Pathways to Behavioral Health Equity: Leveraging Culture and Language to Address Immigrant Health Disparities

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Vision

➢ All populations will have equal access to high quality behavioral health care.

Mission

➢ To reduce the impact of substance abuse and mental illness on populations that experience behavioral health disparities by improving access to quality services and supports that enable individuals and families to thrive, participate in and contribute to healthy communities.
Today’s Conversation

- America and Health
- What Creates Health
- Social Determinants of Mental Health
- Role and Opportunity for Communities
- Government Efforts
What creates health?

Figure 4: State of primary resettlement for Bhutanese refugees, FY 2008-FY 2012 (N=49,010)

<table>
<thead>
<tr>
<th>Top 10 States*</th>
<th>No.</th>
<th>(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pennsylvania</td>
<td>4909</td>
<td>(10.0)</td>
</tr>
<tr>
<td>Texas</td>
<td>4873</td>
<td>(9.9)</td>
</tr>
<tr>
<td>New York</td>
<td>4000</td>
<td>(8.1)</td>
</tr>
<tr>
<td>Georgia</td>
<td>3446</td>
<td>(7.0)</td>
</tr>
<tr>
<td>Ohio</td>
<td>2335</td>
<td>(4.7)</td>
</tr>
<tr>
<td>Arizona</td>
<td>2329</td>
<td>(4.7)</td>
</tr>
<tr>
<td>Colorado</td>
<td>2117</td>
<td>(4.3)</td>
</tr>
<tr>
<td>Washington</td>
<td>1944</td>
<td>(3.9)</td>
</tr>
<tr>
<td>Virginia</td>
<td>1883</td>
<td>(3.8)</td>
</tr>
<tr>
<td>North Carolina</td>
<td>1671</td>
<td>(3.4)</td>
</tr>
</tbody>
</table>

* The remaining 19,503 refugees resettled to 31 other states. Source: WRAPS
Figure 5: Demographic characteristics of Bhutanese refugees resettled to the United States, 2008-2011 (N=48,846)

Source: Electronic Disease Notification System (EDN)
Why do we continue to see such disparate health outcomes across our communities, despite our efforts to widen access to the best medical care in the world?
Communities of Opportunity

- Parks & trails
- Grocery stores
- Thriving small businesses and entrepreneurs
- Financial institutions
- Better performing schools
- Good transportation options and infrastructure
- Sufficient healthy housing
- Home ownership
- Social inclusion
- IT connectivity
- Strong local governance

Good Health Status

Poor Health Status
Contributes to health disparities:
- Obesity
- Diabetes
- Cancer
- Asthma
- Injury

Low-Opportunity Communities

- Unsafe/limited parks
- Fast food restaurants
- Payday lenders
- Few small businesses
- Poor performing schools
- Increased pollution and contaminated drinking water
- Few transportation options
- Poor and limited housing stock
- Rental housing/foreclosure
- Social exclusion
- Limited IT connections
- Weak local governance
What interrupts health?

- School/Job/Workplace Issues
- Substance Use Problems
- Social and Relationship Problems
- Family & Parenting Issues
- Violence and Trauma
- Chronic Health Problems
- Mental Health Problems
- Homelessness, Housing Insecurity
- Incarceration
- Suicide
- PTSD
- Depression
- Schizophrenia
Impact of Trauma over the Lifespan

Effects of childhood adverse experiences:
• Neurological
• Biological
• Psychological
• Social

(Felitti et al., 1998)
SAMHSA’S Comprehensive Public Health Approach to Trauma

Integrate & “Hard-wire” an understanding of trauma and strategies for implementing a trauma-informed approach across SAMHSA, interested federal agencies, and other public service sectors.

Key Objectives
- Reduce the impact of trauma on individuals, families and communities
- Develop/implement trauma-informed approach across systems and workplaces; for users and providers of services
- Make trauma-informed screening, early intervention and treatment common practice
- Promote recovery, well-being, and resilience

Activities
- Trauma Concept Paper
- Measurement Strategy
- Funding & RFA Language
- Training and Technical Assistance
- Partnerships
SAMHSA’s General Adult Trauma Screening and Brief Response Initiative in Primary Care Settings

Build a framework for screening and brief response for trauma across the lifespan in primary care and other health/public health settings

### Key Questions
- Why screen in primary care and what to do with the information?
- What models, tools, and resources currently exist?
- What needs to be in place before moving forward?
- What workforce development and training is needed?
- How to solicit buy-in from primary care settings?

### Activities
- Face-to-Face Experts Meeting
- Virtual Discussion Network meetings
- Toolkit Development
- On-going engagement with federal and other stakeholders

### Partners
- Federal, National Associations, Foundations
- Health care Providers, Researchers, Payers, Content Experts, Advocates
Prevalence of Trauma in Behavioral Health

- Majority of adults and children in inpatient psychiatric and substance use disorder treatment settings have trauma histories (Lipschitz et al, 1999; Suarez, 2008; Gillece, 2010)

- 43% to 80% of individuals in psychiatric hospitals have experienced physical or sexual abuse

- 51%-90% public mental health clients exposed to trauma (Goodman et al, 1997; Mueser et al, 2004)

- 2/3 adults in SUD treatment report child abuse and neglect (SAMHSA, CSAT, 2000)

- Survey of adolescents in SU treatment > 70% had history of trauma exposure (Suarez, 2008)
Why is Understanding Trauma Important?

• To provide effective services, we need to understand the life situations that may be contributing to the persons current problems.

• Many current problems faced by the people we serve may be related to traumatic life experiences.

• People who have experienced traumatic life events are often very sensitive to situations that remind them of the people, places or things involved in their traumatic event.

• These reminders, also known as triggers, may cause a person to relive the trauma and view the treatment setting/organization as a source of distress rather than a place of healing and wellness.
What is the Real Narrative for What Creates Health & Development Inequities?

• Disparities are not just due to lack of access to health/education resources or to poor individual choices.

• Disparities are mostly the result of policy decisions that systematically disadvantage some populations over others.
  – Especially, populations of color and low income communities
  – Structural Racism/Implicit Bias Critical Explanations (e.g. grantmaking, federal resources, insurance access, social determinants of well-being)
General Barriers To Care for AAPI Populations

Lack of Access
- Language
- Stigma; Individual & Family Resistance
- Education about Services
- Health Insurance Variations Among Subgroups
- Economic

Lack of Identification of Behavioral Health Problems
- Cultural and Linguistic Mismatch
- Focus on Somatic Symptoms
- Family Shame and Guilt
- Fear of Reprisal

Lack of Appropriate Treatment/Recovery Supports
- Models of Care Not Culturally Responsive
- Lack of Providers & Those Trained to Work w AAPIs
- Aligning Appropriate Assessments with Right Care
- Fragmented, Confusing Service System
• AAPIs less likely to seek mental health care
• Use fewer services per capita than other groups
• Do not seek or engage in services in a timely manner; those who get into services more severely ill than the white population who use same services
• Onset of mental disorders, earlier in life
Past Year Mental Illness and Service Use Among Adults

- Adults with Any Mental Illness
  - AAPI: 15.8%
  - Hispanics: 18.3%
  - Amer Indians: 18.7%
  - Blacks: 19.7%
  - Whites: 20.6%

- Past Year MH Service Use Among Adults
  - AAPI: 5.3%
  - Hispanics: 7.9%
  - Am Indian: 13.5%
  - Blacks: 8.8%
  - Whites: 16.2%

Source: SAMHSA’s National Survey on Drug Use and Health, 2010
OBHE Health Insurance Enrollment Project:
Nonelderly Health Coverage by Race/Ethnicity, 2014

Importance of Within Group Variation: Percentage of Uninsured Among AAPIs

Source: Assistant Secretary for Planning and Evaluation, based on U.S. Census figures
Moving Toward Behavioral Health Equity

- Most vulnerable populations focus of outreach and engagement
  - Congruent referral sources
- Enhanced service capacity
  - Perceptions of effectiveness
  - Evidence-supported practices
- Training and technical assistance
  - Cross-training with partners
- Data availability and use
Key Messages re AAPIs & Mental Health

1. Prevalence rates of mental disorders fairly equivalent across race and ethnic groups
2. AAPI’s slightly lower rates
3. For AAPIs there is much within group variability in terms of behavioral health disorders/conditions
4. There is variability across generational groups
5. While prevalence may be slightly lower, burden of disease may be greater
Stigma as a Barrier to Treatment

Self-stigma

<table>
<thead>
<tr>
<th>Statement</th>
<th>Asian-American (n = 10)</th>
<th>African-American (n = 27)</th>
<th>Latino (English) (n = 80)</th>
<th>Latino (Spanish) (n = 18)</th>
<th>White (n = 421)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I feel inferior to others who haven’t had a mental health problem</td>
<td>36</td>
<td>31</td>
<td>49</td>
<td>46*</td>
<td>29</td>
</tr>
<tr>
<td>Having had a mental health problem has spoiled my life</td>
<td>24</td>
<td>22</td>
<td>46*</td>
<td>58</td>
<td>22</td>
</tr>
<tr>
<td>I am embarrassed or ashamed that I have had a mental health problem</td>
<td>21</td>
<td>24</td>
<td>46*</td>
<td>52*</td>
<td>33</td>
</tr>
<tr>
<td>I feel out of place in the world because I have had a mental health problem</td>
<td>37</td>
<td>37</td>
<td>54</td>
<td>64</td>
<td>33</td>
</tr>
<tr>
<td>People who have not had a mental health problem could not possibly understand</td>
<td>33</td>
<td>33</td>
<td>52</td>
<td>72*</td>
<td>77</td>
</tr>
</tbody>
</table>

Percentage who strongly/moderately agree

Treatment Attitudes

<table>
<thead>
<tr>
<th>Condition</th>
<th>Asian-American (n = 10)</th>
<th>African-American (n = 27)</th>
<th>Latino (Spanish) (n = 18)</th>
<th>White (n = 421)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Would go for professional help if had a serious emotional problem</td>
<td>85</td>
<td>94</td>
<td>90</td>
<td>90</td>
</tr>
<tr>
<td>Would put off seeking treatment for fear of letting others know about</td>
<td>35</td>
<td>24</td>
<td>24</td>
<td>24</td>
</tr>
</tbody>
</table>

(Wong, Collins, Cerully, Seelam, & Roth, 2016)
Reasons for Stigma

• For men, stereotypes about strength, endurance, pride, and courage.

• For AANHPI men, stereotypes about intellect, work ethic, and resolve.

• Cultural values emphasize reliance on the family system (collectivism), faith, and conformity to norms.
Recovery Beliefs

- **A person with mental illness can eventually recover**
  - Asian-American: 77%
  - African-American: 87%
  - Latino (English): 75%
  - Latino (Spanish): 83%
  - White: 83%

- **A person with mental illness can lead a normal life with treatment**
  - Asian-American: 99%
  - African-American: 95%
  - Latino (English): 92%
  - Latino (Spanish): 93%
  - White: 77%

- **People who have had a mental illness are never going to be able to contribute much to society**
  - Asian-American: 12%
  - African-American: 5%
  - Latino (English): 5%
  - Latino (Spanish): 2%
  - White: 39%
Perceptions of Support

Percentage who strongly/moderately agree

People with mental illness experience high levels of prejudice and discrimination

- Asian-American: 86
- African-American: 61
- Latino (English): 84
- Latino (Spanish): 95
- White: 76

People are generally caring and sympathetic to people with mental illness

- Asian-American: 56
- African-American: 36
- Latino (English): 31
- Latino (Spanish): 64*
- White: 38

* Indicates a statistically significant difference.
National Network to Eliminate Disparities in Behavioral Health (NNED)

www.nned.net

National Partners
- 2008: 35
- 2009: 85
- 2010: 323
- 2011: 464
- 2012: 541
- 2013: 685
- 2014: 756
- 933 Affiliates
Total: 1,598
Data…Data…Data

- Policy
- Practice
- Performance Accountability
Thank you!

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http://www.samhsa.gov/behavioral-health-equity