Achieving Equity in Behavioral Health Care: Policy and Practice
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Sierra Health Foundation
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Sacramento, California
Overview

• What do behavioral health disparities look like?
• From individuals to populations
• What creates health equity?
• Re-thinking actions and solutions
Past-Year Major Depressive Episode (MDE) Among Adolescents Aged 12–17, by Race/Ethnicity and Gender (2013)\textsuperscript{3,4}

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2013.
Past-Month Binge Alcohol Use Among Adolescents Aged 12–17, by Race/Ethnicity (2013)

- White: 7.3%
- Black: 3.9%
- American Indian or Alaska Native: 5.6%
- Native Hawaiian or Other Pacific Islander: 4.5%
- Asian: 2.8%
- Hispanic or Latino: 6.3%

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2013.
Past-Year Depression Treatment Among Adolescents Aged 12–17 With MDE, by Demographic Characteristics (2013)\textsuperscript{1,7}

- **Males** (657,000 Adolescents With MDE):
  - 29.7% Received Treatment
  - 70.3% Did Not Receive Treatment

- **Females** (1.9 Million Adolescents With MDE):
  - 40.9% Received Treatment
  - 59.1% Did Not Receive Treatment

- **White** (1.4 Million Adolescents With MDE):
  - 41.6% Received Treatment
  - 58.4% Did Not Receive Treatment

- **Black** (289,000 Adolescents With MDE):
  - 28.6% Received Treatment
  - 71.4% Did Not Receive Treatment

- **Hispanic or Latino** (617,000 Adolescents With MDE):
  - 36.9% Received Treatment
  - 63.1% Did Not Receive Treatment

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2013.
Past-Month Illicit Drug Use Among Adolescents Aged 12–17, by Race/Ethnicity (2009–2013)¹

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2009 to 2013.
Past Year Misuse of Prescription Psychotherapeutics among Youths Aged 12 to 17, by Drug Type and Past Year Major Depressive Episode (MDE) Status: Percentages, 2015 NSDUH

+ Difference between this estimate and the estimate for youths with no past year MDE is statistically significant at the .05 level.

Note: Youth respondents with unknown past year MDE data were excluded.
Source Where Pain Relievers Were Obtained for Most Recent Misuse among People Aged 12 or Older Who Misused Prescription Pain Relievers in the Past Year: Percentages, 2015 NSDUH

Note: The percentages do not add to 100 percent due to rounding.
Note: Respondents with unknown data for the Source for Most Recent Misuse or who reported Some Other Way but did not specify a valid way were excluded.
Suicide Rates by Ethnicity and Age Group – United States, 2007-2011

Unadjusted crude rates per 100,000 population; A. Crosby, CDC, 2014
Behavioral Health Data for LGBT Population

• LGB Data Report: to be released by SAMHSA next week
• Prevalence data for Serious Mental Illness, Any Mental Illness and Substance Use: higher for LGB than general population
• Treatment Access → higher than sexual majorities.
• Announcement: Oct 6, 2016 re Disparity Population & Research
Health Insurance and LGB Population

• 2013-2015: LGB adults without insurance coverage decreased from 21.7% to 11.1%.
• The decline in uninsurance for LGB adults during this period is larger than the decline for non-LGB adults.
• 2013-2015: The share of LGB adults with income below 400 percent of Federal Poverty Level who have insurance increased 15.5%
ACCESS DISPARITIES: During the first half of 2014, declines in rates of uninsurance were larger among Black and Hispanic adults ages 18-64 than among Whites, but racial differences in rates remained.

*Adults ages 18-64 who were uninsured at the time of interview, by race/ethnicity, 2010-2014*

ACCESS DISPARITIES: In 2012, disparities were observed across a broad spectrum of access measures (AHRQ, QRDR, 2014)

Disparities: Access measures for which members of selected groups experienced better, same, or worse access to care compared with reference group, 2012

- Poor vs. High Income (n=19)
- Black vs. White (n=21)
- Hispanic vs. White (n=21)
- Asian vs. White (n=18)
- AI/AN vs. White

0% 20% 40% 60% 80% 100%

Better Same Worse

19 11 4
10 14 3
3

6

4
9

4

9
QUALITY DISPARITIES: Overall quality (top map) and racial/ethnic disparities (bottom map) varied widely across states and often not in the same direction (AHRQ, 2014: National Health Quality/Disparities Reports)
2015 Meta-analyses of 130 Research Studies

• In 2001: U.S. Surgeon General Report: Mental Health – Culture, Race and Ethnicity alerted to racial and ethnic minorities underserved.

• In 2015: Racial and ethnic disparities have decreased somewhat, but still substantial. Minorities are less likely than white European Americans to use mental health services.
  – Continued underutilization of services
  – Lower treatment completion rates
  – Workforce needs
  – Culturally adapted service needs

  • (T. Smith and J. Trimble, Foundations of Multicultural Psychology: Research to Inform Effective Practice, 2015)
Under-Representation of People of Color in Behavioral Healthcare

Although minorities make up approximately 30% of the U.S. population, they currently account for only:

- 24.3% of all psychiatrists,
- 5.3% of psychologists,
- 14.9% of social workers,
- 20% of counselors,
- 8.5% of marriage and family therapists,
- 4.9% of school psychologists, and
- 9.8% of psychiatric nurses (Duffy et al., 2004).
Perceptions of Public Stigma and Support

NOTE: Significant differences relative to whites are indicated by * p < 0.05.

RAND RR1441-1
Recovery Beliefs

**A person with mental illness can eventually recover**
- Asian-American: 77%
- African-American: 87%
- Latino (English): 83%
- Latino (Spanish): 99*
- White: 75%

**A person with mental illness can lead a normal life with treatment**
- Asian-American: 77%
- African-American: 95%
- Latino (English): 92%
- Latino (Spanish): 93%
- White: 39****

**People who have had a mental illness are never going to be able to contribute much to society**
- Asian-American: 12*
- African-American: 5
- Latino (English): 5
- Latino (Spanish): 2

NOTE: Significant differences relative to whites are indicated by * p < 0.05; **** p < 0.0001.
What Creates Health

**Determinants of Health**

- Genes and Biology: 10%
- Environment: 10%
- Clinical Care: 10%
- Health Behaviors: 30%
- Social and Economic Factors: 40%

**Necessary conditions for health (WHO)**

- Peace
- Shelter
- Education
- Food
- Income
- Stable eco-system
- Sustainable resources
- Health Care
- Transportation
- Social justice and equity


Communities of Opportunity

- Parks & trails
- Grocery stores
- Thriving small businesses and entrepreneurs
- Financial institutions
- Better performing schools
- Good transportation options and infrastructure
- Sufficient healthy housing
- Home ownership
- Social inclusion
- IT connectivity
- Strong local governance

Low-Opportunity Communities

- Unsafe/limited parks
- Fast food restaurants
- Payday lenders
- Few small businesses
- Poor performing schools
- Increased pollution and contaminated drinking water
- Few transportation options
- Poor and limited housing stock
- Rental housing/foreclosure
- Social exclusion
- Limited IT connections
- Weak local governance

Good Health Status

Poor Health Status Contributions to health disparities:
- Obesity
- Diabetes
- Cancer
- Asthma
- Injury

SAMHSA
“...A person’s mental health and many common mental disorders are shaped by various social, economic, and physical environments operating at different stages of life. Risk factors for many common mental disorders are heavily associated with social inequalities, whereby the greater the inequality the higher the inequality in risk...”

Source: World Health Organization (2014), Social Determinants of Mental Health
What is the Real Narrative for What Creates Health& Development Inequities?

• Disparities are not just due to lack of access to health/education resources or to poor individual choices.
• Disparities are mostly the result of policy decisions that systematically disadvantage some populations over others.
  – Especially, populations of color and American Indians, and low income communities
  – Structural Racism/Implicit Bias Critical Explanations (e.g. grantmaking, federal resources, insurance access, social determinants of well-being)
Disproportionate Incarceration Rates by Policy

**INCARCERATED AMERICANS (1920-2013)**

- States pass “tough on crime” laws, including Three-Strikes and Truth in Sentencing
- Congress enacts new Mandatory Minimum Sentences for drugs
- The U.S. declares War on Drugs
- President Nixon proclaims drug abuse “public enemy number one”
- 501,500 incarcerated for drug offenses
- 2.3 million incarcerated Americans
- 501,886 incarcerated Americans
- 41,000 incarcerated for drug offenses

*Source: www.justleadershipusa.org*
Ferguson Missouri
Traffic Stops, 2013: Population Stopped and Reason

Population stopped

- White
  - 1 in 8

- Black
  - 1 in 2
  - Blacks were over 3.5 times as likely as whites to be stopped.

Reason for stop

- Moving
  - 68% White
  - 43% Black
  - The majority of whites were stopped for a moving violation; the majority of blacks for an equipment or license problem.

- Equipment and License
  - 58% White
  - 32% Black
  - Blacks were also more likely to be stopped for investigative reasons.

- Investigative
  - 4%
  - 7%

Source: Office of the Missouri Attorney General (2014). Racial Profiling Data/2013: Ferguson Police Department. Note: Because data are based on stops and not drivers, drivers with multiple stops are counted multiple times. Reasons for stops exceed 100% because some stops were made for multiple reasons.
Lifetime Likelihood of Imprisonment

All Men: 1 in 9
White Men: 1 in 17
Black Men: 1 in 3
Latino Men: 1 in 6

All Women: 1 in 56
White Women: 1 in 111
Black Women: 1 in 18
Latina Women: 1 in 45

Preschool Students Receiving Out-of-School Suspensions by Race/Ethnicity

FIGURE 1. PRESCHOOL STUDENTS RECEIVING OUT-OF-SCHOOL SUSPENSIONS BY RACE AND ETHNICITY

<table>
<thead>
<tr>
<th></th>
<th>Overall Enrollment</th>
<th>Out-of-School Suspension (Single)</th>
<th>Out-of-School Suspension (Multiple)</th>
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<tbody>
<tr>
<td>IN PERCENTAGES</td>
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</tbody>
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- **White**: 43% (Overall), 26% (Single), 26% (Multiple)
- **Two or More Races**: 4% (Overall), 3% (Single), 4% (Multiple)
- **Hispanic/Latino**: 29% (Overall), 25% (Single), 20% (Multiple)
- **Black or African American**: 18% (Overall), 42% (Single), 48% (Multiple)
- **Native Hawaiian or Other Pacific Islander**: 1% (Overall), 1% (Single), 1% (Multiple)
- **Asian**: 1% (Overall), 1% (Single), 1% (Multiple)
- **American Indian or Alaska Native**: 2% (Overall), 1% (Single), 1% (Multiple)

What is Equity?

Secretarial Priority #1

1. Assess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that:

   (c) Program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits
### Court/Jail Diversion – Access Data: Demographics of Program Enrollees

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<tbody>
<tr>
<td><strong>Race</strong></td>
<td>White</td>
<td>69%</td>
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<td></td>
<td>African American</td>
<td>22%</td>
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<td></td>
<td>Multi-racial</td>
<td>5%</td>
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<td></td>
<td>American Indian</td>
<td>2%</td>
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<tr>
<td><strong>Gender</strong></td>
<td>Male</td>
<td>89%</td>
</tr>
<tr>
<td><strong>Hispanic/Latino</strong></td>
<td>(Yes)</td>
<td>15%</td>
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<tr>
<td><strong>Age in Years</strong></td>
<td>Mean</td>
<td>39 yrs</td>
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<tr>
<td><strong>Education</strong></td>
<td>Some college or more</td>
<td>51%</td>
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<td></td>
<td>High School/GED</td>
<td>41%</td>
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<td>Less than High School</td>
<td>8%</td>
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Baseline Data (N=642)
Enrollees in Opioid Treatment Program

- **Male**: The graph shows the distribution of enrollees by age for males, with a peak at around 25-30 years. The lines represent different racial/ethnic groups:
  - White (non-Hispanic)
  - Black (non-Hispanic)
  - Mexican origin
  - Puerto Rican origin
  - Am. Indian/Alaska Native
  - Asian/Pacific Islander

- **Female**: Similarly, the distribution for females is shown, with a peak at around 20-25 years. The lines for each racial/ethnic group are also indicated.
Disparity Impact Statement: A Requirement in SAMHSA Grants

• Strategically focus on tracking disparities in access, use and outcomes for racial, ethnic or sexual/gender minority subpopulations.
• Use program performance data to implement a QI process.
• Leverage the National CLAS Standards as part of the QI process to ensure better access, use and outcomes for the identified disparate population(s).
• Link to funding award.
Disparity Impact Strategy Framework for SAMHSA Grant Programs

**Access**
- Who is enrolled in the grant program?
- Who are you serving?
- What populations being reached?

**Use**
- What interventions are being used?
- Who’s getting what dosages of what intervention?

**Outcomes**
- How are enrollees in the program doing?
- How differ across groups?

GPRA Data Disaggregated by Population Groups
Enhanced CLAS Standards
Released by DHHS, April 2013

Culturally and Linguistically Appropriate Services (CLAS) Standards

<table>
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<th>Standard 1</th>
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<td>Principal Standard</td>
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<th>Standards 2-4</th>
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<td>Governance, Leadership &amp; Workforce</td>
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<th>Standards 5-8</th>
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<td>Communication &amp; Language</td>
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<th>Standards 9-15</th>
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<tr>
<td>Engagement, Continuous Improvement &amp; Accountability</td>
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https://www.thinkculturalhealth.hhs.gov/Content/clas.asp#clas_standards
Early Childhood Grantee: QI Efforts
Across Multiple Towns: Head Start, Family Centers, State/County Dept of Health, Community Health Center

- Formed **Language Access Learning Community**
  - Set goals; accountability; strategies
  - Translated/simplified parent handbook
  - Each entity completed pre and post assessment re language access
  - Survey on use of interpreters
  - Data used by management for training needs

- Hired worker from new Americans community
  - Job description; trained staff to collaborate with new staff member

- Partnered with Community Health Center re phone interpreters
Example – Middle School Grantee

Figure 1d: Rate Ratio Exclusionary Discipline

- Asian
- Black
- Hispanic
- American Indian

2012-2013 (Year 0):
- Asian: 0.22
- Black: 1.17
- Hispanic: 1.99
- American Indian: 0.00

2013-2014 (Year 1):
- Asian: 4.71
- Black: 4.55
- Hispanic: 1.50
- American Indian: 0.00
ER Visit for Mental Health Reasons

Percentage of participants with a risk of an ER visit for mental health reasons over a 3 month period, by cohort over time:

*statistically significant
Presidential Initiative: *My Brother’s Keeper*  
Public/Private Effort to Support “MBK Communities”  

Building on Strengths: Tools for Improving Positive Outcomes  
Ensuring the Well-being of Boys and Young Men of Color: Factors that Promote Success and Protect Against Substance Use and Misuse

Advancing Best Practices in Behavioral Health for Asian American, Native Hawaiian, and Pacific Islander Boys and Men

SEPTEMBER 2016

“Most Significant Change”

For Grantees

- Broader inclusion of racial/ethnic populations
- “Discoveries” of un/under-served populations
- Innovative outreach and engagement strategies
- New collaborations
- Revisiting screening and assessment tools
- New exposure to CLAS standards
- New awareness of disparities/disproportionality

For Agency: Staff Initiated DIS Activities

- Administrators/evaluators working with staff on DIS data collection and intervention strategies
- Change thinking about how to use data
- Behavioral Health Disparities Online Module

For People & Communities Served

- Increased attention to vulnerable populations
- Better outreach, engagement
- Better and individualized prevention and treatment services
Trauma as a Social Determinant: Impact of Trauma Over the Life Span

Effects of childhood adverse experiences:

- Neurological
- Biological
- Psychological
- Social

(Felitti et al., 1998)
Count of Major Clinical Problems* at Intake by Severity of Victimization

*Based on count of self reporting criteria to suggest alcohol, cannabis, or other drug disorder, depression, anxiety, trauma, suicide, ADHD, CD, victimization, violence/ illegal activity

Source: SAMHSA CSAT 2011 GAIN AT Summary Analytic Data Set subset to AAFT (n=5,489)
Where do we start to address historical trauma?
Effects of Violence and Trauma Tell Part of the Story about the Achievement Gap

- Decreased IQ and reading ability (Delaney-Black et al., 2003)
- Decreased rates of high school graduation (Grogger, 1997)
- More days absent from school (Hurt et al., 2001)
- Lower grade point average (Hurt et al., 2001)
- More suspensions and expulsions (LAUSD survey, 2006)
“How does it feel to be a problem?”

... W.E.B. Du Bois. *Souls of Black Folk* (1903)
ReCAST Grant: Resiliency in Communities After Stress and Trauma

- For: Communities experiencing civil unrest
- Purpose:
  - Assist high-risk youth and families
  - Promote resilience and equity in communities
  - Use violence prevention/community youth engagement programs
  - Link with trauma-informed services
- Goal: local community entities and government (law enforcement, education, etc.) agencies to work together to improve behavioral health, empower community residents and reduce trauma
- http://www.samhsa.gov/grants/grant-announcements/sm-16-012
Builds on Principles to Advance Community Defined Optimal Well-being

• Community voice and context are primary driver

• Communities define conditions, measurement, resources and outcomes that promote Optimal Well-being

• Communities are partners in conceptualizing, collecting, conducting evaluation for optimal well-being.

• Emphasize the context for learning about social determinants of optimal well-being.

• Strategic learning in population health is community centered.

• Data use is valued as part of the strategic planning and decision making in real time.

Leon Caldwell, 2016; Adapted from Coffman and Beer, 2011
Public Health 3.0

- Breakthroughs in medicine, epidemiology, & lab sciences
- Uneven access to care and public health
- Infectious diseases

Public Health 1.0

- Public Health 2.0
  - Preventive services
  - Chronic diseases
  - Accreditation
  - Surveillance
  - Access to care

Public Health 3.0

- Social determinants
- Equal access to health, not just healthcare
- Cross-sector actions
Public Health 3.0:
“emphasizes cross-sectorial environmental, policy- and systems- level actions that directly affect the SDOH.” Karen DeSalvo, MD,MPH, HHS, Assistant Secretary of Health, September, 2016
The Accountable Health Communities Model is based on emerging evidence that addressing health-related social needs through enhanced clinical-community linkages can improve health outcomes and reduce costs. Unmet health-related social needs, such as food insecurity and inadequate or unstable housing, may increase the risk of developing chronic conditions, reduce an individual’s ability to manage these conditions, increase health care costs, and lead to avoidable health care utilization.

This model will promote clinical-community collaboration through:

• Screening of community-dwelling beneficiaries to identify certain unmet health-related social needs;
• Referral of community-dwelling beneficiaries to increase awareness of community services;
• Provision of navigation services to assist high-risk community-dwelling beneficiaries with accessing community services; and
• Encouragement of alignment between clinical and community services to ensure that community services are available and responsive to the needs of community-dwelling beneficiaries.
National Network to Eliminate Disparities in Behavioral Health (NNED)

www.nned.net

National Network to Eliminate Disparities in Behavioral Health

Striving for behavioral health equity for all individuals, families, and communities.

July is National Minority Mental Awareness Month

Jul 02, 2016

We come together this time of year in recognition of National Mental Health Awareness Month to keep building awareness of the importance of mental health and supports in every community. 

→ FULL STORY

RECENT NEWS

- 2016 Annual Tribal Health Conference Call for Award Nominees · Jul 25, 2016
- No Shame Day: The Siwe Project Erases Mental Illness Stigmas One Tweet at a Time · Jul 21, 2016
- Clinic Offers Combined Mental, Primary Health Services · Jul 19, 2016
- Pioneering Trans Writer Jan Morris on Gender, Identity, Belonging, and Integration of Body & Spirit · Jul 14, 2016
- American Indian & Alaska Native Mental Health Journal Issue on Strength-Based Approaches to Wellness · Jul 15, 2016

National Partner

- 2008: 60
- 2009: 129
- 2010: 323
- 2011: 464
- 2012: 541
- 2013: 685
- 2014: 756
- 2015: 802
- 2016: 897
- 1285 Affiliates

Total: 3,015
NNED Desired Goals

Strategies:
• Linkages
• Identify “Pockets of Excellence
• Infrastructure Support
• Capacity Building
  • e.g. Community Defined Evidence Project
• National Influence
• Coordinated Responses

Goals:
• Community & System Change

Ultimately:
• Behavioral Health Equity
Opportunities Through NNED

NNED on the Web. Interactive website with relevant hot topics, news items, calendar events, funding opportunities. Active social media presence on Facebook, Twitter, and Linked In.

E-newsletter with relevant news, partnership opportunities, and announcements of timely federal and foundation funding.

Professional development opportunity to receive training in evidence-supported and culturally appropriate clinical and consumer practices.

On-line collaborative space to share resources and intervention efforts.

Raise awareness about the importance of minority mental health.
Advancing Health Equity and Optimal Health for All

(E. Ehlinger, President. ASTHO 2015)

Triple Aim of Health Equity

- Implement Health in All Policies Approach With Health Equity as the Goal
- Expand Our Understanding of What Creates Health
- Strengthen the Capacity of Communities to Create Their Own Healthy Future

Implement Health in All Policies

Strengthen Community Capacity

Expand Understanding of Health
Asking the Right Questions is a Path to Health Equity

• What would it look like if equity was the starting point for decision-making?

• How would your work be different?

• How would you need to be organized and committed to reducing disparities and promoting equity in your work and in your workplace?