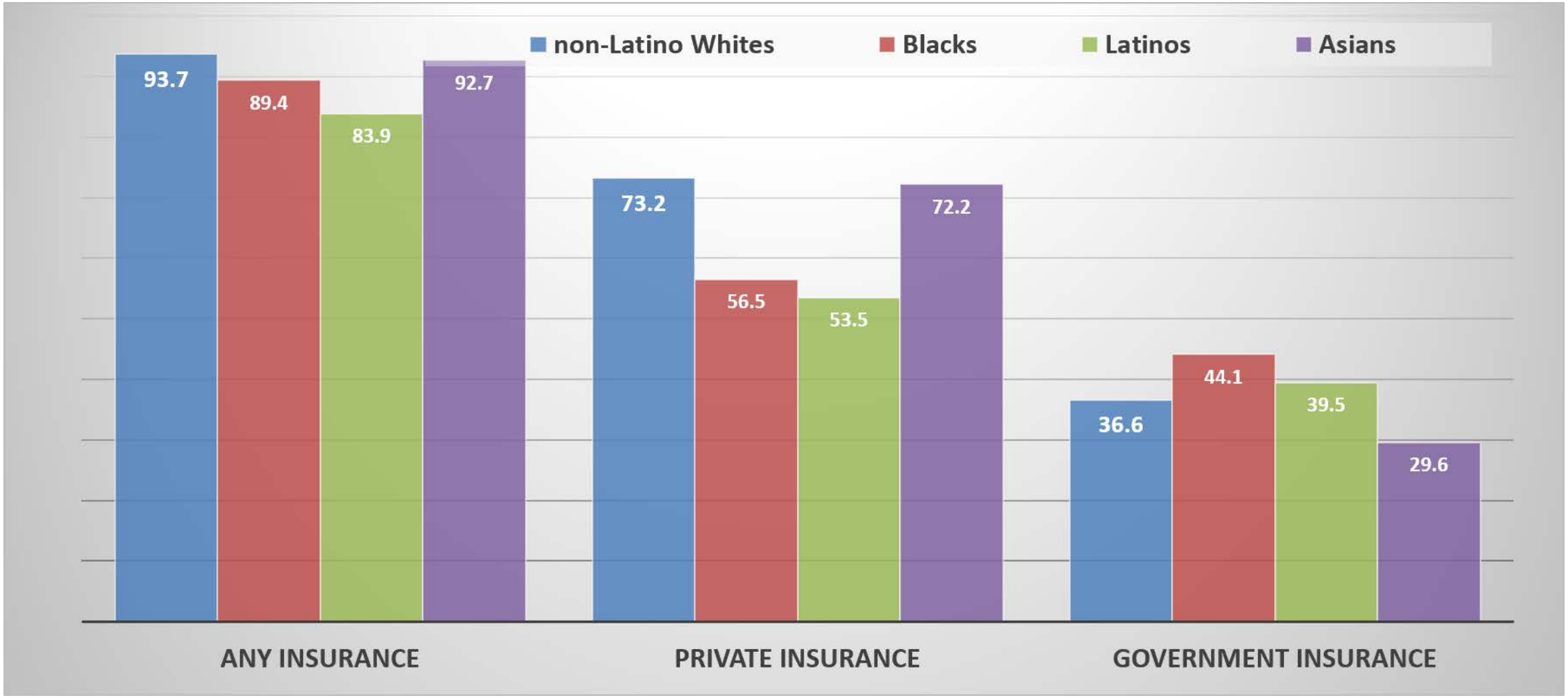
U.S. Health Insurance Coverage (%) By Race- 2017



Source: Berchick, Edward R., Emily Hood, and Jessica C. Barnett, Current Population Reports, P60-264, Health Insurance Coverage in the United States: 2017, U.S. Government Printing Office, Washington, DC, 2018.

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In Conclusion – Population Disparities

- Despite the growing diversity of the U.S. population, disparities continue to exist in the mental healthcare system for multicultural populations.
- Racial/ethnic minorities represent over 50% of the uninsured population.
- Research and reports continue to show that gaining access to behavioral health services alone, does not eliminate the service disparities.
- Need for a more culturally responsive, collaborative, integrated/patient-centered approach to care, including understanding patient preferences.

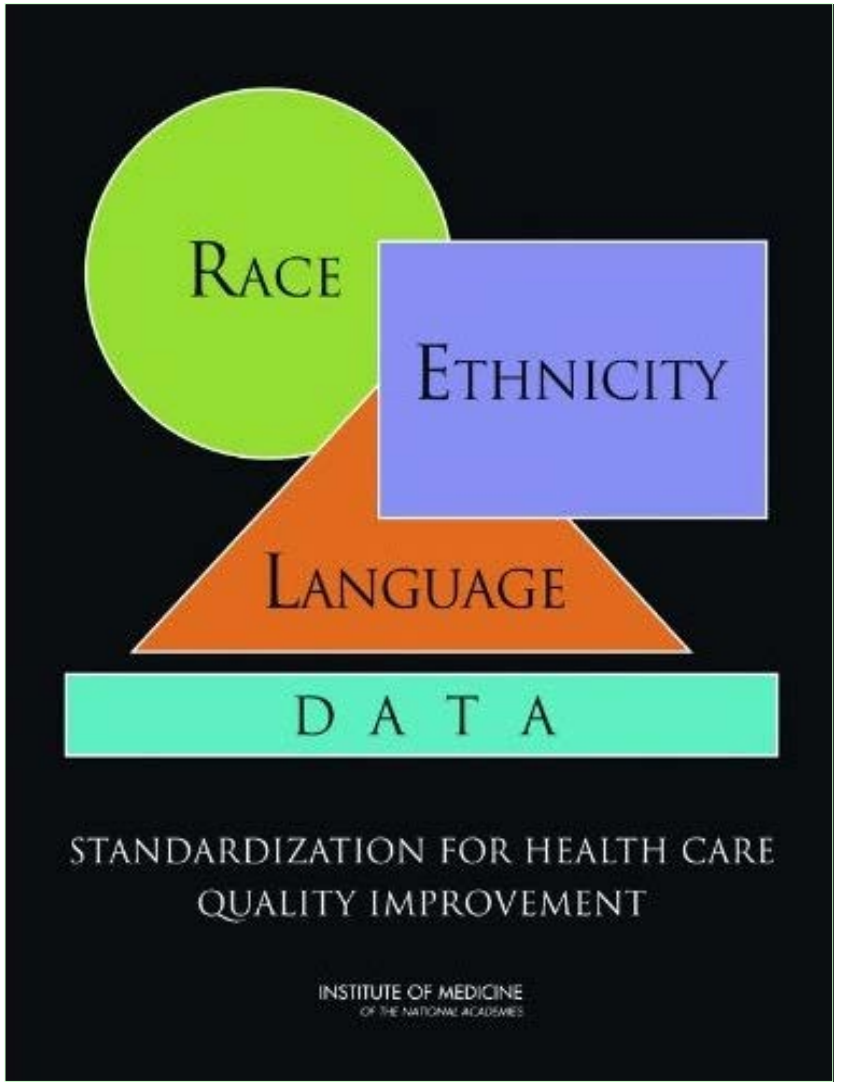
WANTED: New Approaches to Eliminate Mental Healthcare Disparities

- Health Reform and the Mental Health Parity Act propelled the expansion of improved access to mental health and substance use healthcare.
- Policies, initiatives and programs that consider the whole person.
- Innovative disparities reduction approaches needed.
- Must reflect and serve our changing demographics and diversity and bridge gaps.

Lessons From Disparities Research

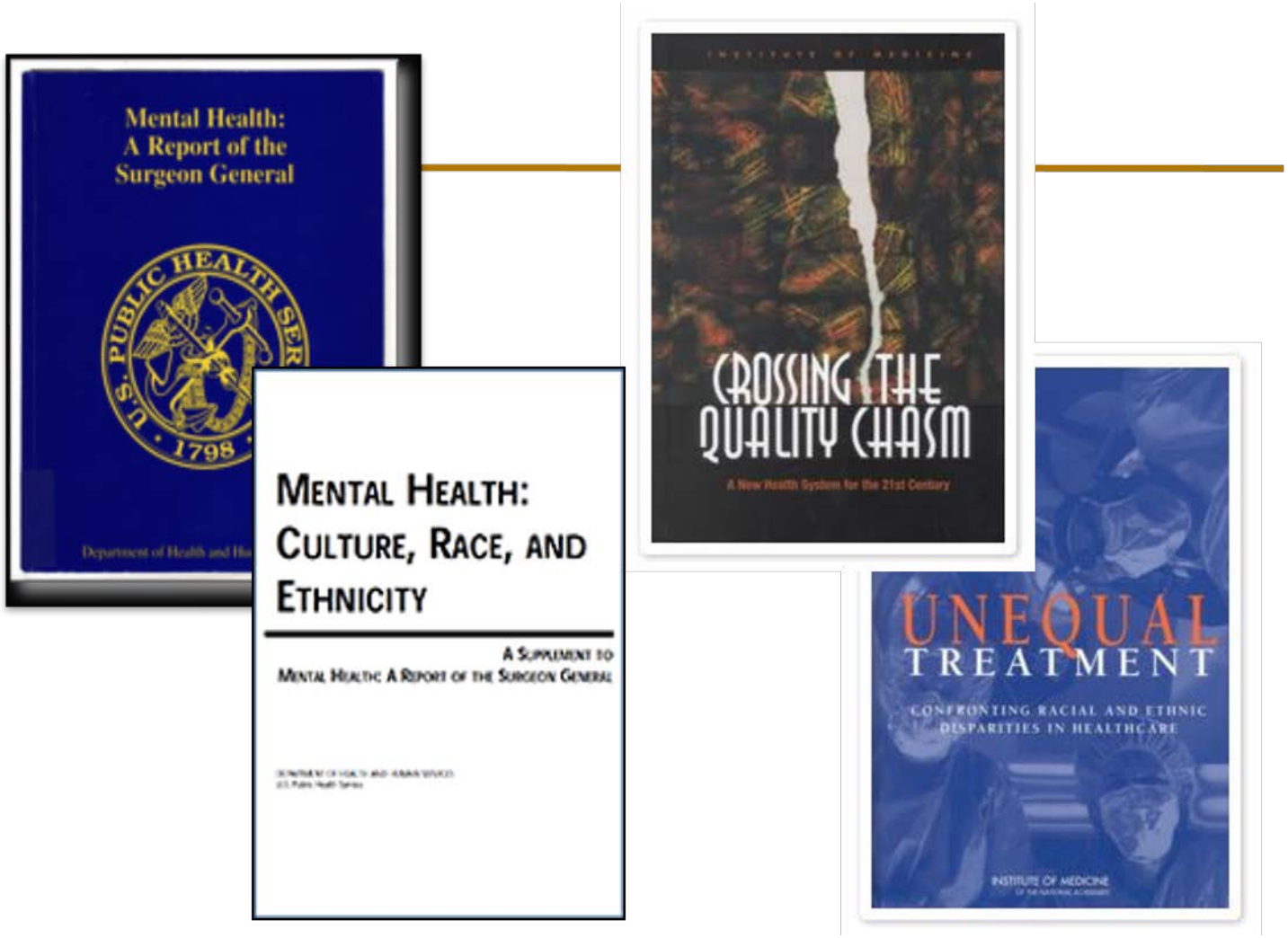
Performance reports by race/ethnicity:

- Since 2007, Massachusetts requires hospitals to collect race, ethnicity & language data
- IOM report, August 2009 (pictured here)
- Broad quality improvement efforts to reduce disparities in processes of care
- Disparities diminish in more organized systems of care: e.g. large HMO's, Veteran's Administration



Source: https://www.ahrq.gov/sites/default/files/publications/files/iomracereport.pdf

Examples of Disparities Reports



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Addressing Disparities Through Quality Performance Measures

- **Disparities are quality problems.**
- **Current data suggests some success but overall slow progress.**
- **Stratify quality measures by race/ethnicity & socioeconomic position.**

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Racial and Ethnic Disparities in the Quality of Health Care

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Keywords

health care disparities, race, ethnicity, health care quality, public health

Abstract

The annual National Healthcare Quality and Disparities Reports document widespread and persistent racial and ethnic disparities. These disparities result from complex interactions between patient factors related to social disadvantage, clinicians, and organizational and health care system factors. Separate and unequal systems of health care between states, between health care systems, and between clinicians constrain the resources that are available to meet the needs of disadvantaged groups, contribute to unequal outcomes, and reinforce implicit bias. Recent data suggest slow progress in many areas but have documented a few notable successes in eliminating these disparities. To eliminate these disparities, continued progress will require a collective national will to ensure health care equity through expanded health insurance coverage, support for primary care, and public accountability based on progress toward defined, time-limited objectives using evidence-based, sufficiently resourced, multilevel quality improvement strategies that engage patients, clinicians, health care organizations, and communities.

Source: Fiscella et al. Annual Review of Public Health 2016

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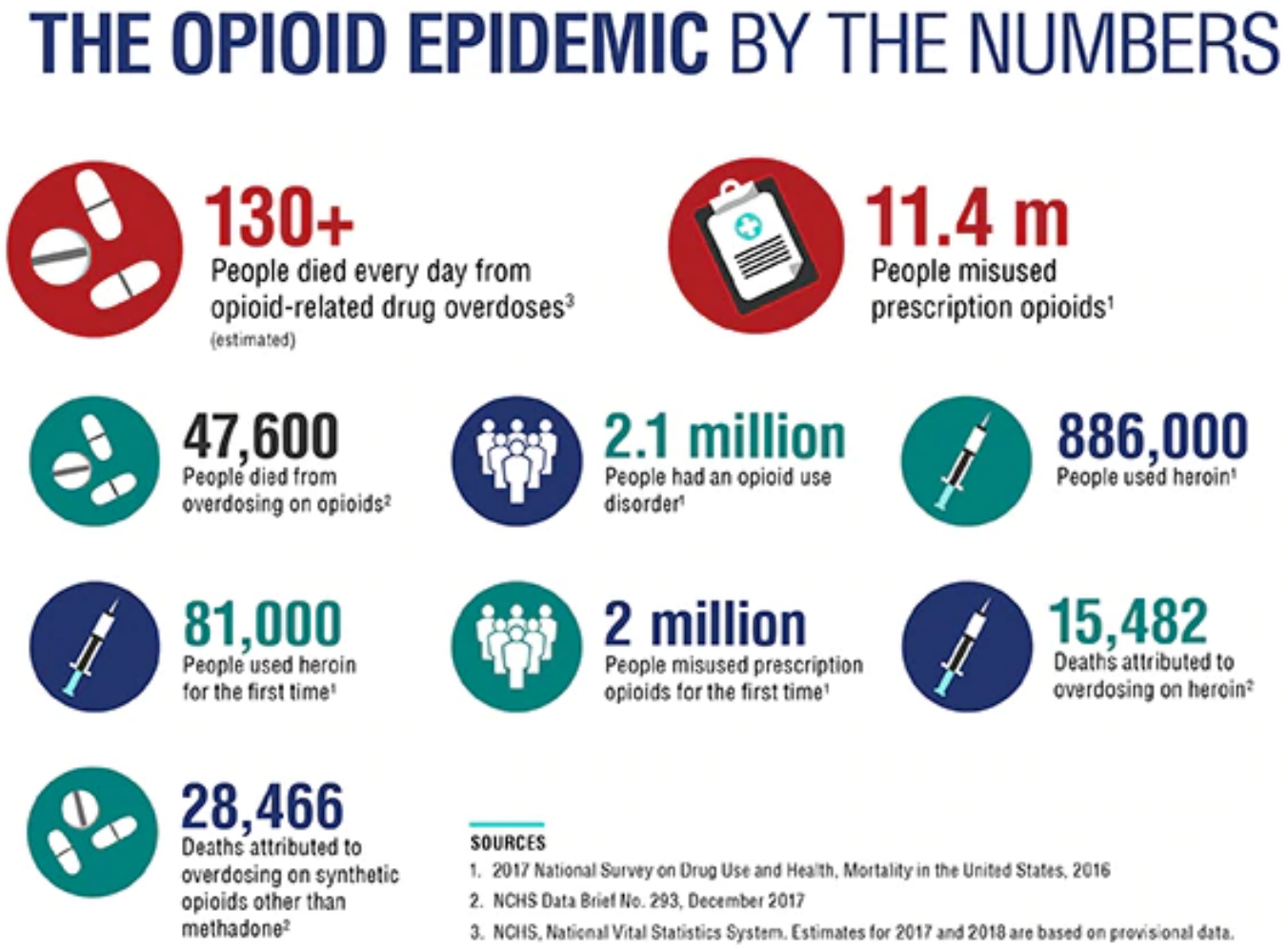
Identifying Factors that Contribute to Health Disparities

Disparities research is guided by both **normative** and **statistical principles**

- Distinguishes between acceptable (age, genetics) and unacceptable (race, SES) sources of difference.
- Assigns **responsibility** and **causality** for adverse health inequity.

Public Health Crisis

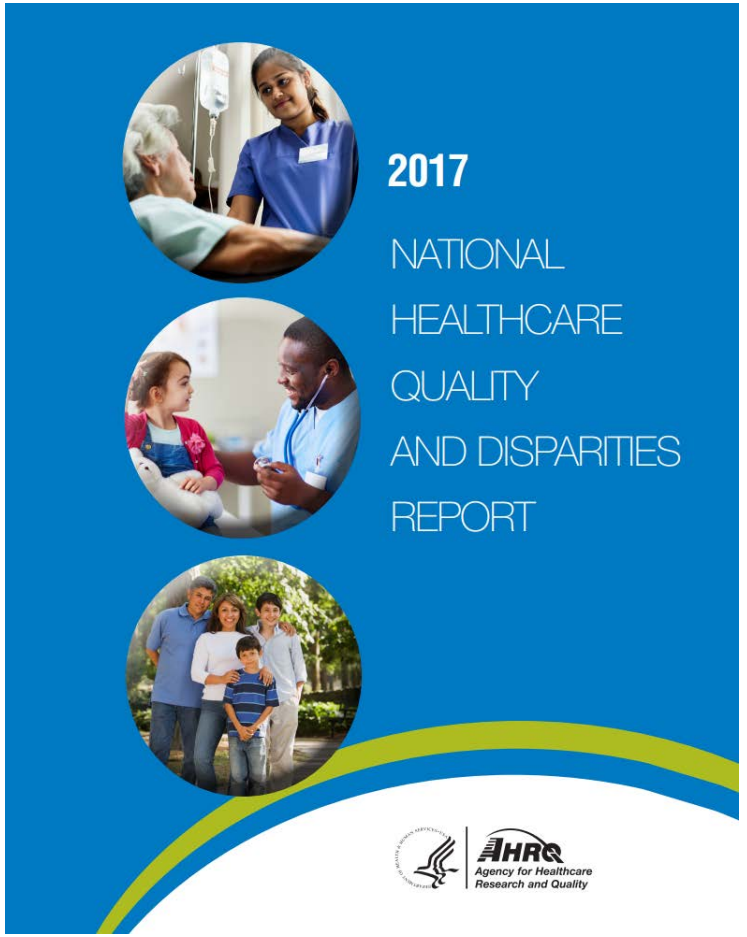


Source: https://www.hhs.gov/opioids/

Key Findings - 2017 National Health Care Quality and Disparities Report

Demonstrates that the Nation has made clear progress in improving health care delivery system to achieve the three aims of better care, smarter spending, and healthier people, but continued work needed to specifically address disparities in care.

- Access improved for 43% of measures, while 14% of measures showed worsening.
- Quality improved for most National Quality Strategy priorities.
- **Disparities persist, especially for poor and uninsured populations in all priority areas.**
- Many challenges in improving quality and reducing disparities remain.



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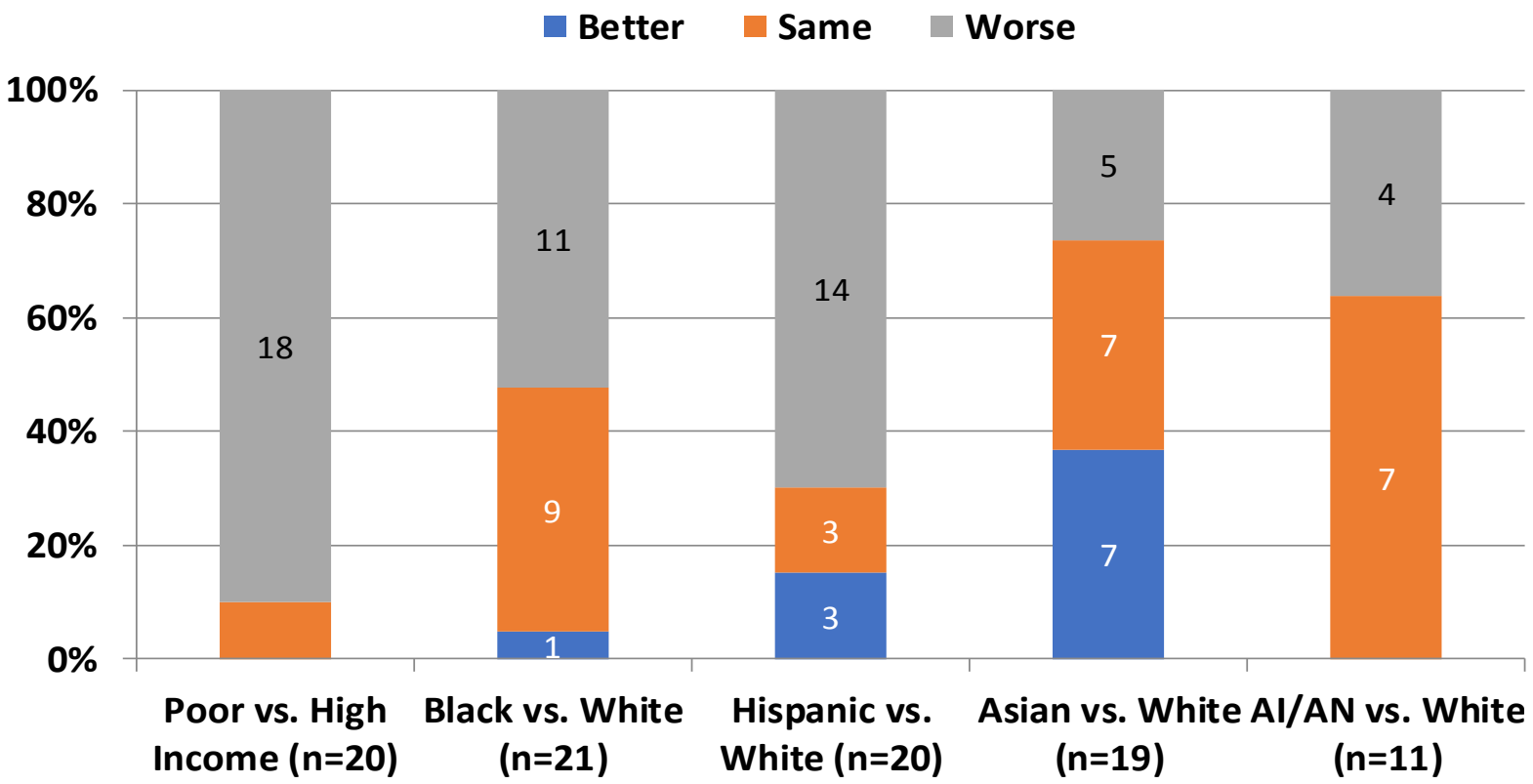
Access Disparities

Access measures for which members of selected groups experienced better, same, or worse access to care compared with reference group, 2017



Source: Page 21 of the 2017 National Healthcare Quality and Disparities Report. Rockville, MD: Agency for Healthcare Research and Quality

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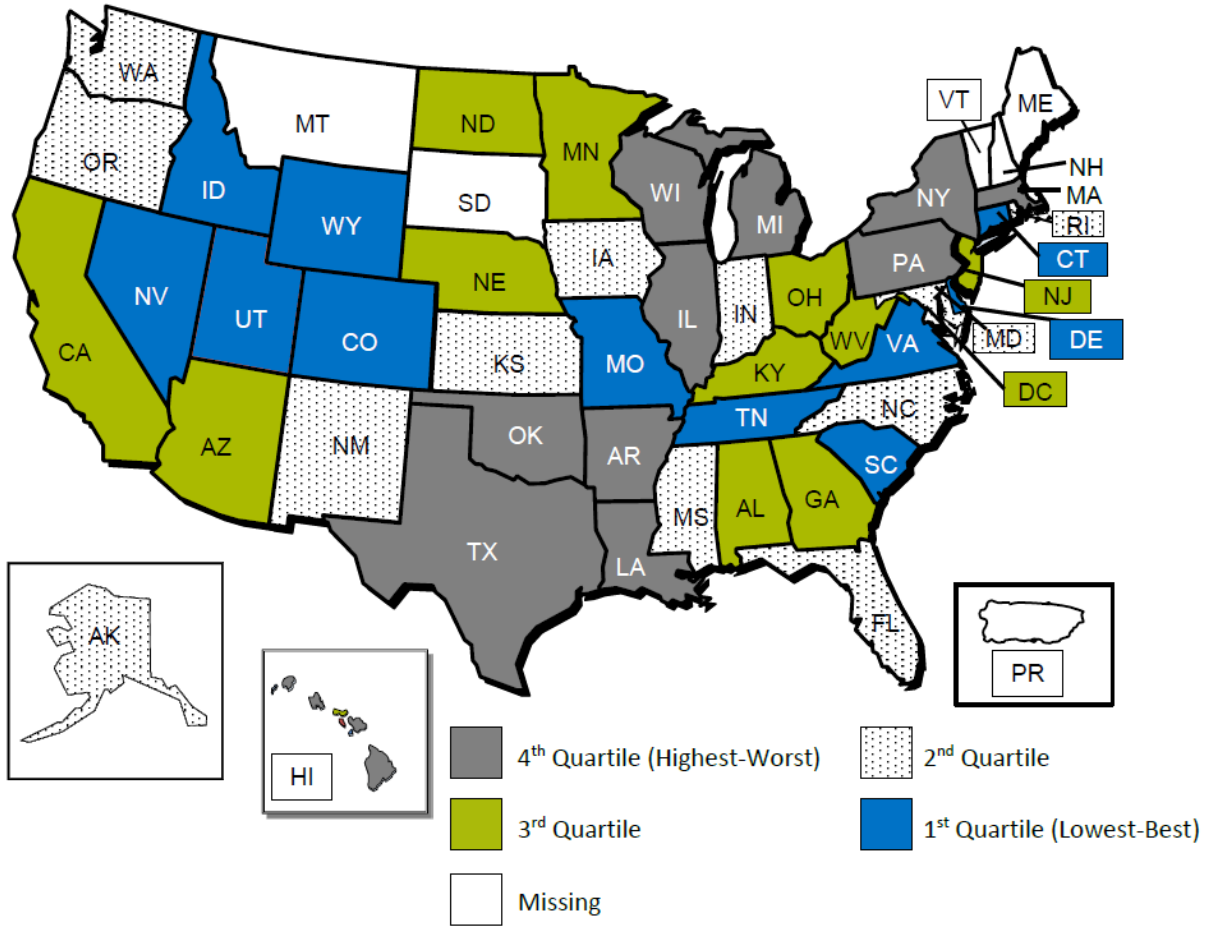
Healthcare Quality and Disparities: By Race (2014-2016)

Figure 10. Average differences in quality of care for Blacks, Hispanics, and Asians compared with Whites, by state, 2015-2016

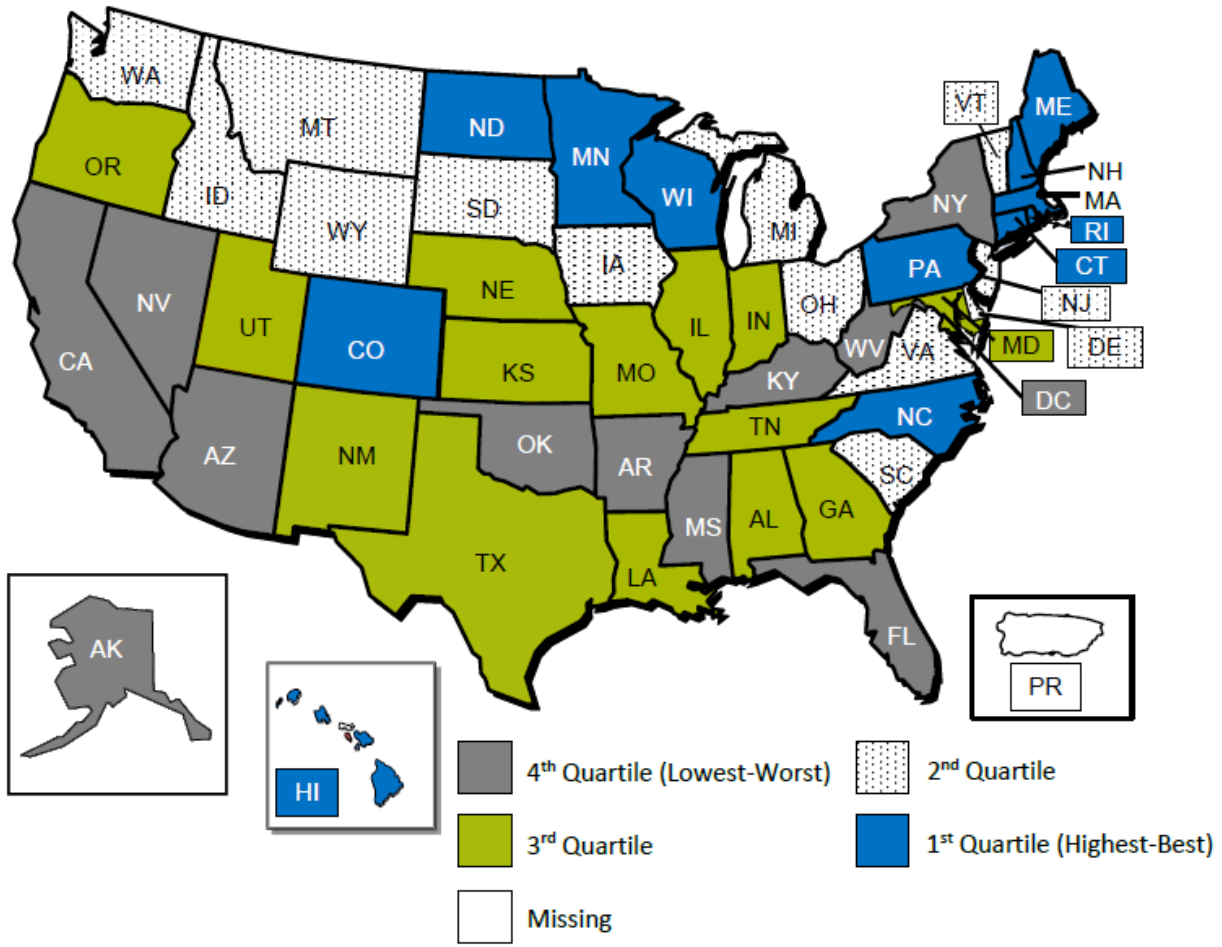


Note: All measures in this report that had state-level data to assess racial and ethnic disparities were used. Separate quality scores were computed for Whites, Blacks, Hispanics, and Asians. For each state, the average of the Black, Hispanic, and Asian scores was divided by the White score. State-level AI/AN data were not available for analysis. States were ranked on this ratio, and quartiles are shown on the map. The states with the worst disparity score are in the fourth quartile, and states with the best disparity score are in the first quartile. Disparity scores were not risk adjusted for population characteristics in each state, so these findings do not take into account population differences between states. See Appendix B for a list of measures used for this map.

Source: Page 18 of the 2017 National Healthcare Quality and Disparities Report. Rockville, MD: Agency for Healthcare Research and Quality

Healthcare Quality and Disparities: State-level (2014-2016)

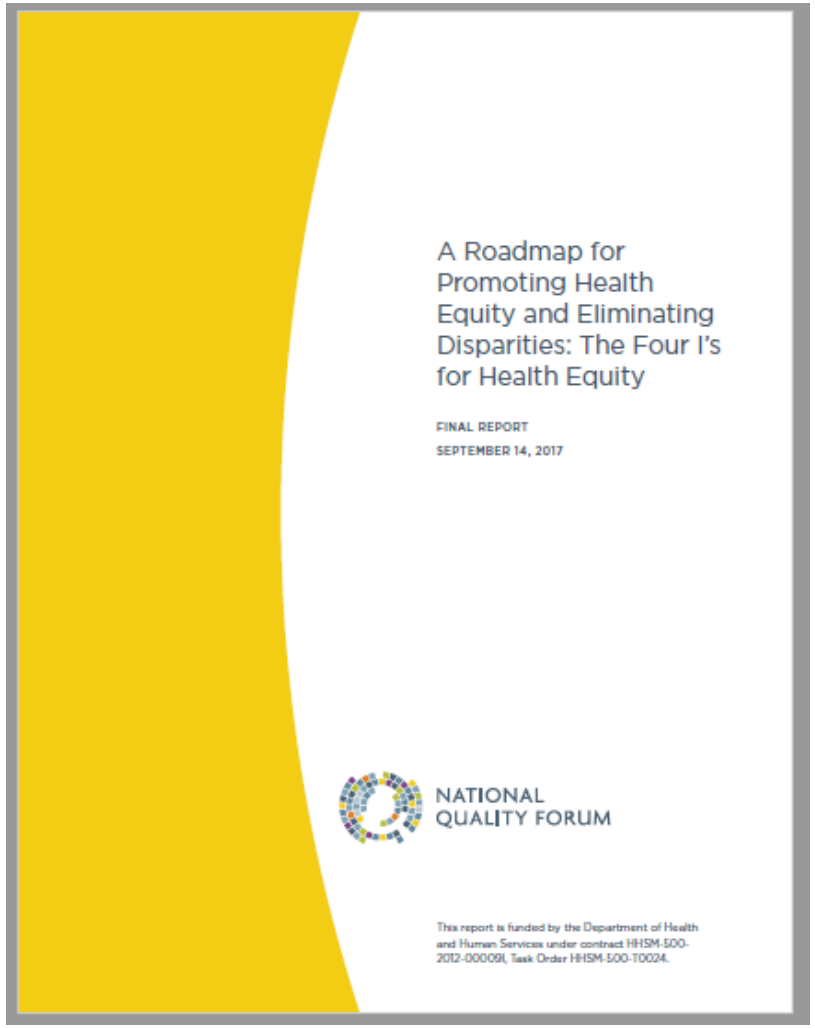
Figure 9. Overall quality of care, by state, 2014-2016



Note: All state-level measures with data are used to compute an overall quality score for each state based on the number of quality measures above, at, or below the average across all states. States were ranked and quartiles are shown on the map. The states with the worst quality score are in the fourth quartile, and states with the best quality score are in the first quartile. See Appendix B in the report for a list of measures used for this map.

Source: Page 17 of the 2017 National Healthcare Quality and Disparities Report. Rockville, MD: Agency for Healthcare Research and Quality

The 4- I's For Health Equity



- **Identify** and prioritize reducing health disparities.
- **Implement** evidence-based interventions to reduce disparities.
- **Invest** in the development and use of health equity performance measures.
- **Incentivize** the reduction of health disparities and achievement of health equity.

The National Quality Forum (2017) A Roadmap for Promoting Health Equity and Eliminating Disparities: The Four I's for Health Equity

In Conclusion – Disparities Findings

Over the past 20 years we've experienced substantial growth and focus on multiple efforts to better understand, reduce and eliminate health and mental health disparities. Some of those efforts include:

- Development of federal, state and university centers/institutes to eliminate health disparities.
- Increased knowledge and awareness from research, reports and outcome studies.
- Attempts to understand various contributors to disparities.
- Setting goals for achieving health equity.

Specific Mental Health Needs of Ethnic & Racial Minorities and Immigrants

Children and Adults:

- High rates of trauma
- Few resources to access care
- Chronic stressors (isolation, hopelessness, food insecurity, socio-economic disadvantage)
- Acculturative stress
- Language barriers

Consequences can include :

- Chronic depression (Negele et al., 2015)
- Anxiety disorders such as PTSD, substance use, and delinquency (Lopez et al, 2017)
- Other adjustment difficulties

Barriers To Access and Utilization: Deferred Or Delayed Care (2016)

Percent of non-elderly adults who did not receive or delayed care (past 12 months) by race/ethnicity

	White	Asian	Latino	Black	AIAN	NHOPI
Did Not See a Doctor for Needed Care Because of Cost	13%	10%	22%	18%	20%	17%
Delayed Needed Care for Reasons Other than Cost	22%	19%	30%	28%	35%	21%

Source: https://www.kff.org/disparities-policy/issue-brief/disparities-in-health-and-health-care-five-key-questions-and-answers/

Utilization of Mental Health Services Among Minorities

Annual average percent utilization by adults of mental health services in the past year, by race/ethnicity and service type, 2008-2012

Race/Ethnicity	Any Mental Health Service Use	Prescription Medication	Outpatient Services	Inpatient Services
White	16.6%	14.4%	7.8%	0.7%
Black or African American	8.6%	6.5%	4.7%	1.4%
American Indian or Alaska Native	15.6%	13.6%	7.7%	1.6%
Asian	4.9%	3.1%	2.5%	0.6%
Two or More Races	17.1%	14.1%	8.8%	1.1%
Hispanic	7.3%	5.7%	3.8%	0.8%

Source: SAMHSA http://www.samhsa.gov/data/sites/default/files/MHServicesUseAmongAdults/MHServicesUseAmongAdults.pdf

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Persons with Serious Mental Illness are Dying 15-25 Years Earlier

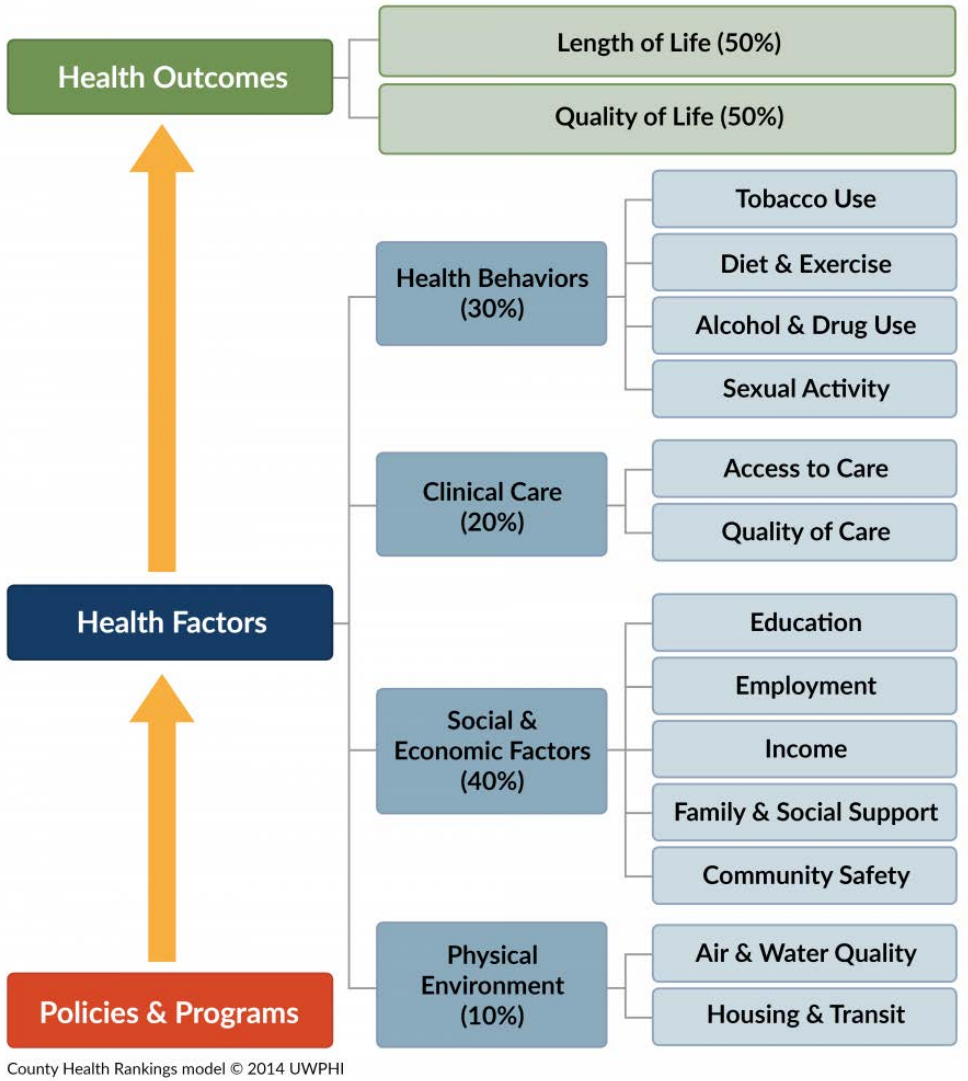
- Increased morbidity and mortality- largely due to treatable medical conditions, caused by modifiable risk factors such as poor diet, lack of exercise, smoking, substance use/abuse, depression and inadequate access to medical care.

- Eighty-five percent of the premature deaths were due to largely preventable conditions such as high blood pressure, high cholesterol, diabetes, and heart disease.

Source: https://www.nimh.nih.gov/news/science-news/2015/combating-early-death-in-people-with-serious-mental-illness.shtml

The Bigger View

The relationship between health, behavior health and social determinants.



Source: https://www.countyhealthrankings.org/county-health-rankings-model

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SDOH- Factors Contributing to Health Outcomes

Social determinants of health are the conditions in which people are born, grow, live, work and age. They include factors like socioeconomic status, education, neighborhood and physical environment, employment, and social support networks, as well as access to health care.

Addressing social determinants of health is important for improving health and reducing health disparities. Though health care is essential to health, it is a relatively weak health determinant. Research shows that health outcomes are driven by an array of factors, including underlying genetics, health behaviors, social and environmental factors, and health care.

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider availability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
Debt	Parks	Vocational training		Discrimination	
Medical bills	Playgrounds	Higher education		Stress	Quality of care
Support	Walkability				
	Zip code / geography				

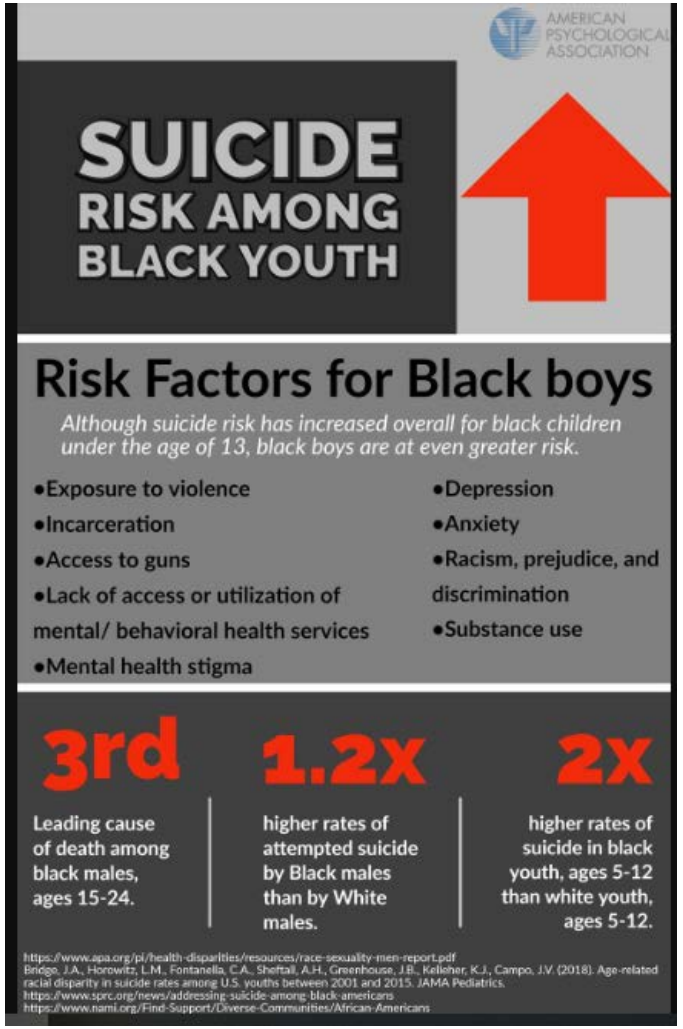
Health Outcomes
Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

Source: [Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity]

Additional Social Determinants and Comorbidities as Risk Factors for Poor Mental Health Outcomes

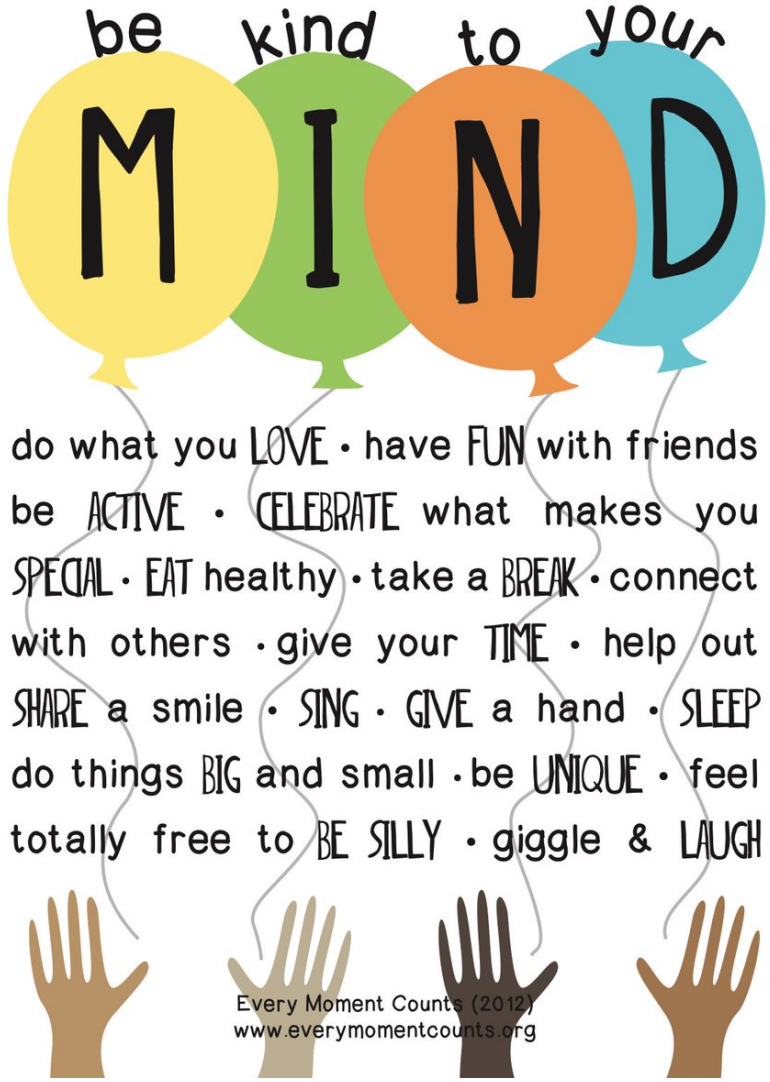
- Racism and discrimination
- Low income, unemployment & poverty
- Homelessness
- Food insecurity
- Trauma, Violence & Crime
- Children in out-of-home placements/foster care
- Developmental disabilities
- Substance use/abuse disorders and addictions
- Serious and persistent mental illness
- Incarceration
- Chronic health conditions, e.g. obesity, diabetes, asthma, cardiovascular disease, stroke, Hepatitis B & C, Sickle Cell Disease, HIV/AIDS

Impacts of Social Determinants and Risk for Suicide



Source: Bridge, J.A., Horowitz, L.M., Fontanella, C.A., Sheftall, A.H., Greenhouse, J.B., Kelleher, K.J., Campo, J.V. (2018). Age-related racial disparity in suicide rates among U.S. youths between 2001 and 2015. JAMA Pediatrics.
https://www.apa.org/pi/health-disparities/resources/race-sexuality-men-report.pdf

Consumer Barriers: Stigma and Shame



- Mental illness is a leading cause of disability, yet nearly two-thirds of people with a diagnosable mental illness do not seek treatment, and racial and ethnic groups in the U.S. are even less likely to get help.
- African Americans and Hispanic/Latinos used mental health services at about one-half the rate of Caucasian Americans in the past year and Asian Americans at about one-third the rate.
- Encourage family, friends, loved ones and patients/clients to learn more about normalizing and increasing awareness about mental health and illness.

Source: http://www.ahrq.gov/research/findings/nhqrdr/nhdr10/index.html

Migrant Health

Barriers and Service Gaps among migrants leading to Chronic and Disabling Mental Health and Addiction Conditions.

- Lack of understanding about mental health and addictions
- Unaware that services exist or where to receive them
- No insurance coverage
- Stigma (i.e. personal weakness, shame, fear of labels)
- Cultural considerations in approaches to treatment (i.e. seek help from friends, church, sobador, curanderos…)
- Language barriers between consumer and provider

Source: L. E. Gulbas, L. H. Zayas, H. Yoon, H. Szlyk, S. Aguilar-Gaxiola, G. Natera (2015). Deportation experiences and depression among U.S. citizen-children with undocumented Mexican parent. https://doi.org/10.1111/cch.12307

Barriers to Treatment Experienced among Migrants

- Migrants more likely to experience emotional and physical vulnerabilities related to separation from their social networks, potentially leading to increased substance abuse and sexual risk behaviors.
- Migration is associated with separation from families and communities of origin.
- High stress related to fear of deportation, as well as labor and housing conditions.
- Increased exposure and use of drugs & disconnection from social networks/communities among migrants may lead to more perceived barriers to accessing treatment compared to non-migrant Mexicans.

Source: Gulbas, et.al, 2015; Lopez,2018

Immigration Stressors

Immigration may represent major sources of stress:

- Family dislocation, loss, fragmentation and reconstruction
- Culture change for individuals and across generations
- News law, policies and actions in host country
- Fear of deportation

Immigration may include experiences of trauma, acculturation stress, and substance use and abuse:

- Migrants are more likely to develop significant mental-health problems than individuals who remained in Mexico.
- Migrants between 18 and 25 have the greatest risk of experiencing a depressive disorder — nearly four-and-one-half times greater than their same-age Mexican peers who do not immigrate.

Source: The Effect of Migration to the United States on Substance Use Disorders Among Returned Mexican Migrants and Families of Migrants (Oct. 2011). https://ajph.aphapublications.org/doi/full/10.2105/AJPH.2006.097915

What is Cultural Competence, Responsiveness and Humility?

- The ability to relate effectively to individuals from various groups and backgrounds.
- Services tailored and responding to the unique needs of members of all populations, including children, families, schools, and communities.
- Sensitivity to the ways in which people with disabilities experience the world. Within the behavioral health system (which addresses both mental illnesses and substance use/abuse/addiction).
- Must be a guiding principle, so that services are culturally sensitive and provide culturally appropriate prevention, outreach, assessment and intervention.
- Cultural and linguistic empathy embedded into all aspects of engagement & work.

Source: Betancourt, et.al, 2015

National Culturally & Linguistically Appropriate Service Standards

The National CLAS Standards are a set of 15 action steps intended to advance health equity, improve quality, and help eliminate health care disparities by providing a blueprint for individuals and health and health care organizations to implement culturally and linguistically appropriate services.

The National CLAS Standards
https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53

Cultural Considerations for Immigrant Consumers of Mental Health and Addiction Services

- Be familiar with cultural conceptions of health and mental health.
- Hire and support bilingual/bicultural providers.
- Use interpreters who are trained in the mental health field.
- Collaborate with health care providers through integrated care.
- Infuse traditional health and healing practices.
- Use approaches such as psychoeducation and home visits.

Challenges in Delivering CLC Health, Mental Health and Substance Use Services

- Limited access to meaningful and quality care
- Lack of health insurance
- Poverty
- Language barriers
- Little Care Coordination
- Long waiting lists
- Over-representation in vulnerable populations
- Few bilingual, bicultural providers that serve LEP communities
- Lack cultural and linguistic competence
- Clinician Bias in Diagnosis and Treatment
- Missing leadership and program development specific to racial/ethnic minority mental health and substance use needs
- Stigma

Source: *NAMI, 2017* https://www.nami.org/About-NAMI/Publications-Reports/Public-Policy-Reports/The-Doctor-is-Out/DoctorIsOut.pdf

Cultural and Linguistically Competent Workforce Strategies

- **Build**

  Build a diverse multidisciplinary workforce
- **Attract and Retain**

  Attract and retain bilingual/bicultural providers
- **Identify and Engage**

  Identify and engage individual health care workers early in their studies/career
- **Provide**

  Provide in-culture and in-language internships & supervision
- **Build and Support**

  Build and support diverse, empowered leadership

Source: Elsevier, 2018

Recommendations From the Field: Implement National CLC Standards in Behavioral Health Training Programs

- **Require and implement**

  Require and implement national standards for CLC accreditation and credentialing in all mental health training and certification programs for working with LEP populations.

- **Standardize**

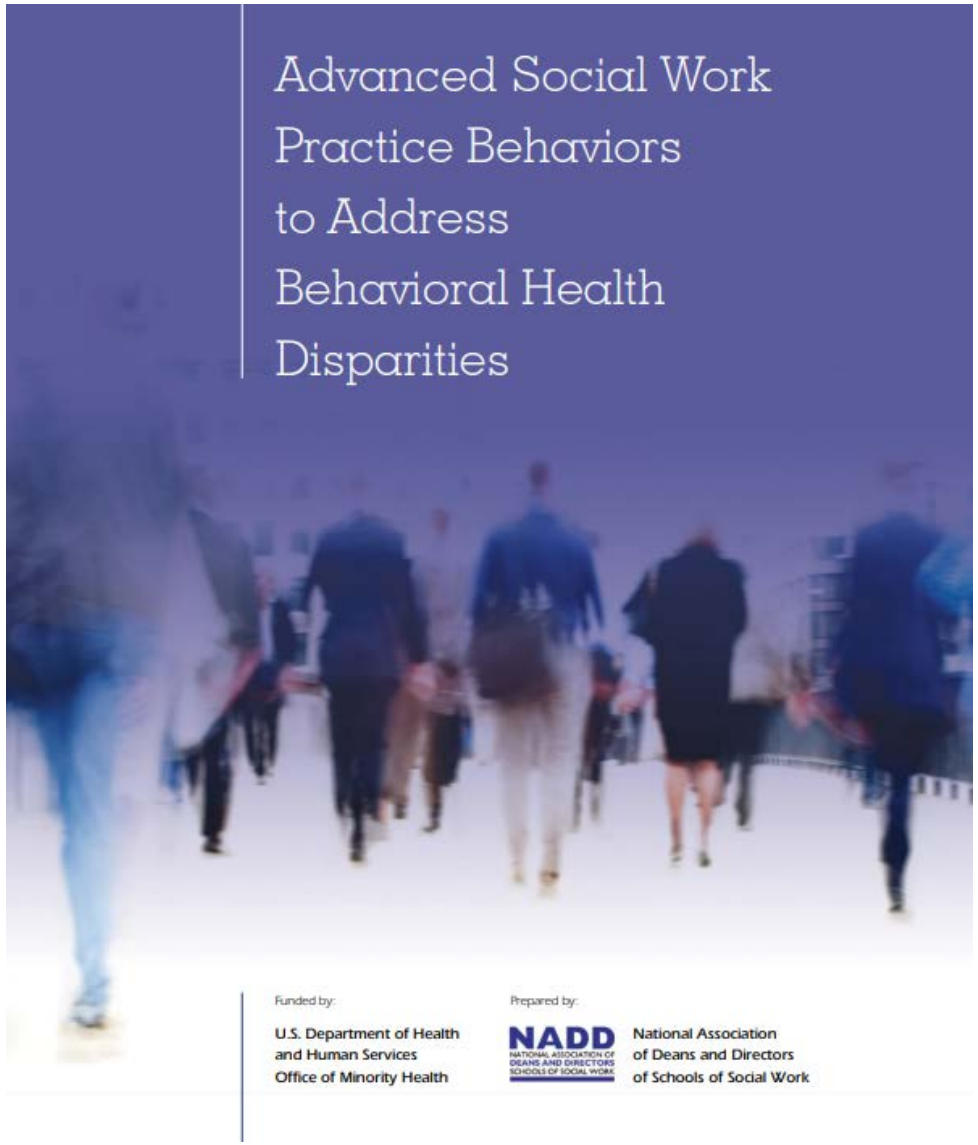
  Standardize a national licensure and/or certification program for mental health professionals.

- **Revamp**

  Revamp accreditation for institutions of higher education to include coursework in CLC in health and mental health services.

Source: https://www.thenationalcouncil.org/wp-content/uploads/2015/11/Cultural-and-Linguistic-Competence-and-CCBHC-Criteria.pdf

Thought Leadership turned into Advanced Competencies



[Advanced Social Work Practice Behaviors to Address Behavioral Health Disparities]

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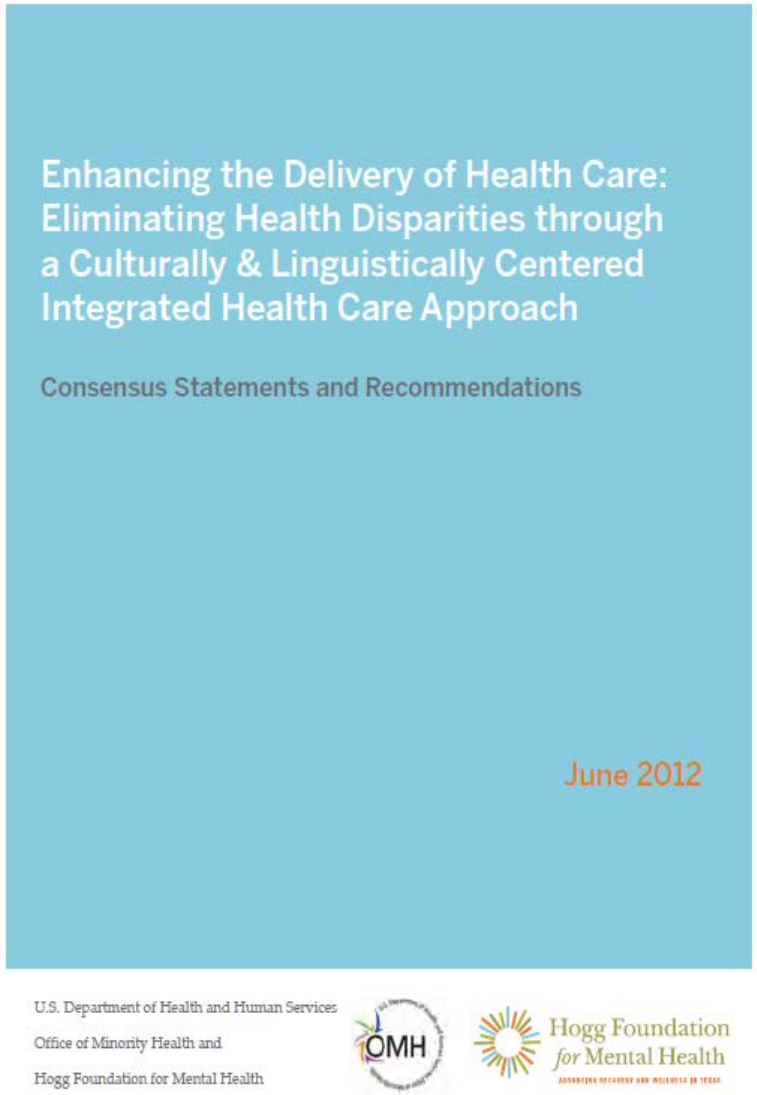
Eliminating Racial and Ethnic Disparities through Integrated Health Care



- Literature review
- Consensus Meeting
- Consensus Statements
- Recommendations
- Innovations from the field

Source: http://www.integration.samhsa.gov/@Final_Health_Report.pdf

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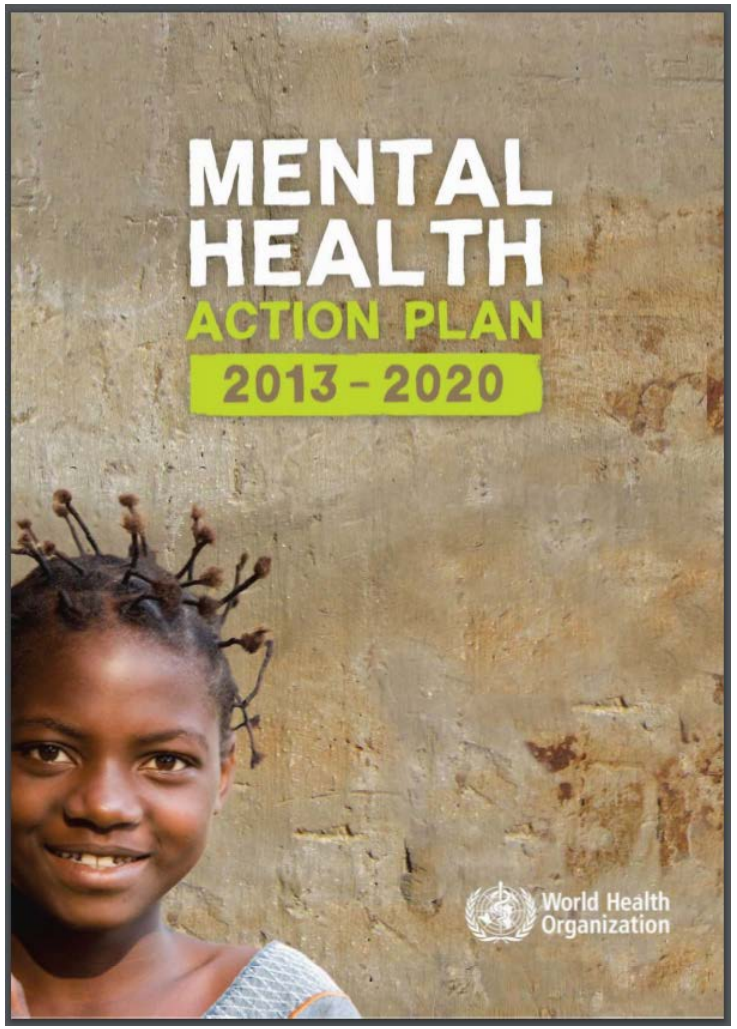
World Health Organization Mental Health Action Plan

Four major objectives of the action plan:

1. Strengthen effective leadership and governance for mental health
2. Provide comprehensive, integrated and responsive mental health and social care services in community-based settings
3. Implement strategies for promotion and prevention in mental health
4. Strengthen information systems, evidence and research for mental health



Source: http://www.who.int/mental_health/publications/action_plan/en/

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In Conclusion: Social Determinants & Cultural Sensitivity

- Its imperative to be knowledgeable and understand the intersections of mental health, mental illness, social determinants of health/mental health and their impacts on achieving wellness.
- Cultural and linguistic competence must be a guiding principle, so that services are culturally sensitive and provide culturally appropriate prevention, outreach, assessment and intervention.
- Learn and implement approaches to care that resonate with the population/community served.

Food for Thought

"This world's not going to change unless we're willing to change ourselves".

Rigoberta Menchu Tum

Nobel Peace Prize Laureate

1992

The Role of Provider Bias

Hall et al. (2015) conducted a systematic review of 15 studies examining implicit racial/ethnic bias among health care providers.

- Low to moderate levels of bias found in all but one of the examined studies.
- Most providers were found to display a positive bias towards White patients and negative bias towards patients of color.

Mistaken Assumptions

Three mistaken assumptions that underlie the expansion of behavioral health care run the risk of replicating existing service disparities.

1. Improvement in healthcare access alone will reduce disparities
2. Current service planning addresses minority patients' preferences
3. Evidence-based practices are readily available for diverse populations

Source: Alegria et al., 2016

Assumption 1:

Improvement in healthcare access alone will reduce disparities

- There are fewer providers in racially-segregated neighborhoods because of lower reimbursement rates.
- Higher proportion of African Americans and Latinos are either covered by Medicaid or uninsured.
- The percentage of Black and Latinx psychiatrists and Black, Latinx, and Asian psychologists and social workers is well below the representation of those groups in the population.

Assumption 1: Improvement in healthcare access alone will reduce disparities.

DELIVERING SERVICES

By Margarita Alegría, Kiara Alvarez, Rachel Zack Ishikawa, Karissa DiMarzio, and Samantha McPeck

Removing Obstacles To Eliminating Racial And Ethnic Disparities In Behavioral Health Care

DOI: 10.1377/hlthaff.2016.0029
HEALTH AFFAIRS 35,
NO. 6 (2016): 991–999

ABSTRACT **Despite decades of research, racial and ethnic disparities in behavioral health care persist. The Affordable Care Act expanded access to behavioral health care, but many reform initiatives fail to consider research about racial/ethnic minorities. Mistaken assumptions that underlie the expansion of behavioral health care run the risk of replicating existing service disparities. Based on a review of relevant literature and numerous observational and field studies with minority populations, we identified the following three mistaken assumptions: Improvement in health care access alone will reduce disparities, current service planning addresses minority patients' preferences, and evidence-based interventions are readily available for diverse populations. We propose tailoring the provision of care to remove obstacles that minority patients face in accessing treatment, promoting innovative services that respond to patients' needs and preferences, and allowing flexibility in evidence-based practice and the expansion of the behavioral health workforce. These proposals should help meet the health care needs of a growing racial/ethnic minority population.**

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According to the *2014 National Healthcare Quality and Disparities Report*, racial/ethnic disparities in access to treatment for mental health and substance use disorders changed little between 2008 and 2012.[1] In 2012, black (62.1 percent) and Latino (55.6 percent) adults were less likely than white adults (72.0 percent) to receive treatment for depression, compared to 56.1 percent of blacks, 57.4 percent of Latinos, and 71.8 percent of whites in 2008. For the twenty-three million people who needed substance use disorder treatment in 2012, all racial/ethnic groups were equally unlikely to enter treatment. Blacks and Latinos were less likely than whites to complete treatment for alcohol and drugs, while Native Americans were less likely than whites to complete alcohol treatment[2]—which highlights the fact that even those racial/ethnic minority patients who receive treatment do not have their treatment needs met adequately. Similarly, blacks who used services had significantly lower odds of receiving adequate depression care, compared with whites.[3]

Disparities in care lead to excess morbidity and disease burden for racial/ethnic minorities. Given evidence that access to care and high-quality interventions can improve the course of behavioral health conditions, the primary goal of the *Action Plan to Reduce Racial and Ethnic Health Disparities* of the Department of Health and Human Services (HHS) is to transform the health care system through initiatives to reduce access and quality disparities.[4] However, prospects for reducing racial/ethnic disparities, particularly in behavioral health care, are uncertain at best.

Many of the thirty-two million people expected to gain health insurance through Medicaid expansions or subsidized plans offered through

"The ACA seeks to improve health equity through the expansion of insurance coverage, health care delivery provisions (for example, related to health homes and workforce training support), data collection requirements (such as requiring data on race and ethnicity to be linked to reporting), and population health improvements (for example, community prevention initiatives). **But the policy levers intended to improve health care delivery systems may not be well aligned to the actions needed to reduce disparities**..."

Source: Alegría et al., 2016

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Assumption 1: Neighborhoods

- Residential proximity to services is an important factor in the utilization of behavioral health services.
- Isolated Latino neighborhoods are disproportionately affected by these shortages.

Source: Dinwiddie et al., 2013

Assumption 2:

Current service planning addresses minority consumer/patient preferences

- Patients from different cultural groups may differ in what matters to them in health care
- While policy makers and clinicians may not approve of these preferences, they remain part of the reality that must be accommodated when planning service and policy interventions

Assumption 2: Current service planning addresses minority patients' preferences

- **African Americans**

  Listening involved provider acknowledgment of patient expertise on self

- **Latinx**

  Listening involved the provider paying attention to what the patient is saying

- **Whites**

  Listening involved the provider making the patient feel comfortable to self-express

Source: Mulvaney-Day, Earl, Diaz-Linehart, & Alegria, 2011

Assumption 3:

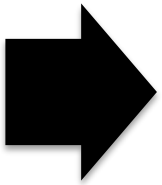
Evidence-based practices are readily available for diverse populations

There were 36 new evidence-based programs in SAMHSA's National Registry, between September 2015-June 2016

- Less than half were developed with racial and ethnic minority populations
- Only two described treatment that were culturally-tailored to treat these populations

Assumption 3: Evidence-based practices are readily available for diverse populations

Despite the documented barriers to care and the enormous gap for mental health and addiction services among immigrants/minorities



Few interventions have been developed and/or adapted to service this population's mental health and addiction needs (Priester et al. 2016).

Only a handful of studies provide a detailed description of the cultural adaptation process of evidence based treatments and health literacy considerations (Gonzalez Castro, Barrera, & Steiker, 2010) .

Important Role for Health Care Providers and Health Care System

"…physicians and the health care systems in which they operate are key to making sure that all patients get the very best care."

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“If You Do Not Create Change, Change Will Create You”

Mental Health leaders are poised to make effective changes:

- Are on the front lines in delivering health care to racial/ethnic minority and other underserved and vulnerable communities.
- Understand impacts of laws and regulations.
- Can instill a culture of change within their organizations and in partnership.
- Persistently promote innovative strategies and approaches.

Health Disparities – Federal Resources

Department of Health and Human Services (HHS)

- National Institute on Minority Health and Health Disparities funded 2019 special AJPH supplement: *New Perspectives to Advance Minority Health and Health Disparities*
- Think Cultural Health e-Learning Program from OMH **New online program for Behavioral Health Professionals (5 contact hours)**
- JULY - National Minority Mental Health Awareness Month (OMH) to help raise awareness about mental illness and its effects on racial and ethnic minority populations.

Substance Abuse & Mental Health Services Administration(SAMHSA)

- The Office of Behavioral Health Equity (BHEP) coordinates SAMHSA's efforts to reduce disparities in mental and/or substance use disorders across populations
- SAMHSA-HRSA Center for Integrated Health Solutions (CIHS) - Health Disparities Resources
- National Network to Eliminate Disparities in Behavioral Health (NNED) was formed with support from

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Thank You

SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.

If you have questions or need additional information about this or other webinars
Contact the Minority Fellowship Program Coordinating Center: MFPCC@mayatech.com

www.samhsa.gov

1-877-SAMHSA-7 (1-877-726-4727)

1-800-487-4889 (TDD)

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