Against the Odds: Addressing Race/Ethnicity Barriers via Systems of Care

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Overview

Systems of care offer unique opportunities to reduce race/ethnicities barriers for youth with SED:

- Access to Care - Race/ethnicity for families enrolled in MHSPY vs. compared to surrounding communities
- Engagement/Retention - Length of enrollment and drop-out rates
- Care Experience - Family Centered Behavior Scale collected from families; quantifiable measure of access, engagement and culturally competent processes

Background

- Health care *status* and health care *access* disparities exist, based on race and ethnicity (DHHS, 2001)
- Though access to mental health services for children in the U.S. is inadequate in general (DHHS, 1999), access to mental health services for children of color is worse (DHHS, 2004)
- Children receiving Medicaid half as likely to get treatment as children who are privately insured (Glied, 2003)

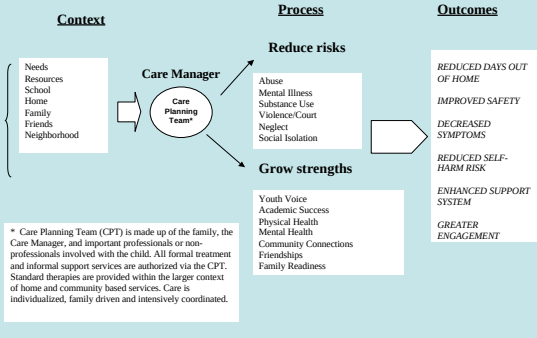
Background, cont.

- Given the trajectory of untreated mental illness (WHO, 2005), mental health delivery systems must improve access for all children
- Especially urgent to even the odds for children now at-risk of getting poor quality or no care at all

Mental Health Services Program for Youth

- MHSPY is an intensively coordinated system of care using blended funding from: Medicaid, Mental Health, Child Welfare, Juvenile Justice and Education (Grimes, 2006)
- Promotes mental health of youth at-risk of out-of-home placement; voluntary home and community-based clinical intervention
- Supports sustainable strategies for youth with mental health needs to live in the community

MHSPY Clinical Intervention: Logic Model



Population At-Risk for Disparities

- Many MHSPY families have extensive histories of prior involvement with state agencies but few actual services; perceived and concrete barriers (e.g. cultural, linguistic differences, transportation, homelessness)
- MHSPY enrollees are a heterogeneous population; children and their families come from numerous countries and many are recent immigrants, including some undocumented

Methods: Engagement

- Intensive individualized home-based outreach extended as a key element of the referral, enrollment and care delivery processes
- Availability of family support specialists, themselves parents of children with special needs, to connect with enrolled families
- Uses natural supports in combination with traditional health services

Methods: Care Delivery

- Care Management: intensive interaction with the child/family, low case ratio (8:1), individualized and flexible service planning
- Access to culturally competent community services within the MHSPY benefit (both traditional medical and mental health services and non-traditional services)
- Coordination and funding of support services such as interpreter services, transportation, etc.

Methods: Cultural Competence

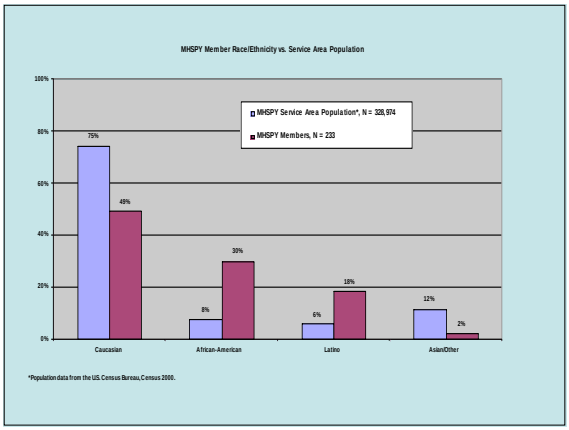
- Diversity is a major focus of staff recruitment
- Regular group training opportunities and individual supervision occurs for all staff; open dialogue promoted to support cultural competence
- Access to community based providers who have clinical expertise with a range of cultures
- MHSPY staff includes bi-cultural Care Managers and family support specialists

Methods: Data Collection

- Race/ethnicity data, based on self-report, is collected at enrollment; aggregate race/ethnicity rates compared to community prevailing rates
- Gender, Diagnosis, CAFAS, Referral Source, ALOE, Graduation and drop-out rates and Location at disenrollment; broken out by race/ethnicity
- Family Centered Behavior Scale (FCBS): The FCBS measures fidelity to system of care principles; measure of “family friendliness”

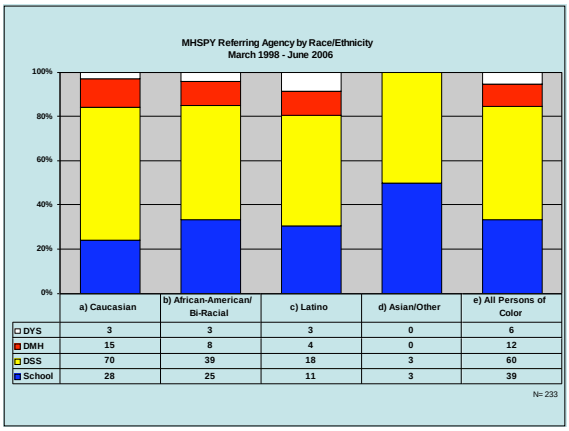
Results: Race/Ethnicity

- Community comparison - Race/ethnicity self-report survey results indicate more than half (51%) of MHSPY members are children of color (N=233) vs. 25% families of color in their communities
- Gender comparison – While MHSPY enrollees who are white have a 1:1 male to female ratio; among children of color, the ratio changes to 3:1 male.



Results: Sources of Referrals

- More children of color referred by schools and juvenile justice (N = 117)
- Latino children appear to be more likely to have been referred by juvenile justice than any other group (N = 36)
- More white children referred from the state mental health system and protective services (N = 116)



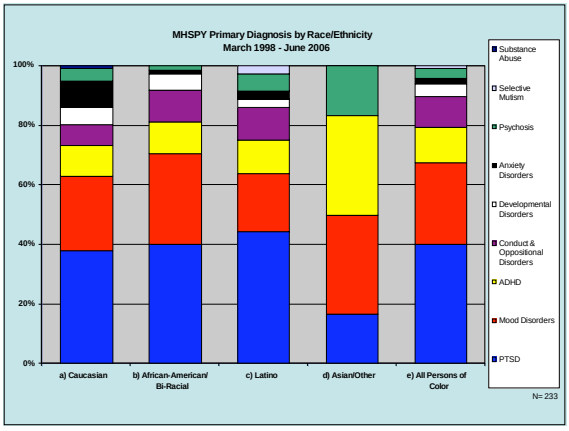
Results: Diagnosis

Review of diagnosis by race/ethnicity raises questions about access to state resources:

- Although higher percentage of white children are referred by protective services, a higher percentage of children of color have PTSD (40%)

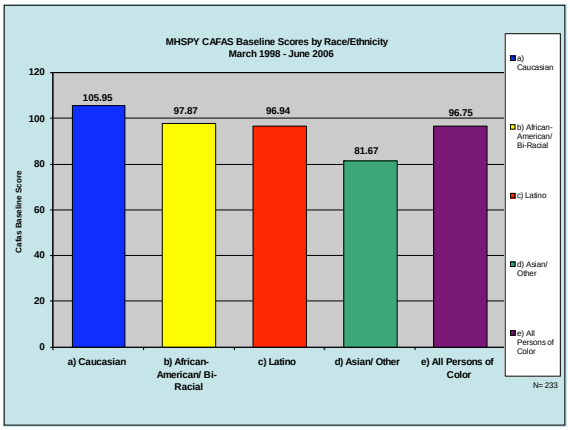
White children referred by state mental health system 13% of the time vs. Latinos 11%, however:

- Higher percentage of Latinos (6%) than whites (4%) are diagnosed with Psychosis
- Enrollees of color more likely to have Mood Disorders (28%) vs. Caucasians (25%)



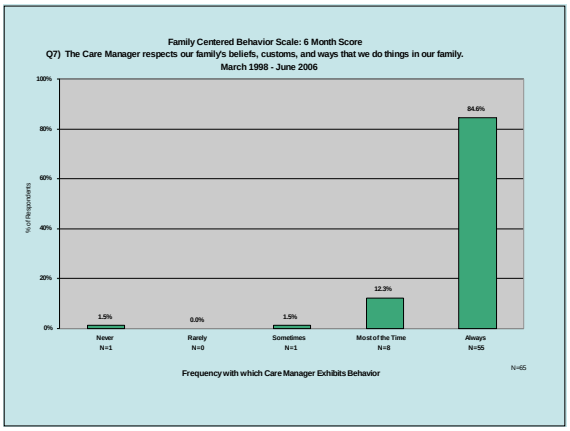
Results: Baseline CAFAS

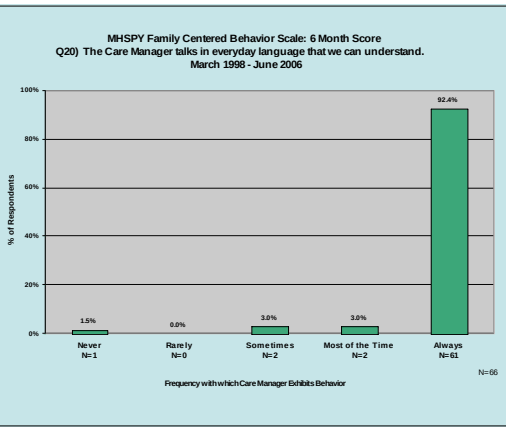
- MHSPY youth on average score > 100 on CAFAS at baseline (N = 233)
- Scores for enrollees of color (N = 117) in aggregate are approximately 10% lower on baseline CAFAS than those for white youth (N = 116)
- Baseline CAFAS scores for African-American/Bi-racial youth (98) and Latino youth (97) are comparable



Results: FCBS

- Results from the FCBS survey indicate families scored their Care Managers at 80 % or higher on all 26 questions
- Current vs. past care experience ratings differ widely
- Responses suggest that interactions with the Care Manager frequently fall into categories which could promote family engagement and resilience





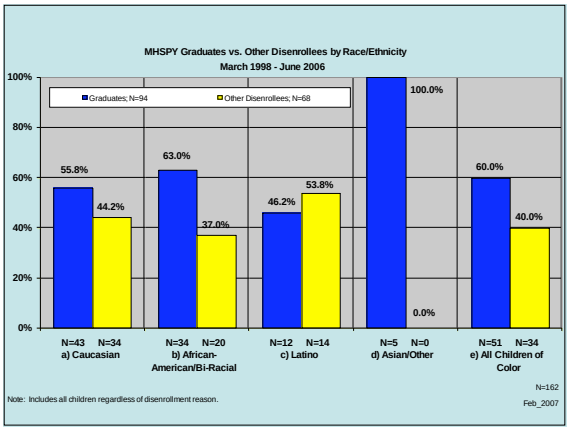
Results: Average Length of Enrollment

- White: 18.3 months
- African American / Bi-Racial: 20.1
- Latino: 17.9
- Asian: 23.5
- All Persons of Color: 19.6

Results: Program Retention

MHSPY, a voluntary program, has maintained a program retention rate between 95-97 % for eight years. The distribution by race of those youth or families who have voluntarily disenrolled is:

- White: 3
- Black/Bi-Racial: 1
- Latino: 1



Conclusions

- Access to MHSPY system of care services appears not to be limited by race/ethnicity; more children of color among enrollees than in reference population
- Active outreach and follow-up on referrals may help build relationships with referring parties and parents/guardians, thereby reducing barriers to initial engagement
- By attending to individualized needs and strengths, family culture is an integral part of the equation for how care is delivered.
- Deliberate efforts toward family-driven care, cultural competence and accessible home and community-based processes may drive low drop-out rate

Conclusions, cont.

- Access to broad network of community based providers promotes increased cultural competence for all participants on Care Planning Team
- These collaborative activities further reduce community level risk for racial/ethnic disparities in care delivery
- Recruitment and training of culturally competent clinicians contributes to shift in work-force, both in race/ethnicity make-up and in attitudes and behavior
- These shifts improve family resilience; greater chance for sustainable changes in consumer health care attitudes and health seeking behavior, thereby improving overall health status

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