Access to Effective Behavioral Health Services for Insured Minority Populations: What Works?

February 2011

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and

AETNA

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EXECUTIVE SUMMARY

The 2001 U.S. Surgeon General’s Report on Mental Health: Culture, Race, and Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General (USDHHS 2001) highlighted the greater burden of unmet mental health needs faced by minorities compared to other populations, and called for the study of the mental health of racial and ethnic groups to advance the nation’s health and welfare. Almost a decade after the Report, some of the main challenges to improving the mental health of racial/ethnic minorities persist, and new challenges have emerged.

Since the release of the Report, progress has been made in defining behavioral health disparities, but differences persist in the prevention and treatment of behavioral health disorders, as well as in access to and utilization of behavioral health services. Progress has been made toward achieving mental health equity and parity of mental health services, in understanding stigma, mistrust and resiliency, and appreciating the importance of behavioral health outcomes research. However, these changes have not been sufficient to overcome the barriers that minorities face in accessing and utilizing behavioral health services.

Factors that hamper access and utilization exist in both the demand and supply sides of health care. On the demand side, community and organizational environments, socioeconomic status, race/ethnicity, patients’ coping skills and perceptions, and satisfaction with the quality of care are major determinants of access and utilization. On the supply side, the main barriers relate to health service organizational and administrative issues, as well as to providers’ cultural and language competence, and the quality of the services they deliver.

This report discusses persistent and emerging barriers that minorities face in accessing mental health services. The Patient Protection and Affordable Care Act (PPACA) of 2010 offers new opportunities to increase the access to and quality of behavioral health services for improvements in the mental health of racial/ethnic minorities. Hopefully, as the provisions of PPACA are implemented over time, they will pave the path to mental and behavioral health equity.

This report, commissioned by Aetna, reviews the current determinants of access to behavioral health programs, including for minority populations who are insured. The aims and objectives of this project were developed by researchers from Morgan State University’s School of Community Health and Policy (SCHP), behavioral health experts, and health executives from Aetna. The development of this document occurred in two phases: the first phase included a compilation and review of the relevant research and literature; the second phase included interviews of key informants and a group discussion that developed a consensus assessment of current practices in behavioral health services for ethnic and racial minorities. The Surgeon General’s Report was reviewed and used as a foundation for developing recommendations in the following analytical domains: a) social context; b) culture; c) access; d) systems of care; and e) prevention.
Social Context

Racial/ethnic minorities in this country have always suffered overt and covert discrimination, negative stereotyping and stressful life events. Despite their disproportionate burden of behavioral health problems, they also have less access to and use fewer behavioral health services. For example, racial/ethnic minorities are overly represented among the homeless, incarcerated, impoverished, migrant and foster care populations where behavioral health problems, including substance abuse and violence, are significantly higher than in the general population. Even when they are insured, low-socioeconomic-status (SES) racial and ethnic minorities are less likely to seek behavioral health care. When they do access care, the services they receive are not comparable to those received by White beneficiaries with similar coverage.

The following recommendations to enhance behavioral health services for racial and ethnic minorities are based on the findings of this study.

- Enhance partnerships with public and private institutions that offer behavioral health support services. This should occur at the federal level through agencies of the U.S. Department of Health and Human Services, including the Health Resources and Services Administration, the Substance Abuse and Mental Health Services Administration, and the Centers for Disease Control and Prevention, and through state and local health departments. Resources at all these levels should be coordinated to identify needs, refer clients, train providers, and strengthen health education among and communication with the populations most in need.
- Policymakers should acknowledge and deal with barriers to needed behavioral health services posed by SES and race/ethnicity.
- Support outreach by providers, including Employee Assistance Programs (EAP), to address the factors that disproportionately impact minorities, including racism, perceived discrimination, acculturation, language, stigma and mistrust.
- Build networks of community and faith-based leaders to increase awareness of behavioral health issues, reduce stigma and increase utilization of behavioral health services. Enlist their help as a referral network to connect individuals in need to appropriate services.
- Fund activities that support health and wellness such as gym memberships, yoga, meditation, patient support groups, weight reduction programs, alcohol, tobacco and other drug treatment services.
- Develop minority health disparities programs to conduct and monitor research, and assist in applying the findings to improve policies and programs, including clinical protocols and health education.
- Assess, monitor and improve the efficacy of services provided to minorities by private insurers; use continuing research to develop more effective approaches and interventions for minorities.
- Collaborate with academic partners and community agencies to pursue grants for research and demonstration projects to reduce minority health disparities.
The following recommendations are made to insurers and providers to address cultural issues.

- Educate providers about the fact that people of color, even when they have health insurance, are not receiving care comparable to that received by Caucasians in most settings.
- Tailor the language and culture of behavioral health services to the populations being served.
- Collaborate with schools of Public Health, Social Work, Psychology and Medicine to develop undergraduate and graduate programs that train minority behavioral healthcare providers.
- Recruit, support and retain minority providers.
- Develop curricula in academic institutions that address culture, race and ethnicity issues regarding mental health problems, care-seeking and service utilization.
- Offer incentives to promote the cultural education of providers. Train mid-level providers such as behavioral health nurse practitioners, community health workers and patient navigators to increase outreach, monitor and improve adherence to treatments.
- Increase group case management in communities where this mode of interaction fits cultural norms. Collective approaches should incorporate culturally relevant interventions such as faith-based practices, elder-facilitated group meetings, complementary and alternative treatments, and culture-centered care. Assess outcomes and compare satisfaction between group approaches and individual patient-centered care.
- Address the stigma attached to mental health problems and the negative perceptions of behavioral health services in individual and collective encounters as part of culturally competent care.
- In collaboration with community networks, locate behavioral health services in places and provide them at times that will facilitate access.
- Monitor the utilization of health services, adherence to treatment, reimbursement and claim processes and cost-sharing policies among minorities and make continuous improvements.
- EAPs should offer culturally-relevant services on a small or local area scale. They should also monitor, assess and report program effectiveness, especially increases in work productivity resulting from prevention and treatment of behavioral health problems.
- Adopt the American Psychological Association's Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists (http://www.apa.org/pi/oema/resources/policy/multicultural-guidelines.aspx). These Guidelines address the development of multicultural and multilingual services, the training and education of health providers in multicultural sensitivity, and the provision of culturally and linguistically appropriate information.
Access

Lack of insurance is one of the major barriers to accessing behavioral health services. However, insured populations also face barriers, including the shared cost, the stigma associated with mental problems and a mistrust of behavioral health care providers. Despite improved insurance coverage expected to result from implementation of PPACA, millions will remain without coverage. Even when individuals receive services, patients’ satisfaction with their care, compliance with treatment and adequate follow-up vary widely. Monitoring satisfaction requires the availability and use of evidence-based practices, quality and performance indicators, and benchmarks for EAP effectiveness.

The following recommendations are made to improve access to behavioral health services.

- Increase coverage by working with states to improve their Comprehensive Health Plans, as recommended by the New Freedom Commission.
- Conduct research to assess utilization, adherence to treatment and cost barriers for people of color.
- Develop and implement evidence-based practices informed by culturally-relevant data to decrease the variability of care including misdiagnoses and inappropriate treatments.
- To increase access to behavioral health care, private insurance companies should inform clients about public behavioral health services that may be available to them and their families through federal, state and local programs.
- Reduce economic, administrative and location barriers to services by providing assistance with claims paperwork and transportation, by relocating services near to where minorities live and work, and by extending service hours.
- To assuage concerns about law enforcement, stigma and mistrust, assure client confidentiality. To reduce stigma, threats to employment and insurance eligibility, behavioral health services might be included under the umbrella of “wellness programs.”
- Develop indicators to assess the outcomes of different treatment and financing approaches. Variations in the number of visits, co-payments, level of case-management, degree of integration in primary care settings, etc., can be monitored and evaluated for their impact on patient compliance, use of emergency care, reduced hospitalization, work absenteeism and total health care costs. Available indicators such as the National Committee for Quality Assurance’s Antidepressant Medication Management quality measures should be used to evaluate the outcomes of specific therapies among different ethnic groups.
- Conduct more research on EAP behavioral health services and their effectiveness. EAPs should also evaluate the effectiveness of case management systems and integrative treatment programs for the populations they serve.
- To increase the behavioral health provider workforce and overcome the uneven geographic distribution of psychiatrists, psychologists, and psychiatric social workers, behavioral health education and training should be provided to general health care providers, emergency room staff and first responders, such as law enforcement personnel and emergency medical technicians.
Equity, parity and cultural competence for minority populations should be institutionalized by health insurance companies developing a mission statement that explicitly establishes values, principles and guidelines for the cultural competency of providers and services delivered to minorities. Policies and procedures should be consistent with the mission statement. For example, a policy could be developed for differential reimbursement of behavioral health services for illnesses that have a longer period of morbidity in people of color. Minority representation on organizations’ executive boards and advisory committees would help to promote and monitor the development of culturally relevant services. Given the increasing proportion of behavioral health services delivered in the criminal justice system, private insurers should explore financial and service partnerships with public behavioral health agencies and the justice system for incarcerated and ex-offender populations and their families. Collaboration with drug and mental health courts should be included in these efforts.

Even when cost is eliminated as a barrier, many minorities do not have access to culturally competent services. Given the current disparities in behavioral health needs and access to care for minorities, appropriate, culturally competent coverage in private and public systems is imperative.

The following recommendations for behavioral health services are made to health insurance companies.

- Develop a mission statement that explicitly establishes the values, principles and objectives for cultural competency and minority service delivery. Develop and implement policies and procedures consistent with this mission, including measurable objectives and indicators for evaluation.
- Include minority representation on boards of directors and advisory committees to ensure community and client accountability and to increase access to, utilization and quality of care available to minorities.
- Develop reimbursement strategies that will adequately support extended care for mental illnesses that have a longer duration in people of color.
- Private insurance companies can play a significant role in informing the public that progress has been made in treating behavioral illness over the past 25 years. Private insurers should participate in public education efforts to show that mental illness can be treated and prevented effectively.
- To better reach the target markets, EAPs should utilize existing resources in communities of color including community centers, religious and athletic facilities. EAPs should offer on-site counseling and referrals where people live, worship and congregate.
- Develop and implement consistent criteria for major behavioral health diagnoses and recommended therapies for all providers to use, including those in primary and emergency care.
- Support behavioral health programs in the criminal justice system and for ex-offenders returning to their communities. These efforts should include the families of the incarcerated and collaboration with special drug and mental health courts.
- All providers of a minimum size determined by private insurance companies should provide behavioral health services tailored for the minority populations they serve. This should not be optional.
- Improve health information systems for minorities. Data on race and ethnicity should be collected, analyzed and reported consistent with guidelines from the Institute of Medicine.
• Current data shows that African Americans are less often treated with psychopharmacology than their White counterparts. This differential should be studied to determine if it is based on relevant factors such as patient preference and outcome, or systemic weaknesses such as provider ignorance or financial barriers.
• Assess and correct common misdiagnoses of African Americans.
• Provide family support for the management of schizophrenia.
• Conduct continuous medical audits for treatment appropriateness.
• Ensure competitive reimbursement for behavioral health providers who serve minority populations.
• To address the common co-occurrence of behavioral and other chronic diseases, integrate behavioral health services into primary health care and vice versa.
• The increasing co-occurrence of mental illness with substance abuse and other chronic diseases in populations of color should be considered in developing comprehensive behavioral health services.
• Behavioral health services must be available in traditional settings including primary care centers, but also in nontraditional settings frequented by the target populations such as community organizations, the justice system and schools.
• Provide protection against insurance coverage loss with the change or loss of employment. Assure seamless access to behavioral health services across private and public insurance plans.
Prevention

Prevention is central to decreasing behavioral health disparities. For minorities, prevention campaigns must be culturally relevant, designed with input from the targeted communities and located in those communities. Some culturally appropriate behavioral health screening tools have been developed, but they are not routinely used. Prevention interventions adapted for minorities are also available but not commonly offered in health and wellness programs including EAPs. Support for patient-only treatments precludes delivery of prevention interventions in the family, community and workplace settings. Integrated programs increase the mental and physical well-being of the individual, families and communities, thereby strengthening individuals’ coping capacity when facing stressors. This integration is particularly important for racial and ethnic minorities who face discrimination as a “normal” aspect of everyday life.

The following recommendations are made for preventing mental illness.

- Insurance companies should assess the efficacy of the wellness programs they offer to clients and use information about program effectiveness to determine benefit coverage.
- Incentives and competitions designed to encourage healthy habits, including weight loss, increased physical activity and tobacco cessation can be provided by EAPs.
- The package of health benefits provided by employers should reflect the importance of family, community and mental health. Extending coverage to workers’ family members increases retention and productivity in the workplace.
- Employer-based health initiatives should emphasize preventive care through wellness programs that utilize community-based resources.
- The roles of spirituality, ethnic identification, traditional values and local leadership should be considered in the planning and delivery of preventive mental health services.
- Prevention policies developed for public sector behavioral health systems should be explored for private-public funding and pilot tested for market feasibility. If effective and feasible, such initiatives should be integrated into private sector care to reduce mental health disparities among racial and ethnic minorities.
- Promote awareness of behavioral health issues and services through health fairs, community activities and mass media, using materials adapted for minority audiences.
- Support strategies to diagnose and treat depression and post-traumatic stress disorder in primary care settings. Pediatric practices should include depression screening and treatment.
- Implement effective mental health screening tools in all primary care settings.

Implementation of these recommendations can increase access to and utilization of behavioral health services, especially by minorities. Such increased utilization would improve health outcomes for people of color, increase the stability and productivity of our workforce, and enhance the social capital of communities across our nation.
Health Care Reform, the Road Ahead

Health policy has continued to evolve since completion of this report. The Patient Protection and Affordable Care Act (PPACA), signed into law by President Obama on March 23, 2010, was designed to remove several barriers to accessing behavioral health services that were identified in this report. New incentives and organizational structures are expected to enhance the quality of behavioral health services as well as insurance portability, coverage, and parity. Full implementation of the Act will prohibit annual and lifetime caps, the exclusion of individuals because of preexisting conditions, and the unfair rescission of coverage. PPACA requires that mental health and substance abuse services be part of the essential benefits package for qualified health plans that participate in state Health Benefits Exchanges. The Act seeks to promote primary and integrated care with a national focus on prevention.

Implementation of the Act will be phased in over time, with many key provisions not taking effect until 2014. Implementation of PPACA must be carefully implemented, monitored, evaluated and reported on in order to ensure the optimal outcome for persons with behavioral health problems.
ACKNOWLEDGMENTS

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This study was commissioned and funded by Aetna Inc.
INTRODUCTION

This report, commissioned by Aetna, reviews the determinants of access to and utilization of behavioral health programs, including for minority populations who are insured. The objectives of this project were developed with researchers from Morgan State University’s School of Community Health and Policy (SCHP), health executives from Aetna and additional behavioral health experts. The development of this document occurred in two phases: the first included a compilation and review of the relevant research and literature; the second phase consisted of key informant interviews with identified experts and a consensus group meeting. Approval to conduct this study was obtained from Morgan State University’s Institutional Review Board.

The 2001 U.S. Surgeon General’s Report on Mental Health: Culture, Race, and Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General (USDHHS 2001) provided the general framework for this project. A summary of this Report, including updates since its publication, is presented in the Background section below. It is followed by sections including: a summary of the current behavioral health services offered by Aetna; the aims and objectives of this project; a review of the literature on mental health disparities and the factors that affect prevention and treatment of mental illness in minority populations, including a brief synopsis of the President’s New Freedom Commission Report Achieving the Promise: Transforming Mental Health Care in America (NFC 2003). The final section incorporates findings from key informant interviews and the consensus group meeting in a discussion of this report’s main findings, conclusions and recommendations. This project serves as an assessment of current needs and an intervention guide for improving preventive and therapeutic mental health services for ethnic and racial minorities.
BACKGROUND

Health disparities refer to the differences among racial, ethnic, linguistic and cultural groups in: a) health risks and disease predisposition; b) disease prevalence and health status; c) the quality of health care services; d) health outcomes and mortality. In 2001, the U.S. Surgeon General released a report on disparities in mental health prevalence, status, treatment and outcomes among racial and ethnic minorities titled Mental Health: Culture, Race, and Ethnicity – A Supplement to Mental Health: A Report of the Surgeon General (USDHHS 2001). This Report focused on the mental health status of the chief racial and ethnic minorities in the U.S. – African Americans (AA), American Indians and Alaska Natives (AIAN), Asian Americans and Pacific Islanders (AAPI), and Hispanic Americans/Latinos (HA/L). It was the first major effort to describe the mental health of racial and ethnic minorities and people of color.

Striking disparities in knowledge about mental health, the manifestations of mental wellness and illness, and the availability and utilization of mental health services exist between people of color and the general population. The 2001 Supplemental Report documents that “racial and ethnic minorities bear a greater burden from unmet mental health needs” than other populations. It sends a clear message that improving the mental health of ethnic and racial minorities is critical to advancing our nation’s welfare.

The Surgeon General’s Supplemental Report is reviewed and discussed below under the analytical domains of social context, culture, access, systems of care and prevention.

Social Context

Relative to the majority population, people of color in the United States experience greater exposure to racism, discrimination, violence and poverty. In his 1999 work, Mental Health: A Report of the Surgeon General (USDHHS 1999), Dr. David Satcher stressed that the causes of health and disease, including mental health and mental illness, are generally viewed as products of “the interplay or interaction between biological, psychological, and sociocultural factors.” The 2001 Supplemental Report emphasizes that, relative to their White counterparts, people of color are exposed to the additional stressors of racism and discrimination which adversely affect both their general health and their mental health. The negative stereotyping of people of color reduces their self-worth and their psychological functioning. The pervasive discrimination experienced in personal relationships and from institutions represents persistent stress that can lead to mental disorders such as depression and anxiety.

Though mental illness exists in all populations, its prevalence is two to three times higher in poor populations where people of color are over-represented. African Americans and Native Americans are over-represented among the homeless, the incarcerated and foster care populations, where the rates of mental illness are significantly higher than in the general population. Despite the fact that prisoners endure higher rates of mental illness, they are less likely to receive mental health care. Native Americans and Latinos also experience higher prevalence of drug and alcohol abuse. In addition, elevated rates of mental illness among these minority populations are strongly correlated with their higher exposure to violence and trauma. Immigrant status plays a role in mental health outcomes. Among immigrant populations of color, rates of mental illness (specifically depression and phobias) increase with length of time and number of generations in the U.S.
Culture

**Consumer Culture:** The 2001 Surgeon General's Report describes “culture” as a “system of shared meanings . . . a dynamic structure to which an individual looks for standards of behavior.” Research since the 1990’s has documented major ethnic and cultural differences in the manifestations of mental disorders. Differences in symptom presentation across cultures are influenced by coping mechanisms and stigma, which in turn affect motivation to seek treatment, what kind of treatment is received, and from where. All of these complexities must be better understood for the most effective delivery of care to people of color.

Many examples throughout the 2001 Report document “culture bound syndromes” among the major ethnic groups, especially the degree to which feelings are somaticized. The distinction between physical and mental manifestations of symptoms is less in many cultures than it is in the U.S. The 2001 Report notes that “In many traditional societies, mental health problems can be viewed as spiritual concerns and as occasions to renew one’s commitment to a religious or spiritual system of belief and to engage in prescribed religious or spiritual forms of practice.” For example,

... consistent with a cultural emphasis on restraint, certain Asian American groups ... encourage a tendency not to dwell on morbid or upsetting thoughts, believing that avoidance of troubling internal events is warranted more than recognition and outward expression.... Their emphasis on willpower is similar to the tendency documented among African Americans to minimize the significance of stress and, relatedly, to try to prevail in the face of adversity through increased striving.

The Report emphasizes that patients’ cultures shape their mental health and affect the types of services they use. Similarly, the clinician’s culture and the institutional culture of the service system affect diagnosis, treatment, and the organization and financing of care. In 1998, only 2% of psychiatrists, 2% of psychologists, and 4% of social workers were African American. In 1996, only 29 psychiatrists identified themselves as American Indian, and only 1% of psychologists self-identified as Hispanic, representing a Latino provider/patient ratio of 29/100,000, compared to 173/100,000 for White mental health professionals. The 1999 Report emphasized the importance of increasing the number of ethnically and racially-matched providers, noting that providers bring their cultures with them to the clinical setting.

Linguistic differences between mental health providers and consumers of color also limit access to and the quality of care. Asian Americans and Pacific Islanders are extremely diverse, including 43 different ethnic subgroups and more than 100 different languages and dialects. Thirty-five percent of AAPI households report limited English proficiency. Research shows that matching the ethnicity of clinician and client within this population improves outcomes. American Indians and Alaskan Natives include 561 different tribes and more than 200 different languages. Forty percent of Hispanic Americans identify language as a barrier to accessing mental health care.

**Cultural Resilience:** It is important to note that not all diagnoses and symptoms of mental illnesses are higher among people of color than Caucasians in the U.S. For example, suicide rates are lower among African Americans than among Whites. It would be good to know what factors contribute to the resiliency of African Americans, who bear a history of slavery and continued overt and covert racial discrimination. It would also benefit us to understand how Latino and Asian immigrants cope with the dislocation from their native cultures, the traumas that caused many of them to leave their home countries, and the challenges of their new social environments. Research on this resilience may provide important clues to improving the mental health of all cultures.
Success in mental therapies relies heavily on clinicians’ understanding of the cultural contexts of their clients, and vice versa. Clinicians who are unaware of cultural influences on their patients may incorrectly label specific behaviors, misdiagnose signs and symptoms, and mismanage treatment. The 2001 Surgeon General’s Report emphasized that mental health services for people of color must be tailored to the cultures from which they come, “meeting people where they are.” As noted in the Report, “cultural and social influences are not the only influences on mental health and service delivery, but they have been historically underestimated — and they do count. Cultural differences must be accounted for to ensure that minorities, and all Americans, receive mental health care tailored to their needs.”

**Access**

Access to mental health care is disparate and limited for people of color. African American adults with mental illness are half as likely as Whites to enter treatment, and those who do terminate sooner than their White counterparts. When compared to others with similar diagnoses, African Americans are more likely to receive mental health services in an emergency, primary care or inpatient setting, and less likely to obtain outpatient services. Hispanics are less likely to use mental health services than Whites, but when they do, they are twice as likely as Whites to go to a primary care provider.

Only 20% of Native American Indians report regular access to Indian Health Services. Those AIANs who reside off of reservations, in areas with no organized Indian Health Services, are less likely to have access to any health care. Less than one third of AIANs diagnosed with a mental illness received care in the year prior to the publication of the 2001 SG’s Report.

It appears that Asian Americans use fewer services than Whites, and when they do access care, they are more severely ill. However, our knowledge of the rates of mental illness, access to care, quality of care and effectiveness of treatment in this population remains limited.

As with physical health care, poverty is noted to be a major obstacle to accessing mental health care. Unfortunately, researchers have found that poor individuals are two to three times more likely to have a mental health problem compared to those who are not poor. While 16% of the total U.S. population were without health insurance when the 2001 SG’s Report was published, people of color were more likely to be uninsured, including 25% of African Americans, 21% of AAPI, 37% of Hispanics, and 24% of AIANs.

**Treatment:** People of color are not only less likely to receive necessary care for their mental problems, but when they do receive treatment, it is usually of lower quality. Minorities are more likely to seek mental health care from primary care providers or in emergency rooms than Whites. The 2001 Supplemental Report highlights studies showing that one third to one half of patients with mental health problems who are seen in primary care settings leave without their mental illness being properly diagnosed.

People of color are more likely to turn to clergy, alternative healers, friends and family with their mental problems. The 2001 Report also shows a preference for counseling over drug therapy among African Americans. Compared to majority Whites, AAPIs use alternative remedies more frequently, and AIANs are more often treated by native healers.

An historical fear and mistrust of medical providers and health care institutions persists among people of color, presenting barriers both to accessing appropriate health care, and following through with recommended treatment. This mistrust is confirmed by both direct and indirect evidence of clinician bias and stereotyping across racial and cultural divides. Especially in minority cultures, stigma also remains a formidable obstacle to accessing necessary and appropriate mental health care.
Ethno-psychopharmacology is a growing discipline that examines differences in ethnic groups’ reactions to the same drugs. For example, African Americans show a decreased metabolic rate for certain antipsychotic medications that may increase side effects and reduce compliance. The appropriateness of pharmacologic interventions for mental illness among people of color was highlighted in the Surgeon General’s Report. To ensure competent treatment and patient adherence, providers must be aware of ethno-psychopharmacologic differences in the clients they serve.

**Systems of Care**

Mental health care in this country is a patchwork of service provision, often referred to as the *de facto* mental health system. In 1996, half of mental health services were financed from public funds, with private insurance accounting for approximately 27% of total costs (USDHHS 1999). Less than five years later, managed care became responsible for providing the majority of services, both public and private.

The *de facto* mental health service system is comprised of four sectors of service delivery funded by private and public dollars. These include:

1. the specialty mental health sector, including psychiatrists, psychologists, psychiatric nurses and psychiatric social workers;
2. the medical primary care sector, where mental health services are provided by general practitioners, internists, pediatricians and nurse practitioners;
3. the human services sector, including social services, school-based counseling services, residential rehabilitation services, vocational rehabilitation, criminal justice/prison-based services and religious professional counselors; and
4. the voluntary support network sector, including peer counselors and self-help groups such as 12-step programs.

Health insurance, both private and publically funded (e.g., Medicaid and Medicare), is the major source of payment for mental health services. According to the 1999 Surgeon General’s Mental Health Report:

... approximately 63 percent of the U.S. population had private insurance, 13 percent had Medicare as a primary insurer (with about 7 percent also having supplemental private insurance), 12 percent had Medicaid (2 percent had dual Medicaid/Medicare), and 16 percent were uninsured.... [about] 84 percent of Americans have some sort of insurance coverage—primarily private insurance obtained through the workplace. However, its adequacy for mental health care is extremely variable across types of plans and sponsors.... Slightly more than 13 percent of the U.S. population is entitled to Medicare, which includes mental health coverage. Nearly 12 percent of U.S. adults (27 million low-income individuals on public support) receive Medicaid coverage (with more than 2 percent having dual Medicare/Medicaid coverage).... the average cost of this coverage [for this population] is 2.5 times higher than that in the private sector. An explanation for this higher average cost is the severity of illness of this population and greater intensity of services needed to meet their needs.... Most (75 percent) of the uninsured are members of employed families who cannot afford to purchase insurance coverage.

People of color and immigrants are overrepresented in the lowest socioeconomic categories and consequently at increased risk for being uninsured or underinsured. The Report documented that many racial and ethnic minorities who lack private health insurance may qualify for Medicaid but are not enrolled. The Report also emphasized the unjustified disparities in overall coverage for mental health care compared to coverage for physical health problems. According to the 1999 SG Report:
Health insurance companies often set lower annual or lifetime limits to protect themselves against costly claims leaving patients and their families exposed to much greater personal financial risks. The legacy of the public mental health system safety net as the provider of catastrophic coverage encouraged such practices. Further, when federal financing mechanisms such as Medicare and Medicaid were introduced, they also limited coverage of long-term care of “nervous and mental disease” to avoid shifting financial responsibility from state and local government to the Federal government.

Given that members of minority groups prefer to receive mental health care in the primary care system, and that primary care is where most individuals who need mental health treatment are initially diagnosed, the Report recommends an expanded role for primary care physicians and allied health practitioners in providing these services. Primary care providers in the de facto mental health system need more and better training for the prevention and early detection of mental health problems, and their appropriate referral to the specialty mental health service sector.

**Prevention**

For the health and welfare of our nation, the mental health system should be comprehensive and coordinated. The 2001 Surgeon General’s Report emphasized that:

Mental health promotion and mental illness prevention can improve the health of a community and the Nation…. Efforts to prevent mental illness and promote mental health should build on intrinsic community strengths such as spirituality, positive ethnic identity, traditional values, educational attainment, and local leadership…. Families are the primary source of care and support for the majority of adults and children with mental problems or disorders. Efforts to promote mental health for racial and ethnic minorities must include strategies to strengthen families to function at their fullest potential.

Culturally appropriate mental health services, a sufficient number of programs to meet the need, productive partnerships with community-based treatment programs, easy access to these programs for those most at risk, and parity of insurance coverage for mental and medical/surgical health services will help to ensure the best health and highest productivity for our nation. Appropriate services should include health with housing, employment and other social services where necessary. Where long-term treatment for chronic emotional illness and relapsing mental illness is indicated, adequate treatment should include case management. Engaging existing community services such as faith-based initiatives, recreational center outreach programs and other community-based initiatives will help assure culturally appropriate care, provide “mental health homes” for affected individuals, and improve the outcome of mental health prevention and treatment.

The 2001 Surgeon General’s Report on Mental Health calls for the integration of social context, cultural values and historical factors in the provision of mental health services. It states that “systematic work in areas of epidemiology, evidence-based treatment, psychopharmacology, ethnic and culture specific interventions, diagnosis and assessment, and prevention and promotion needs to be developed and expanded.” It also emphasizes that research is needed to better understand how each group’s cultural context may or may not influence the different determinants of mental health.
Several commentaries have been published since release of the 1999 Surgeon General’s Report on Mental Health and the 2001 Supplement on Culture, Race, and Ethnicity. A 2002 commentary reported that a continuing major obstacle to accessing mental health services remained the lack of parity in insurance coverage (Barry 2002). Compared to medical and surgical coverage, most health insurance plans limited coverage for mental disorders, imposed higher co-payments, lower limits on number of covered inpatient hospital days and outpatient visits for mental health treatment, and lower lifetime and annual expenditure limits. While the 1999 Surgeon General’s Report on Mental Health suggested that the increase in managed care coverage of mental health services could be beneficial, it also cautioned that the quality of behavioral health care had not improved after passage of the Mental Health Parity Act of 1996. In 2000, a report issued by the General Accounting Office (now the Government Accountability Office) found only minor benefit changes in states that had never recognized mental health parity (Allen 2000).

The federal Mental Health Parity and Addiction Equity Act of 2008 provides for the following.

- If a group health plan includes medical/surgical benefits and mental health benefits, the financial requirements (e.g., deductibles and co-payments) and treatment limitations (e.g., number of visits or inpatient hospital days of coverage) that apply to mental health benefits must be no more restrictive than the predominant financial requirements or treatment limitations that apply to substantially all medical/surgical benefits.
- If a group health plan includes medical/surgical benefits and substance use disorder benefits, the financial requirements and treatment limitations that apply to substance use disorder benefits must be no more restrictive than the predominant financial requirements or treatment limitations that apply to substantially all medical/surgical benefits.
- Mental health benefits and substance use disorder benefits may not be subject to any separate cost sharing requirements or treatment limitations that only apply to such benefits.
- If a group health plan includes medical/surgical benefits and mental health benefits, and the plan provides for out-of-network medical/surgical benefits, it must provide for out-of-network mental health benefits.
- If a group health plan includes medical/surgical benefits and substance use disorder benefits, and the plan provides for out-of-network medical/surgical benefits, it must provide for out-of-network substance use disorder benefits.
- Standards for the determination of medical necessity and reasons for any denial of benefits relating to mental health benefits and substance use disorder benefits must be made available upon request to plan participants.
- The parity requirements for the existing law (regarding annual and lifetime dollar limits) will continue and will be extended to substance use disorder benefits.

The Patient Protection and Affordable Care Act (PPACA), signed into law by President Obama on March 23, 2010, also requires parity of coverage for mental health and medical/surgical services, and funds a number of initiatives to promote integrated care. Under PPACA, mental health care must be included as a basic service for Medicaid beneficiaries. And Medicare must implement parity of co-payments, currently at 50% for mental health services, but only 20% for medical/surgical care. Many provisions of PPACA do not take full effect until 2014. As this report goes to press, regulations are being drafted to implement the mental health parity provisions. It remains to be seen what impact these laws will have on access to and use of mental health services.
Additional commentaries questioned whether the science collaborators on the 2001 Report were sufficiently diverse, and if all relevant research on disparities in mental health counseling, psychotherapy and psychopharmacology had been reviewed (Bell 2003). Some commentators felt that the effect of historic and current racism and oppression on peoples of color in the United States had not been adequately covered in the 2001 Report, including the multidimensional effect of these stressors on general as well as mental health status (Chang 2003).

Several commentaries reviewed the strategies used to research and analyze the causes of racial and ethnic disparities in mental health, including the fact that the degree and type of disparities differ among different minority groups. African Americans have a lower prevalence of mental illness despite a long and strong history of prejudice, discrimination and related stress. American Indians and Alaskan Natives, who also bear the burden of a history of prejudice, oppression and resultant stressors, experience higher prevalence of mental illness. As Mexican Americans become more acculturated, they exhibit higher rates of mental illness; but less acculturation is associated with more symptoms of mental distress among Asian Americans (Sue 2003).

One commentary concluded that using both a “common or universal cause” among all racial and ethnic minorities and a “group and cultural-context specific cause” between racial and ethnic minorities would help to distinguish general and specific determinants of the disparities in mental health. This approach would involve identifying risk and resiliency factors at the individual, family, neighborhood and population levels (Chang 2003).

These publications subsequent to the 2001 Surgeon General’s Report reinforce the Report’s main recommendations for improving our nation’s system of mental health care: parity for mental health in all insurance programs, and cultural relevance in planning access and treatment. The commentators have added to our understanding of the general and specific roles that culture plays in affecting mental health outcomes in different racial and ethnic minority groups. This enriched understanding will help us identify both risk and protective factors within racial and ethnic minorities and improve the planning, implementation and assessment of interventions that are more relevant and effective for racial and ethnic minorities.
Before presenting the findings from this report, a description of the programs and services currently available under Aetna’s Behavioral Health division is offered. This description provides a foundation for discussing the report findings and a framework for the recommendations it makes.

Aetna’s Behavioral Health Organization provides an array of mental health services within Aetna’s network as well as to providers who are not Aetna clients. The available products and services include a number of case management models that target businesses, providers and beneficiaries, all with an emphasis on consumer-centered care. Aetna is currently assessing its behavioral health programs to better tailor these services for racial and ethnic minorities, and improve utilization by those groups.

**Employee Assistance Programs (EAP)**

Aetna provides a number of products and services to businesses under their Employee Assistance Programs. The approaches in these programs include telephone, face-to-face and event-specific support. EAPs address a variety of behavioral health and related health issues including stress, alcohol and substance abuse, depression, anger and family issues. Members who can access these services through their employers do not need to file a claim to use them. In addition to direct support, Aetna provides website support and other online services, and monitoring of follow-up referrals.

**Disease Management (DM) Services**

Through its provider bases, Aetna offers an array of case management services in the areas of depression, alcohol use, anxiety, medical psychiatry, behavioral health intensive care and eating disorders. The case management model uses medical databases and pharmacy records to identify potential clients for enrollment in appropriate programs. The med-psych program is based on the premise that mental health and chronic health problems commonly occur together. Members enrolled in this DM program develop a Care Plan that identifies specific goals and objectives, and establishes a treatment approach for achieving those goals.

**Primary Care Physician (PCP) Services**

Aetna supports a variety of opportunities to deliver behavioral health services in the primary care setting, with an emphasis on identifying and treating depression and substance use. Services that support this integrated diagnosis and treatment include: training programs for primary care providers to identify and assess depression and alcohol problems; reimbursement for screening depression through use of the Patient Health Questionnaire (PHQ9); reimbursement for addressing alcohol abuse through use of the Screening, Brief Intervention, Referral and Treatment (SBIRT) approach; reimbursement for extended time spent with patients with behavioral health issues; and consultation with Aetna’s mental health professionals. The depression management system has an extensive electronic and web-based support system that links the Primary Care Provider (PCP), patient and Aetna resources together.
GOALS AND OBJECTIVES

The chief goal of this report is to provide recommendations for accessible and effective behavioral and mental health treatment programs for Aetna’s managed care consumers of color. Social context, culture, access, systems of care and prevention were identified as the main analytical issues that frame the dimensions of this goal and the supporting recommendations.

As noted in the Introduction, these analytical issues were identified and developed in brainstorming sessions with the research group at Morgan State University’s School of Community Health and Policy and representatives of Aetna (contributors to this effort are listed on page 9). Brainstorming was followed by synthesis and concept reduction to identify analytical domains and specific objectives.

LITERATURE REVIEW

The New Freedom Commission on Mental Health

In 2002, a federal commission was convened to conduct a systematic study of mental health care in the United States and offer recommendations to address identified deficiencies. Established through an executive order from the Office of the President of the United States, the commission, formally designated the New Freedom Commission on Mental Health, completed its assessment entitled Achieving the Promise: Transforming Mental Health Care in America, in 2003 (NFC 2003). Consistent with our approach to the current investigation, the Commission acknowledged the landmark contribution of the 1999 Surgeon General’s Report on Mental Health. What follows is a synopsis of several of the Commission’s most salient and relevant findings and recommendations.

Culture: Regarding the role of cultural barriers, the Commission concluded that:

Unfortunately, the mental health system has not kept pace with the diverse needs of racial and ethnic minorities, often underserving or inappropriately serving them. Specifically, the system has neglected to incorporate respect or understanding of the histories, traditions, beliefs, languages, and value systems of culturally diverse groups. Misunderstanding and misinterpreting behaviors have led to tragic consequences, including inappropriately placing minorities in the criminal and juvenile justice systems (NFC 2003, p. 49).

Access: The Commission identified access as the chief barrier to improving the prevention and treatment of mental illness.

Over the years science has broadened our knowledge of mental health and illnesses, showing the potential to improve the way in which mental health care is provided…. However, despite substantial investments that have enormously increased the scientific knowledge base, and have led to developing many effective treatments, many Americans are not benefiting from these investments. Far too often treatments and services based on rigorous clinical research languish rather than being used effectively at the earliest opportunity (NFC 2003, p. 2).
In many communities, access to quality care is poor, resulting in wasted resources and lost opportunities for recovery. More individuals could recover from even the most serious mental illnesses if they had access in their communities to treatment and supports that are tailored to their needs (NFC 2003, p. 3).

Given that uneven, inequitable access to care impedes the treatment of mental illness, the Commission recommended integrating mental health services more completely into primary care and more fully utilizing allied health professionals in diagnosis and treatment.

Mental health education and training [should] be provided to general health care providers, emergency room staff, and first responders, such as law enforcement personnel and emergency medical technicians, to overcome the uneven geographic distribution of psychiatrists, psychologists, and psychiatric social workers (NFC 2003, p. 10).

**Systems of Care:** Psychiatrists and psychologists are specially trained and credentialed for the treatment of serious mental disorders. The need for additional personnel to provide mental health services in institutions that are not adequately equipped to treat serious psychological ailments reflects a large systematic problem.

The Commission’s Report highlighted the fact that numerous entities – including federal, state, and local governments as well as private for-profit and charitable organizations – are involved in treating or caring for the mentally ill. However, there is no seamless flow of services or even coordination among these different entities, so overlapping, competing and contradictory functions often result. Instead of providing additional benefits, these disparate systems of care can impede access to needed services, and raise the cost of care unnecessarily. To address this problem of fragmentation and redundancy, the Commission recommends “the development of a Comprehensive State Mental Health Plan [that] would create a new partnership among the Federal, State, and local governments and…include consumers and families” (NFC 2003, p. 33). Such an initiative could better manage limited mental health resources and improve access and quality for all.

**Prevention:** The Commission’s Report emphasized the importance of a public health model of prevention and early detection for mental health, which “can result in a substantially shorter and less disabling course of illness. As the mental health field becomes increasingly able to identify the early antecedents of mental illnesses at any age, interventions must be implemented, provided in multiple settings, and connected to treatment and supports” (NFC 2003, p. 60).

Screening for mental illness is a powerful tool for early detection and can often lead to cost-effective prevention and early treatment. The Commission highlighted the role of stigma as an important barrier to early detection and treatment. “Stigma is widespread in the United States and other Western nations…. It deters the public from seeking and wanting to pay for care. Responding to stigma, people with mental health problems internalize public attitudes and become so embarrassed or ashamed that they often conceal symptoms and fail to seek treatment” (NFR 2003, p. 4).

**Summary:** The New Freedom Report was published two years after the Surgeon General’s Report on Mental Health. It reiterated the need for greater integration of mental health services and a cross-disciplinary approach to providing them. However, though the Commission identified the same barriers and offered many of the same recommendations as the Surgeon General, neither provided a specific plan of action. For example, neither Report identified which of the disparate service providers should initiate and guide a plan to create a seamless flow of services. Neither identified which departments within current mental health systems should initiate a more public health and preventive model for services delivery. Neither identified sources of funding for cross-training primary care providers in mental health. Neither suggested how cultural sensitivity should be developed and infused throughout the system. Neither recommended who should evaluate the effectiveness of services. Without such explicit guidelines, many of these important recommendations will be difficult to implement and assess, and all too easy to ignore.

Access to Effective Behavioral Health Services for Insured Minority Populations: What Works?
Juried Literature Review

A review of the recent peer-reviewed literature regarding disparities in mental health access and treatment for racial and ethnic minorities provides overwhelming support for the 2001 Surgeon General's Report on the mental health of these populations. Current research elaborates the findings and recommendations of the 2001 Report, and provides additional details about what causes and exacerbates racial and ethnic disparities in mental health.

**Burden of Disease:** Review of the literature published since the 2001 Report revealed an important additional dimension that provides a more complete picture of mental health disparities. It is called the burden of disease.

The prevalence of many psychiatric disorders is lower among African Americans and Hispanics compared to Whites both across life-spans and within the past 12 months (National Comorbidity Survey Replication 2001-2003). However, research shows that once ill, African Americans and Hispanics experience a greater risk of persistence, i.e., a longer duration of illness (Kessler 2005; Breslau 2005). The National Center for Health Statistics' (NCHS) 2005-2006 household survey showed rates of depression among African Americans and Mexican Americans that were higher than among Whites (8.0%, 6.3%, 4.8% respectively) (CDC 2008).

Data from the National Comorbidity Survey show a higher prevalence of post-traumatic stress disorder (PTSD) and alcoholism among American Indians selected from two North American tribes relative to the general population (Beals 2005). Psychosis, substance dependence and depressive neurosis were found to be the most prevalent psychiatric diagnoses among African Americans in a national sample of approximately four and a half million inpatient medical records from 33 U.S. states (Bolden 2005).

During the past 10 years, the scope of mental health research has expanded to include more focus on how different communities of color exhibit mental health and illness. These recent studies confirm the need for more standardized methods of assessing and reporting mental health and illness by race, ethnicity and social factors.

**Social Context:** The social contexts of economic status, geographic distribution, immigration and acculturation affect the mental health of individuals. When the differential distributions of these factors are corrected for, morbidity and mortality rates among minorities are often moderated.

Recent research that examined socioeconomic status (NCHS 2005-2006) reported higher rates of depression among persons living below the poverty line than among those with higher incomes, regardless of color (CDC 2008). Two studies confirmed that a major reason for depression going untreated among both minorities and the general populations was a lack of health insurance (Harman 2004; Vasialadis 2007). A study of 700,000 Canadian residents showed that, though national health insurance provides universal access to care, those in the lowest SES were less likely to seek mental health services (Steele 2006). In seeking to separate the contributions of race and ethnicity from that of SES in the U.S., one study showed that both publicly-funded (N=300) and privately-funded (N=300) substance abuse treatment centers with a higher percentage of minority clients prescribed fewer SSRIs (a popular type of antidepressant), compared to centers with fewer minority clients (Knudsen 2007). Similarly, despite having uniform access to care, compared to their White counterparts, minority beneficiaries enrolled in Medicare + Choice plans received less follow-up after hospitalization for mental illness, lower rates of antidepressant medication management, and inferior care as measured by a variety of other differences (Virnig 2004). These disparities persisted after adjusting for age, income, geographic location and other demographic variables.
A prospective study of approximately 12,000 children tracked into adulthood documented that, compared to Whites, African Americans had a three-fold greater likelihood of being diagnosed with schizophrenia, moderated to a two-fold increased likelihood when corrected for SES (Breshnahan 2007). Another study found that medically insured Blacks and Hispanics were less likely to receive specialty mental health services than their similarly insured White cohorts; this disparity remained for Blacks after adjusting for income (Alegria 2002). These studies confirm that SES and racial and ethnic identity are independent risks for mental health disparities. They demand additional research on how sociodemographic factors moderate mental health disparities in racial and ethnic minorities, both individually and collectively.

The differential effects of geographic setting and immigration status on mental health was evidenced by studies showing an increased prevalence of PTSD among African Americans living in urban settings, compared with the national average (Davis 2008). Data from the National Health Interview Survey (2003) showed that foreign-born Blacks and foreign-born Hispanics reported fewer symptoms of severe psychological distress than their respective counterparts born in the U.S. (Dey 2006).

Larger sample sizes and more sophisticated statistical analyses have allowed researchers in the last 10 years to better separate the effects of SES, race and ethnicity on mental health. Improved data have also elucidated the contributions that place of birth and place of residence make to mental health outcomes. Additional research along these dimensions would facilitate a better understanding of how social contexts affect racial and ethnic minority groups, both generally and specifically. As the results of these studies are fed back into the mental health system, prevention and treatment programs can be tailored to have the greatest impact among their served populations.

**Culture:** Recent attention to the dimension of cultural resilience offers insight to the factors that may ameliorate the effect of stress on individuals’ mental health. Among Mexican Americans, those who are more acculturated (i.e., have spent more time in the U.S.) exhibit higher rates of psychiatric disorders compared to their less acculturated or foreign-born counterparts. However, less acculturated Asian Americans show greater symptoms of psychological distress than do their more acculturated counterparts (Sue 2003). More research is needed to understand and capitalize on the role of resiliency among racial and ethnic groups.

Language remains a major barrier to accessing and receiving mental health care for non-English speaking populations. In a 2007 report of 42,000 participants in the California Health Interview Survey, non-English speaking individuals were less likely to receive mental health care than those who spoke only English. Within groups, non-English speaking AAPIs and non-English speaking Latinos had significantly lower odds of receiving mental health services than their English-only AAPI and Latino counterparts (Sentell 2007).

Linguistic competence is a pivotal requirement for culturally competent care in all segments of the mental health system. Research on the Chinese language version of the Beck Depression inventory confirmed that it reliably reports symptoms of depression in the Chinese speaking population (Yeung 2002). Similar translations and evaluation research should provide standardized assessment tools for all the languages needed to serve mental health consumers.

While linguistically appropriate screening and diagnostic instruments are useful to establish mental health diagnoses, information about the individual’s medical and mental health histories and social context are crucial to understanding the etiology of mental illness. The cultural norms of a group influence the health outcomes of its members. Not having information about history, background, cultural norms and context fosters unstructured attempts at assessment which result in greater variability in diagnosis and greater reliance on providers’ biases and stereotypes. Unfortunately, at least one in five resident physicians recently surveyed (from seven specialties) reported not being prepared to deal with cross-cultural issues (Weissman 2005). Approximately half of these residents reported receiving little or no training in how to address patients from different cultures (50%), how to identify patient mistrust (56%), relevant religious beliefs (50%), and relevant cultural customs (48%).
Several studies have documented the effect of patients’ cultural beliefs and attitudes toward mental health on the utilization of services. One study reported that a significant factor reducing the utilization of mental health services among Blacks may be mistaken beliefs about the etiology and natural course of mental disorders, specifically, that without treatment “it will go away,” and that treatment is not likely to be effective (Anglin 2008). International research showed that financial barriers were more prohibitive for poor people who needed mental health services in the U.S. than in Ontario or the Netherlands. However, across all sites, attitudinal barriers (i.e., a belief that the problem would get better on its own) were more important than structural barriers for people who needed mental health services but did not get them (Sareen 2007).

Another cultural difference confirmed by research is a stronger preference among African Americans for psychotherapeutic interventions over pharmacologic interventions when seeking mental health care. A survey of 40,000 individuals in the Veterans Administration (1999-2006) confirmed that African Americans were less likely to receive guideline-concordant pharmacologic treatment and more likely to receive guideline-concordant psychotherapeutic treatment than their White counterparts (Chermack 2008). Different rates of prescribing psychotropic drugs to African Americans and Hispanics may reflect disparities in treatment quality or differences in cultural preferences for treatment modality (Depp 2008). Understanding different cultural attitudes, preferences and norms regarding mental health and its treatment would help us design more appropriate and effective interventions with which patients are more likely to comply. More research in this area is required.

**Access:** Studies on access and treatment for mental health services continue to reflect disparities for racial and ethnic minorities. The National Healthcare Disparities Report showed that among adults who suffered from depression in the last 12 months, African Americans and Hispanics were less likely to receive treatment than Whites (58.9%, 51.8%, 71.1% respectively) (AHRQ 2008). Several reports confirmed that when treatment is received, disparities persist. A study by Bender showed that African Americans and Hispanics received a more limited range of psychiatric treatments compared to Whites, including fewer psychosocial services and fewer psychotropic medications (Bender 2007). Several studies also confirmed persistent treatment disparities after correcting for SES variables. Mallinger and Zito reported that, after controlling for access and demographic differences, Black adults and minority youth were less likely to receive psychotropic medications than their White counterparts (Mallinger 2006; Zito 2005). Zimmerman and Garland showed that, after controlling for inferred need and socioeconomic differences, Black and Latino youth were less likely to receive any mental health services, including treatment for depression (Zimmerman 2005; Garland 2005). Cultural differences in consumers’ treatment preferences were not reported in these studies.

The perceived cost of mental health care also affects patients’ access to services. Low-income groups in the U.S. are more likely to report cost as a barrier to mental health services; because racial and ethnic minorities are disproportionately represented in lower-income brackets, they are less likely to access such services (Sareen 2007). Mojtabai (2005) confirmed the power of the cost barrier in research showing that minority populations are more likely than their White counterparts to report that they cannot afford mental health care.

Cultural attitudes and norms, often a reflection of historically disparate treatment in the health care system, also affect decisions to access mental health care. Blacks and Latinos reported a greater mistrust of the health system which is related to their decreased utilization of services compared to Whites (Shattell 2008; Whaley 2004). Whaley (2004) found that Black men with mild paranoia were significantly less likely to be hospitalized because their lack of trust in the mental health system led them to avoid seeking care. The researcher concluded that acknowledging racial biases in the mental health system and sincere efforts to eliminate disparities in treatment were key to increasing Blacks’ trust in mental health care.

These studies deepen our understanding of the racial, ethnic and cultural disparities in mental health access and treatment. More research incorporating standardized reporting, larger sample sizes, diverse age groups, more racial and ethnic categories,
including country of origin and immigration status, would help us to distinguish the intentional and unintentional causes of disparities in access and treatment, and to improve the cultural competence of the mental health system and mental health outcomes for all.

**Systems of Care:** Access to mental health care is significantly affected by the ability to pay. Approximately half of the 46 million Americans who have no health insurance are members of racial/ethnic minorities; 44 percent of low-income Hispanics and AIANs are uninsured. African Americans, especially those at the low end of the SES scale, are most likely to receive coverage through Medicaid or other public insurance program. More than half of the 35 million adult Medicaid beneficiaries under 65 years old are racial and ethnic minorities. The majority of the 42 million Medicare recipients are White.

Although a majority of Americans get employer-provided health insurance, racial and ethnic minorities, especially Hispanics, are less likely than Whites to be covered through their jobs (James 2007). Low-income Hispanics, African Americans, and AIANs are least likely to receive health insurance coverage from their employer. Workers in small businesses, entry-level and low-income workers, and the self-employed are least likely to have employment-based health insurance.

In 2008, 98% of the employer-based plans among 2,832 randomly selected public and private firms with three or more employees provided coverage for mental health benefits, but a majority of them limited coverage for both outpatient and inpatient mental health care (Claxton 2008). Sixty-two percent of insured workers were in plans that covered 30 or fewer outpatient mental health visits in a year; 55% of small firms’ plans and 24% of large firms’ plans (200 or more workers) covered 20 or fewer outpatient mental health visits per year. Twenty-two percent of covered workers had an unlimited number of mental health inpatient days; 62% were limited to 30 days or less; 33% of small firms and 11% of large firms limited coverage to 20 days or less. These data reflect persistent discrimination against mental health care compared to medical/surgical care in insurance plans. This discrimination has weighed most heavily on minorities, because they are overrepresented in low-income jobs, public insurance programs and the uninsured. Hopefully, these same minority populations will gain the most from the physical/mental health parity required by PPACA.

Recent studies continue to highlight the need to integrate behavioral health into the primary care system, especially to address the high co-occurrence of depression, substance abuse and medical illness (Robinson 2005; Wells 2005; Keyes 2008). Integration is most important for racial minorities who access specialty care less and primary care more than Whites, and who suffer more from chronic medical illnesses and substance use disorders (Robinson 2005; Wells 2005; Keyes 2008). Studies show that screening for depression in primary care settings improves health outcomes, particularly when screening is coupled with system changes, including provider training and patient education, that help to ensure adequate treatment and follow-up (Pignone 2002; Wells 2005). Adapting culturally competent screening tools for depression and other mental disorders for use in the primary care setting would help assure consistent care and outcomes (Kroenke 2003).

Because the mental health system of care would benefit from being able to compare findings within and among racial and ethnic groups, more research is needed to standardize the instruments and methods for data collection in areas including access, diagnosis, treatment, compliance and prevention (Sue 2003). For example, Coyne (2006) reported that the DSM-IV’s use of “receipt of care” as a criterion to assess the clinical significance of depression may underestimate its prevalence in African Americans, not because they show fewer symptoms of depression compared to Whites, but simply because they are treated for it less often.

The criminal justice system has become, by default, a substantial provider of mental health services. Unfortunately, the criminal justice system was not designed and is not funded or operated to provide such care. As with other systemic faults, these inadequacies fall most heavily on racial and ethnic minorities, who represent the majority of the adult prison (62%) and jail population (57%), and more than two-thirds of those confined in the juvenile justice system (Primm 2005). The adult and
juvenile correctional systems report that 15% to 27% of their population present with at least one serious mental illness; more than half of these have substance abuse disorders. It is clear that the criminal justice system must be incorporated into the development of a successful, comprehensive system of mental health care for all.

The mental health system can work to ensure that its services are appropriate, affordable, accessible and effective for the communities served. Recent studies show that providing adequate health insurance, with mental health parity, significantly increases access to and use of services. Integrating competent mental health services into primary care also minimizes barriers. Providing culturally sensitive mental health services through adult and juvenile correctional institutions, schools, churches and other nontraditional venues would “meet the people where they are,” a powerful approach for the prevention, early diagnosis and treatment of mental illness. Employee Assistance Programs also have the capacity to bring culturally relevant services to the people who need them in convenient, accessible, inexpensive settings.

**Prevention:** An understanding of cultural norms and beliefs is crucial for developing successful primary and secondary mental health prevention programs. For example, Coyne (2006) reported that African Americans report just as many symptoms of depression as do Whites, but significantly less treatment and interference with functioning. This suggests we must ask the right questions to elicit accurate information from different target audiences. More social marketing should be done to ensure we are tailoring and targeting services for the populations who need them most.

Bolden (2005) reported that understanding the prevalence of mental health disorders in the population being served is necessary to provide appropriate prevention and intervention programs. For example, because African Americans who live in urban areas and immigrant Asian Americans and Hispanics who were refugees exhibit higher rates of post traumatic stress disorder compared to the general population (Davis 2008; Marshall 2005), prevention and early intervention programs emphasizing PTSD should be a priority in these communities.

Incorporating the community, workplace, family and faith-based organizations into the design and implementation of prevention programs would help to ensure their cultural relevance and efficacy. A model example of such a multi-system, comprehensive, culturally appropriate treatment approach is the New York City-based substance abuse treatment program that provides mental, medical and social services targeted primarily to African Americans. The Addiction Research and Treatment Corporation (ARTC) is staffed with specialists in mental health, substance abuse, primary care, HIV/AIDS, as well as social service providers and care managers largely of African American, Afro-Caribbean and Latino descent, reflecting the population they serve. ARTC works closely with other non-profits to offer: comprehensive services for the victims of domestic violence, including shelter, social support services, vocational training and jobs; training for developmentally disabled youth; and intermediate care facilities for developmentally disabled and mentally ill adults. This “one-stop” approach to providing comprehensive services helps to ensure effective, long-term care (Ducharme 2007). ARTC facilities are located in the communities they serve, providing a community “health home” that employs community members and serves as the community voice for public health messages and mental health advocacy.

Research over the past 10 years has revealed the importance of racial and ethnic identity in mental health care. This importance was underscored in a recent report by the Subcommittee on Standardized Collection of Race/Ethnicity Data for Healthcare Quality Improvement published by the Institute of Medicine (IOM 2009). It is imperative that mental health systems collect and report race/ethnicity data in conformance with federal standards. Such data are key to developing and implementing appropriate prevention programs that can meet each population “where they are.”
DISCUSSION

To complete the research for this report, five identified experts in minority mental health and health insurance were interviewed in-depth about mental health research, policy, programs and treatment from a variety of providers. (Key informants are listed on page 9. The questions and verbatim responses are available upon request from Morgan State University, School of Community Health and Policy.) Following that, members of the Research Group (also listed on page 9) met, together with the key informants, to review and assess all the information gathered to that point, and make final recommendations.

Based on our literature review and qualitative research, and guided by the Surgeon General’s Report on Mental Health: Culture, Race, and Ethnicity, the recommendations for optimal mental health and behavioral treatment programs for Aetna’s managed care consumers of color follow. The dimensions of social context, culture, access, systems of care and prevention as mediators of the accessibility and effectiveness of behavioral health treatment programs serve as the framework for our analysis and conclusions.

Social Context

The mental health needs of minority populations require that we deliver care where they are by incorporating mental health expertise into the criminal justice system, the public health system, community-based and faith-based organizations. Consumer needs also demand that services be provided by professionals who understand and appreciate the cultural context of the individuals they serve. Disparities in mental health cannot be eliminated without addressing the social contexts of the communities in which consumers live and the institutions and individuals that serve them.

The effect of social context on the mental health of minority individuals may be even more important than it is for persons in the majority. For many persons of color, living in a social context of continuous perceived discrimination generates stress that diminishes mental well-being. The Surgeon General’s Report and subsequent research also highlighted the additional risk to mental health of being in the lower socioeconomic strata, where racial and ethnic minorities are overrepresented. Poor people are less likely to receive mental health services, and when they do, they are more likely to be served in public institutional settings such as schools and prison facilities. Key informants interviewed for this work reported that persons of color perceive the criminal justice system as a natural context for mental health care. In fact, many mental health services provided in schools, athletic facilities, faith-based organizations and criminal justice settings have a substantial positive impact on the people they serve, though the services are not labeled and not perceived as “mental health.”

Our recent literature review confirmed the increased prevalence of depression in poor communities, and reiterated the confounding effects of socioeconomic status, geographic setting and immigration status on mental health status. After correcting for socioeconomic status including income and insurance coverage, people of color still receive disparate treatment. This research argues strongly that race and ethnicity be recorded and reported as independent variables in evaluation research, and suggests additional research on a variety of other social factors that may moderate mental well-being differentially among racial and ethnic minorities.

Key informants who urged the need to maintain race as an independent variable also recommended more in-depth study of heterogeneity within racial and ethnic groups. In addition, they stressed the importance of mental health service providers’ understanding of how social context impacts mental status, the perception of mental illness, mental health treatment and recovery in persons of color. Using the framework of “social determinants of health,” several key informants emphasized that treating individuals within their social context would improve mental health outcomes. The importance of maintaining
racial and ethnic data in all prevention and treatment programs was repeatedly stressed as critical to improving mental healthcare for all populations. For persons with insurance, benefits delineated in the health plan determine the extent of coverage and hence, the cost to the beneficiary.

EAPs can help to enhance the quality and availability of mental health services and reduce their cost. EAPs should establish good working relationships with their local and state mental health agencies to better serve individuals and families who may wander in and out of insurance coverage. It would be wise for employers to consider how improving the mental health status of their workforce affects their bottom line. Employers have the data to monitor whether lowering co-pays and increasing limits for mental health services works to reduce absenteeism and improve productivity. The consensus was clear that Aetna and insurance companies should be proactive in ensuring the high quality of and easy access to mental health care.

Families and communities are also important to the social context of mental health. Our work confirms that the prevention and treatment of mental illness can best be ensured by providing services to family members to maximize the contributions they can make to improving the health of individual patients.

**Culture**

Culture plays a major role in determining how individuals assess changes in mental status and whether they seek assistance in dealing those changes. Culture may affect mental health positively (e.g., cultural resilience) or negatively. Knowledge of the variable impact of different cultures on behavioral health is critical in training providers as well as in planning, implementing and operating effective systems of care. Knowledge of the consumer's culture is also necessary to establish accurate diagnoses, to implement effective public policy, to identify and engage community resources and to design meaningful research studies. The Surgeon General's Report highlighted these areas of importance and encouraged development of cultural and linguistic competence in all mental health services. Literature reviewed since the Report was published revealed the significant role of resilience in the acculturation of immigrants and in the African American history of struggle. Key informants noted evidence of increased cultural awareness, e.g., the availability of printed information in a variety of languages. But they lamented the lack of funding for expanding this important work. Although the term “cultural competence” is often used, its syntax is usually as a point of discussion, not a goal in itself. The leaders of our mental health systems must take responsibility for ensuring cultural awareness and competence in all sectors of service delivery.

Researchers continue to report language as a significant barrier for minorities who need mental health services. Ensuring sufficient linguistic skill to serve specific populations must also be monitored and improved by the leaders of both government and private-sector mental health programs. The standardization of practices described in system-specific cultural guidelines would benefit both consumers and providers of mental health services. Expanded linguistic services would encourage minorities to seek mental health care from systems they may have never trusted before.

Key informants confirmed prior reports of how norms for collectiveness, presumptions about body and mind connections, and the importance of religion, family and friends differ among African American, White, Hispanic and other racial and ethnic groups. Informants expressed great concern that different cultural norms are not incorporated by insurance companies into the design and delivery of services, or the development of evidence-based best practices. Adequate funding and consistent documentation of the role of culture in affecting health status is necessary to achieve cultural competence in providing care.

The consensus meeting highlighted the successes of EAPs in providing behavioral health programs that match the cultural norms of the populations they serve, incorporating cultural competence into outcome assessments, and guarding against culturally irrelevant practices that may deter access to services. Evaluation of how cultural relevance improves the performance and outcome of these services for minority employees would help to further enhance the services provided to these consumers.
Access

All racial and ethnic minorities are less likely than their White counterparts to access behavioral health services. When they do, they receive less total treatment over a shorter duration, and poorer quality care. Minorities disproportionately seek mental health services from primary care settings. Poverty, the stigma of mental illness, the fact of current and historical racism, and a lack of trust of the health care system in general and the mental health system in particular also limit access to and compliance with treatment.

Key informants emphasized the social costs of inaccurate diagnosis, inadequate treatment of mental illness and limited access to the newest medications for minorities. Culturally competent providers who share an understanding of their patients’ world views and preferences for intervention enjoy better communication and treatment outcomes. Key informants also emphasized the appropriateness of the site of service delivery, and the benefits of using community resources. EAPs were highlighted at the consensus meeting for having the opportunity to capitalize on their intimate knowledge of their consumer base in tailoring programs to their target populations. Evaluation of the different types of treatment programs offered by employers can improve performance in all EAPs.

Systems of Care

The 2003 Report from the New Freedom Commission confirmed the conclusions of the 2001 Surgeon General’s Report regarding the need to: reduce barriers to accessing behavioral health programs; integrate mental health services into primary care and allied health services; improve the mental health training of providers at sites where such care is more frequently sought by minorities, including emergency rooms, primary care sites and the criminal justice system. Key informants considered current systems for mental health evaluation to be cumbersome, stigmatizing and inaccessible for many African Americans. They also stressed the importance of integrating mental health services, training culturally sensitive providers in diagnosis and treatment, and establishing referral systems for care that is culturally competent and locally accessible.

Key informants confirmed research findings that the criminal justice system has become the default mental health provider for many racial and ethnic minorities. Unfortunately, our jails and prisons are already underfunded to fulfill their primary function of public safety; they are quite unprepared to address the mental health problems that may have contributed to the incarceration of many of their prisoners. The inattention to these mental health needs is very costly to society since most people who enter prison are eventually released and return to the neighborhoods where they used to live. Well designed programs to evaluate and treat mental illness should be matched with sufficient funding to meet the needs of the entire population under the control of criminal justice.

Research shows that the 47 million individuals who currently have no private or public health insurance are less likely to receive mental health care no matter how badly it is needed. While the majority of EAPs provide mental health services, the limitations in coverage and required co-payments present a challenge to those who need them most. Workforce productivity is directly affected by the physical and mental well-being of workers. Health insurance companies such as Aetna are poised to help employers provide the services to treat and prevent chronic physical and mental illnesses.

Key informants highlighted the need for more research to identify and improve community resources that are culturally relevant and effective in addressing mental illness in communities of color. Suggestions included funding community mental health centers to employ and train culturally competent professionals, and using publicly-funded community health cen-
ters as hubs for assessing needs and making appropriate referrals. Establishing systems that support seamless flow through physical and mental health providers would reduce stigma and better address the mental, physical, social and spiritual needs of the community. Although federally qualified community health centers currently exist in most low-income urban and rural communities to serve the primary care needs of uninsured, underinsured and Medicaid-insured populations, they do not consistently and competently address mental health needs. These centers should be appropriately staffed, funded and supported to provide mental health services appropriate for the populations they serve. Such centers could also serve as sites for continuing research on and development of culturally relevant practices, and training grounds for culturally competent professionals, para-professionals, and researchers in mental health. The consensus group identified increased funding to develop a culturally sensitive mental health workforce as critical.

**Prevention**

The key directive of the Surgeon General’s Report was to promote mental health and prevent mental illness, especially through the use of community-based resources and culturally relevant practices. Key informants reflected that while there is greater awareness of the need for a public health or preventive approach to mental health, there is little evidence of its implementation.

All experts believed that partnerships with community-based resources that are trusted and culturally aligned with the people they serve help to address the multiple social factors that affect the mental well-being of racial and ethnic minorities. While anecdotal reports support the benefits of such collaborations, improved outcomes have not been confirmed through large-scale, controlled research. Collaboration between mental health systems and community-based programs to monitor treatment and outcomes through standardized data that is systematically reported and analyzed would build a database of valuable information. Such information could be used for quality control and improvement of services, and could be disseminated throughout the nation.

Insurance companies are in an ideal position to support the synergistic connections between mental and physical health, public and private systems. Insurers, who have a clear stake in health outcomes, could coalesce community health centers, EAPs, health departments, religious institutions and mental health professionals and help to focus their joint efforts on the common goal of improved social and individual well-being. A more public health or preventive approach to achieving this goal would incorporate cultural norms, local resources and community leaders. Community health centers could serve as hubs linking community centers, faith-based organizations, gyms, after-school programs, programs for the elderly and a variety of government resources including the criminal justice system, schools, social services and health departments.

Insurance companies can also support the research that is necessary to link specific approaches and treatments with improved outcomes, and to identify the social determinants of mental illness. Where they are evidence-based, current programs are based primarily on knowledge gained from research in which people of color were significantly underrepresented. Research designed to incorporate minorities in numbers that correspond to their need for services can help us to plan and implement programs that produce better and more cost-effective results.


Mental Health Parity Act of 1996 (P.L. 104-204).

Mental Health Parity and Addiction Equity Act of 2008 (P.L. 110-343).


Websites

• Cultural competence training: http://www.nccccurricula.info/awareness/C4.html
• Treating depression in a primary care setting: http://cme.medscape.com/viewarticle/702891
• Social determinants of health training: http://www.healthnexus.ca/projects/primer.pdf
• Unnaturalcauses.org

Websites accessed in February 2010.