# THE BEHAVIORAL HEALTH CARE SYSTEM OF THE FUTURE:

## Caring for a Culturally and Linguistically Diverse Population

*Background Paper for the ACMHA Summit: 2010*

Prepared by Vivian H. Jackson, Ph. D., LICSW
ACHMA Diversity Committee
Affiliation: National Center for Cultural Competence and the National Technical Assistance Center for Children's Mental Health, Georgetown University Center for Child and Human Development, Washington, DC.

One of the factors that will impact the nature of the behavioral health care system is the composition of the service population. The United States of America is becoming a substantially culturally diverse nation, due to the progressive aging and low birth rate of European origin population, lower ages and increasing birth rates of non-European minority group, and rise in immigration from Latin America, Asia, and Africa (Pumariega, 2009). However, while this diversification is taking place, there is a persistence of disparities in mental health care experienced by those in currently and historically marginalized cultural[1] groups. How shall the behavioral health care system recreate itself to link the science, the service infrastructure, service delivery process, and providers to meet the unique needs prompted by the changes in the demography of this nation?

[1] The phrase "currently and historically marginalized groups" is used to include groups marginalized by virture of race, ethnicity, national origin, language spoken, immigration status, religion or other faith community, sexual orientation, gender identity and expression, disability, etc. In some cases the demographics are changing, as in race, ethnicity, and language. In other cases, the numbers may not have changes, but the groups are more visible and open in claiming their identity, as in sexual orientation, gender identity and expression, and disability.

## Demographics

In 1960 85% of the population was white non-Hispanic, in contrast to 67% in 2005 with a projection of only 47% in 2050. The Census Bureau (2008) projects that by 2023 more than half of all children will be in groups defined by the Census Bureau as minority - all populations except non-Hispanic, single race whites. By 2020 Latinos will account for one of every three persons born in the US and Asian Americans will represent the fastest growing ethnic category in the group (Alegria, et al., 2004).The analysis by the Pew Research Center (Passel and Cohn, 2008) indicates that 82% of the growth in population in the United States in this time period will be due to increased births for immigrants and their U.S. born children and grandchildren. This report provides the following key projections:

- In 2050 the immigrant population in the US will be nearly 20% as compared to 12% in 2005.
- The Latino population will make up 29% of the US population as compared to 14% in 2005
- Births in the US will play a growing role in Hispanic and Asian population growth, and the birthrates of non Hispanic, single race whites will decline.
- In 2020 Non-Hispanic whites will be 47% of the population as compared to 67% in 2005
- Blacks will remain 13% of the population over this time period
- Asians will grow to 9% of the population from 5% in 2005.

As of 2008, approximately 90% of individuals immigrating to the US came from countries and regions of the world outside of Europe. Mexico represents the source of one third of this immigration, while South East Asia represents about 27% and Central America about 10%. Of these, 52% of this foreign born population speaks English less than “very well” (OMH, 2010). Even with the recent drop in immigration from Mexico, there is still an expectation of significant growth in

the percentage of the population of immigrants and of immigrant descendants. (Passel and Cohn, 2008, Passel and Cohn, 2009)

Within the country, there are variations in population distribution. Already the District of Columbia, Hawaii, New Mexico, California and Texas are now “majority-minority” states in which more than 50 percent of their population is made up of people other than single race non-Hispanic whites. (OMH, 2010).

These demographic shifts have implications for the general workforce. The Bureau of Labor Statistics predicts that 41.5 percent of the US workforce will be members of racial and ethnic minority groups within the next decade. Employers have a vested interest in the impact of poor health including behavioral health on worker productivity (OMH, 2010).

As the minority become the majority issues of health equity becomes a practical mandate for all – loss of economic capital, loss of human intellectual and leadership capital, and social instability (OMH, 2010). The mental health aspect of this dilemma is significant especially as one considers the impact of depression alone as a major source of disability.

## Disparities

The Surgeon General’s Supplement to Mental Health on Culture, Race, and Ethnicity(2001) noted that racial and ethnic minorities have less access to and availability of care, receive generally poorer quality mental health services, experience a greater disability burden from unmet mental health needs, and are underrepresented in mental health research. Inaccurate diagnoses, inappropriate medication choice and medication dosage continue to be reported for all racial and ethnic minorities. Access continues to be a problem for these groups, particularly for those who do not speak English as their primary language. (Primm and Ruiz, 2010). In general

there continues to be an underutilization of psychiatric services, problems in treatment engagement and retention, over-diagnosis of schizophrenia among African Americans and depression among Latinos, inappropriate use of antipsychotics among African Americans and Latinos (higher doses among African Americans and lower doses among Latinos), and higher rates of substance use disorders and death by suicide among Native Americans. Further there is higher diagnosis of solitary conduct disorder and fewer diagnoses of anxiety disorders, substance abuse disorders and personality disorders for African American youth and Latino youth than white youth, and more frequent involuntary commitment, even though they have the same behavioral and symptom presentation (Pumariega, 2005).

The solid comprehensive data is limited, but see Primm and Ruiz (2010) for a review of existing research. One example of efforts to correct that dilemma is the National Latino and Asian American Study, funded by NIMH, which provides comprehensive baseline data on the prevalence of mental health disorders and services use by Latinos and Asian Americans as compared to non-Hispanic whites (Alegria, et al., 2004). The 2007 National Survey on Drug Use and Health noted that African Americans were less likely to receive prescription medications and outpatient services than whites (OMH, 2010). The Youth Risk Behavior Survey of the CDC reports that Latino and African American youth now have significantly higher rates of suicidal ideation and attempts compared with white youth (Pumariega, 2009). More effort is required to fully understand the experiences of these populations and other marginalized groups who experience disparate care as compared to mainstream America.

Jackson (2008) offers five major categories to track and analyze the experience of populations to better understand the nature of the disparities that exist in various communities:

Availability - Raises questions of existence of the service

- Does the service exist where people live their lives (live, work, study, play, shop, worship, etc.)? If so, are the services in adequate supply?

Accessibility -Raises questions of ease and convenience to obtain and use the services

- Referral process, wait time for appointment, wait time for service, hours and days of operation, travel time, travel access- by car, parking, public transportation – routes (any transfers? How many?, costs, availability, schedule, cab – ease of getting, costs, physical accessibility, child care, language, interpreters, translation)

- Consider the system within which the services are made available – private/public, health, mental health, criminal justice, child welfare, school, employer/workplace. Do these systems impose processes that facilitate or inhibit access to services?

Affordability - raises questions of the costs to consumer and financial viability of service provider

- Out of pocket expenses to consumer - pricing and pricing policy [e.g., sliding fee scale, co-payments, deductibles, exclusions

- Ability to acquire third party coverage – eligibility rules, administrative process/requirements to document eligibility (e.g., birth certificates with raised seal, rent receipt in own name) – relationship between multiple funding streams

- Level of adequacy of direct funding to service provider from local, state, federal authorities to support adequate supply of quality services (direct grants and contracts, fee scale, case rate, capitation rates)

Appropriateness - raises questions of correctness of service offered/provided for prevention and treatment

- Screening and assessment tools and processes take cultural issues into account in the construction, implementation and analysis

- Diagnoses are accurate and appropriate for context of population

- Interventions including medications are designed to achieve optimal outcomes for the context of the recipient of services (consider dosage, intensity of service, duration of services, location of service such as home, facility, school, church, etc., level of restrictiveness of care, etc.)

- Communicated within the language that is meaningful to the service recipient for the nature of the service (Title VI compliance)

- Outcomes are outcomes that provide relief from signs and symptoms of distress, including interpersonal and social functioning AND reflect outcomes that are important to the person receiving service based on cultural perspectives

Acceptability - raises questions of the degree to which the recipient of services believes that the services are congruent with cultural beliefs, values, world view

- Services offered within the context of the norms and values of the cultural group – including who is to be included or not included in decision making
- Use of persons that the cultural group deems as appropriate service providers – by race/ethnicity, discipline/education, western or nonwestern provider indigenous, sexual orientation/gender identity
- Role of stigma within the cultural community
- Demonstration of respect and honor of norms and values

These factors highlight the various areas in which there are different experiences of mental health care. The correction of these issues requires an understanding of the causal factors related to disparities in mental health care as discussed in the next section.

## Causal Factors for Disparities in Mental Health

There are multiple reasons for the disparities that exist. The broad explanation rests in the social determinants of disparities. Institutionalized racism, discrimination and prejudice against marginalized populations contributes to the cause and perpetuation of mental health disparities, as manifested by limited availability of services, lack of access, inadequate investment in care, inadequate preparation of providers of care, inadequate diversity of providers of care, etc. In addition, culture does matter. Both the recipients of service and the providers of

**Social Determinants of Health**

There are factors within society that historically and currently have placed certain populations in situations in which the elements that contribute to positive health are limited and factors that contribute to illness are greater. Then once having developed an illness there is limited access to services. And once access is achieved, there is limited likelihood that those services will successfully address the needs…. The poor health of the poor, the social gradient in health within countries, and the marked health inequities between countries are caused by the unequal distribution of power, income, goods, and services, globally and nationally: the consequent unfairness in the immediate, visible circumstances in peoples lives – their access to health care, schools and education, their conditions of work and leisure, their homes, communities, towns or cities – and their chances of leading a flourishing life. ***This unequal distribution of health damaging experiences is not in any sense a "natural" phenomenon but it is a result of toxic combination of poor social policies, programs, unfair economic arrangements and bad politics. Together, they structure determinants and conditions of daily life and constitute the social determinants of health and are responsible for a major part of health inequities between and within countries. {Emphasis added}***

World Health Organization, 2008, p. 1

services bring with them their own beliefs and attitudes about each other, their own understanding of the malady, the expected intervention, and the role of each other in the helping process. Let's look at the social determinants and the cultural factors in more depth.

## Social Determinants

The World Health Organization defines the social determinants of health as "conditions in which people are born, grow, live, work and age, including the health system." These conditions are shaped by the distribution of money, power, and resources at the global, national and local levels, which are in and of themselves influenced by public policies. The social determinants of health are mostly responsible for health inequities. (WHO, 2008) Operatively, health inequities often play out as differences in opportunities for healthy lifestyles, differences in quality of care within the healthcare system and differences in access to the healthcare system (both preventive and curative care) (OMH, 2010).

As one examines the experience within mental health, diagnosis is more complex due the additional factors of immigration, acculturation stress, community violence, and discrimination. Lack of insurance, multiple care giving burdens, and bureaucratic and logistical barriers contribute to the delayed use of services. Stigma regarding mental illness within the culture and distrust of mental health service providers also conspire to delay use of services and diminish the likelihood of positive engagement in working therapeutic alliances (Wholehealth Campaign, 2009; APA, n.d.).

Alegria (2004) suggests consideration of the interplay between the following factors to understand the experience of mental illness and patterns of service use:

1)Social position – ethnicity race, education, occupation, income, wealth, social status

2)Environmental context –

a. neighborhood – social cohesion and neighborhood safety

b. geographical factors – average household income, percent unemployed, ethnic density, population density

c. physical and social contexts – attitudes about life

3) Psychosocial factors – migration, acculturation, discrimination, social networks

It is the interaction of these factors that leads to disparities in mental health status and mental health care. It is these factors that must be taken into account as one develops the science and creates the service structure for culturally diverse populations.

## Role of Culture and Cross-Cultural Relationships

In addition to the social determinants, the role of culture for both the providers and the recipients of services are key in understanding disparities. The Institute of Medicine (IOM) report on Unequal Treatment (Smedley, 2001) is very clear that bias, stereotyping, prejudice, and clinical uncertainty on the part of providers contribute to racial and ethnic disparities in health care. However, that does not explain fully the dynamic within mental health services. Consider the following:

1) There are challenges, though different in the specifics, in the interpersonal interactions between providers and users of services whether they are of the same or different cultural groups (Comas-Diaz, 1991)

2) Culture influences the level of comfort recipients of service have with providers (ie., safety to disclose personal information, the assessment by the consumer of the attitude toward and knowledge about cultural groups, the flexibility of the provider)

3) There are different cultural ideas about illness and health

4) There is “persistent evidence that cultural background colors every facet of the illness experience from linguistic structure and content of delusions to the unique meaning of expressed emotion.”(Algeria,2004 p. 212)

5) There are differences in symptom presentation or idioms of distress (Pumariega, 2005)

6) There are differences in help-seeking behaviors (i.e., role of family, primary health care providers, spiritual leaders, etc.)

7) Stigma about mental illness is a major force within many racially, ethnically and culturally diverse communities.

8) Bias, stereotyping, prejudice and lack of cultural knowledge influences provider behavior.

    a. This Includes presumptions about what is normative behavior as reflected in assessment tools, CSM checklists, IQ tests, and personality inventories based on Eurocentric values and norms (Atdgian, 2005)

    b. Often includes assumptions about the value of individualism, competitiveness, time-efficiency, measures of success, appropriate family structure, and gender role obligations that insert themselves into therapy (Atdgian , 2005)

These societal factors, system factors, population group factors and provider factors all converge to create disparities in mental health care. While there are some aspects that may be beyond the direct influence of the behavioral health system as currently constructed, several actions must be taken to make a difference.

*"Dr. Louis W. Sullivan, a former Secretary of the U. S. Department of Health and Human Services... expects a thorough study would more than justify the federal government spending several billion dollars more each year over a couple decades to boost biomedical research on health disparities and train more health professionals of color"*

*Kenneth Cooper,* Blacks Still Face Disparities in Health Care*, The Crisis. Winter. 2008. p. 12*

## Implications for System Design

Note suggestions from within the mental health field for possible approaches for next steps. (adapted from APA Background Paper, n.d.)

1. Expand the science base, expand the level of research in this domain to

a. Understand the influence of acculturation, stigma, spirituality, socioeconomic status, education and perceived discrimination on mental health outcomes

b. Determine the efficacy of evidence based treatment for racial, ethnic and other cultural groups, determinations of when and how to adapt evidence-based treatments, creation of culture-specific evidence based interventions

c. Document community defined evidence and associated interventions – discover what is working in communities that may have not been investigated within the academic research community or may be validated by forms of evidence that are not necessarily acknowledged by the academic research community but determined to be meaningful by the community)

d. Identify differential responses to medications by race and ethnicity

e. Study clinician bias and diagnostic accuracy and strategies to promote change

f. Identify differences in stress coping and resilience that will provide the groundwork for new prevention and treatment strategies

g. Discern more clearly the causal patterns related to factors of race, ethnicity, socioeconomic status, education, sexual orientation, gender identity and expression, religion or faith community, and so forth

2. Educate and empower patients

a. Implement patient education programs to increase knowledge of how to access care and participate in treatment decisions (mental health literacy)

b. Develop strategies /social marketing to address stigma within cultural communities

3. Improve access, reduce barriers to care, and improve quality of care

a. Improve geographic availability of mental health services

b. Integrate mental health care and primary health care

c. Improve language access

d. Coordinate care to vulnerable, high need groups such as people who are incarcerated and homeless

e. Support the use of quality interpretation and translation services

4. Avoid fragmentation of health plans along socioeconomic lines – assure funding strategies to promotes access in lower socioeconomic communities (that have a disproportionate number of persons from racial ethnic minorities)

5. Provide of evidence *informed* care tailored to the individual according to age, gender, race, ethnicity and culture

a. incorporate "culture- specific" practice models

b. incorporate "culturally and linguistically competent" practice models – services that are responsive to the cultural concerns including language, histories, traditions, and values

c. Address formulary issues and access to the most appropriate medications at affordable costs

6. Develop the capacity of providers in mental health care professions

a. Expand the volume and acceptability of the workforce by supporting the use of community health/behavioral health workers

b. Promote knowledge and skill development in tailoring treatments to age, gender, race, ethnicity and culture

c. expand the racial, ethnic and cultural diversity of providers, researchers, administrators, policy makers, and consumer and family organizations through effective recruitment and retention strategies and pipeline development from the elementary and middle school grade levels

d. Develop curricula that address the impact of culture, race, and ethnicity on mental health and mental illness, service use, and service provision

e. Incorporate didactic and experiential training to include the role of cultural identity of the provider and the service recipient in their therapeutic relationship (Comas-Diaz,1991; Atdjian, 2005)

7. Engage in partnerships with the communities to be served in the design, planning, implementation and evaluation of the mental health service systems in their community.

8. Promote mental health and prevention efforts

a. Build on community strengths such as spirituality and educational attainment

b. Engage with local leadership and focus on families

c. Reduce negative social conditions such as poverty, community violence, racism, and discrimination

9. Intervene in the legal, regulatory, and policy arenas

a. Collect data to identify points of disparities – race, ethnicity, education, income, and language as minimum data fields (See IOM Report on Collection of Race, Ethnicity and Language Data)

b. Evaluate services for effectiveness

c. Evaluate services for consumer satisfaction

d. Establish collaborative relationships with culturally driven, community-based providers

e. Establish benchmarks and performance measures

10. Engage employer investment in accessible quality mental health services for its diverse workforce

## Charge to Summit Participants

Let's use the Summit to build on these ideas and develop steps that can be implemented in the near and distant future within each person's own organization or system and provide additional guidance to the behavioral health field.

REFERENCES


Alegria, M., Takeuchi, D., Canino, G., Duan, N., Shrout, P., Meng, X., Vega, W., Zane, N., Vila, D., Woo, M., Vera, M., Guarnaccia, P., Auilar-Gaxiola, S., Sue, S., Escobar, J., Lin, K., & Gong, F. (2004). Considering context, place and culture: The National Latino and Asian American Study, *International Journal of Methods in Psychiatric Research 13(4*) pp 208 -220.

American Psychiatric Association (nd.) Roundtable Resource Document. Arlington, VA: American Psychiatric Association

Atdjian, S. & Vega, W. (2005) Disparities in mental health treatment in U.S. racial and ethnic minority groups: Implications for psychiatrists *Psychiatric Services 56(12).* pp.1600-1602.

Comas-Diaz, L. & Jacobsen, F. (1991). Ethnocultural transference and countertransference in the therapeutic dyad. *American Journal of Orthopsychiatry 61(*3), pp. 392-402

Jackson, V. (2008). Mental health disparities: the Five A's. Presentation at the Center for Mental Health Services xternal Workgroup on Eliminating Mental Health Disparities Meeting, May 19, 2008 in Rockville, MD.

Office of Minority Health (2010). Draft *Changing outcomes - Achieving health equity – The National Plan for Action.* Rockville, MD: Author

Office of the Surgeon General (2001). *Mental health: Culture, race and ethnicity: Supplement to mental health: Report of the Surgeon General*, Rockville, MD: U.S. Department of Health and Human Services, U.S. Public Health Services

Passel, J. & Cohn, D. (2008). *U.S. population projections: 2005-2050* Washington, DC: Pew Research Center

Passel, J. and Cohn, D. (2009). *Mexican immigrants: How many come? How many leave?* Washington, DC: Pew Hispanic Center Accessed 2/21/20 at http://pewhispanic.org/reports/report.php?ReportID=112

Pumariega, A. (2005). Culturally competent systems of care for children's mental health: Advances and challenges. *Community Mental Health 43(5)* pp. 539-55.

Pumariega, A., Rothe, E.,& Rogers, K. (2009). Cultural competence in child psychiatric practice *Journal of the American Academy of Child and Adolescent Psychiatry 48(4)* p 362-366

Ruiz, P. & Primm, A., Eds. (2010). Disparities in psychiatric care: Clinical and cross-cultural perspectives. Baltimore, MD: Lippincott Williams & Wilkins

Smedley, B., Stith, A., and Nelson, A. (2001). Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care, Washington, DC: National Academy Press

U.S. Census Bureau, (2008). An older and more diverse nation by mid-century. *U.S. Census Bureau News* Washington, DC: U.S. Department of Commerce Accessed 2/21/10 at http://www.census.gov/Press-Release/www/releases/archives/population/012496.html

Whole Health Campaign (2009). Whole Health policy brief: Behavioral health disparities Accessed on 2/21/10 at http://www/wholehealthcampaign.org/?page-id=132

World Health Organization (2008). Closing the gap in a generation: Health Equity through action on the social determinants of health. Final Report, Executive Summary. Geneva, Switzerland: WHO Press