The Time is Now: Tackling Racial and Ethnic Disparities in Mental and Behavioral Health Services in Massachusetts

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Massachusetts Health Policy Forum Summit, Dec. 11, 2014
Despite increasing diversity in MA, knowledge about ethnic/racial disparities in behavioral health is limited.

- Massachusetts (MA) is an increasingly diverse state with more than 25% adult minority population.
- For children the proportion is higher - 34%.
- 14.8% of the state population is foreign-born.
- 21.7% speaks a language other than English at home.
But why should we care about disparities?

Negative social consequences:

- Untreated behavioral health conditions have been linked to:
  - Augmented suffering for family caregivers
  - One of the leading and growing causes of disability
  - Reduced life expectancy—estimates range from 10–20 years.
  - Increased morbidity and worst self-management of chronic conditions.
  - Increased likelihood of unemployment, unwanted pregnancy, homelessness, incarceration, school dropout and many others.
What is this Brief and what it is not?

What is it about?
- Analyzing available data to describe current status.
- Examining literature and other evidence to identify potential solutions to problems.
- Generating a discussion that leads to an action plan.

What it is not about?
- A compilation of all data sources in MA.
- A description of all actions, policies and interventions being done in MA.
Definitions

- Based on WHO definition as differences in health which are not only unnecessary and avoidable and, in addition, are considered unfair and unjust.

- Based on Institute of Medicine definition as differences in service use that are not justified by underlying health conditions or patient preferences.

Behavioral Health Disparity

Behavioral Health Service Disparity
Overview of our Presentation

- Review Data Sources
- Explain Analytical Methods
- Ethnic/Racial Diff in Rates of Mental Illness for Adults
- Ethnic/Racial Disparities in Mental Health Services
- Ethnic/Racial Diff in Rates of Substance Use for Adults
- Ethnic/Racial Disparities in Substance Tx Completion
- Model of Potential Mechanisms Explaining Disparities
- Present Recommendations
- Give Rationale for Recommendations
- Generate a Discussion of these alternatives.
Data Sources

- National Survey of Drug Use and Health (NSDUH)
  - ~5,000 MA residents interviewed between 2004 and 2012
- Treatment Episode Data Set (TEDS) (2013)
  - ~18,000 publicly funded treatment center admissions (~65% of all treatment admissions)
- 2005–2013 Youth Risk Behavior Surveillance System (YRBSS) among Massachusetts high school students
- 2012 MA Behavioral Risk Factor Surveillance System (BRFSS)
- Boston Survey of Children's Health, 2012
Overall goal to compare rates of mental illness and substance use and service use among adults and youth in Massachusetts

- Age- and gender- adjustment for racial/ethnic comparisons of rates of mental illness and substance use
- Age- and gender- and “need”-adjustment for racial/ethnic comparisons of rates of service use
- Some but not all analyses weighted to be representative of the state of Massachusetts
Rates of any mental illness – Adults

Any mental illness in the last year among adults in US and MA

White

Black

Asian

Latino

*difference from Whites is significant at p<.05.
Latinos report higher lifetime depression.

Blacks and Latinos more likely to report poor mental health.

Percent of Adults Ever Diagnosed with Depression or Reporting Poor Mental Health in the Last Year, 2012 Massachusetts BRFSS

- **Depression Diagnosis (Lifetime)**
- **Poor Mental Health**

<table>
<thead>
<tr>
<th>Race</th>
<th>Depression Diagnosis (Lifetime)</th>
<th>Poor Mental Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>20.4</td>
<td>11.3</td>
</tr>
<tr>
<td>Black</td>
<td>19.5</td>
<td>14.7</td>
</tr>
<tr>
<td>Latino</td>
<td>26.3</td>
<td>15.5</td>
</tr>
<tr>
<td>Asian</td>
<td>Not available</td>
<td>5.4</td>
</tr>
</tbody>
</table>

Age-adjusted estimates. Source: Massachusetts Department of Public Health. A Profile of Health among Massachusetts Adults, 2012: Results from the Behavioral Risk Factor Surveillance System (BRFSS).1
Significant U.S. disparities in mental health service use.

In MA, significant Latino-white disparities.

Blacks and Asians doing better on this measure than other parts of the U.S.

**Chart:**

- **US MA**
  - Any mental health services in the last year among individuals with mental illness in US and MA (NSDUH 2004-2012)

**Data from the 2004-2012 National Survey of Drug Use and Health among adults predicted to have mental illness based on K-6 scale of psychological distress and WHO-DAS scale of disability due to mental illness.**

Estimates are age- and gender-adjusted

n=65,100 for US and n=900 for MA

*significant at p<.05 level
Rates of substance use were similar or greater among whites compared to minorities.

Age- and gender-adjusted estimates of substance use within the last year among adults 18+.
Data from the 2004-2012 National Survey of Drug Use and Health (NSDUH); n=5,600.
*Significantly different from white (p<0.05)
Once in treatment, Latinos and Asians are less likely to complete treatment.

2013 Treatment Episode Data Set
* Difference from whites is significant at p<.05 level
Summary – Adults

- Adult Mental Illness
  - Latinos more likely to report lifetime depression
  - Latinos and Blacks more likely to report poor mental health

- Adult Mental Health Treatment
  - Significant Latino–white disparities in MA
  - Blacks and Asians doing better on mental health care access than rest of U.S.

- Adult substance use
  - No or “reverse” disparity in substance use

- Adult substance use treatment
  - Once in treatment, Latinos and Asians are less likely to complete treatment
  - Blacks and Native Americans less likely to complete alcohol treatment in MA
Compared to white students, Hispanics and Native Americans had higher rates of:

- Sadness
- Suicidal ideation
- Suicidal attempt

Age-adjusted data from the 2005-2013 Youth Risk Behavior Surveillance System among Massachusetts high school students.

*Significantly different from white (p<0.05)

(Feeling sad: n=14188, suicidal ideation: n=14,307, suicidal attempt: n=14,209)
Mental health service disparities among youth

Percent of youth ages 12–17 with depression receiving last year mental health treatment

Latino–white disparities in youth depression treatment

Data from the 2004-2012 National Survey of Drug Use and Health among youth ages 12-17. Adjusted for age, sex, and depression diagnosis (n=15,100 in US and n=200 in MA)

* Difference from whites is significant at p<.05 level
Substance use among youth

Less use of marijuana among Blacks, Asians, and Latinos compared to whites

Less use of alcohol among Blacks and Asians compared to whites

Percent of MA youth ages 12–17 reported having consumed marijuana or alcohol at least once in the last year (NSDUH 2004–2012)

Age- and gender-adjusted estimates from the 2004-2012 NSDUH among Massachusetts youth (ages 12-17). (n=2,800)
* Significant at p<.05 level
Summary – Youth

- Youth Mental Illness
  - Latinos and Native Americans had higher rates of sadness, suicidal ideation, and suicidal attempt

- Youth Mental Health Treatment
  - Significant Latino–white disparities in MA (less than ten percent of Latino youth with depression received treatment)

- Youth substance use
  - No or “reverse” disparity in substance use

- Youth substance use treatment
  - National rates are low (~10%) and similar across racial/ethnic groups
Based on idea that disparities in behavioral health care are inextricably linked to larger legal, social, economic context.

Divides causes or “mechanisms,” of disparities into 3 separate levels (Macro, Meso and Micro Levels).

Service inequities arise from interactions between community system domains (neighborhoods, operation of community, individuals) and health treatment system domains (health/economic policy, operation of healthcare system, provider organizations, clinicians). Each point of interaction between community and treatment systems represents a key site for intervention.
The Socio-Cultural Framework for the Study of Health Service Disparities (SCF-HSD)

Legal, Economic & Socio-Cultural Parameters (Scope Conditions)

Interface of Community & Treatment Systems

Health Care System Domains

Federal, State, and Economic Policy
- Health care policies
- Regulations at state and federal levels
- Market forces

Operation of Health Care System and Provider Organizations
- Provider burden
- Design of services for minority groups
- Workforce diversity
- Organizational culture and climate

Provider/Clinician Factors
- Use of guideline concordant care
- Attitudes towards and perceptions of clients
- Provider’s training and resources
- Gender, race, and ethnicity

Domains Linked Through Mechanisms

Health Care Market Failure
- Lack of availability, accessibility
- Institutional bias
- Limited financing

Restricted Pathways to and of Care
- Differential pathways into mental health and substance abuse health care
- Poor patient-provider interaction and communication
- Mismatches in mental health and substance abuse services offerings; minorities services needs

Poor Clinical Encounters
- Lack of community trust
- Erroneous service expectations
- Limited workforce availability
- Limited provider training to treat minorities

Cumulative Disadvantage

Disparities in Health Services Outcomes
- Functioning
- Social integration & participation
- Burden of illness
- Quality of life

Community System Domain

Environmental Context
- Poverty / wealth
- Residential segregation
- Isolation
- Health programs available

Operation of Community System and Social Networks Sectors
- Community perceptions of health service; mistrust in service providers
- Social cohesion and support
- Caregiver’s recognition of health problems
- Perceived effectiveness of healthcare system
- Previous health care experience

Individual Factors
- Acculturation / language
- Patient beliefs
- Competing needs
- Prior experience
- Health literacy
- Gender, race, and ethnicity
Macro Level Recommendations
Although Massachusetts currently has the highest rate of insurance coverage in the U.S., some racial and ethnic minority groups may face other barriers to getting services such as:

- lack of citizenship/documentation status or
- may still have difficulty paying for subsidized coverage, leading to uninsurance or underinsurance,
- or confront absence of treatment facilities.

Health insurance coverage does not appear as a sufficient condition for accessing behavioral healthcare, so other barriers must be considered.
Macro Level– Larger Policy and its Impact in Environmental/Neighborhood Contexts

- State limits reimbursement payments for Medicaid and MassHealth

- Significantly lower percentage of psychiatrists who accept private non-capitated insurance (55.3%) or Medicaid (43.1%) in 2009–2010 as compared to physicians in other specialties who accept non-capitated insurance (88.7%) or Medicaid (73.0%).

- Low supply of multilingual service providers at neighborhood level in communities with ethnic/racial minorities, making it more difficult to obtain treatment.

- Suffolk county has highest minority population, with 25% of residents identifying as black, 21% as Latino, and 9% as Asian; also accounts for almost a third of MA’s Mental Health Professional Shortage Areas.
Interstate Medical Licensure simplifies procedures for getting medical licenses in multiple states.

Allow providers to practice where supply is low and demand is high.

Either in-person or telemedicine appointments increases flexibility of service use for patients.
Recommendation #5

- Expand access to behavioral health service to anyone in need, independent of insurance coverage, documentation status or ability to pay:

- Make access to behavioral health services as high a priority as access to treatment for maternal and child health.

- Behavioral health is so intricately woven to functioning and wellbeing that it requires an investment.
Meso Level Recommendations: Organizational, institutional and community issues
Meso: Healthcare Organizations and its Impact on Ethnic/Racial Minority Communities

- From 2003–2012, AHRQ has published reports showing that measures of disparity in quality of behavioral healthcare are not improving for Blacks, Asians and Latinos in US.

- Campbell, Roland & Buetow argue that most significant issues is getting minorities the care they need and care that is effective. But minority patients in behavioral health treatment receive lower quality tx and for a shorter period of time.
Both MA and federal government require hospital collection of race/ethnicity data
- Incentives could increase use of these data to look at disparities in treatment within healthcare systems
- MA could create hospital level reporting system for race/ethnicity and language-based disparities in outcomes, including behavioral health
- However, much current information on disparities comes from large national surveys that may not reflect Massachusetts diverse population.

Recommendation #2

Expand the supply of qualified core mental health providers, peer counselors and paraprofessionals with competence in behavioral health care:

- a) create state database to map supply of qualified mental health and addiction providers and identify shortage areas;

- b) ensure an adequate supply of licensed culturally competent and linguistically appropriate behavioral health providers and paraprofessionals;

- c) strengthen ongoing training, supervision and constructive monitoring for specialty competencies for professionals as well as competency enhancements for paraprofessionals by certification;

- d) require adequate enrollment of core behavioral health professionals in provider networks; and

- e) provide organizational interventions in community behavioral health programs to support evidence-based implementation and service innovation.
A recent study showed that almost 25% of people with SMI were arrested over 10–year period.

Blacks and Latinos with serious mental illness are at even higher risk of incarceration.

Meso: Healthcare Organizations and its Impact on Ethnic/Racial Minority Communities

- MA prison population is disproportionately Black and Latino

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<thead>
<tr>
<th>Race/Ethnicity</th>
<th>% of MA General Population (2010 census)</th>
<th>% of MA Prison Population (2011)</th>
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</thead>
<tbody>
<tr>
<td>White</td>
<td>83.2%</td>
<td>34%</td>
</tr>
<tr>
<td>Black</td>
<td>6.6%</td>
<td>38%</td>
</tr>
<tr>
<td>Latino</td>
<td>9.6%</td>
<td>23%</td>
</tr>
</tbody>
</table>


MA should identify individuals with behavioral health problems for treatment rather than punishment

- Expanded mental health courts could provide monitoring and are better equipped to understand behavioral health issues
- Diversion especially important for justice-involved youth

The Treatment Advocacy Center estimates that about 5,000 homeless individuals in Massachusetts have a serious mental illness.

- Housing may provide a better environment for treatment and recovery.
- Massachusetts’ current supportive housing program is an excellent model, but overall housing shortages leave many out.

Recommendation #1

- Increase early identification and enhance consumer self-management of behavioral health problems, particularly for older adults and those suffering from severe mental illness.

- Early identification should be pursued in social, criminal justice and human services sectors:

  - Engage and train community health workers (CHWs) and peer counselors in quick screening of behavioral health symptoms, self-management of illness, and brief collaborative behavioral health care.
Mental health needs to be treated as product of an individual’s context.

- Segregation by neighborhood can concentrate risk factors.

- Increasing community cohesiveness and access to resources can improve mental health.

- Community-based projects can be used to develop public health infrastructure and provide opportunity while promoting evidence-based prevention.

Engaging Community Coalitions: Vermont created a network of community coalitions called New Directions to implement evidence-based drug abuse prevention programs.

MA could train community organizations in prevention techniques and outcome tracking
- Allows for implementation of proven methods
- Leverages existing infrastructure for prevention
- Allows for community-specific efforts

Innovative approaches used in low-resource environments have been successful

- Stepped care for depression used in both Chile and India has shown high recovery rate for low cost

- Use of community health workers allows for provision of culturally relevant and lower cost care

- These strategies especially useful when access to regular care is limited

- These are supplementary measures used to reach disadvantaged populations and engage them in behavioral health system – NOT a replacement for comprehensive care

Recommendation #3

- Build community coalitions to help prevent suicide and mood disorders in minority youth and older adults and substance problems in white youth and adults:

- Leverage existing community organizations for population health and foster additional service capacity through a centralized and well-planned statewide initiative that coordinates prevention activities that apply evidence-based strategies.

- Focus community-based projects on prevention and treatment of specific health problems, such as depression or substance misuse, as well as on environmental factors that contribute to illness.
People tend to attribute negative behaviors of “outgroup” members to inherent dispositions.

Negative behaviors of “ingroup” members are more often attributed to situational factors.

These processes are related to prejudice and stereotyping, and they play a key role in the development of health disparities (IOM 2003).
Bias is a particular problem because people tend not to recognize their own biases. Researcher Emily Pronin calls this the "bias blind spot": people see themselves as objective and others as biased.
Micro Level Recommendations

- Evidence that we need to target improved communication and shared-decision making
  - Better patient-provider communication can improve experience of care for minority patients.

Consider Language and Cultural Matching: Some research shows higher retention, better outcomes for patients with ethnically/culturally matched providers.

Providers better able to understand patient’s context – extremely important for behavioral health.

Language match improves ability to detect delusions or disordered thinking.

Recommendation #4

- Reduce disparities attributable to interactions within health care system:
  - Establish better alignment of incentives in payment systems with desired disparities outcomes as a way to reduce disparities.
  - Increase the use of data and analytics generated by electronic medical record systems to identify problems in the provider-level interaction with all patients.
  - Once problems are identified, provide coaching for providers who demonstrate low treatment retention and limited quality care standards, monitor improvement and provide feedback to providers.
  - Increase premium payments to providers who treat Medicaid patients, patients with low health literacy, those who require interpreters or non-English languages, and for those with dual diagnoses or severe mental illness.
  - Include a system of feedback for providers and patients mimicking the eBay 5-star review system for both buyers and sellers.
  - Require additional tracking and reporting of disparities data to the state Department of Public Health and the Department of Mental Health and incentivize progress in reducing disparities.