Faulty assumptions behind persistent racial/ethnic disparities in behavioral health care

June 9 2016

Racial and ethnic disparities in the treatment of mental health and substance use disorders may result from key faulty assumptions about the best ways of addressing the needs of minority patients. Those assumptions are detailed, along with recommendations for potential improvement strategies, in an article in the June issue of *Health Affairs*

"Despite increased attention to racial/ethnic disparities in health care since the early 2000's, national reports show that disparities in access to mental health and substance use treatment have not changed," says Margarita Alegría, PhD, chief of the Disparities Research Unit in the Massachusetts General Hospital (MGH) Department of Medicine, lead author of the article. "Even when minority patients enter care, the care they receive is often low quality because the current design of our health care system doesn't incorporate the latest research findings on novel treatment models or engagement strategies for ethnic/racial minorities."

The 2014 National Health Quality and Disparities Report of the U.S. Agency for Healthcare Research and Quality noted that racial and ethnic disparities in access to treatment of mental health and substance use disorders had changed little between 2008 and 2012. Overall, minority group patients were less likely to receive treatment for depression and less likely to remain in treatment for substance use disorders. Those who did enter treatment for drug or alcohol use were less likely to complete a treatment program.

Even though more than 30 million Americans have gained access to health insurance under the Affordable Care Act, the paper's authors note that current policies designed to improve access to health care may not address issues affecting minority patients. Based on published studies and their own experiences with patients, they describe three mistaken assumptions that may lie behind the persistence of racial/ethnic disparities in behavioral health care:

- That a universal approach to improving access to care by itself will reduce disparities;
- That the current planning of behavioral health service delivery addresses the preferences of minority patients;
- That research-backed treatment practices can be easily adapted to health care setting serving diverse populations.

In contrast to those assumptions, studies have documented that bringing minority patients into behavioral health care may require frequent, persistent follow-up and re-scheduling from their providers - something that may conflict with the more recent standard clinical practice of dropping patients after missed appointments. Since the needs and preferences of patients from different racial and ethnic groups can vary widely, a range of approaches on how and where behavioral health treatment can be accessed and delivered is required. And implementing evidence-based interventions in real-world setting has often proven difficult because of a lack of supporting infrastructure to providers that see minority patients and the lack of linguistic and cultural diversity of the workforce.

To help counter these limitations, the authors make three recommendations:

- "Tailor the provision of care to remove obstacles" by expanding outreach efforts "beyond clinic walls, with a focus on engaging

racial/ethnic minority groups." Suggested measures include mobile health clinics, mobile technologies - including telephone and video-basted treatment - and social marketing campaigns designed to reduce stigma and inform patients of available options.

- "Respond to patients' needs and preferences," by collecting data on their behavioral health needs, current options and the barriers they encounter. This information could be used to inform providers and policy makers about the needs of minority patients and to guide the development of personalized programs and accessible decision aids.
- "Be flexible in using evidence-based practices and expanding the workforce." The implementation of research-backed practices needs to be done through partnerships among researchers, caregivers and community leaders. Providing behavioral health training to the more than 120,000 community health workers working in clinics and community organizations would be a key step towards expanding access to and availability of behavioral health care.

"Current payment models can impede the implementation of behavioral health innovations," says Alegría, who is a professor in the department of Psychiatry at Harvard Medical School. "To be most effective, payment structures should facilitate care continuity, flexible scheduling and alternative forms of treatment such as telemedicine. The collection of data regarding patient satisfaction with and adherence to care should include racial, ethnic and language background of patients that could help us track and report on disparities and treatment outcomes and be used to incentivize the reduction of disparities. And partnerships among researchers, clinicians, administrators and policymakers can help us ensure that the substantial evidence we have already accumulated on behavioral health disparities can be effectively and consistently translated into improved patient care."

More information: M. Alegria et al, Removing Obstacles To Eliminating Racial And Ethnic Disparities In Behavioral Health Care, *Health Affairs* (2016). DOI: 10.1377/hlthaff.2016.0029