CA. MHSA PEI - Reducing Disparities Project Why Community Defined Evidence

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Overview

- How DMH made the case for Community Defined Evidence investment- Finding solutions for CA multicultural communities disparities in behavioral health services
- Brief history- how we got here.
- Types of evidence
- Definition of Community Defined Evidence
- Why Community Based Evidence

CA. Proposition 63- MHSA

- 2004 passage of MHSA major new investment in Community Mental Health for treatment and Services for persons with mental illness.
- CA MHSA funded by a new tax of 1% to CA tax payer earning income over $1 million dollars
- Funded expansion of services across the life span
- Full Services and Support, FSP, Workforce, Housing, innovations, **PEI. /Reducing Disparities**

CRDP Phase II

- Phase I- 1.5 Million investment in 5 population reports
- Phase II - MHSA funded $60m initiative to identify promising practices and systems change recommendations to address persistent disparities in historically underserved populations.
- **Priority Populations:**
  (African American; Asian and Pacific Islander; Latino; LGBTQ; and Native American communities.)
- In total, over 40 contractors and grantees are funded over six years to implement Phase II of the CRDP

- Sergio Aguilar Gaxiola, UC Davis CRHD

Mental Health: Culture, Race, and Ethnicity

A Supplement to
Mental Health: A Report of the Surgeon General

U.S. Department of Health and Human Services

Mental Health: Culture, Race, Ethnicity A Supplement to Mental Health: A Report of the Surgeon General

(U.S.DHHS, Public Health, Office of the Surgeon 2001)

- Racial and ethnic minorities bear a greater burden for unmet mental health needs and thus suffer a greater loss to their overall health and productivity.
- Most minority group's are less likely than whites to use services and they receive poorer quality mental health care.
- Unmet mental health needs are disproportionately high for racial and ethnic minorities.
- Racial ethnic minorities are significantly under-represented in mental health research.

Who is Represented by the Evidence

- Limited science base on racial/ethnic minority mental health
- Clinical trials from 1986-1994 documented absence of racial/ethnic minority participants
- This has begun to change under impetus from NIMH
- For example, grant applications must specify minority inclusion goals
- However, great variability in whether and how research questions and design address issues of culture (and language)

Surgeon General's Report (2001)

Whose Evidence?

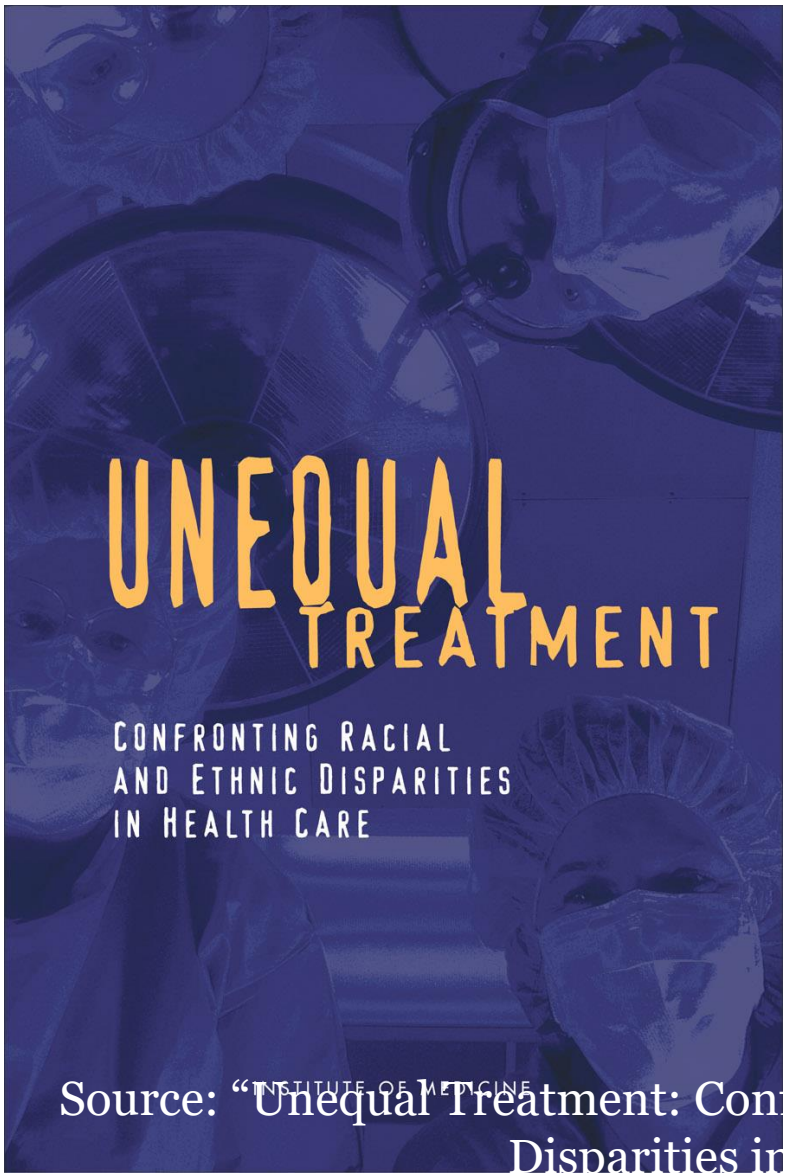
- Most studies reporting findings for racial and ethnic minorities had small samples and were not randomized controlled trials.
- The research used to generate professional treatment guidelines for most health and mental health interventions does not include or report large enough samples of racial and ethnic minorities to allow group specific determinations of efficacy.

Source: Blasé & Fixsen, 2004, National Implementation Research Network, Louie de la Parte Florida Mental Health Institute, Consensus Statement on Evidence-Based Programs and Cultural Competence.

Reported Research Concerns

- Lack of ethnic/racial groups participation in the efficacy studies that determine the evidence (Surgeon General Report, 2001).
- Between 1986 and 2001:
- Out of 9,266 participants in randomized controlled trials evaluating the efficacy of interventions for bipolar disorder, schizophrenia, depression, and ADHD:
- 561 African Americans (6 percent)
- 99 Latinos (1 percent)
- 11 Asian Americans/Pacific Islanders (0.1 percent)
- 0 American Indians/Alaska Natives identified
- Not a single study analyzed the efficacy of the treatment by ethnicity.
- Source: Mental Health: Culture, Race, and Ethnicity" A Supplement to Mental Health: A Report of the Surgeon General, 2001 (p. 3

Disparities in Health Care



Source: "Unequal Treatment: Con
Disparities in

- In 2002 the Institute of Medicine published Unequal Treatment which compiled research demonstrating substantial racial and ethnic variation in quality of health care.
- It brought healthcare disparities to the attention of the nation, placing the issue on the forefront of the nation's health policy agenda.

THE PRESIDENT'S NEW FREEDOM
COMMISSION ON MENTAL HEALTH

Achieving the Promise:

TRANSFORMING MENTAL HEALTH CARE IN AMERICA

EXECUTIVE SUMMARY

FINAL REPORT
JULY 2003

THE PRESIDENT'S NEW FREEDOM
COMMISSION ON MENTAL HEALTH

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FINAL REPORT
JULY 2003

Source: www.MentalHealthCommission.gov

President's New Freedom Report Achieving the Promise: Transforming Mental Health Care in America

- "The mental health system has not kept pace with the diverse needs of racial and ethnic minorities, often undeserving or inappropriately serving them."

Underlying Factors Affecting Disparities

- Systems unprepared, institutional bias
- Lack of systems capacity to adjust to changing demographics- embracing diversity
- Lack of multicultural consumers involvement in policy, planning
- Lack of diversity in health care leadership
- Lack of bilingual - bicultural providers
- Lack of access to treatment
- Lack of appropriateness of treatment
- Lack of effectiveness of treatment (quality) interventions
- Over representation of minorities in jails and juvenile justice settings
- EBP-Lack of racial/ethnic specific Research

Moving from Defining Disparities to Seeking New Solutions

- Investment in communities most impacted by health disparities
- **Supporting "Community-Defined Evidence"** vs. Adapting and Adopting Evidence Based Practices for California underserved multicultural communities
- **A 9 year investment** in identifying new community defined approaches to reduce disparities
- **Include solutions coming from communities most impacted by disparities**
- Willingness to invest in **community-based participatory evaluation**
- **Solutions that are inclusive across the life**

Source: Guerrero, 2009

3 types of Practices

1. **Research Validated Best Practice**
2. **Field Tested Best Practice**
3. **Promising Practice /Community Defined Evidence/Practice Based Evidence**

   Community- Based Participatory research

What is Evidence Based Practice

- EBP is commonly defined as:
  - “the conscientious, and judicious use of current best evidence in making decisions about the care of individual patient.”
- The practice of EBP means:
  - “integrating individual clinical expertise with the best available external clinical evidence from systematic research."

Source: Sackett, DL, et al. British Med J 1996;312:71-2. 9 (S. Gaxiola)

Key Concerns Regarding EBPs

- Lack of consideration of context:

- EBP's have typically been normed or standardized irrespective of cultural context and socioeconomic realities
- Models are sweepingly applied to all people, regardless of their history, race/ethnicity, and environmental context

- Lack of demonstrated generalizability:
- The generalizability of EBP's to ethnic communities has not been substantially or systematically demonstrated especially in terms of their appropriateness, relevance, and applicability to Latinos, Asian-Pacific Islanders, and Native Americans Aisenberg, 2005

Status of EBPs

- Little research related to evidence-based programs has been conducted with diverse, underserved populations.

- This makes it difficult to ascertain whether currently identified evidence-based programs are, in fact, best practices models for specific racial, ethnic, and cultural communities.

- Source: Blasé & Fixsen, 2004, National Implementation Research Network, Louie de la Parte Florida Mental Health Institute, Consensus Statement on Evidence-Based Programs and Cultural Competence.

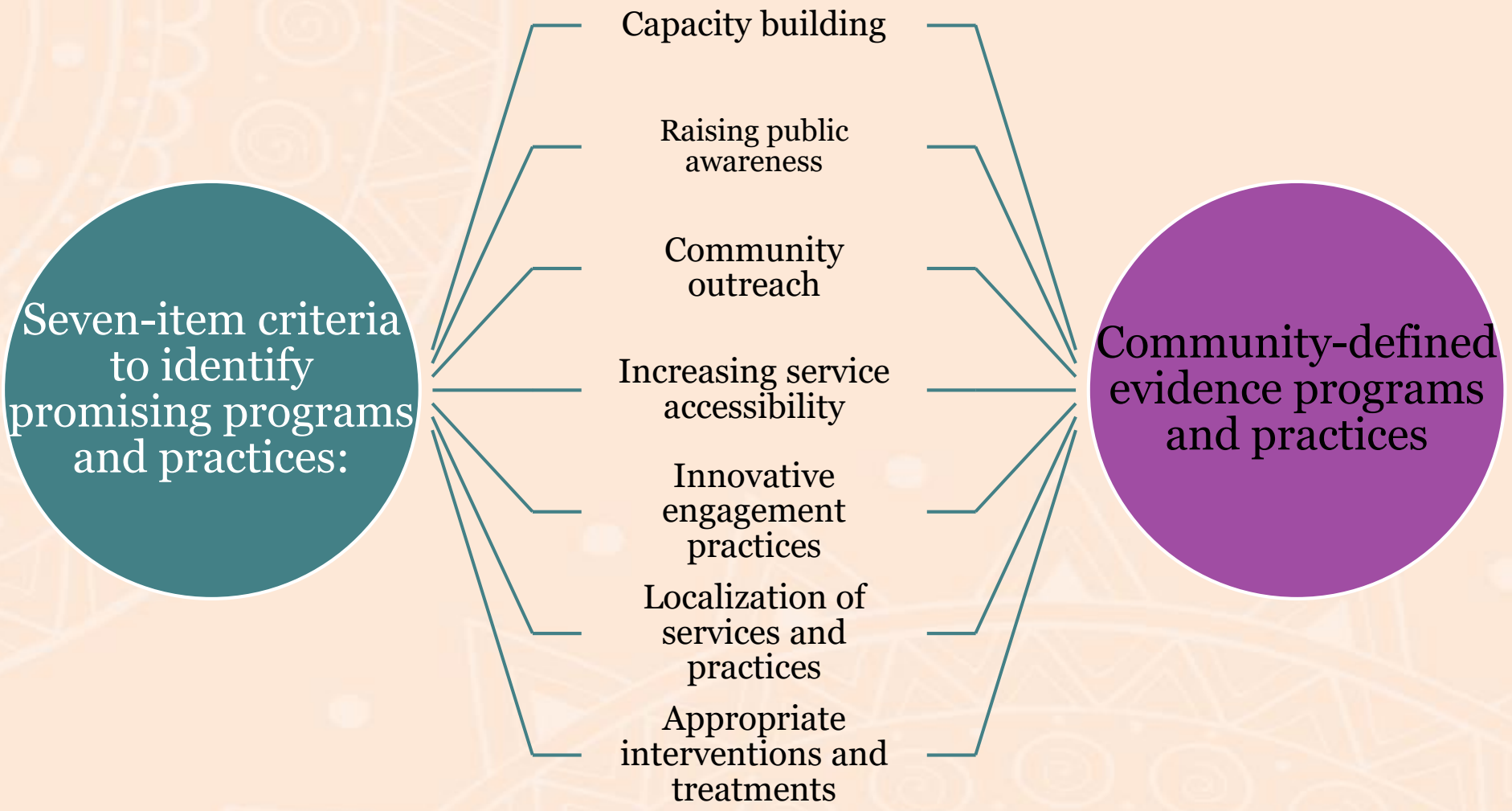
CDEP Definition

Community-Defined Evidence Practices are Defined as:

"A set of practices that communities Have used and determined to yield positive results as determined by community consensus over time and which may or may not have been measured empirically but have reached a level of acceptance by the community"

- Community Defined Evidence project work group National Network Eliminate Disparities hhtp://nned.net 2007 SAMHSA

Community-Defined Evidence Programs and Practices



CDEP is a Major CA Investment for Seeking Solutions for Behavioral Health Disparities

- CDPH is making one of the largest investment in growing new Community Defined Evidence
- Using a community based participatory Research lens
- Funding local evaluators in each of 35 sites
- Funding statewide evaluation being done by the University of Loyola Marymount University, Under leadership of Dr. Cheryl Gills.

Thank You

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