Transforming Behavioral Health Services: Diversity, Accessibility, Flexibility

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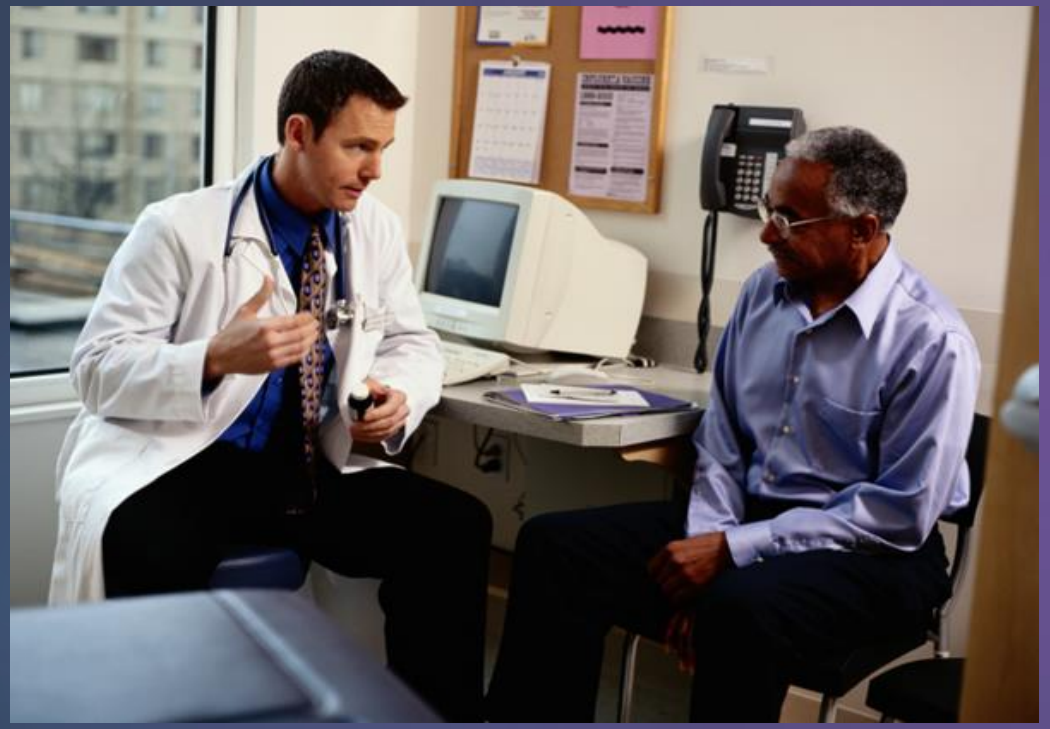
Disclosure

- I have no actual or potential conflict of interest in relation to this program/presentation.

Agenda

- Background on Behavioral Health Inequities
- Building a Diverse Clinical Staff
- Improving Access to and Quality of Behavioral Healthcare
- Innovations to Better Address the BH Needs of the Population

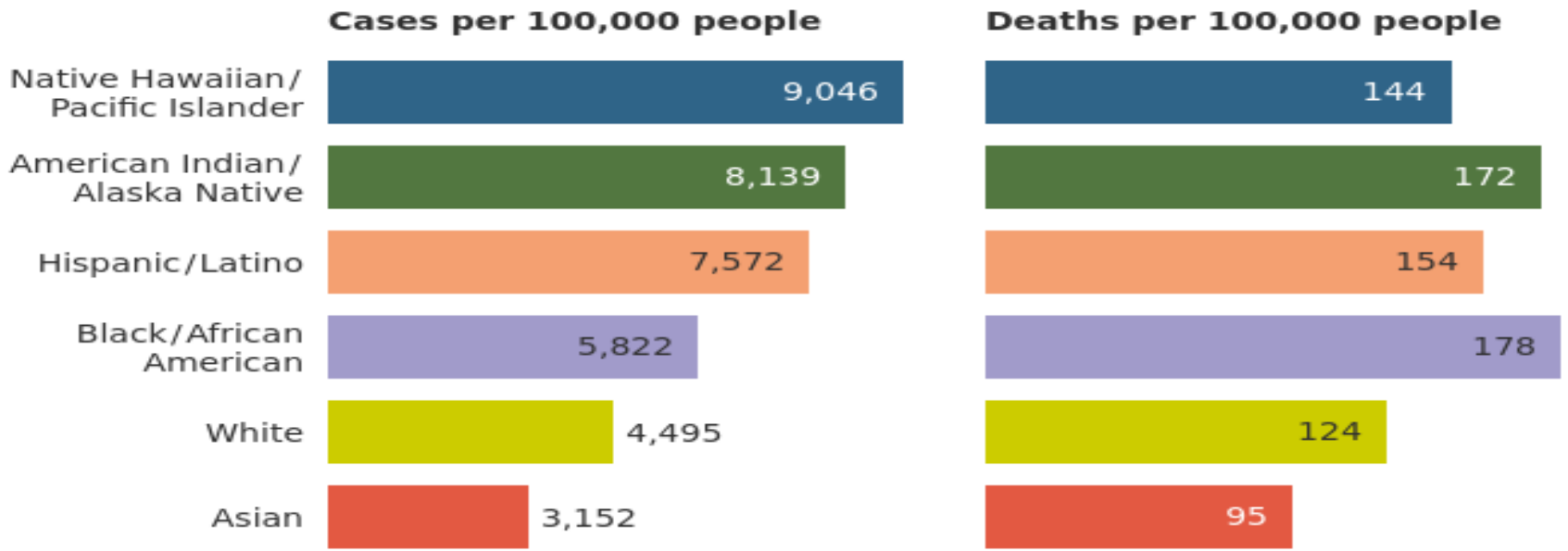


BACKGROUND ON BEHAVIORAL HEALTH INEQUITIES

Disparities in Behavioral Health Care

AHRQ reports that racial/ethnic minorities: have less access to mental health services, are more likely to use emergency departments, and are more likely to receive lower quality care. Poor access and quality contribute to poor outcomes, including suicide, low productivity, academic and employment underperformance, among racial/ethnic minorities (2018).

COVID-19 Health Disparities
Unequal risk of contracting COVID-19



Notes: Nationwide, 51 of 56 states and territories report race/ethnicity information for cases and 51 of 56 report race/ethnicity for deaths. Graphic includes demographic data from all states and territories that report, using standard Census categories where possible, and scaled to the total US population for each Census category. Race categories may overlap with Hispanic/Latino ethnicity. Some rates are underestimated due to lack of reporting of race and ethnicity categories for COVID-19 cases and deaths.

BOSTON UNIVERSITY

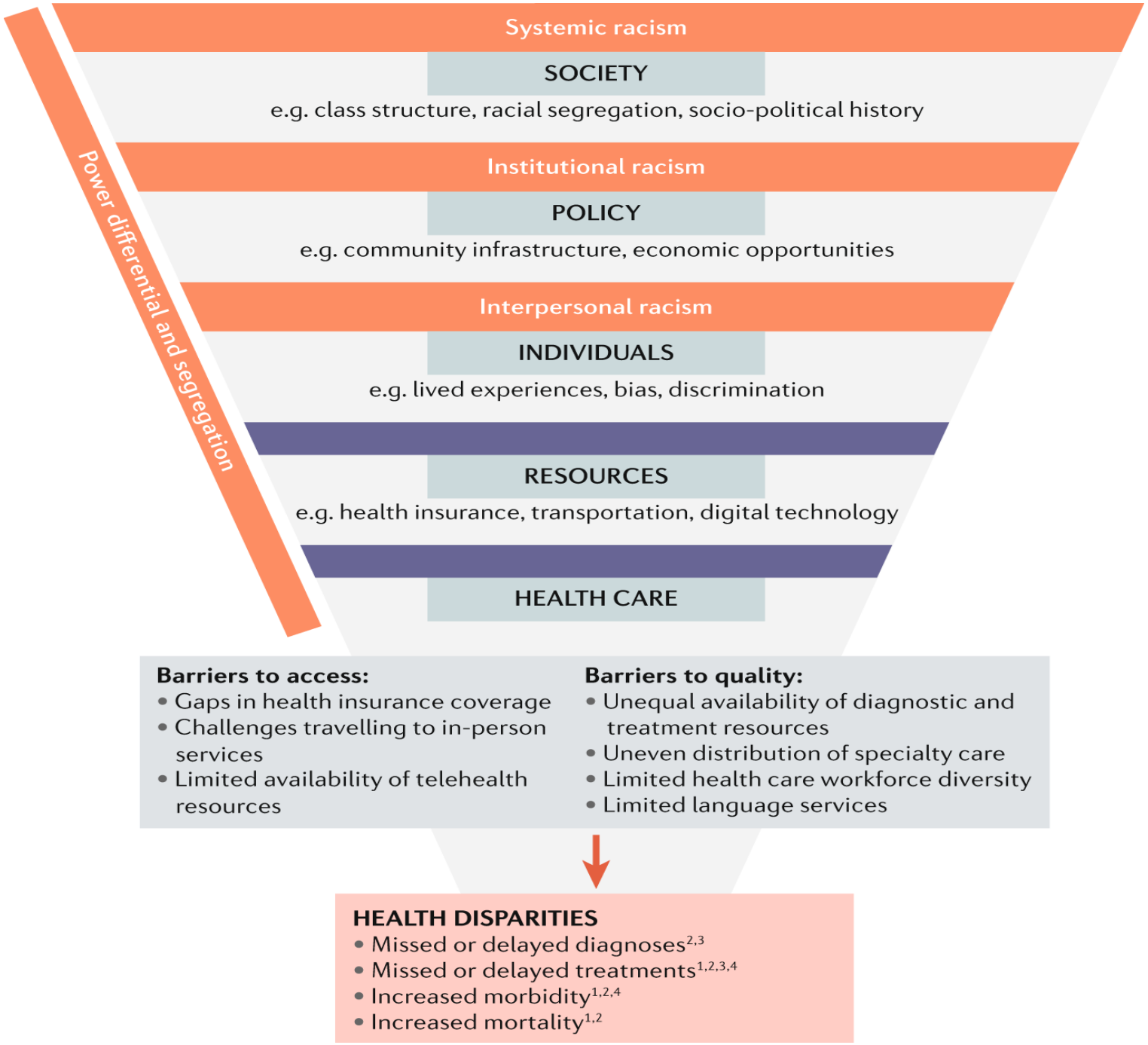
The COVID Tracking Project

https://covidtracking.com/race/infection-and-mortality-data

Great Unmet Need

- National Survey on Drug Use and Health Survey from 2019:
  - Only 45% of adults with any mental illness received mental health services
  - Only 10% of people ages 12 and older who had an SUD received substance use treatment
- Behavioral Health policy initiatives have made advances in achieving parity in financing, yet there is more to be done particularly for marginalized groups traditionally excluded from the MH and SUD care system

SAMHSA, 2020


Systemic racism
SOCIETY
e.g. class structure, racial segregation, socio-political history
Institutional racism
POLICY
e.g. community infrastructure, economic opportunities
Interpersonal racism
INDIVIDUALS
e.g. lived experiences, bias, discrimination
RESOURCES
e.g. health insurance, transportation, digital technology
HEALTH CARE
Power differential and segregation
Barriers to access:
• Gaps in health insurance coverage
• Challenges travelling to in-person services
• Limited availability of telehealth resources
Barriers to quality:
• Unequal availability of diagnostic and treatment resources
• Uneven distribution of specialty care
• Limited health care workforce diversity
• Limited language services
HEALTH DISPARITIES
• Missed or delayed diagnoses[2,3]
• Missed or delayed treatments[1,2,3,4]
• Increased morbidity[1,2,4]
• Increased mortality[1,2]

Structural Racism and Health Disparities: Reconfiguring the Social Determinants of Health Framework to Include the Root Cause (Yearby 2020)

- Social Determinants of Health Framework includes five key areas:
  - Economic Stability
  - Neighborhood and Built Environment
  - Health and Health Care
  - Social and Community Context
  - Education

- Yearby recognizes that structural racism is a contributor to health disparities, emphasizing the need for **multilayered approach to the SDOH framework to achieve racial health equity**

Advancing health services research to eliminate health care disparities (Wasserman et al., 2019)

Role of Patient Preferences: need to explore whether sources of patient preferences (ie: beliefs) can be modified by outreach or education to improve patient/provider interaction

Clinical Decision-making: lack of adaptation of guidelines for racial/ethnic groups; new research needed to explore how providers make decisions based on guidelines for patients

Stereotype, bias, and stigma: can contribute to unequal treatment of patients; need to examine effects of stigma & discrimination in health care settings and structural barriers that drive disparities

Patient-Clinician Interaction: need for evidence and data on how best to deliver culturally competent care & linguistically-tailored services; additional research on construct of "cultural competency"

BUILDING A DIVERSE CLINICAL STAFF BY LEARNING TO BE AND THINK LIKE THEM: TO BE IN THEIR SKIN

CHANGING PATIENT POPULATION

- Today, professional health and mental health care providers are increasingly required to interact with families whose race, culture, national origin, and family composition are different from their own.
- Since 2000, six out of every 10 babies born in New York City has had at least one foreign-born parent.
- In contrast to immigrants from Europe who arrived during the 19th century, most families that immigrated to US in last two decades have come from Latin America, the Caribbean, Asia and Africa.

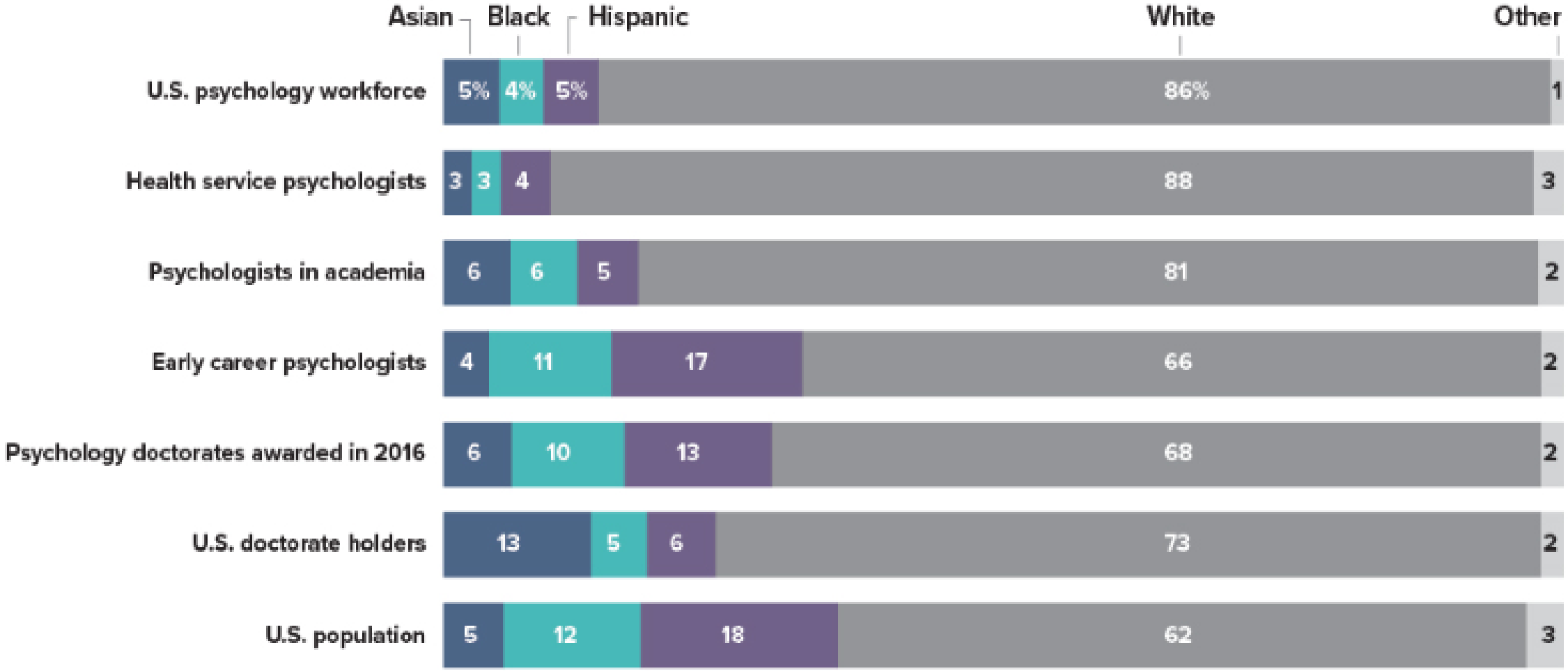
Addressing Different Definitions of the Problem

- These facts suggest that cultural differences will play a crucial role in the recognition of mental illness, the perception and intensity of stigma associated with mental health help-seeking, and the understanding of what might be considered mental health and appropriate mental health services.

- Cultural sensitivity and awareness are essential in recognizing diversity, but these factors rarely result in mental health professionals breaking completely free from their own culture to truly understand the world of diverse children and families through a different cultural lens.

- Cultural sensitivity and awareness should be helpful for recognizing the mental health provider's own assumptions, expectations, norms, etc. and to open the door to exploring how these correspond to those of "others" – that is their patients and families.

Diversity of the Psychology Workforce



https://www.apa.org/monitor/2018/02/datapoint

Challenges and barriers for non-English speaking families

- One third of the Latinx population in the U.S. speak English "less than very well" and are considered limited English proficient (LEP) (Pew Research Center, 2017).
- Among Latino and Asian Americans with mental health disorders, LEP contributes to disparities in access to care and longer duration of untreated disorders (Bauer, Chen, & Alegria, 2010).
- Barriers include lack of professional interpreters, use of informal ad-hoc interpreting, non-translated or incorrectly translated health materials, and resources that are not culturally appropriate (Floríndez et al., 2020)
- National Standards for Culturally and Linguistically Appropriate Services (CLAS): not enforced

Thinking of Culture at the Organizational Level

- Important to recognize the organizational culture for both how treatment will be done, whether evidence-based interventions are likely to be conducted, and their desired outcomes.
- To what extent does the way in which work is done in an organization reveal the organizational culture and influences the recognition of culture at other levels?

- Attention given to organizational culture as an entity that is shaped by and affects employees instead of as a ***dynamic process*** that is relevant to and influenced by the interplay of these employees and families/youth they work with.

Organizational culture is a "deep" or "super" construct that characterizes an organization.

More formal attention should be given to ways in which organizational culture mirrors, supports, and diminishes the role of these diverse families' culture at other levels.

Understanding their Neighborhoods

- Neighborhoods, schools and work environments also play a critical role in patient's mental health outcomes:
- Families living in high-risk neighborhoods might select strategies of childrearing that differ from those living in low-risk neighborhoods, constraining opportunities for social interaction and increasing isolation from peers and socialization activities.
- Neighborhood safety relates to risk for mental illness
- Neighborhood socioeconomic conditions correlate with suicide rates, violence, well-being, and behavioral and emotional problems

Culture at the Community/Society Level

- For many individuals, families, and even organizations, the local community IS as "macro" as it gets.
- Adoption from expectations, norms, values, goals, traditions, from a relatively small physical region is typical for most people.
- Most people, including mental health providers, have a difficult time truly understanding cultures that are far afield from their own experiences.

Thinking of Culture at the Family Level

- There's been a tremendous amount of effort/interest in family centered treatments.
- However, it seems rare that providers actually seek a full understanding of a family's current "culture" to examine roles, expectations, goals, "fit," etc. The way a family experiences treatment, wants to be involved in treatment, etc. are contingent upon the family's culture; yet rarely assessed.

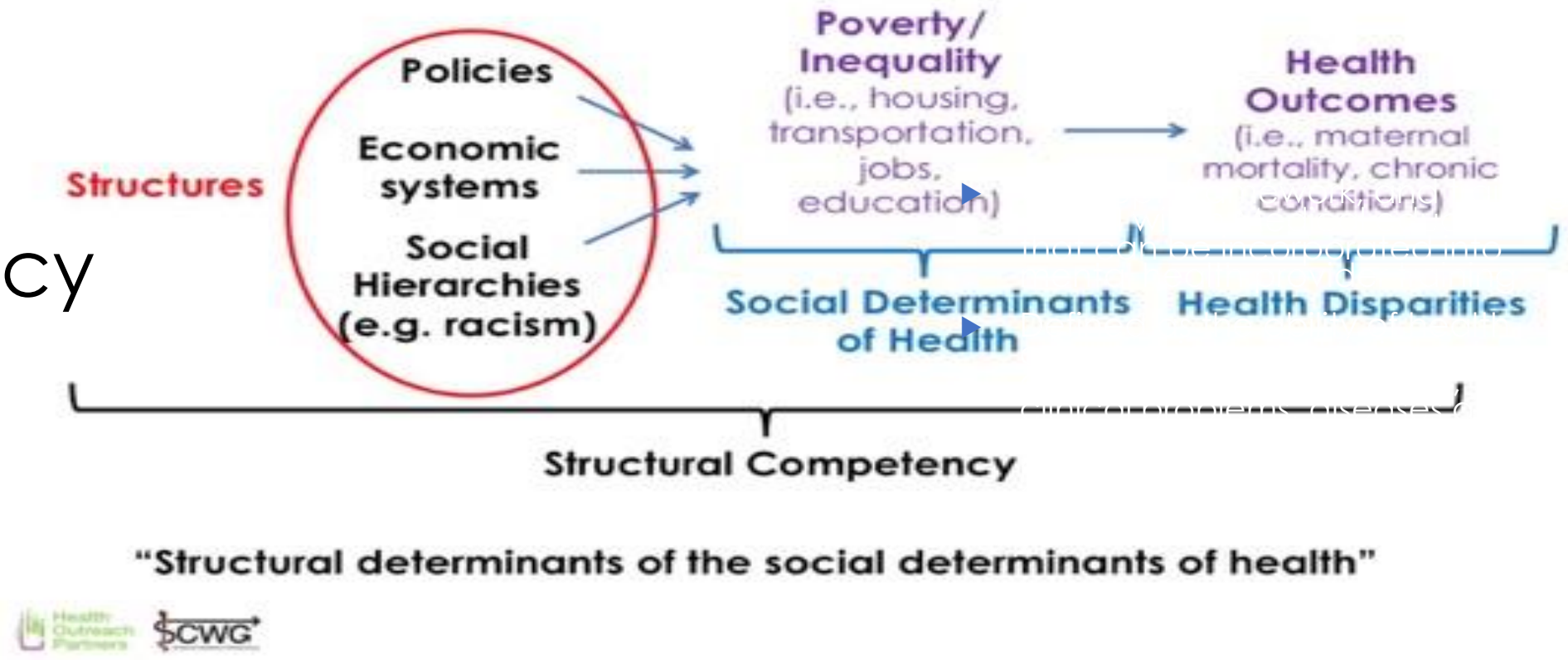
Highlighting the need for MH Services: Cost of MH Higher for communities of color

- **Greater mental health burden** can be best understood by **structural inequities** attributed to policy, law, governance, and culture. Greater poverty in communities of color. Less options to work remotely; unstable scheduling; low wages and benefits.
- Steer people of color to unfair experiences, **differences in opportunity and limits on social determinants**. Inequities negatively influence ability to cope with stress and to recover from MH.
- It is not only adults that suffer, but their **children** too who are more likely to **experience negative changes** in family relations (domestic violence, child maltreatment, withdrawal in close personal relationships, family conflict) and quality of parenting.

Structural vulnerability

- Quesada and colleagues (2011) application of structural vulnerability to health care: "**to expand and define more practically the diversity of forces, both external and internal to the clinical encounter, that can sabotage the health of patients** regardless of the conscious intentions of the caregiver or the patient. "
- "A patient's structural vulnerability is the outcome of a combination of:
  - **socioeconomic and demographic attributes** (gender, socioeconomic status, race/ethnicity, sexuality, citizenship status, institutional location)
  - **assumed or attributed status** (including health-related deservingness, normality, credibility, assumed intelligence, imputed honesty). " (Bourgois et al., 2017)
- "Operationalizing structural vulnerability in clinical practice and introducing it in medical education can help health care practitioners think more clearly, critically, and practically about the ways social structures make people sick."

Structural Competency



Source: Hansen, H., & Metzl, J. M. (Eds.). (2019). *Structural competency in mental health and medicine: A case-based approach to treating the social determinants of health*. Springer.

Structural Competency (Metzl & Hansen)

- 5-point model:
- Recognition of "structures that shape clinical interactions"
- Development of "an extra-clinical language of structure"
- Rearticulation of " 'cultural' presentations in structural terms"
- Observation and imagination of "structural intervention"
- Development of "structural humility"

SDOH- Factors Contributing to Health Outcomes

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider availability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
Debt	Parks	Vocational training		Discrimination	Quality of care
Medical bills	Playgrounds	Higher education			
Support	Walkability				

Health Outcomes
Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

Source: https://www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/

Structural Interventions to reduce and eliminate health disparities (Brown et al., 2019)

"**Structural interventions** attempt to change the social, physical, economic or political environments that may shape or constrain health behavioral and outcomes, altering the larger social context by which health disparities emerge and persist"

Workforce Recommendations

- To increase the **diversity of mental health workforce**
  - Offer **loan repayment programs** to underrepresented minorities
  - Invest in training opportunities to create the pipeline-CHWs & peers
- Increase behavioral health care providers knowledge and understanding of issues impacting their clients' lives
  - Require provider training on role of **structural racism**, social determinants and implicit bias

HSRA 2020; Hansen, Braslow & Rohrbaugh 2018; Yeager & Bauer-Wu 2013

IMPROVING ACCESS TO AND QUALITY OF BEHAVIORAL HEALTHCARE

National Academy of Medicine's Vital Directions for Health and Health Care: Priorities for 2021

- Health Costs and Financing-Challenges and Strategies
- Optimizing Health and Well-Being for Women and Children
- **Transforming Mental Health and Addiction Services**
- Actualizing Better Health and Health Care for Older Adults
- Infectious Disease Threats: A Rebound to Resilience

Alegría, M., Frank, R. G., Hansen, H. B., Sharfstein, J. M., Shim, R. S., & Tierney, M. (2021). Transforming Mental Health And Addiction Services: Commentary describes steps to improve outcomes for people with mental illness and addiction in the United States. *Health Affairs*, 10-1377.

BEHAVIORAL HEALTH CARE

By Margarita Alegría, Richard G. Frank, Helena B. Hansen, Joshua M. Sharfstein, Ruth S. Shim, and Matt Tierney

COMMENTARY

Transforming Mental Health And Addiction Services

ABSTRACT Even with great advances in behavioral health policy in the last decade, the problems of mental illness and addiction persist in the United States—so more needs to be done. In this article, which is part of the National Academy of Medicine's Vital Directions for Health and Health Care: Priorities for 2021 initiative, we describe the steps needed to improve outcomes, focusing on three strategies. We argue for transforming the behavioral health system to meet people where they are, decriminalizing mental illness and substance use disorders to facilitate recovery, and raising awareness of social context and social needs as essential to effective care. We call for supporting structures in the workforce and structures of accountability, outcome measurement, and more generous financing of behavioral health care. These steps have costs, but the enormous benefits of a major transformation in behavioral health policy far outweigh the expenses.

For the past fifty years the model for care and advocacy in the mental health and addiction field, usually referred to as "behavioral health," funds treatment programs and waits for "patients" with behavioral health conditions to arrive. The result is relentless unmet need. The National Survey on Drug Use and Health estimates that in 2019 only 45 percent of adults with any mental illness received mental health services and that only 10 percent of people age twelve or older who had a substance use disorder received substance use treatment—estimates that are consistent with those of the four previous years.[1] Recent behavioral health policy advances include achieving parity in financing and expansion of access to behavioral health care as part of the Affordable Care Act and other policies (see online appendix exhibit A).[2] Yet more needs to be done to address the persistently poor behavioral health outcomes for so many,[3] particularly for people of color, including immigrants; those with low incomes; and those from disadvantaged communities.[4]

Meanwhile, advances in neuroscience and clinical experience highlight the importance of early interventions to address risk factors for mental illness such as adverse childhood experiences.[5] These advances emphasize the importance of effective interventions during the early stages of a first psychotic episode[6] to counteract negative behavioral health outcomes. Improvements in these outcomes would be reflected in patient engagement and willingness to complete treatment, as well as in participation in mainstream society through employment, good relationships with families, and social connections for people with behavioral health conditions.[7] Achieving these ends requires an emphasis on prevention and equity and challenges the biomedical model with the need to shift to a community-based model that brings care to the person in need and focuses on the outcomes that matter most to them.

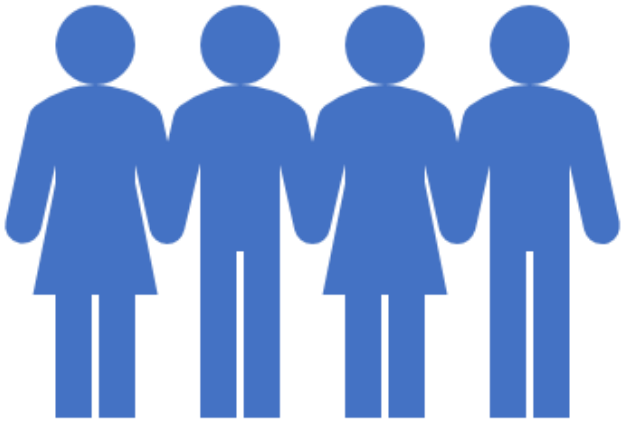
The coronavirus disease 2019 (COVID-19) pandemic and protests against racial injustice have called attention to systematic inequities in health and mental health outcomes,[8] creating

Change the Service Paradigm

Current State	Moving to where People Are
Individuals must find treatment	Treatment programs find those in need of Tx services
Patients must "prove" intent to engage before starting Tx	Invite person to Tx, allowing patients to engage and re-engage-CHWs/peers
Patients not given choices of what they want and need	Patients encouraged to participate in range of offerings accommodating to them
Patients discharged from treatment if they do not attend	Relapse recognized as part of disease process; addressed through intensified engagement, follow-up

What can paraprofessionals do?

- Paraprofessionals should not be seen as only facilitators who connect individuals to services but as part of the healthcare workforce
- Referred to by a variety of terms: CHWs, promotores, lay health workers, lay providers, indigenous paraprofessionals, peer support specialists, and natural helpers



Conduct outreach to facilitate entry into provider settings. "Bridge" between the community and care providers

Can provide auxiliary support of treatment delivery through case management and promotion of patient adherence to treatment

Provide lower levels of care to patients with less intensive needs

Can be responsible for the delivery of services as the sole treatment provider

Barnett ML, Gonzalez A, Miranda J, Chavira DA, Lau AS. Mobilizing Community Health Workers to Address Disparities for Underserved Populations: A Systematic Review. Administration And Policy In [Internet]. 2018 Mar [cited 2019 Jul 26];45(2):195–211.

Workforce infrastructure alignments of services to needs

- "A **more racially and ethnically matched workforce** are not only more likely to work with URM populations, but can help to **minimize disparities**, while also designing and **delivering culturally tailored programming** (Jordan 2020, citing Gainsbury, 2017).

Lack of outreach to engage individuals and retain them in care

- Help-seeking research has generally focused on recent service use among prevalent cases over relatively short time periods rather than on delays in initial treatment contact among incident cases over longer time periods

- Analysis of first treatment contact for depression in a nationally representative sample of people with a lifetime history of depression estimated that more than 80 percent eventually seek treatment, but that the **median delay is seven years.**

- The focus should be on doing outreach in non-traditional settings and screening to engage people who aren't being met.

Wang PS, Berglund PA, Olfson M, Kessler RC. Delays in initial treatment contact after first onset of a mental disorder. Health Services Research. April 2004;39(2):393–415.

Community and Home Outreach

- Leverage the unique position of **Community-Based Organizations** to offer prevention, access to early identification and treatment of behavioral health conditions (Rusch, Frazier & Atkins 2015)
  - Staff under supervision of licensed professionals can administer preventative programs and treatments
  - Trusted institutions in community, offering wide range of social services
  - Often place for care for non-English speaking minority groups

Home Visits

Can aid in identifying unmet behavioral health needs

- Evidence points to home visits to effectively treat maternal depression and improve behavioral health needs among families (Goodson et al., 2013)

Meal delivery services for older people serves critical gap in preventing malnutrition as well as meeting behavioral health needs

- Aids in reducing isolation or loneliness experienced at high rates throughout this demographic group (NASEM, 2020)

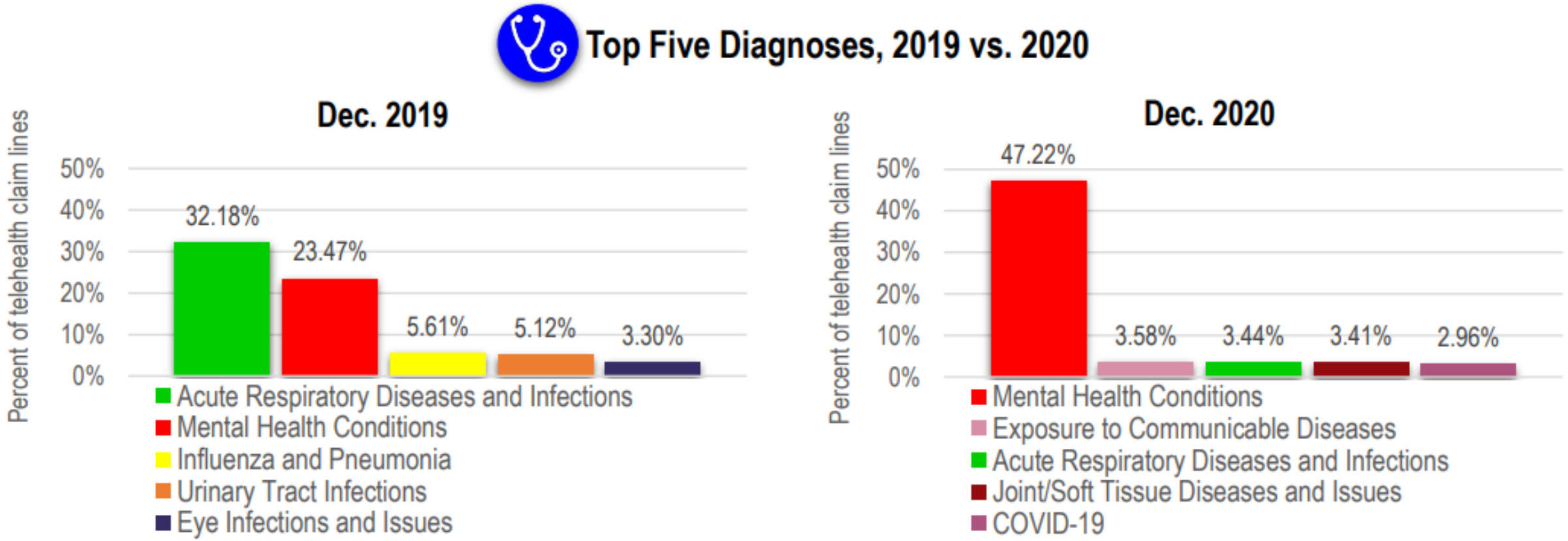
Accountability and Outcome Measurement

- Recovery Capital
- Substance use and sobriety
- Global psychological health
- Global physical health
- Citizenship and community involvement
- Social support
- Meaningful activities
- Housing and safety
- Risk-taking
- Coping and life functioning
- Recovery experience
- ARC total score

Innovations in Behavioral Healthcare

Telehealth & COVID-19

- **Mental health condition was number one telehealth diagnosis** in every region since March 2020



FAIR Health 2020

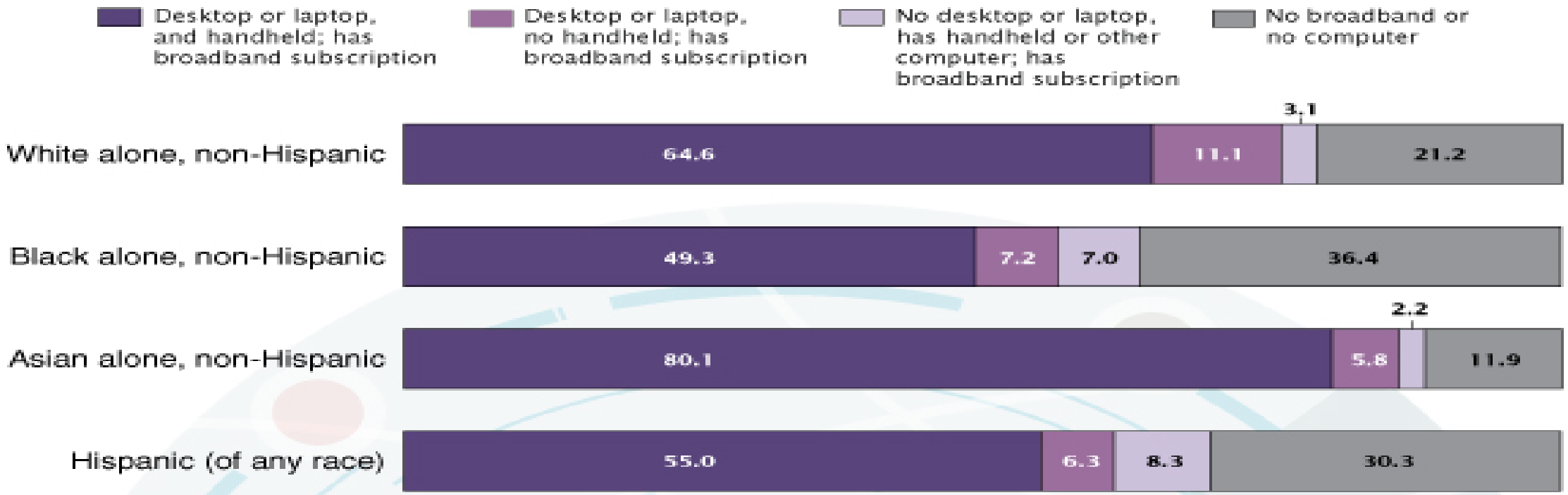
Telehealth

Delivery of behavioral health services via telehealth have been shown to be comparable to receiving in-person care (Hubley et al., 2016)

Modality of delivery meets the needs of homebound individuals, or those with other limitations that make it difficult to seek out care

Barriers to widespread adoption include reimbursement issues and privacy issues

Percentage of Households by Broadband Internet[1] Subscription, Computer Type, Race and Hispanic Origin



[1] Broadband internet refers to households who said "Yes" to one or more of the following types of subscriptions: DSL, cable, fiber optic, mobile broadband, satellite or fixed wireless.

Note: Estimates may not sum to 100 percent due to rounding.

United States Census Bureau

U.S. Department of Commerce
Economics and Statistics Administration
U.S. CENSUS BUREAU
census.gov

Source: 2015 American Community Survey
www.census.gov/programs-surveys/acs/

Mobile Health Clinics

- Provide screening, behavioral health medication management, referral and timely access to behavioral care (Yu et al., 2017)
- Function as an accessible and cost-effective outreach mechanisms by which to deliver care to underserved yet high need populations

Integrated Care: A Strategy to Reduce Disparities

- Comprehensive, multidisciplinary approach to health care proven to be effective in detection and management of mental disorders (Sanchez et al., 2016)

- Potential savings of $26-$48 billion annually via integration of general medicine and behavioral healthcare (Hoge et al., 2014; Sanchez et al., 2016)

- Lack of studies focusing on integrated care for racial/ethnic minority groups and people with Limited English Proficiency of concern given evidence suggesting benefits of integrated care for improving quality for minority populations (Sanchez et al., 2016)

Neighborhood-Level Factors & Integrated Care

- National study examining neighborhood-level access to geographically-proximate BH and primary care services found that:
  - Primary care physicians in rural areas were 20.1% more likely not to have geographically-proximate behavioral health services compared with physicians in urban areas
  - Primary care physicians practicing in communities with increased African American and Hispanic populations (compared with Whites) had less geographically proximate behavioral health services

- To improve patient access to behavioral health services, need to incentivize behavioral health professionals to practice in these communities and/or equip primary care providers with capacity to provide BH services
  - Ideally BH services would be fully integrated into primary care clinics to help defragment health care and address complex needs of vulnerable communities

Wielen et al., 2015

Components of the Next Generation of Integrated Care (Ross & Greenberg 2020)

- Qualitative data gathered from focus groups identified several key barriers:
  - Need for **broader adoption of integrated care**
  - Difficulty **replicating existing models** in other practice settings
  - Restrictions in the **flow of information** across different types of care providers within organizations, need for payment mechanisms to support integration
  - **Increased transparency** about type of BH service and provider types reimbursed by which payer

A Call to Action

- **We already have a lot of knowledge of what we need to do and models of how it can be done, but we are missing the action**.

- We need to move away from focusing so much on behavior change of individuals to how to use research and practice evidence to take on needed actions.

- This might require building interorganizational and multisectoral partnerships to connect to supporters in policy, grassroots movements and advocacy to carry it through.

Recommendations

Interpersonal Level: Connecting to Resources

- **CHWs can successfully deliver evidence-based treatments**, tackling personnel shortages, increasing diversity, and addressing the lack of bilingual/bicultural clinicians as a potential strategy to reduce disparities.

- **Peers, or people with lived experience** with BH conditions, have long been a critical support to each others' recovery

Alegria et al., 2021; Eddie et al., 2019

Community Level: Building & Strengthening Networks

- **Academic-community partnerships** can help lay the organizational groundwork to move treatments to CBOs
- Build collaborative **provision of prevention treatments in community-based organizations (CBOs)** by community health workers .
- Include **people with lived experience in planning resource allocations** with decision-making roles.

Alegria et al., 2021; Rubin et al., 2016

Community Level: Targeting Social Determinants of Health

- Job instability: fixed times, ensure equity, training in the job
- Target the built environment to be safe-as much as possible eliminate neighborhood violence.
- Mobilize affordable housing initiatives and provide support to mitigate evictions.
- Increase school-based mental health service: the number of psychologists, counselors, nurses, social workers, and other health professionals in schools

Policy Level: Opportunities for Equity

- Reinstate **Deferred Action for Childhood Arrivals (DACA) program and review Temporary Protected Status (TPS)** designations
- Earmark funds for the next round of **PPP loans specifically for minority-owned businesses** and businesses in high-density minority neighborhoods.
- Launch a **linguistically and culturally appropriate campaign for minority business** owners to provide technical assistance about eligibility guidelines, the application process, and loan forgiveness requirements.
- Poverty: increase wages, NAM report on how to best deal w child poverty
- Strengthen resources in diverse communites-**strengthen Medicaid home and community-based services** (for example, school and community-based suicide prevention programs)
- Increase Marketplace enrollment by **extending open and special enrollment opportunities** and increase Marketplace subsidies

Ong et al., 2020; Musumeci , Watts & Chidambaram 2020

Thank You!

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