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on the Elimination of Disparities in Mental Health Care

Center for Mental Health Services
Substance Abuse and Mental Health Services Administration

Annotated Bibliography Policy Literature Relevant to Reducing Disparities in Mental Health Care

Defining the Problem – Proof of Disparity

Racial and Ethnic Disparities

Racial/ethnic differences in social vulnerability among women with co-occurring mental health and substance abuse disorders: implications for treatment services

Amaro, H., Larson, M., Gampel, J., Richardson, E., Savage, A., & Wagler, D. (2005).
Racial/ethnic differences in social vulnerability among women with co-occurring
mental health and substance abuse disorders: implications for treatment services.
Journal of Community Psychology, 33 (4), 495-511

Available at: <http://www3.interscience.wiley.com/journal/110502543/abstract>

(From abstract) The authors present findings about racial and ethnic differences in demographic and clinical profiles of women in the Substance Abuse and Mental Health Services Administration-sponsored Women, Co-Occurring Disorders and Violence Study, using statistical analysis of survey data. Co-occurring disorders are any disorders that are often paired, like substance abuse and mental health problems. Black and Hispanic women experience more economic and environmental hardships than do white women – more Black and Hispanic women live below the poverty line, are more likely to live in dangerous neighborhoods, less likely to be highly educated, and more likely to have been homeless. These factors combine theoretically to make Black and Hispanic women more vulnerable to mental health disorders, but they are not receiving as much treatment as white women. Black and Hispanic women are also much more likely to have criminal records and be involved with the criminal justice system.

Efforts to treat co-occurring disorders should be combined so that there is no wrong door for entry into the mental health care system, so that, for example, if a person comes in for substance abuse treatment they can receive mental health treatment if necessary. By adding an access point to something besides traditional mental health, it may increase minority utilization of mental health services.

Disparities in mental health treatment in U.S. racial and ethnic minority groups: implications for psychiatrists

Atdjian, S., & Vega, W. (2005) . Disparities in mental health treatment in U.S racial and ethnic minority groups: implications for psychiatrists. *Psychiatric Services*, 56 (12), 1600-1602

Available at: <http://www.ps.psychiatryonline.org/cgi/reprint/56/12/1600>

The authors argue that eliminating racial and ethnic disparities in mental health care, as well as health care in general, is a matter of utmost importance. Deaths by suicide, infant mortality, and the incidence of diabetes are all more likely for minority groups, and therefore disparities in treatment lead to deaths that may have been prevented in a more equitable system. The paper seeks to give mental health professionals the knowledge they need to address some of these disparities in their own practice. Important in the discussion is the comfort level with the mental health care provider that the patient perceives. Patients are especially sensitive to cues, like waiting room materials, the health care providers demeanor, non-clinical staff, and other patients, that may give them insight into any biases the provider may have about them, and how that will influence the treatment they receive.

Many criteria for assessing mental health, like DSM checklists, IQ tests and personality tests are culturally biased. For example, African Americans score higher on measures of mistrust and paranoia, which can result in misdiagnosis. Language is often a barrier, and translators and interpreters are not often used. Efficacies of medications vary across different racial and ethnic groups, as well as likelihood of sticking with a difficult medication regime. Psychiatrists must understand their own racial identity and biases before trying to consider the positions of their patients.

By increasing the cultural competence and sensitivity of mental health care providers, it can improve mental health services utilization by minority populations by reducing the discomfort they experience with the mental health care system. Policies to promote a culturally competent or sensitive environment can therefore address and reduce mental health care disparities.

Conceptualizing mental health disparities in communities of color

Davis, K. (2005). Conceptualizing mental health disparities in communities of color. [PowerPoint Slides].

This presentation defines the term cultural competence, and lists disparities in mental health care between whites and minorities, such as fewer housing alternatives for minorities, greater delays in help seeking for minorities, and reduced inclusion rates in research or clinical trials for minorities. Then, Davis discusses methods by which

disparities may be decreased, using the Six Critical Goals framework introduced by the New Freedom Commission Report on Mental Health Care, and includes discussions of cost benefit analyses, makes recommendations as to how mental health care could be improved, and addresses the need for behavioral health care in the US.

This presentation well defines the scope of the problem of mental health care disparities, as well as defining cultural competence, and its importance in addressing these disparities.

Racial and ethnic disparities in adolescent health and access to care

Fox, H., Mcmanus, M., Zarit, M., Fairbrother, G., Cassedy, A., Bethell, C., & Read, D. (2007) . Racial and ethnic disparities in adolescent health and access to care. *Incenter Strategies for the Advancement of Mental Health*

This paper analyzes differences in mental health care received by children of different races in the foster care system. It discusses outcomes among a number of variables that make mental health care more or less likely, and confirms that race and ethnicity still account for differences in mental health care received by these children, despite confounding factors like socioeconomic status, severity of mental health problems, age and gender. The authors go into some detail about possible causes for these cultural differences in mental health care. Language is discussed prominently, as well as other factors, such as cultural stigmas associated with mental health care, and distrust of the health care system in general, and specifically mental health care.

Racial/ethnic differences in court referred pathways to mental health services for children in foster care

Garland, A., & Besinger, B. (1997) . Racial/ethnic differences in court referred pathways to mental health services for children in foster care. *Children and Youth Services Review*, 19 (8), 651-666

Available at: <http://www.sciencedirect.com/>

This study examines the role of the courts in the referral process to mental health services for children in foster care. Courts play a significant role in referring children to services, and white children were more likely to receive orders for psychotherapy and to have documented use of psychotherapy than were African American and Hispanic youth, even when possible confounding effects of age and type of maltreatment were controlled. Differences likely reflect an interaction of factors – family and cultural help-seeking attitudes and behaviors, and service system factors. Once the youth were referred however, utilization of ordered services was high across all three ethnic groups, suggesting that differences in overall service use may be due more to service referral biases than to families' help-seeking patterns.

Policy makers could try to improve the equity of judicial mental health recommendations, either by simply informing their judges of the difference, or by more structured efforts – like education programs. Perhaps making a mental health screening the norm for foster care cases may be a way to improve the disparity in treatment.

Self-reported discrimination and mental health status among African descendants, Mexican Americans, and other Latinos in the New Hampshire REACH 2010 initiative: the added dimension of immigration

Gee, G., Ryan, A., Laflamme, D., & Holt, J. (2006). Self-reported discrimination and mental health status among African descendants, Mexican Americans, and other Latinos in the New Hampshire REACH 2010 initiative: the added dimension of immigration. *American Journal of Public Health*, 96 (10), 1821-1828

Available online at: <http://www.ajph.org/cgi/reprint/96/10/1821>

The effects of discrimination on mental health status are well documented and negative. These authors examine the role of discrimination on new immigrants. According to their findings discrimination has a negative influence on mental health and immigrants report more discrimination and worse mental health the longer they have been in the US.

In order to improve the mental health care system, policy makers should seek to reduce discrimination and racism, both perceived and actual, through public relations campaigns and the education of the mental health workforce. If people perceive racism, they will be less likely to utilize services. Besides a moral imperative, racism also leads to health disparities, both physical and mental.

Disparities in the adequacy of depression treatment in the United States

Harman, J., Edlund, M., & Fortney, J. (2004). Disparities in the adequacy of depression treatment in the United States. *Psychiatric Services*, 55 (12), 1379-1385.

This report demonstrates that barriers to access to mental health care are a significant factor in mental health care disparities. The authors argue that there is no disparity once access has begun, but their measurements are not long term, and do not account for numerous factors that could influence the quality of care, once initiated. Despite these problems, it is heartening to know that once care is initiated, disparities can be reduced.

Racial and ethnic differences in patient perceptions of bias and cultural competence in health care.

Johnson, R., Saha, S., Arbelaez, Beach, M., & Cooper, L. (2004). Racial and ethnic differences in patient perceptions of bias and cultural competence in health care. *Journal of General Internal Medicine*, 19, 101-110.

Available at: <http://www3.interscience.wiley.com/cgi-bin/fulltext/118783782/PDFSTART>

Racial and ethnic minorities are more likely to perceive bias and lack of cultural competence when seeking treatment in the health care system than whites. Whether or not the differences exist empirically, which there is much evidence to support, the perception of bias can discourage minorities from seeking health care, especially mental health care, which may be viewed as non essential. Programs to address this perception of racism and bias should be enacted, both to reduce the perception, and more importantly the incidence, or racism and bias against racial and ethnic minorities.

Culture and child maltreatment: cultural competence and beyond

Korbin, J. 2002. Culture and child maltreatment: cultural competence and beyond. *Child Abuse & Neglect*, 26, 637-644.

Available at: <http://www.sciencedirect.com>

Major census categories of race and ethnicity do not capture cultural reality and may mask rather than illuminate culture. There is much variation within each of these racial categories, and individual differences in education socio-economic etc. also influence an individual's culture.

Current demographic trends require more cultural competence, and diversity is greater and increasing at a higher rate among children. Maltreated children of color suffer more serious consequences of abuse than majority children. This represents a policy opportunity to improve mental health care for minority children by increasing the cultural competency of the mental health system.

The author stresses the need to increase cultural competence in research. By funding research that seeks to examine cultural competency issues, or to give more precise information on specific cultural groups, states can improve their knowledge of cultural issues and thereby promote cultural competence toward more specific populations, like the American Samoan sub population in Hawaii, for example.

Mental health in the context of health disparities

Miranda, J., McGuire, T., Williams, D., & Wang, P. (2008). Mental health in the context of health disparities. *American Journal of Psychiatry*, 165 (9), 1102-1108.

This paper offers a brief review of health disparities in general, before delving in to disparities in mental health status and mental health care. Mental health status disparities exhibit a decidedly different pattern than do health disparities. According to their data, Hispanic, Asian and black Americans experience less mental disorders than white Americans. For recent immigrants, rates of mental disorders increase with time spent in the United States. The disparities in mental health care are more definite – minority

groups have less access to mental health services, so the perceived lack of prevalence of mental health disorders may just be due to under diagnosis. These health care disparities are highly correlated with lack of access and lack of health insurance. They also site problems with therapists, that they are less able to read the severity of a condition in minority patients.

Since mental health status has a different profile than does regular health status, programs aimed at improving the environment and that emphasize social factors would not be as effective. The authors suggest a specific focus on mental health care to address these disparities. They also suggest increasing minority participation in the health care workforce, due to the importance of communication and common language for mental health care. They call for more research oriented at dealing with mental health disparities

Cultural barriers to care: inverting the problem

Tripp-Reimer, T., Choi, E., Skemp Kelley, L., & Enslein, J. (2001) . Cultural barriers to care: inverting the problem. *Diabetes Spectrum*, 14 (1), 13 - 22

Available at: <http://spectrum.diabetesjournals.org/cgi/content/abstract/14/1/13>

The authors discuss treatment in terms of disparities in diabetes care, but the salient points work across sectors of health care. Instead of viewing the problem as having to do with how various minority cultures approach medicine, the authors view the problem as the culture of medicine's approach to minority cultures. The culture of biomedicine, as they see it, has many of it's own barriers to effective care, which include; ethnocentrism and racism woven into the health care system; the belief that biomedicine is "right" and that science is the only appropriate basis for practice; the assumption that traditional beliefs should be changed or abandoned, not built upon; that failing to adhere to a treatment regime is the fault of the patient; and the assumption that health care is available and accessible to all who seek it.

To treat these mistreatments, physicians, and by extension health care providers can be taught to; adapt communication and interaction patterns to promote respect, indirect communication and to use interpreters when necessary; perform targeted cultural assessments, modify education programs to make them more palatable for individual patients, possibly by making the materials more visual or experiential; learn why patients are failing to follow through with their own treatment; determine if successful strategies at the individual level can be generalized to the cultural or cross-cultural level; work with, instead of against, ethnic communities; and assess personal and agency level cultural competence. Policies to promote changes in the way physicians view their patients, less as adversaries and more as colleagues, could improve doctor patient interaction, and improve cross cultural communication and treatment.

Ethnic disparities in unmet need for alcoholism, drug abuse, and mental health care

Wells, K., Klap, R., Koike, A., & Sherbourne, C., 2001. Ethnic disparities in unmet need for alcoholism, drug abuse, and mental health care. *American Journal of Psychiatry*, 158, 2027-2032.

Available at: <http://ajp.psychiatryonline.org/cgi/content/abstract/158/12/2027>

This article, published in the *American Journal of Psychiatry*, offers additional evidence that African American and Latino persons were almost half as likely as whites to receive needed treatment for alcoholism, drug abuse and mental health care.

Mental health: culture, race, and ethnicity

US Department of Health and Human Services, (2001). *Mental health: culture, race, and ethnicity*

(From message from Tommy G. Thompson, Secretary of Health and Human Services)
The Surgeon General has determined that disparities in mental health services exist for racial and ethnic minorities, and thus, mental illnesses exact a greater toll on their overall health and productivity. (From Executive Summary) The most striking disparities found in the report were: reduced access and availability of mental health services for minorities; minorities are less likely to receive needed mental health services; minorities in treatment often receive lower quality mental health care; and minorities are underrepresented in mental health research. By recognizing these disparities, steps can be taken to address them. These disparities mean that mental health problems take a greater toll on minorities than on whites, causing higher levels of disability in terms of lost workdays and limitations in daily activities. Understanding cultural differences is key to providing effective mental health care, whether by addressing mental health problems that are more common in or specific to certain cultural groups, or by making the patient more comfortable with treatment, or by understanding cultural differences in help-seeking behaviors. Certain cultures put more or less of a stigma on mental health disorders than on others, and understanding those differences can make mental health service professionals more sensitive and more effective in treating patients from those groups. Minorities are much more likely to have experiences that make mental health disorders more likely: living in poverty, experiencing racism or other types of discrimination, and being the victim of violence. And due to these experiences, many minorities may distrust mental health service providers, and these negative impressions can be reinforced by experiences with clinician bias and stereotyping.

The report then discusses cultural differences and mental health needs for different racial and ethnic groups in the US, including African Americans, American Indians and Alaska natives, Asian Americans and Pacific Islanders, and Hispanic Americans. States can tailor their programs to address the needs of their own minority populations.

Linguistic Disparities

Inequalities in use of specialty mental health services among Latinos, African Americans, and non-Latino whites

Alegria, M., Canino, G., Rios, R., Vera, M., Calderon, J., Rusch, D., et al. (2002). Inequalities in use of specialty mental health services among Latinos, African Americans, and Non-Latino Whites. *Psychiatric Services*, 53 (12), 1547-1555

Available at: <http://www.ps.psychiatryonline.org/cgi/content/abstract/53/12/1547>

(From Objective) The authors determined that disparities exist in the rates of specialty mental health care for Latino and African American minorities when compared with non-Latino whites in the US. They found marked differences in social position, expenditures for and use of mental health services, access to care, quality of care, and various other indicators. Economic factors, once controlled for, did not have a significant effect on outcomes. Several barriers were found: language (for Latinos); lack of knowledge about the system; cultural differences; and undocumented immigration status (Latinos). Therefore, programs designed to educate and inform specific minority groups about available mental health treatments, and to de-stigmatize said treatments, in a language that they can comprehend, may help in reducing mental health disparities.

Linguistic disparities in health care access and health status among older adults

Ponce, N., Hays, R., & Cunningham, W. (2006). Linguistic disparities in health care access and health status among older adults. *Journal of General Internal Medicine*, 21, 786-791.

Language barriers are a large problem facing immigrants. These difficulties are compounded for older persons, who have a harder time learning a new language, and face more frequent and severe health problems. This can have an especially profound impact on mental health, where feelings of alienation and helplessness compound to increase the prevalence of depression and other mental health disorders. Policy makers that wish to improve the health status of recent immigrants and thereby reduce racial and ethnic health disparities among the older population can attempt to make acculturation to the US easier, by improving linguistic competence across the board, not just in health programs, but throughout the range of government available programs.

Environmental Disparities

Toward a policy-relevant analysis of geographic and racial/ethnic disparities in child health

Acevedo-Garcia, D., Osypuk, T., McArdle, N., & Williams, D. (2008). Toward a policy-relevant analysis of geographic and racial/ethnic disparities in child health. *Health Affairs*, 27 (2), 321-333

Available at: <http://content.healthaffairs.org/cgi/content/abstract/27/2/321>

(From abstract) The authors discuss the importance of neighborhood on mental health service utilization, as well as high levels of residential segregation. Conventional public health solutions may not be enough to combat these problems. Instead, the authors suggest that policies be considered to improve access to opportunity-rich neighborhoods by increasing housing mobility, and to increase the opportunity for healthy living in traditionally disadvantaged neighborhoods.

Racial/ethnic disparities in the use of mental health services in poverty areas

Chow, J., Jaffee, K., & Snowden, L. 2003. Racial/ethnic disparities in the use of mental health services in poverty areas. *American Journal of Public Health*, 93 (5), 792-797

Available at: <http://www.ajph.org/cgi/reprint/93/5/792>

This study attempts to determine how living in a high poverty area interacts with racial and ethnic aspects of identity. People with mental illness are over represented in high poverty neighborhoods, and therefore minority dominated neighborhoods, and since these people who need mental health care live in areas with reduced access, their mental health state may decline further. However, safety-net providers have been shown to have fewer racial/ethnic disparities in their mental health clientele. These studies also indicate that these public hospitals and mental health centers are especially adept at recruiting and retaining minorities. Increasing their funding or prevalence could be policy avenues pursued to reduce disparities in utilization.

High poverty areas show greater disparities in mental health services utilization along racial/ethnic lines than low poverty areas. States that have many high poverty areas should give priority to programs that specifically target mental health services to minority and immigrant children in these high poverty areas, as well as improving access by increasing the number of treatment centers that are easily accessible to people in high poverty/low-income areas.

Geographic disparities in children's mental health care

Sturm, R., Ringel, J., & Andreyeva, T. 2003. Geographic disparities in children's mental health care. *Pediatrics*, 112 (4), 208-315

Available at: <http://pediatrics.aappublications.org/cgi/content/full/112/4/e308>

This paper documents differences in mental health services utilization for children in various states participating in the National Survey of America's Families. By understanding what states perform well at increasing children's utilization of mental health services, other states can replicate their methods, especially if a state models its program on a state that has similar demographics. A state with low utilization can use

this study as an opportunity for implementing policies that improve access and utilization of mental health services for all children.

Racial residential segregation: a fundamental cause of racial disparities in health

Williams, D., & Collins, C. (2001). Racial residential segregation: a fundamental cause of racial disparities in health. *Public Health Reports*, 116, 404-416

Available at: http://www.publichealthreports.org/userfiles/116_5/116404.pdf

(From synopsis) The physical separation of the races by residence in certain areas promotes disparities in health care. It does so in several ways. By limiting access to schools and employment opportunities of high quality, residential segregation, even though it is not enforced by statute, perpetuates racial disparities in socio-economic status. These socio-economic disparities lead to disparities in health outcomes and treatment. Instead of simply controlling for SES differences among races, this approach calls attention to these differences. If SES does lead to different health outcomes, then attempts to reduce SES disparities will also improve health care outcomes for minorities.

Also discussed are the effects of living in high poverty, high minority areas. These areas have low quality housing, limited access to nutritious foods, higher crime rates, and greatly reduced access to quality health care, mental as well as physical, greatly reducing the likelihood of preventative care. The argument can be made that were policies enacted to reduce racial housing segregation and to increase the diversity not just of poor minority neighborhoods, but also of well off white neighborhoods, minority health care, and therefore minority mental health care, might be improved.

Policy Alternatives

The role of public policies in reducing mental health status disparities for people of color

Alegria, M., Perez, J., & Williams, S. (2003). The role of public policies in reducing mental health status disparities for people of color. *Health Affairs*, 22(5), 51-64

Available at: <http://content.healthaffairs.org/cgi/content/abstract/22/5/51>

This paper examines the role of non-mental health care targeted policies, like Section 8 housing and the Earned Income Tax Credit, in addressing mental health status differences between minorities and whites. The discussion is couched in the idea of “nonmedical determinants of health,” like housing environment and unemployment, and how these factors can have a positive or negative impact on minority mental health. The paper focuses on three policies. 1) Section 8 housing, 2) The Earned Income Tax Credit, and 3) The Individuals with Disability Education Act.

These programs, which helped individuals financially, can be seen as improving their access to higher quality care and therefore reducing health disparities. They were found to have a positive effect on service utilization, and can therefore be seen as effective mental health care policies.

Closing the gap: solutions to race-based health disparities

Applied Research Center & Northwest Federation of Community Organizations. (2005).
Closing the gap: solutions to race-based health disparities

The report begins by highlighting racial disparities in America, and lists reasons that people of color are underserved by the system. 1) Inaccessibility due to financial or geographic barriers, 2) lower quality of care to people of color, due to discrimination, cultural incompetence, a focus on individual rather than on community and family, or fiscal restraints 3) Inability to meet the needs of limited-English speakers, 4) Disregarding and/or misunderstanding the role and benefits of alternative medicine. The report does not rule out environmental, social and economic causes of health disparities.

Some of the more promising practices outlined in the report include interpretation and translation services at Bellevue Hospital in New York City, improving the cost-effectiveness and quality of the health-care system as a whole in Alaska, and improving access by expanding public health programs to include more people of color, like in Washington, D.C and Santa Clara County, California. Less traditional approaches, like community gardening in Berkeley, California, and Tribal Returns to Agriculture in Arizona have shown promise, as have increasing the role of health institutions in social policy areas like housing and education in New Orleans, Louisiana.

This report offers many examples of successful strategies to reduce race-based mental health disparities, and these programs could be tailored to fit specific needs in other locations serving different populations. They also demonstrate that a non-traditional approach can be quite effective in reducing health disparities, even if the area of its primary efficacy is not obviously health related.

Defining cultural competence: a practical framework for addressing racial/ethnic disparities in health and health care

Betancourt, J., Green, A., Carillo, J.E, & Ananeh-Firempong, O. 2003. Defining cultural competence: a practical framework for addressing racial/ethnic disparities in health and health care. *Public Health Reports*, 118, 293 - 302

Available at: http://www.publichealthreports.org/userfiles/118_4/118293.pdf

The problem of racial/ethnic disparities in health care is defined, citing disproportional rates of diabetes, cancer and asthma. The authors suggest increasing cultural competence to better address these disparities. They also stress the importance of a culturally competent health care system, which emphasizes the importance of culture, honest

assessment of cross-cultural relations, attention to dynamics caused by cross cultural differences, expanding cultural knowledge, and tailoring services to meet culturally specific needs.

Sociocultural barriers to care were identified at organizational, structural and clinical levels. At each level, different policy interventions are suggested. At the organizational level, the authors suggest an increase in minority recruitment into the health professions, or developing interpreter services. At the structural level they suggest language-appropriate health education materials, among other innovations. At the clinical level the authors recommend the education of service providers in cross-cultural issues.

Coming demographic changes in the US population magnify the importance of these issues as minorities will come to make up more and more of the population. By increasing cultural competence, care to minority populations should become more effective, be seen as more appropriate by minority populations, become destigmatized and therefore reduce mental health disparities, which will only be magnified by demographic changes to the US population if nothing is done.

Cultural competence and health care disparities: key perspectives and trends

Betancourt, J., Green, A., Carrillo, J.E., & Park, E. (2005). Cultural competence and health care disparities: key perspectives and trends. *Health Affairs*, 24 (2), 499-505

Available at: <http://content.healthaffairs.org/cgi/content/abstract/24/2/499>

(From abstract) This paper is the result of surveys and interviews with experts in cultural competence to determine the prevalence of cultural competence and to see where the field may be going. Cultural competence has emerged as an important issue for several reasons. The population of the United States is becoming more and more diverse, which leads to a more racially, ethnically, and culturally diverse patient pool. Patient satisfaction, adherence to medical instructions, and overall health outcomes have been linked to provider-patient communication. Poorer communication leads to worse health outcomes. Also, two IOM reports, *Crossing the Quality Chasm* and *Unequal Treatment* have highlighted the importance of eliminating racial and ethnic disparities and patient-centered care.

The views of experts varied depending upon the sector in which they worked— managed care, government, and academia. Some insights from the managed care sector included the idea that cultural competence can be a boon to managed care corporations, by offering them a way of handling care more efficiently, and as a selling point in an increasingly diversified work force. Several large corporations, like Aetna, Kaiser Permanente, and BlueCross BlueShield of Florida have developed initiatives in cultural competence. Academics are concerned with training the future health care work force to be more culturally competent, and to be itself more culturally diverse, as well as calling for a focus on outcomes research. The government experts focused on increasing access

to high-quality care to more vulnerable populations, using their purchasing power as leverage to advance the cultural competence agenda, and recognizing that cultural competence is one step among a variety of options, many of them non traditional, like housing projects, to address racial and ethnic disparities in health care.

Creating a front porch: strategies for improving access to mental health services

Callejas, L., Nesman, T., Mowery, D., & Hernandez, M. (2008). Creating a front porch: strategies for improving access to mental health services. *University of South Florida, Louis de la Parte Florida Mental Health Institute, Research & Training Center for Children's Mental Health* (FMHI pub. No. 240-3)

Available at:

<http://rtckids.fmhi.usf.edu/rtcpubs/CulturalCompetence/porch/CultCompPorch.pdf>

The authors of this monograph seek to describe strategies by which states and localities may improve access to mental health services for all children, but especially for minority children, who systemically are disadvantaged in terms of access. They have identified organizations that they feel are doing exemplary work, all of which must meet certain criteria. Some of these benchmarks include: treating traditionally underserved populations; strategies for increasing access for an underserved population; properly addressing language and cultural barriers; evidence that targeted populations value and use the available services; and show evidence of sustainability. Key organizational strategies to improve access (simplified intake processes, family focus, outreach, and addressing the stigma associated with mental health problems) are discussed, along with specific strategies for various racial and ethnic groups, like African Americans, Latinos, Asian American/Pacific Islanders, and Native Americans.

States and localities with specific minority populations, like a large Native American population in the Great Plains states or African American populations in the South and in urban areas, can model programs after those that have proven successful for improving care for that minority group.

Places to watch: promising practices to address racial disproportionality in child welfare services

The Casey-CSSP Alliance for Racial Equity. (2007). Places to watch: promising practices to address racial disproportionality in child welfare services

(From introduction) This report, prepared by the Annie E. Casey family of foundations, with the Center for the Study of Social Policy in order to identify promising strategies to combat racial and ethnic inequalities in child welfare services, documents the efforts of individual municipalities across 10 states and counties. Each is unique, yet there are common themes. The authors suggest a common trajectory for policies that address the issue of race equity. First, leaders identify racial disproportionality as a problem for their child welfare agency and seek to address it. The evidence of racial and ethnic disparities

usually cause agencies to increase the priority of fixing racial disparities. Most municipalities create a taskforce or some other entity to lead in the effort. There is no single approach that seems to dominate. Jurisdictions often tailor programs to their individual needs, usually combining multiple strategies. Since these policies are relatively new, they are best viewed as emerging practices, and no definitive best practice has yet been identified.

Programs that seek to draw attention to racial and ethnic disparities in health can increase legislative and public awareness, and move these policies along the agenda stream. By following these steps – awareness, task force, policy, observation, and refinement, policy makers can improve mental health care efficacy for all persons, and reduce the mental health utilization gap.

Unclaimed children revisited: the status of children’s mental health policy in the United States

Cooper, J., Aratani, Y., Knitzer, J., Douglas-Hall, A., Masi, R., Banghart, P., & Dababnah, S. (2008). Unclaimed children revisited: the status of children’s mental health policy in the United States. *National Center for Children in Poverty*.

(From executive summary) This report seeks to assess how well children with mental health conditions are treated, and their needs met, across all 50 states and the three territories of the United States, using a survey of mental health advocacy organizations, 80 child mental health directors and multicultural directors focused on cultural and linguistic competence, as well as case studies in California and Michigan. Besides recommendations for the children’s mental health care system in general at the national and state level, they also offered recommendations to address racial and ethnic disparities in care – specifically annual county by county reports on efforts to address disparities using nationally established benchmarks, while at the same time assessing their own cultural and linguistic competence plans and publishing updates.

Policy makers can see how well their state is doing, and use these benchmarks to address specific areas that their mental health care system may not currently be addressing.

Designing and evaluating interventions to eliminate racial and ethnic disparities in health care

Cooper, L., Hill, M., & Power, N.R. (2002). Designing and evaluating interventions to eliminate racial and ethnic disparities in health care. *Journal of General Internal Medicine*, 17,477-486

Available at: <http://www3.interscience.wiley.com/journal/120132695/abstract>

The authors present a framework for developing programs to change disparities in health care between minority and majority populations. Their efforts focus on improving access to appropriate and effective care and reducing barriers to healthy behaviors. These

barriers that prohibit help seeking behavior or limit healthy behaviors are very much related to cultural factors, and culturally competent health care providers can help limit their affects. Family structures, patient preferences and expectations of treatment, patient involvement, personal health behaviors, beliefs about health and disease and benefits of alternative or folk medicine, and health literacy all contribute to reduced utilization of mental health services. They also report that ethnic minority patients are often cared for by physicians of lower technical quality.

For a program to address mental health care disparities, the authors suggest, by way of example, programs to target patient attitudes about mental health care, such as stigma associated with mental health care, increasing the availability of mental health care providers in low income neighborhoods, among other possible remedies.

The authors also discuss the importance of identifying which groups need intervention the most, either due to a large disparity, or a health issue that is affecting the entire population, regardless of ethnicity. Programs that were most successful used intensive recruitment and follow up approaches, ensured community commitment and incorporated input from community leaders, and possessed libraries of support materials. Also discussed are cultural competency practices which should improve the cultural competence of mental health care providers – interpreter services, recruitment and retention policies, training, coordinating with traditional healers, utilization of community health workers, culturally competent health promotion, including family and community members, immersion in another culture, and administrative and organizational accommodations.

Compendium of cultural competence initiatives in health care

The Henry J. Kaiser Family Foundation. (2003). Compendium of cultural competence initiatives in health care.

This report focuses on four challenges to cultural competency 1) lack of agreement on the terms, definitions and core approaches; 2) limited research on impact and effectiveness; 3) a misperception that the activities are focused exclusively on people of color, rather than also on diverse populations groups that, for example, arise from religious affiliation, class, or sexual orientation; and 4) absence of financing /funding source considered sufficient to implement new initiatives, and what steps are being taken to address these problems by various public and private institutions. The initiatives are broken down by Agency, the name of the initiative, an overview of the initiatives goals and provisions, and the initiative's source of funding. The report offers a brief glossary of terms, including several of the more popular definitions of the term cultural competence. These policies can serve as blue prints for policy makers facing similar problems in their own cultural competence programs.

Unequal treatment: what health care system administrators need to know about racial and ethnic disparities in healthcare

Institutes of Medicine, (2002). Unequal treatment: what health care system administrators need to know about racial and ethnic disparities in healthcare.

(From executive summary) The Institute of Medicine published a report on racial and ethnic disparities in health care. The report made, through meta-analyses of approximately 100 other studies, several findings of particular importance. Minorities are less likely to be insured, more likely to refuse treatment, and their doctors are more likely to have a negative impression of them, and less likely to propose certain procedures, like open heart surgery. African American and Hispanic patients tend to receive a lower quality of care across a variety of diseases, like cancer and HIV/AIDS. Minorities often receive less desirable treatments – like amputation. Even after confounding factors are controlled for, such as socioeconomic status, education level, insurance status, these disparities exist.

The report argues that racial stereotyping plays a large roll in provider biases. These stereotypes are automatic and often operate on a subconscious level. If providers can learn to recognize their own stereotyping behavior, they may be able to address some of these disparities. However, some of the disparities operate on a systemic, and not an individual level. Hospitalization rates, insurance status, and cultural norms about what constitutes illness all contribute to different rates of health care services utilization.

The report calls for reform in three areas: Health Care Systems; Legal, Policy, and Regulatory Strategies; and Educational Strategies. Each of these areas of reform offer opportunities for policies to address racial and ethnic disparities in mental health care.

Policy challenges and opportunities in closing the racial/ethnic divide in health care

Lillie-Blanton, M., & Lewis, C. (2005). Policy challenges and opportunities in closing the racial/ethnic divide in health care. *Race, Ethnicity, and Health Care*

(From introduction) Racial and ethnic disparities in health care are a major cause of differences in health status between whites and minorities, and addressing these disparities can improve the equality of the system as a whole. The paper discusses 5 general types of problems, and proposed solutions to each discussed in an Institute of Medicine (IOM) study commissioned in 2003. They were: 1) Raising public and provider awareness of racial/ethnic disparities in care; 2) Expanding health insurance coverage; 3) Improving the number and capacity of providers in underserved communities; 4) Improving the quality of care; and 5) Increasing the knowledge base on causes and interventions to reduce disparities. Policies that address these specific issues can improve mental health care for minority children, and reduce disparities between minority and majority children.

A state policy agenda to eliminate racial and ethnic health disparities

McDonough, J., Gibbs, B., Scott-Harris, J., Kronebusch, K., Navarro, A., & Taylor, K. (2004). A state policy agenda to eliminate racial and ethnic health disparities. *The Commonwealth Fund*, 746

Available at:

http://www.cmwf.org/usr_doc/McDonough_State_Policy_Agenda_Eliminate_Racial.pdf

(From abstract) provides a “menu” of policy interventions that have already been implemented to address disparities in minority health and health care. These policies were divided into those that target infrastructure, management, and capacity or those that targeted a specific health condition. The authors identified eight (8) key needs that policy makers will need to consider, and will provide a rubric with which to compare various policy options. 1) Consistent racial/ethnic data collection; 2) effective evaluation of disparities-reduction programs; 3) minimum standards for culturally and linguistically competent health services; 4) greater minority representation within the health care workforce; 5) expanded health screening and access to services, 6) establishment or enhancement of state offices of minority health; 7) involvement of all health system stakeholders in minority health improvement efforts; and 8) the creation of a national coordinating body to promote continuing state-based activities to eliminate racial and ethnic health disparities.

In order for health policy change to occur the authors echo Richmond and Kotelchuck (1997) who posit that three ingredients are necessary to turn public health knowledge into policy change: 1) the knowledge base; 2) the social strategy to accomplish change; and 3) the political will to support change.

State-level strategies to address health and mental health disparities through cultural and linguistic competency training and licensure: an environmental scan of factors related to legislative and regulatory actions in states.

National Center for Cultural Competence, 2008. State-level strategies to address health and mental health disparities through cultural and linguistic competency training and licensure: an environmental scan of factors related to legislative and regulatory actions in states. *The Robert Wood Johnson Foundation*.

The authors report on states whose legislatures received bills to require cultural competency training for health care professionals. The fate of the bills is reported, and explained using both a rational decision making model, and the model of successive limited comparison, or “muddling through.” Factors making legislation more likely and successful are explained, such as democratically controlled legislatures and governorships, more diverse populations, and a more regulatory approach to health care, as well as factors making passage of a bill less likely, such as republican controlled legislature, divided government, part time legislatures, and a less regulatory approach to health care. Policy entrepreneurs can learn from the mistakes of other, and follow the example of the more successful states, like California and New Jersey. The report also

discusses which groups traditionally support cultural competence training, and which oppose it.

Culturally competent systems of care for children's mental health: advances and challenges

Pumariega, A., Rogers, K., Rothe, E. (2005). Culturally competent systems of care for children's mental health: advances and challenges. *Community Mental Health Journal*, 41 (5), 539- 555

Available at: <http://www.springerlink.com/content/12773g4w84753108/>

This report documents the rapid demographic changes in the US, and discusses the impact those changes will have on the mental health system. These populations differ markedly in their value systems and beliefs, especially when compared with European Caucasians. By understanding cultural differences, like perceived differences about severity and necessity of treatment, and their impacts on development and mental health, treatment can be adapted to be more effective. Culture has a major influence on how we experience, understand, express, and address emotional, behavioral, and mental distress. And these differences in expression can lead to misdiagnosis of mental health problems. Also, different cultures may be more at risk for mental health disorders, such as depression, anxiety, drug abuse or aggressive behaviors. Many minorities view the mental health system with suspicion, due to past experiences of discrimination and oppression. Some cultures view mental illness with shame, and may be less willing to seek treatment due to those feelings. By understanding these differences that lead to under utilization of mental health services, policy makers can try to address these problems of perception by educating minority groups, while being sensitive to their concerns about the system.

The system should also seek to promote cultural competent practices. Like using a cultural consultant, or addressing the inherent biases associated with psychoanalysis (importance of the individual, tendency to challenge traditional authority roles) that can cause conflict between the individual and the culture in which they live. The authors also stress that home or community based programs usually work better for diverse children than hospitalization and isolation. This finding should encourage policy makers to promote community based mental health programs, within the systems of care model, that also seek to include the family in the treatment of the child's illness. These community based programs are less threatening and more easily accessible to minority populations. Also important are nutritional factors in improving mental health. Policy makers seeking to improve children's mental health and to reduce disparities may then be able to focus on nutritional methods and programs.

State purchasing and regulation of health care services: a snapshot of strategies to reduce racial and ethnic health disparities

Rosenthal, J., Neva, K., & Flowers, L. (2002). State purchasing and regulation of health care services: a snapshot of strategies to reduce racial and ethnic health disparities. *National Academy for State Health Policy*

This report documents various strategies that states are using to reduce disparities in their health care systems between minority and white patients. As the largest purchasers of health care policies, states have a powerful bargaining position from which to make demands on health care providers, and they can also leverage providers through regulation of health care services or accreditation requirements. State purchasers and regulators use a variety of tools to address racial and ethnic disparities, like translation and interpreter services. Increasingly, states are attempting to address cultural barriers to care, like cultural competence initiatives and community outreach programs. States are tailoring their needs to fit their populations, offering more cultural competence programs, but these programs often lack focus on the issue of racial disparities, and states that do focus on racial disparities often lack performance measures to focus their actions, and often bemoan a lack of specific data on their states particular racial and ethnic minorities, and the crude categorization that takes place. States, through the Office of Minority Health, can improve by increasing their collaboration with insurance departments or state employee benefits agencies, as well as strengthening ties with Medicaid and SCHIP programs and focusing their efforts under the auspices of one office, like the Office of Minority Health. States have been choosing to focus on targeting racial disparity specifically, or trying to improve the quality of their health care system in general.

Strong leadership and policy entrepreneurs can shape where policy is headed by choosing areas with defined problems and articulating opportunities for change.

Cultural aspects of the pharmacological treatment of depression: factors affecting minority and youth

Rothe, E., Pumariega, A., & Rogers, K. (2008). Cultural aspects of the pharmacological treatment of depression: factors affecting minority and youth. *Psychiatric Times*, 25 (5),

Available at:

<http://www.psychiatrictimes.com/display/article/10168/1153863?pageNumber=2>

This article, while technical, provides an interesting example of a “culture-bound syndrome.” An “ataque de nervios” is a condition that occurs among Hispanic working-class women that involves sighing or screaming loudly and fainting. It is postulated that these attacks are coping methods to deal with stress of family life, as well as promoting sympathetic reactions in family members. Culture-bound syndromes are another aspect of cultural competence, and the authors define them as folk diagnostic categories that supply coherent meaning to certain recurrent and remarkable sets of experiences and observations. Therefore, a behavior that may be extreme in one culture may be more main stream in another, or have a different meaning in different cultures, or may not exist in certain cultures. Policies that are aware of culture bound syndromes would help improve the over all cultural competence of a mental health care system.

Cultural aspects of telepsychiatry

Shore, J., Savin, D., Novins, D., & Manson, S. (2006) . Cultural aspects of telepsychiatry. *Journal of Telemedicine and Telecare*, 12, 116-121

Available at: <http://jtt.rsmjournals.com/cgi/content/abstract/12/3/116>

(From summary) Telepsychiatry may involve working with clinicians, patients and systems of care that are both geographically and culturally distinct. Cultural appropriateness of care becomes a very important component of telepsychiatry in this context. Cultural identity can influence comfort with technology, besides existing cultural barriers to care. Differences are exacerbated when the psychiatrist is often in an urban environment, and the patient from a more rural environment. Despite these challenges, telepsychiatry can be a useful tool in addressing mental health disparities for rural communities, and the minorities that reside therein. States with large rural populations can utilize telepsychiatry to improve their own mental health care systems.

This study focused on the application of telepsychiatry in treating American Indian and Alaska Native populations. The clientele was scattered across five western states, with the psychiatry staff all based in Denver. Comfort level associated with technology is negatively correlated with age and positively correlated with education— the younger the client or the more educated, the more comfortable they appear to be with this form of psychiatric treatment. General concerns for the medium include: Difficulties with verbal and non-verbal communication, requiring providers to be aware of the non-verbal modes of communication found in the patients culture and have methods to account for that in telepsychiatry; establishing trust and rapport are more difficult via this medium, which can be done by having a trusted on-site worker to introduce the patient to the psychiatrist; patients are often concerned about confidentiality, so assuring them that their conversation is not being monitored by anyone other than the psychiatrist, and having that be true, is critical; and cultural differences along a rural-urban gradient must also be accounted for.

The power to reduce health disparities: voices from REACH communities

Centers for Disease Control and Prevention, 2007. The power to reduce health disparities: voices from REACH communities. *U.S Department of Health and Human Services, Centers for Disease Control and Prevention.*

This report documents the efforts of REACH programs funded by the CDC. Each REACH (Racial and Ethnic Approaches to Community Health) program description summarizes the efforts of the program, and outlines which ethnic group or groups the program targeted. The reports offer evidence to verify the effectiveness of each intervention. These programs, while not focused on mental health, do demonstrate community health principles and evidenced based practices which can be modified to address mental health disparities.

Increasing access to care for cultural and linguistic minorities: ethnicity-specific health care organizations and infrastructure

Yang, J., & Kagawa-Singer, M. (2007) increasing access to care for cultural and linguistic minorities: ethnicity-specific health care organizations and infrastructure. *Journal of Health Care for the Poor and Underserved*, 18, 532-549

Available at:

http://muse.jhu.edu/journals/journal_of_health_care_for_the_poor_and_underserved/v018/18.3yang.pdf

(From abstract) The authors propose ethnicity-specific subsystems of the health care system. They use the Chinese community in San Francisco as a model for other ethnicity-specific health organizations, and their model has four stages. The first step is procuring a bilingual and bicultural workforce. The second step involves structuring health care resources to promote maximum access. Thirdly, health care organizations should be expanded to serve the minority populations. Finally, ethnically-specific health care resources should be integrated into the mainstream health care system. Integration occurs when distinctions in quality between the mainstream and ethnicity specific systems cannot be identified.

Specific policy recommendations for each stage of the creation of ethnicity specific health care programs are offered. To promote a bilingual and bicultural workforce, the authors suggest policies to promote hiring of foreign medical graduates, professional training of native born, ethnic professionals, and recruitment of training of native born, ethnic minority professionals, and also improve educational opportunities for ethnic minority enclave residents. To create an ethnically-specific health care system, public funds must be available for organizations serving disadvantaged immigrant communities, allow flexible regulatory policies, and minimize barriers to advocacy. To promote integration into the mainstream, policies should provide incentives for mainstream institutions to contract with qualified ethnicity-specific organizations, as well as monitor and address discriminatory practices against racial minorities and ethnicity specific organizations.