American College of Mental Health Administration

ACMHA ARM CHAIR REFLECTIONS

Reducing Disparities

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More than five years ago, the 2003 ACMHA Summit focused on the topic of reducing disparities in behavioral health services. As we welcome our country's first African-American President, it seems timely to reflect on the Summit and efforts since then to reduce disparities in behavioral health. It is also a particularly good time to present these issues to the incoming administration for their consideration.

The 2003 *ACMHA Summit on Reducing Disparities in Mental Health Services* had a significant effect on many of us; changing our views of the need for and how we can reduce racial and ethnic differences in access, utilization of services, and outcomes. The abstract to the proceedings noted: "The 2003 ACMHA Summit was an initial step… However, much more work remains to be done. The summit clearly demonstrated that the reduction of disparities requires a multi-level approach and multi-disciplinary leaders." [1] It challenged our assumptions, introduced us to best practices, and provided a framework for thinking about and implementing efforts to reduce disparities – from clinical practice to policy and research.

Building on the Surgeon General's mental health report[2] and the Institute of Medicine's "Unequal Treatment" report[3], the ACMHA Summit accomplished several specific things: participants addressed disparities in access, treatment, and outcomes from the perspectives of consumers, providers, purchasers, and researchers. We used the break-out groups in the Summit to develop specific strategies to reduce disparities by the different members of the delivery system - consumers, providers, payers, oversight agencies, and research/academics. Recommendations included increasing training, developing data standards, increasing research on disparities, funding demonstration programs, and increasing coordination among federal, state, county, and provider agencies.

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[1] See Dougherty Richard. "Reducing disparity in behavioral health services: a report from the American College of Mental Health Administration." Administration and Policy in Mental Health. 2004 Jan; 31(3):253-63.

[2] Department of Health and Human Services (DHHS). Mental Health: A Report of the Surgeon General. Rockville, MD, 1999.

[3] Institute of Medicine, "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care" National Academies Press, 2003.

We drew upon the experience and perspective of many ACMHA members including Leighton Huey, Francis Lu, Ken Martinez, Jerome Hanley, Josie Romero, and Ting Mintz and we attracted new speakers and members such as King Davis, Larke Huang, Arthur Evans, and many others.

In their keynote addresses, King Davis and Norman Sartorius made it clear that history and culture profoundly influence our perspectives on mental illness and the services we deliver. The Summit also continued the efforts of past years to expand the role of consumers and family members in the planning and conduct of the event. Participants heard from successful programs in New York's Chinatown district and the Hill District in Pittsburgh. Both programs succeeded in increasing engagement and retention of consumers because they were embedded in the existing health care delivery system or part of the community. Connecticut's initiative, presented by Arthur Evans, highlighted the role that states can play in advancing systems level research and performance measurement of contracts.

The Summit concluded with a challenge to SAMHSA and CMHS 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...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."

Change was slow immediately following the 2003 ACMHA Summit; yet significant shifts in advocacy and funding, within SAMHSA and among researchers, have been taking place in the last several years. Following the Summit, the multiple efforts of different advocacy groups became more focused and led to the creation of the National Alliance for Multi-Ethnic Behavioral Health Associations (NAMBHA). This group consolidated many of the efforts of other organizations and has increased the national impact of the work in service administration and research. Since 2006 NAMBHA has worked on a variety of projects; one of the most significant was a SAMHSA-funded initiative to create the National Network to Eliminate Disparities in Behavioral Health (NNED).[4] NNED was formed to eliminate the fragmentation of efforts to eliminate disparities in behavioral health. Meanwhile, based upon goals outlined in the President's New Freedom report, SAMHSA convened a Cultural Competency and Eliminating Disparities (CCED) work group. As a result of the work of the CCED work group, CMHS formally launched the Eliminating Mental Health Disparities (EMHD) external work group in May 2007.

The EMHD Initiative serves as the primary vehicle to develop and implement strategies at the federal level to reduce disparities. EMHD partners include NAMBHA and numerous others. With the creation of EMHD and NNED, the infrastructure has been created to begin to respond to the challenge issued at

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[4] See http://www.nned.net/index-nned.php/

the 2003 ACMHA Summit. I like to think, that ACMHA helped accelerate these efforts by convening consumers, families, federal and state officials, administrators, researchers, and other advocates from diverse ethnic and racial backgrounds to focus on an area of common concern. However, these groups have not been able to develop consistent funding streams. This threatens their missions.

Reflecting on the 2003 Summit from this armchair, several essential issues for our public behavioral health system emerge five years later:

First, through increased research efforts, we need to continue to better understand the reasons for disparity and the nature and scope of differences in treatment received. Three articles in the November, 2008 issue of *Psychiatric Services* document the growing interest in the research community to study the persistent "…inequalities in health and mental health in the wealthiest society in the world."[5] There are still many unanswered questions about the prevalence of mental illness and addiction, different types and rates of help-seeking behaviors, and different treatment outcomes for people from different racial and ethnic groups. We also need to objectively and speedily evaluate our current efforts, including the NNED and EMHD initiatives described above.

Second, our public programs need to routinely monitor access to and use of services by racial and ethnic groups. States have made good beginnings in this area, but much more work needs to be done. Until states and counties fully convert their data systems to encounter-based reporting, the progress will be slow and states, counties, and health plans will not be able to compare their performance to comparable jurisdictions.

Third, public officials need to be able to communicate with each other about disparity without blame and without defensiveness, with a common goal of improving access and services where we find the need.

For many of us, the focus on reducing disparities, rather than on increasing cultural competence, is a welcome shift. As a white, "over-educated" male, I have always wondered when I was culturally competent enough. I am sure it was not enough for some people, but it wasn't for lack of trying. I welcome the more outcome and data driven focus on disparities. Training and cultural competence are the means to the end rather than ends unto themselves. Improvement requires measuring service penetration and utilization rates, analyzing the reasons for differences in these rates, and identifying effective strategies to change the rates.

We are also not comfortable talking about disparities. Disparity and inequity are emotionally "loaded" terms in the public health system, whether we are referring to racial disparities, income disparities, or geographic funding

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[5] Ruiz, Pedro, "The Persistence of Disparities in Mental Health Care" Taking Issue Commentary. Psychiatric Services: v. 59, No 11: November 2008.

disparities. While funding inequities are usually the result of many years of provider, donor, county, state, and federal decisions, they are perceived as "unfair" and "someone" in power should fix it! Advocates and county governments often turn to states expecting funding to address disparities; states turn to the federal government in the same way. Public officials legitimately fear a public outcry for change, particularly since there is so little understanding of the reasons for the differences in access and utilization data. More research will help. Additionally, using a quality improvement approach can reduce disparities through incremental changes in clinical practice, finding new locations for services and making programmatic changes.

As the research grows and we develop an infrastructure for disseminating findings and best practices, I am increasingly hopeful that our vision from 2003 is closer to a reality: a vision of a comprehensive system that serves all individuals effectively, efficiently, and using person centered principles, regardless of their race or ethnicity. The Obama administration can help to speed our progress by taking the following actions:

1) maintain and strategically expand infrastructure support for efforts to reduce disparities by expanding funding for the current work of NNED, the CCED work group and EMHD;
2) increase public reporting requirements about access to and engagement in behavioral health services for different racial and ethnic groups through the National Outcome Measures and other block grant reporting requirements;
3) increase research funding, particularly on topics evaluating the impact of disparity reduction interventions on the services system; and
4) expand data driven quality improvement initiatives through expansion of the EMHD initiative to incorporate state and local initiatives. This should include quality improvement efforts, expanded learning collaborative, and the compilation of a broad based tool-kit of effective interventions to reduce disparities in access and outcomes at all levels of mental health delivery systems.