

THE



COLORADO TRUST

A GRANTMAKING FOUNDATION

POLICY BRIEF
on

MENTAL HEALTH DISPARITIES

IN COLORADO

INTRODUCTION

INTENT & CONTENTS

The *Policy Brief on Mental Health Disparities in Colorado* was commissioned by The Colorado Trust to inform its ongoing grantmaking activities related to advancing quality mental health care for the people of Colorado. It is based on an extensive literature review on mental health disparities, input from community members and an advisory group comprised of Colorado community mental health leaders (see *listing on back page*), as well as recommendations received from participants in the 2006 Colorado Mental Health Disparities Summit.

IMPACT & OPPORTUNITIES

Good mental health enables individuals from all racial and ethnic backgrounds to pursue healthy relationships, advance their education, succeed in the workplace and cope with adversity. The consequences of inadequate or inappropriate mental health services are serious, resulting in such things as an overrepresentation of communities of color in government systems like juvenile justice, criminal justice and child welfare; decreased productivity in the workplace; increased homelessness; and increased physical health care costs. The effect of mental illness on both quality of life and economic productivity exceeds many physical illnesses, such as heart disease and diabetes. Impacts on quality of life include failed relationships, significant dysfunction and distress, suicide and suicidal ideation, and limited ability on the part of parents to care for their children. And, lost productivity due to mental illness cost U.S. employers \$105 billion in 1990 alone.

A successful mental health system serves the diverse needs of different racial and ethnic communities by working with providers who are linguistically and culturally competent. It also integrates culturally-traditional and -specific services, and providers into the mainstream system to address the mental health needs of communities of color within the broader context of their lives.

UNDERSTANDING DISPARITIES

Unlike health disparities, studies have shown minimal true differences in incidence and prevalence rates of mental illness across racial and ethnic groups. Although there is a lack of effective data on mental health disparities, the data show differences in access and utilization of mental health services across ethnic groups. Additionally, the study of historical and current trauma has connected historical genocide, assimilation, oppression and disparate treatment to such symptoms as depression, suicidal thoughts, anger, anxiety, low self-esteem and difficulty in both recognizing and expressing emotions.

ACCESS AND UTILIZATION BARRIERS

What existing data do show is that – due mainly to a lack of culturally-ethnic providers and relevant treatment – there exists numerous barriers to both access and utilization, specifically:

- A lack of access to services due to systemic factors, such as the unavailability of private insurance, lack of mental health coverage in health plans, limitations of public insurance programs, unavailability or lack of funding for culturally-specific services and the geographic location of mental health services
- A lack of knowledge of available services
- Underutilization of psychiatric and psychological services
- Problems with treatment engagement and retention
- Misdiagnosis, premature termination of treatment and self-discharge
- Culturally-ethnic inappropriate treatments and over-use or -prescribing of medications
- Very high rates of substance use disorders and suicide
- Increased physical symptoms of mental illness (i.e., somatization)
- Limited availability of interpreters and linguistically competent providers and culturally-traditional or -specific providers.



POLICY RECOMMENDATIONS

Many of the barriers that lead to mental health disparities can be addressed through mainstream, as well as culturally-traditional and -specific services with policy changes in financing and systems integration, education and direct service delivery, and data and research.

FINANCING AND SYSTEMS INTEGRATION RECOMMENDATIONS

The policy issues most frequently identified by participants at the 2006 Colorado Mental Health Disparities Summit were financing and integration. Integrated financing includes reimbursement practices of culturally-traditional, indigenous, faith-based or alternative services within the mainstream mental health system. Participants felt this could be addressed in a variety of ways, including the development of:

- Legislation to support payment for culturally-traditional and alternative services
- Methods for integrating culturally-traditional services within mainstream service delivery
- An expanded definition of health care that includes holistic health care services integrating mind, body and spirit in the reimbursement practices of public and private insurance
- Pilots to demonstrate success of culturally-traditional or alternative services.

Reimbursement and integration of culturally-traditional and other alternative services has been demonstrated in other states and is supported by the literature, including:

- In 1998, the Navajo Nation and Carl T. Hayden Medical Center agreed to reimburse traditional ceremonies through the Veteran's Administration.
- The Yup'ik and Cup'ik Eskimo of Southwest Alaska fund tundra walks and time with elders, as well as culturally-traditional treatments of mental health and substance abuse, through Medicaid.
- Some social work and divinity schools provide cross training to increase the capacity of clergy and social workers to identify and provide mental health services within churches.
- Cultural brokers serve as a bridge between mainstream services and communities of color, and may help guide the mental health system in its efforts to enhance services.

Summit participants recommended improving systems integration by removing financial and regulatory barriers, providing incentives, encouraging collaboration and rewarding communities that integrate and utilize culturally-traditional services and best practices. Research supports integration of services across primary health care,

mental health care, substance abuse treatment, education and other social services and systems of care to meet the individualized needs of communities of color, as follows:

- Recent research strongly supports integrated treatment, with services provided through one centralized provider, or a team of providers, to ensure consistency in treatment planning and coordination as the best treatment response.
- Specific to diagnostic issues, mental and primary health care providers need to be trained to recognize physical symptoms of mental illnesses. Primary care physicians should be trained in early detection and treatment and be ready to help patients access services.
- In Colorado, schools partner with regional mental health centers and private therapists to provide onsite services. A Wisconsin model provides training in education-based mental health interventions for therapists located in schools.
- Policies that address mental health disparities by supporting social factors, such as Section 8 housing assistance programs and the Earned Income Tax Credit, have been shown to help in the recovery of people with mental health needs.
- Systems of care create an integrated, holistic, family centered, individualized and culturally-responsive approach that build bridges between different systems and natural supports, providing services in a cultural, family and community context for individuals.

Additional financing and integration areas identified by Summit participants included:

- **Completing a cost-analysis study to look at the implications of health care parity** (equal coverage for mental health and behavioral services with physical health services) through public and private financing streams. The study could help demonstrate the need for an expansion of Colorado parity laws. A study on Vermont's parity law found improvements in access to outpatient mental health services, reduction of spending on mental health and substance abuse services, and no consequent increase in employers dropping coverage.
- **Addressing financing issues for mental and physical health care services for offenders** (individuals convicted of a state felony) transitioning out of corrections who currently are ineligible for public health insurance. Without such health coverage, offenders would not be able to receive health care services and may purposefully return to correctional facilities. In other states, including New York, Massachusetts and Texas, re-entry programs that provide continuity of medication and access to health care after release reduce recidivism and improve individual outcomes.

EDUCATION AND DIRECT SERVICE DELIVERY RECOMMENDATIONS

Summit participants identified the need to enhance education and expand the cultural competency of the current and future workforce at all levels of care. Recognizing that Colorado's cultural competency standards are limited, participants recommended:

- Re-introducing and strengthening the 2006 cultural competency legislation (Senate Bill 2006-111) by incorporating enhancements to higher education cultural competency curricula and developing markers for progress toward a more culturally competent workforce.
- Forming a community-based cultural competency board to help develop legislation to minimize the negative implications for communities of color, and review and develop future legislation that is culturally competent.
- Enhancing curricula and developing minimum standards for cultural and linguistic education competency – as validated by the research – to:
 - Recognize the historical and socio-political implications that are inextricably linked to the mental health and well-being of communities of color and the implications for diagnosis, treatment and delivery of culturally appropriate care.
 - Ensure that minimum standards, certifications and regulations for cultural and linguistic competency are clearly articulated in contracts and other agreements between providers and funding agencies. For example, Colorado currently has no certification or other regulation of interpretation and translation services, resulting in the quality and knowledge of interpreters and translators varying widely throughout the system.
 - Assist immigrants' adjustment to American society and the tremendous quality of life improvements that result from appropriate, early diagnosis and treatment of mental illnesses.

Participants also felt that creating a more diverse workforce was necessary to enhance the mental health of communities of color. In addition to the integration of culturally-traditional and alternative providers into the mainstream mental health system, other recommendations to improve services for communities of color and decrease mental health disparities include:

- Recruitment of more psychiatrists, psychologists and other mental health practitioners from diverse racial and ethnic backgrounds. States such as Florida, Ohio and Virginia have developed effective recruitment programs for providers of color.
- Increased reliance on social workers and nurses to expand the number of racial and ethnic minority, and female mental health workers, as well as flexible use of non-physician providers, including reimbursement policies and quality indicators.



“The teachings of our ancestors are very important in keeping the circle whole. These teachings guide the delivery of care in a more holistic and less individualistic way. The collective approach works because if one person is sick in the family, everyone is sick.”

DATA AND RESEARCH RECOMMENDATIONS

Summit participants recommended convening diverse stakeholders to develop culturally appropriate guidelines.

Stakeholders – including universities and community colleges, state agencies, providers and communities of color – would develop the guidelines with community input and participation, and use them to enhance data collection, research, evaluation and grant processes. This is key, as research findings show that:

- Historical neglect of cultural issues by researchers has resulted in minimal scientific knowledge focusing on mental health differences by culture, acculturation and generational status, race or ethnicity demonstrating the need for improved research. In Colorado, similar issues have resulted in some information being available, but gaps exist due to attempts to simplify thinking by grouping people of color into larger racial and ethnic categories, and the inability to capture data related to acculturation and culturally-specific services.
- To incorporate cultural and linguistic issues fully, research of quality mental health must include active collaboration and participation of communities of color at every stage of research – in the development, analysis, review, recommendations and dissemination. Feedback mechanisms for researchers should also be included to help them gain information and share it with communities so that they, in turn, can improve services. For example, in the aftermath of Hurricane Katrina, the Colorado Division of Mental Health Services created a partnership between formal and culturally-traditional mental health providers and subcontracted with the Black Psychologists Association to conduct a needs assessment.

In addition to the above recommendations, Summit participants identified a range of other policy recommendations for further exploration. The full report, *Mental Health Disparities in Colorado* (available at www.coloradotrust.org), explores these recommendations.

Policymakers, providers, government and other community leaders and stakeholders are encouraged to review all of the issues and recommendations as they work together to identify comprehensive policy solutions to address mental health disparities in Colorado.

PLEASE NOTE: *To view the citations from the extensive literature review used for this Policy Brief and the full report, please see the on-line versions of these reports (www.coloradotrust.org).*



THE COLORADO TRUST *is dedicated to advancing the health and well-being of the people of Colorado.*

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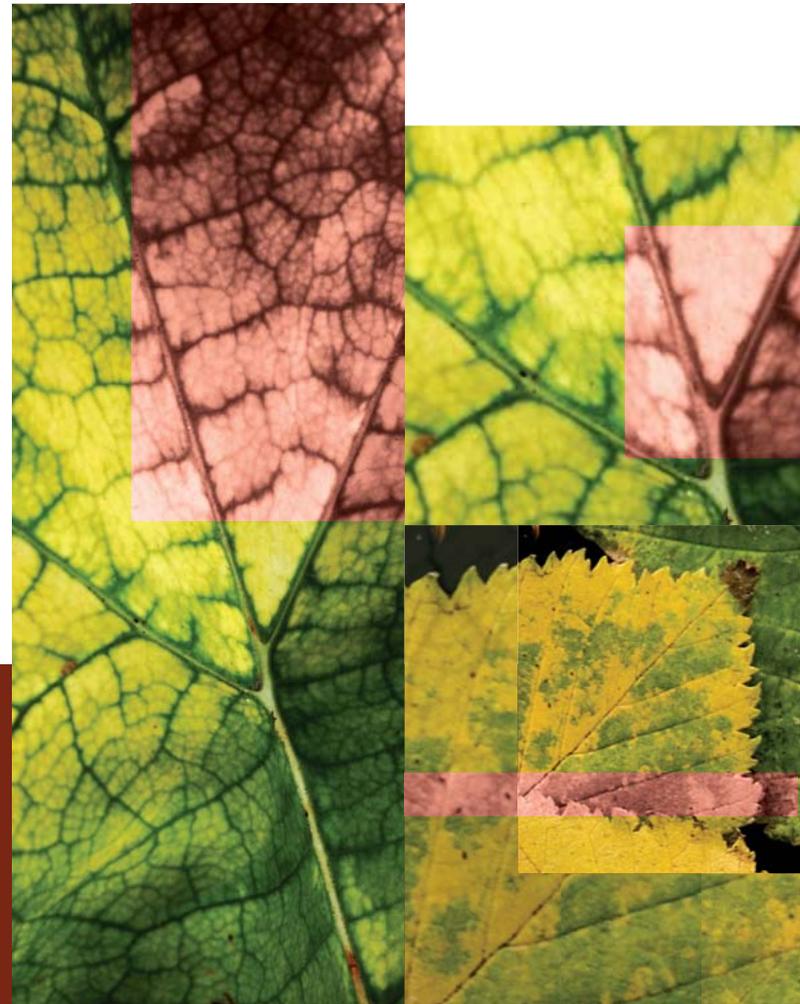
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