

**Reducing Disparity:
Achieving Equity in Behavioral Health Services**

Proceedings of the 2003 Santa Fe Summit

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This paper summarizes the proceedings of the American College of Mental Health Administration's (ACMHA) 2003 Summit entitled "Reducing Disparities: Achieving Equity in Behavioral Health Services". The Summit was held from March 13-15, 2003 in Santa Fe, New Mexico. These proceedings are intended to summarize the results of the Summit and to point to the ways that the College can continue to facilitate progress in this important area.

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Chair, 2003 Summit*



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REDUCING DISPARITY: ACHIEVING EQUITY IN BEHAVIORAL HEALTH SERVICES

Introduction

Our health care system is riddled with disparities. Healthcare purchasers and government programs manage and report on access to services as a core value and measure of quality and yet disparities still occur by geographic area, between racial and ethnic groups, across cultures, between classes and by gender and age. There is disparity in health status, service utilization, procedures used and in the experience of care even after adjusting for the nature of the condition, income and health coverage.¹ For state and federally funded services the level of care used, service utilization, and quality of care are enormously inconsistent across states, from provider to provider and across individual staff. The work of the Institute of Medicine, first in “Crossing the Quality Chasm” and later in “Unequal Treatment”, has highlighted the reduction of disparities as a cross cutting issue and challenge for health care in the next decade.

Behavioral health services are certainly not immune to disparity, inequality and prejudice. The President’s New Freedom Commission on Mental Health outlined six broad areas for reform of the mental health system, including the goal that “disparities in mental health are eliminated”². Mental illness and addictions are enormously stigmatizing conditions by themselves; no surprise that they may also fall victim to racial prejudice and cultural stereotyping. Behavioral conditions are subject to enormous variation in diagnosis and thus more likely to be influenced by differences in the perceptions of professionals and organizational differences between providers. At the heart of our profession and industry are relationships between the caregiver and individual receiving services. As with all human relationships, behavioral health treatment services are based primarily on interpersonal communication and they fall victim to the bias and prejudice that are part of our culture. While professionals in the behavioral healthcare system pride themselves on objectivity and empathy, we often overlook the importance of the cultural and environmental causes of behavior and the impact of cultural differences on the diagnosis and treatment of behavioral conditions.

To begin to address the problems of disparity in behavioral health will require the efforts of individuals receiving services, professionals, managers, policy makers and researchers at all levels of the system. At each stage of our service system – access, treatment and outcomes – different interventions or analyses may be relevant to reduce disparity. The complexity of this type of change effort requires a long and substantial effort first by leaders in the industry and later at all levels. To meet this challenge, the American College of Mental Health Administration devoted its 2003 Santa Fe Summit to the topic of “Reducing Disparities: Achieving Equity in Behavioral Health Services”. This paper reviews the issues and challenges that were identified in that Summit and outlines an agenda for the field to begin to reduce these disparities.

¹ Institute of Medicine. “Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care”, National Academies Press: Washington, DC: 2003.

² President’s New Freedom Commission on Mental Health. “Achieving the Promise: Transforming Mental Health Care in America.” Final Report, July 2003: pp.49-55.



Background and Scope of the Problem

Behavioral health lags behind the overall health care system in identifying the scope and nature of racial and ethnic disparities in our systems of care. Yet the behavioral health field, led at the federal level by the Substance Abuse and Mental Health Services Administration, has for many years taken leadership in efforts to improve the cultural competence of our workforce as one element of the effort to reduce disparity. We have trained thousands of workers and held conferences and seminars on the topic over the last decade. Many public and private funds have been invested in these efforts. Despite significant progress in this area, these efforts are necessary but they are not sufficient to create the needed change. Unfortunately, there is little if any direct evidence of success of many of these training efforts in the actual reduction of disparity in access, treatment and outcomes.

From a research perspective, we have long recognized that the numbers of African American adults in state hospitals significantly exceed their ratio in the population.³ The reasons are unclear and though we have many hypotheses, we have not aggressively pursued answers to them. Hispanic children are under-represented in the children's mental health system and black children are over-represented⁴ and yet we can only offer more hypotheses as to the reasons for this. Finally, we have very little information with any certainty that lets us understand the reasons for the enormous variation in practice that results in the level of geographic variation we see in the behavioral health and the overall health care system. Variation is evident in public programs across states because of the different benefits available to recipients⁵ but significant variation is also seen across counties and regions within states, where the benefits are technically the same. It is extremely difficult in public mental health systems to reallocate resources to match community need – too many providers will be negatively affected. Yet even within Medicaid programs, where any willing and qualified provider should be able to participate and individuals have a relatively high degree of choice of providers, disparate practice patterns persist. To help reduce disparity and yet remain cost neutral, imagine the irony in having to waive “freedom of choice” within Medicaid in order to reallocate resources and improve equity!

Keynote Address: King Davis, Ph.D.

Our research into and our understanding of disparities in our health system cannot be separated from the socio-political context. King Davis, Ph.D., the Executive Director at the Hogg Foundation for Mental Health Policy and Services Research, delivered a keynote presentation at the ACMHA Summit that provided this socio-political context for disparities efforts and

³ Manderscheid, R.W. & Sonnenschein, M.A. (1987). *Mental Health, United States, 1985*. Rockville, MD: National Institute of Mental Health.

⁴ Richard H. Dougherty, PhD. “Reducing Geographic Disparities in Mental Health Access, Utilization and Cost: Implications for Policy and Planning” National Conference on Mental Health Statistics; Center for Mental Health Services. May 28, 2003.

⁵ Dougherty Management Associates, Inc. “Children’s Mental Health Benchmarking Project: Year Three Report”, Lexington, MA: 2003; www.doughertymanagement.com. Dougherty Management Associates, Inc. “Medicaid Managed Behavioral Healthcare Benchmarking Project”. Substance Abuse and Mental Health Services Administration, in press.



reviewed the status of research and findings in the field for the four primary racial and ethnic groups identified in the Surgeon General's Report. Entitled "Behavioral Health Status of People of Color in the United States 2003, Dr. Davis reviewed more than two centuries of history, legislation and public policies that profoundly affect our world-view today. According to Dr. Davis, this review of the historical context and public policies to treat people of color leads us to the conclusion:

"Groups of American citizens and their descendants, identifiable by color, language, culture, race, (and) ethnicity, have been and remain at greater long-term risk of co-occurring poverty, ill health, hunger, violence, impaired self-esteem, powerlessness, sub-standard housing, unemployment, (and) environmental hazards. (This) is manifested in a higher than expected frequency of unrecognized, under-diagnosed, over-diagnosed, and untreated behavioral disorders in unresponsive systems."

Dr. Davis continued with a detailed, and perhaps the most comprehensive review conducted to date, of the status of research on issues of racial and ethnic disparity in behavioral health care. In general, the number of high quality research studies on access to and outcomes of care by people of color in America is minimal. Research over the last two decades has increased on this topic, led in no small degree by Manderscheid and Sonnenschein and his 1985 research on admission rates by type of facility and racial and ethnic group⁶. This study documented significantly higher admission rates to state hospital and general hospitals for African Americans and American Indians than the general population. The rate for African Americans in state hospital was more than twice the general population rate.

The Surgeon General's groundbreaking report on culture race and ethnicity in mental health⁷ documents key findings on mental health status by ethnic group. For instance while African Americans have overall lower rates of depression than the general population, female African American have higher rates than the general population. Poverty is strongly linked to the rate of illness and African Americans have significantly higher rates of homelessness and use of inpatient services. The report went on to document the paucity of Asian Americans and Pacific Islanders in research studies and to highlight the particular importance of culture in defining symptoms in this population. Asian Americans and Hispanics generally experience lower levels of suicide and substance abuse conditions. Incidences for Hispanics are strongly influenced by their countries of origin. Finally, American Indians have much higher rates of substance abuse, aged depression, suicide and conduct disorder.

More recent research studies help to further identify contextual issues in the general statements identified above. For example, there are significant exceptions to general statements about racial and ethnic groups when results are analyzed by age and sex. Current research is delving into

⁶ Manderscheid, R.W. & Sonnenschein, M.A. (1987). *Mental Health, United States, 1985*. Rockville, MD: National Institute of Mental Health.

⁷ U.S. Department of Health and Human Services. "Mental Health: Culture, Race, and Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General." U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services: Rockville, MD: 2001.



issues of access to care, family roles in access and treatment, effective service models for specific populations, workforce training and medication differences. All of these will further help to identify effective service interventions to reduce disparity. In conclusion, King Davis stated:

The level of scientific knowledge, as shown in high quality epidemiological studies, of people of color and behavioral disorders is minimal. The quality of studies conducted on these populations has been minimal over the decades, with greater productivity and quality in the past decade. These populations are often left out of samples or the analysis of data does not focus on differences by culture, race or ethnicity”.

Panel Discussion: Other Perspectives on Race

Larke Huang, Ph.D, Josie Romero, and Candace Fleming, Ph.D. each discussed the unique perspectives of people from Asian American, Hispanic-Latino and American Indian and Native American cultures toward behavioral health services. Dr. Huang also addressed the unique needs of children of color. Each of their presentations highlighted the differences in the incidence of behavioral disorders and the unique experiences in accessing and receiving treatment, by individuals from these specific racial, ethnic and cultural groups. Our attempts to simplify thinking by grouping people of color into larger racial and ethnic categories, as has been done in the Surgeon General’s Supplement and also in this Summit, masks significant variation within these groups. For instance, the needs and cultural strengths of Chinese Americans, Cambodians and Japanese are quite different. Similarly, Hispanics from Cuba, Brazil, Mexico and Spain all have enormously different socio-cultural histories that influence access to care and family and community strengths in treatment. The different needs and reactions to services by people of different ages and sexes within cultures can also be particularly significant. We cannot make assumptions about what is needed by the people we serve. We need to ask the individuals we serve, understand their culture and environment, and listen to their responses!

Culturally Relevant Diagnosis and Assessment

A consumer-centered approach is at the heart of the cultural formulation that has been appended to the DSM-IV Manual. Dr. Francis Lu presented the background and key elements of this cultural formulation to the ACMHA Summit attendees. With an introduction and then by showing us the videotape, “The Culture of Emotions”⁸, Dr. Lu emphasized that the diagnosis of an individual, particularly an individual from a non-majority culture, should be supplemented by a clinical review of several other cultural factors. These include the:

- Cultural identity of the individual;
- Cultural explanations of the individual’s illness;
- Cultural factors related to the psychosocial environment and levels of functioning;
- Cultural elements of the relationship between the individual and the clinician; ;
- Overall cultural assessment for diagnosis and care.

⁸ Koskoff, Harriet, “The Culture of Emotions”. Fanlight Productions, Boston, MA: 2002.



It was clear to all of us that the cultural formulation should be at the heart of the overall diagnostic process, rather than being relegated to an addendum.

Examples from the Field

Four specific examples of efforts to reduce disparities were shared with attendees at the 2003 Summit. Each operated at different levels of the system and exemplified different types of interventions. They included two statewide efforts in California and Connecticut, a community based approach in the Hill District in Pittsburgh and an example of program change in New York City's Chinatown district.

Statewide Efforts:

Statewide initiatives are far reaching and have the advantage of affecting many people. Often, however, there are many barriers to large scale change that can only be addressed at a local level. The California and Connecticut examples are significant because of their scope and the different approaches they take to the reduction of disparities

California:

Josie Romero summarized the efforts to improve the cultural competency in the state of California's mental health system, the most culturally diverse state in the country. More than ten years of work has gone into the development of a statewide effort that was initiated by legislation in 1994 as a part of California's managed care plan. Cultural competency plans are required as a part of each County's managed care plan and standards are embedded in all statewide program planning. The statewide Cultural Competency Advisory Committee provides guidance to state leaders and seeks to implement the following goals/principles:

- The elimination of Access Disparities and improve Quality of Care for California's consumers and Families.
- "Normalize" culture, as we all have it and cannot function outside of it. Culture is dynamic and at the core of Cultural competency.
- Cultural Competence needs to be understood, acknowledged and imbedded at all levels of MH services, from policy to practice.

The scope and persistence of the effort have transformed California's mental health service system.

Connecticut:

A different approach has been taken by the state of Connecticut over the last two or three years. Arthur Evans, Deputy Commissioner of the Connecticut Department of Mental Health and Addiction Services outlined the state's efforts. Initial research using data from the state confirmed many long held beliefs about the extent and scope of disparities. Blacks and Hispanics were hospitalized more frequently in the state hospital than whites and blacks had less access to the newer generation of atypical medications. Similarly, whites were much more successful than other racial and ethnic groups in maintaining the continuity of care between acute detoxification services and longer term rehabilitation services.



Reflecting a somewhat different approach to cultural competency, culturally competent services may not have attributes that we can independently identify, but they can be identified by their effectiveness and their outcomes. The evidence-based definition of cultural competency is:

“Outcomes + Client Satisfaction = Cultural Competence”

Evans presented a framework for thinking about disparities that describes the factors that influence disparities at three levels in the behavioral health care system. These include:

<i>Levels</i>	<i>Factors</i>
Individual	Treatment relationship; Racial Identity; Racism; and Mistrust
Program	Access, Environment, Language, Holistic Approach, Racism, Mistrust, Fear of treatment
System	Service Fragmentation, Workforce Skill; Policy Framework; Racism, Mistrust; Stigma (Public Education); and Physical, Psychological and Financial Access.

Dr. Evans noted that the issues at a system level are responsible for a much larger degree of the variation in disparities and yet the research literature has focused most attention at the individual level of analysis. To address the need for change at a system level, Dr. Evans outlined a multi-level and multi-dimensional approach that includes: training, standard setting, changes in contracts, new data reporting and data systems, quality management approaches, clinical and systems policies, consumer and family input and evaluation. As an example of an effective statewide change effort, Evans proposed multi-method data analysis efforts that include better understanding of disparity data at a system level, case studies of programs that work and “hearing the voice of consumers and communities”. At a policy level, contracts will be modified, RFPs developed and new funding targeted to areas of highest need. Treatment needs to move beyond formal treatment methods to include non-traditional services, faith based services, traditional healers and special efforts targeted at urban areas.

Community Based Change: The Hill District

Community Connections for Families (CCF) is a system of care for families and their children with serious emotional disturbances in Allegheny County, Pennsylvania. This CMHS System of Care grant was awarded to Allegheny County Department of Human Services in November of 1998 to work with five partner communities in the Greater Pittsburgh Area. These partner communities include: The Hill District, Sto-Rox, East End, Wilkinsburg and McKeesport. Dr. Jerome Hanley presented information from the Hill District site at the Summit.

Creating culturally competent services is a complex process in any community. CCF involves a strong neighborhood and family partnership which works with local government and managed care to provide integrated and family directed support and services, rather than just offering families what is dictated by service systems. By hiring people with a positive history in the neighborhood, and giving families and neighborhood residents an opportunity to choose who that person might be, the program has an opportunity to gain trust from local residents. Training is a key feature of the CCF initiative. However, however, some of the most important interventions according to Hanley are the neighborhood interventions. Social and recreational activities are sometimes coordinated with the efforts of other neighborhood groups such as the Resident



Tenant Council or the Community Collaborative so that families are part of the larger community. Family support activities along with training, (which parents can use right in their neighborhood), increase involvement and build trust. Families are not only involved in training, but also may provide support to other families such as going with another parent to an IEP meeting. Finally, food has always been a staple in training and meetings with families. If you come to Allegheny County, the food is reflective of the culture of that neighborhood.

Engaging African American and low income families in planning, leadership, support and decision-making activities with professionals builds self-esteem and gives families an opportunity to meet and influence people within systems that they otherwise might only know through receiving service. It promotes mutual understanding and respect. "Cultural competence and family involvement go hand in hand; you can't have one without the other."

CCF has insisted that every program activity have inclusive procedures and that they are enforced. One way to keep true to this commitment is through program evaluation. Each community in CCF has family and neighborhood representatives that sit on a Community Evaluation Team. Each community also gets a bi-annual outcomes report of their progress, which is compiled and distributed by the CCF Evaluation Team.

Programmatic Change: The Bridge Program

Asian Americans constitute over 9% of the population of San Diego County and yet only 3.6% of the clients served. The patterns are the same elsewhere. When Asian Americans finally seek services their disorders tend to be more severe. Barriers include language and economic barriers but to a very large extent the key issues are cultural stigma and culturally defined differences in the ways the population recognizes and interprets psychiatric symptoms. To address these issues, the Charles B. Wang Community Health Center created the Bridge Program to provide an active link between primary care and mental health services. The program includes training of primary care physicians, early detection and treatment of mental health problems in a primary care setting, and assistance with access to specialty services when they are needed. To better understand the ways in which Asian Americans can be best served in a primary care setting, the program screened nearly 2,000 people and more than 100 individuals have been identified with anxiety and depressive symptoms and agreed to participate in a randomized study that is currently underway. The study compares "integrated care" with "enhanced referrals" between primary care and mental health services. The Bridge Program has been replicated in Boston and Oakland and is a model of effective and culturally relevant, evidence based practice.

International Perspectives on Disparity

Professor Norman Sartorius, MD, Ph.D. spoke to the Summit participants by videoconference from Geneva. In a brilliant, witty and insightful lecture, Dr. Sartorius identified the magnitude of the changes that we are going through as a society, the impact of these changes on mental illness and the enormity of cross cultural difference that exists across the world. Demographic trends such as longer lives, widening gaps between the rich and the poor, our definitions of community and the conflicts between our helping professions have significant implications for our field. His comments forced all of us to step back and recognize the extraordinary differences between the United States, Northern Europe and the rest of the world. Many of the differences in services across countries are defined by wealth and the level of development of countries, but



other factors cannot be explained by wealth – such as the extraordinary average length of stay in the hospital for individuals with Schizophrenia in Japan (440 days) compared to 4.8 days in Canada. It became clear from this and all our other presentations that at each level of analysis - within and across programs, service systems, cultures and countries - we must confront and try to understand a variety of different types and causes of disparity in the mental health system.

Participant Break-Outs

As has been the model for past Summits, the majority of work was accomplished in breakout groups organized by the key functions and levels of the behavioral health system. The levels of the system included: Consumers, Providers, Payers, Policy/Oversight and Research. In the breakout sessions, people participated and contributed action items from the perspective of each of these levels, focusing on the three principle stages of the service system: access, treatment and outcomes. We had an opportunity to hear from each group at the end of the Summit. The messages were clear and motivating. The challenge is large.

The key issues and action items for each of the system levels are summarized below:

Consumers

The overarching message from consumers was consistent with the messages we receive from consumers and family members in other settings – “Listen to what we say we need!” It’s a simple plea and yet one which is quite profound. If we truly listen to and hear the voice of those we serve, then any disparities that remain should be the result of differing needs and perceptions of needs from people we serve. To help to ensure that the voice of consumers is heard, we must ensure that their legal rights under Title VI, to receive interpreter services when needed, are fulfilled. Nowhere is this more important than in behavioral health services, where communication is the core of the treatment intervention. Consumers and family caregivers also want to be involved in services and governance at all levels of the mental health system from direct care to oversight. As a measure of the importance of this, there are less than 5 consumer directed services in the country that are lead by persons of color in which the majority of the participants are of African, Asian, Hispanic, or Native American descent. Consumers, particularly those of similar cultures and backgrounds, can increasingly play important roles to provide peer support, participate as caregivers and provide community services. A nationally recognized and culturally relevant consumer empowerment training program needs to be developed to assist them. This is particularly relevant in helping people from other cultures. This role of peer support specialist may need to be more systematically addressed and guidance given to states on when to use them and how they may be reimbursed under Medicaid rehabilitation services.

Families, caregivers and community members live in the fall-out of mental illness and are critical parts of an effective treatment plan, particularly for people from non-majority cultures. Consumers and family members need to be actively involved in the treatment plan and be informed about the availability and use of advance directives. They need preparation to be caregivers through educations, training and support. Access should be improved through social marketing and public health awareness campaigns designed to help people identify symptoms and understand the benefits of services and treatment. Finally though not mentioned at the



Summit, consumer directed services can help to address many of these areas while raising new challenges of educating individuals so they can be knowledgeable consumers.

Providers

The reduction of disparities in treatment and outcomes must involve changes by providers to better meet the needs of consumers of different cultures. This includes individual practitioners as well as provider organizations. Some of these changes are simple; for instance knowing how others see the organization. Staff need to be routinely trained in cultural competence and sensitivity to the impact of culture on the treatment process. Other aspects are more profound, such as truly individualizing care for the strengths, needs, ability and culture of the person being served, using consumer and family centered treatment planning. Finally, there is an enormous level of knowledge in providers that is poorly utilized when providers stay in their offices and that can benefit the field through the dissemination and analysis of “practice based evidence”.

Participants urged that providers conduct a self-assessment to better understand how others see them. What is it like when people arrive at your offices the first time? What does it say about your culture? Providers were urged to abandon their offices and reach out to the community using a variety of outreach methods. Similarly, providers must move out of their comfort-zone and be able to answer the question of who is the service really for. Treatment must be individualized and all should commit to the treatment goals. The mix of services may need to be adjusted to reflect these goals – less reliance on office-based visits and more focus on community interventions.

Many urged providers to actively try to identify ways to link to other members of the community and other natural supports. Psychiatry that is coupled with effective natural supports may be the most effective way to achieve change. Providing a single point of access within provider organizations and delivering systems is one way to ensure that consumers are educated properly and receive information about the full range of community supports. Several of the participants acknowledged the importance of consumer directed services and how this would change the perspective of providers to be more consumer centered. Finally many felt that providers needed to develop the capacity to track individualized outcomes for the people we serve. These outcomes should have specific operational outcome measures that aim at wellness, recovery and resiliency.

Payers

Changes in the health care delivery system are most likely when driven by payers or purchasers, who establish clear goals and incentives for change. In behavioral healthcare services, the reduction of disparities is one of several major cultural shifts that must transform the delivery system. In many ways they are interconnected. These include:

- A shift from treatment to public health approaches that involve wellness and community development;
- The development of a recovery based approach to care, including self-care and peer support;
- Shifting from reducing spending to reducing waste and increasing quality;



- Leadership by example in the public behavioral healthcare system.

To achieve equity in our behavioral health system, purchasers may have to adopt a more strategic approach to the allocation of resources to underserved communities and providers from minority racial and cultural groups. In the past, many state behavioral health systems have been opportunistic in the development of new programs, providing funding to programs that had innovative proposals. Often these agencies have been the agencies that are the most successful – “success breeds success”. Medicaid services have grown with “any willing and qualified” provider. Once again, successful providers have often been the ones that have taken the most advantage of Medicaid growth. New efforts must more directly target underserved communities and provide funds to build capacity in the providers that serve or are willing to serve these communities.

Other issues that Payers need to consider include:

- Connecting RFPs and contracts to outcomes that are clear and measurable;
- Collect and disseminate data on performance to increase the transparency of the health system;
- Ensure that efforts to implement evidence-based practices are built on a culturally sensitive and relevant framework.
- Build treatment systems on natural supports and communities;
- Plan prevention services and work to increase social capital in local communities;
- Develop a communications, education and marketing campaign to shift the values of the behavioral health system and create the need for systems change.
- Seek to make the reduction of disparities a competitive advantage for private health insurers and an issue of social justice.

Policy/Oversight

As guiding principals, behavioral health systems that seek to reduce disparity must have policies that increase and ensure equitable levels of access, encourage choice, seek to increase the use of evidence based practices, and develop outcomes of interventions that both address personal and social benefits of treatment.

Behavioral health treatment systems must increasingly develop real choice across a range of treatments, services and supports for consumers. These services must be evidence based, but more importantly must be relevant to the individuals being served. This will help to ensure that services are both culturally appropriate and desirable to consumers.

More broadly, however, the participants at the AMCHA Summit felt strongly that our behavioral health service systems must explicitly adopt approaches that seek to increase the social capital of our communities. Social capital is a term used to refer to the characteristics of a social organization or community that facilitate coordination and cooperation for mutual benefit. In the case of behavioral health services, policies that improve social capital would seek to increase the level of communication and connectedness between behavioral health care organizations and other voluntary and government funded programs that serve individuals, and their families, who



have mental illness and emotional disturbance. Critical services that need to be better coordinated include the different levels of behavioral health treatment services, prevention services, primary care, school based services, the criminal justice system and employment services. While this may seem like a broad mandate, it is consistent with and provides a new framework for a public health approach to behavioral health and for many efforts at developing existing community support services in both the child and adult service systems.

Researchers

As King Davis and others noted during the Summit, the research literature and public reports are considerably lacking on data about the nature and scope of disparities in many of our service systems. There is an enormous need for timely and relevant data on access, treatment and the outcomes of services by geographic area and for people from different racial and ethnic groups. These data are essential to understand the problems, design solutions to address these problems and set a baseline for measuring change. This needs to begin by collecting, analyzing and disseminating information on the numbers of people served and penetration rates by geographic area and racial groups.

Many at the Summit agreed that many of our data systems already collect information on the race and ethnicity of individuals being served but these data are not often analyzed in a manner that helps to identify patterns of disparate care. In other cases, key data elements on race and ethnic status may need to be collected and stored in a manner that facilitates their use in analyzing access and utilization data. The core data elements that were recommended for inclusion were as follows:

- Race
- Language
- Gender
- Sexual Orientation
- Education
- Economic Status
- Geographic location of consumer
- Employment status and history
- Housing situation
- Criminal Justice history
- Welfare history
- Family and caregiver history

Because of the lack of data on disparities, there was acknowledged to be little evidence on the effectiveness of cultural competency interventions in the reduction of disparity. The research agenda for the field needs to include cost-effectiveness research on cultural competency training and culturological assessments of the quality of care. As data are made more available, expected levels for different racial and ethnic groups can be estimated and actual access, utilization and



quality levels should be compared to these estimates. In this way, jurisdictions that lag behind the expected levels can be held increasingly accountable for these results and for improvements.⁹

Successful outcomes are defined by the culture and economic status of the individual served. Just as the relevance of certain Quality of Life (QOL) measures vary by economic status, so also QOL measures may vary by racial and ethnic group. The differences include the role of the family, community, religious organizations in the person’s life, and other characteristics. Western dominated outcome measures, such as employment and independence, may not be salient for people of other cultures.

We need to put the issue of disparity in the foreground of behavioral health policy. Only through the collection and dissemination of data on the nature and scope of disparities can we convince public policy makers of the need for fundamental change in our behavioral health system. Suggestions for steps to achieve this include:

- Conducting a survey of public purchasers, health plans, behavioral health MCOs and key provider groups to identify the data that are collected and how they are used in reporting on disparities.
- Studying the effectiveness of cultural competency measures on the reduction of disparity.
- Insisting that disparity data be included as a part of all cultural competence plans and that interventions are designed for areas of significant disparity.
- Developing an annual or biennial report from CMS and SAMHSA reporting on the results of disparity related performance measures.
- Analyze related data from other systems for disparity related information.

Summary

The 2003 AMCHA Summit was an initial step only. It served to provide a broad outline of the socio-political context and key issues involved in reducing disparities and provided some momentum for change. However, much more work remains to be done.

The framework for our discussions produced a considerable level of discussion and recommendations for change at many levels. The principal recommendations to reduce disparities have been organized into the cells of a matrix. An example of some of the most critical elements of this framework follows:

RECOMMENDATIONS TO REDUCE DISPARITY			
<i>System Levels</i>	<i>Access</i>	<i>Treatment</i>	<i>Outcomes</i>
Consumers	Social marketing and public health campaigns designed to increase access	Consumer and family education; peer and family support; self-help; Consumer operated services	Recovery and improvements in functioning
Providers and	Single point of access;	Consumer centered and	Track individualized outcomes

⁹ Examples of preliminary work in these areas include the Children’s Mental Health Benchmarking Project



RECOMMENDATIONS TO REDUCE DISPARITY			
<i>System Levels</i>	<i>Access</i>	<i>Treatment</i>	<i>Outcomes</i>
Provider Organizations	Outreach efforts; Facility location and design	individualized planning and care	by race at the provider level; Ensure cultural competence in providers.
Payers and Service Systems	ID unmet community needs; use existing supports	Strategically reallocate resources to underserved communities; Improve services integration; monitor providers	Monitor disparities; track outcome differences; pay for outcomes
Oversight / Regulation	Ensure equitable levels of access; Increase social capital	Encourage real choice in person centered care	Increasing focus on outcomes and measuring social capital in communities of color.
Research	Collect demographic and access data by race/ethnic group and geographic areas; Implement new core data elements; implement community needs assessments.	Monitor treatment processes by race; Research on the effectiveness of cultural competency training.	Quality of Life improvement by race and ethnic group; Implement culturological assessments of the quality of care.

The Summit demonstrated clearly that the reduction of disparities requires a multi-level approach and multi-disciplinary leaders. As a neutral convener, AMCHA is in a unique position to help advance the debate and lead the field in the reduction of disparities. Our membership and leadership includes people who receive services, researchers, administrators, clinicians, and policymakers from all levels of the behavioral health system. Our leadership has been particularly effective at facilitating groups to reach consensus on controversial topics.

As noted, a change agenda needs to include efforts at national, state and local levels involving consumers, providers, purchasers, oversight organizations and researchers. ACMHA is committed to advancing the field and helping the national effort to reduce disparities. Examples of potential projects include the following:

- *Training:* Much has been done to develop effective cultural competency training modules and to guide states in its implementation. No one should reinvent the wheel at this time. Funding should be targeted to provide incentives to states for dissemination of existing training curricula and the documentation of effectiveness to all providers and administrators.
- *Data:* Nationally, as we heard from our participants, the field will benefit from data standards for the collection of and reporting on system disparities. This will facilitate inter-state comparisons and provide baseline data for change efforts. Conducting surveys of providers, health plans and public behavioral health systems on the availability and current uses of data by race and ethnicity is one example of a useful first step in this process of setting data standards.
- *Research:* Further research on the nature and causes of disparity is needed. Systematic research needs to take place on factors influencing access, treatment and outcomes for people of different cultures. Initially, because of the difficulties in deciding on standardized outcome measures, encounter and claims data will provide the most useful



information for analysis. Later as standardized outcome measures are more widely utilized and the data collected, it may be possible to look for racial and ethnic differences in outcomes. The research agenda needs to be developed with a focus on services and health systems research data.

- *Demonstrations:* Demonstration efforts are urgently needed, similar to Connecticut’s initiative, that integrate data on disparities with provider reporting, performance contracting and system-wide interventions. These best practices need to be shared with the field.
- *Coordination:* The Summit showed that many are eager to learn from others in this area. As we move from further research to demonstration initiatives, AMCHA can play a role in coordinating these projects, particularly at the state and perhaps local levels. State efforts can benefit from best practice presentations from other states and by an improved understanding of the nature and the scope of the change required at a programmatic and local level. Local efforts need to clearly incorporate the views and perspectives of members of the community and consumers.

The 2003 ACMHA Summit has provided a foundation and a framework for work to proceed at all levels of the behavioral health delivery system. To accomplish meaningful change, we challenge SAMHSA, CMS and the other federal agencies to provide the leadership to develop: common and core performance measures focused on the reduction of disparities; to coordinate the research agenda, and; to facilitate the use of new information technologies to collect and review these data. This is completely consistent with the vision of federal “Leadership by example” that has been outlined by the Institute of Medicine¹⁰ for the implementation of the Crossing the Quality Chasm Report. We need to facilitate the efforts of states and the federal government to identify and reduce disparities and provide a forum for states to share the results of their efforts, to benchmark their performance and seek technical assistance. Over the next several years, we also expect that states will expand their efforts to implement evidence based practices. However, we urge these states to implement existing evidence based practices cautiously, especially with culturally diverse populations due to the limited representation of ethnically diverse subjects in the research evidence on current practices. We strongly recommend that data are also collected for “practice based evidence“ - where effective interventions are routinely identified from existing practice and shared with the field, particularly those practices that seem effective with minority populations.

With one effort followed by another, step-by-step, incrementally across the country, the impact of a person’s place of residence, their race, or their ethnic status on the scope and quality of health care they receive can be diminished. The American College of Mental Health Administration looks forward to working with the federal government, states, managed care plans, providers and individuals receiving services to achieve this vision.

¹⁰ Institute of Medicine: Committee on Enhancing Federal Healthcare Quality Programs. “Leadership by Example: Coordinating Government Roles in Improving Health Care Quality”. The National Academies Press: Washington, DC: 2003

