

New York State Office of Mental Health

# Unmet Needs Assessment Report

Statewide Assessment of Treatment Gaps  
for Racial/Ethnic Groups in Need of Mental  
Health Services



2011

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## **New York State Office of Mental Health: Unmet Mental Health Needs Report**

### **I. Introduction**

Pursuant to Chapter 119 of the Laws of 2007, New York State Office of Mental Health (NYSOMH) is required to review and report on unmet mental health needs in New York State (NYS) populations at high risk of needing mental health care. These populations include but are not limited to: racial and ethnic underserved groups, persons with limited English proficiency (LEP), persons with unmet housing needs, high-risk demographic populations, homeless individuals, persons with criminal justice contact, rural communities, lesbians, gay, bisexual and transsexual (LGBT) individuals, and persons lacking sufficient mental health coverage.

NYSOMH has requested its Centers of Excellence for Cultural Competence (CECC) at the Nathan Kline Institute and the New York State Psychiatric Institute to address unmet need by providing information on disparities in the receipt of care of the larger racial and ethnic groups in the State as both Centers focus on these populations. Many persons in these racial/ethnic groups fall into a variety of the other groups as they may have LEP or insufficient mental health coverage, be homeless, live in rural communities, or belong to the LGBT community.

Quantitatively, unmet mental health need is defined as the difference between the number in the community with a mental health need and the number receiving care with respect to that need and estimates of these numbers are made based on community and treated prevalence rates. Calculating estimates of community prevalence of mental health need for the mentioned groups is particularly complex and difficult. Some relevant data on the population treated in the public mental health system (PMHS) can be derived from the NYSOMH biannually conducted Patient Characteristics Survey (PCS). The survey covers the programs funded, operated or certified by the State. This includes over 2,500 non-inpatient programs as well as 20 adult and 5 children/youth state-operated inpatient facilities. (The survey does not cover emergency rooms that are non-CPEP emergency rooms or private providers not providing services through these programs.) Data on the state's inpatient facilities are available from the NYSOMH inpatient Mental Health Automated Record System (MHARS) data set and on inpatient services delivered in psychiatric care units of general hospitals (article 28 hospitals) from the Department of Health's Statewide Planning and Research Cooperative System (SPARCs) data set. MHARS is an electronic clinical patient record system for NYS psychiatric center programs (inpatient and outpatient) and SPARCs is data received from NYS DOH inpatient population in non-OMH facilities.

We address unmet need in racial/ethnic groups through the lens of disparities. When a disparity in care is identified for a specific group it signals an unmet need to the extent that it indicates that the group is receiving care that is different from, and not attributable to biology,

clinical need or treatment preferences, a comparison group, usually taken as White, non-Hispanics.

The available data sets taken together allow an examination of disparities in access and service usage in the public mental health system of Black non-Hispanic, Hispanic and Asian groups in comparison to the White non-Hispanic group. In addition, disparities in the quality of care, an important aspect of an analysis of disparities, can be partially addressed through an examination of the appropriate use of psychotropic medications by Medicaid recipients, data for which is available from the NYSOMH Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES). PSYCKES receives data from NYS Medicaid claims. This administrative data generates quality indicator reports for use in quality management and clinical decision-making. No data are currently available to allow us to address service use in the private sector, i.e., service delivered in non-programmatic settings by private clinicians.

The report begins by first summarizing the national literature of disparities based on a review of documented disparities among racial and ethnic minority adults and children, as well as in rural communities, and the LGBT population (Section II). This is followed by an analysis of the non-inpatient usage of the NYS public mental health system (PMHS) by racial/ethnic groups based on service data obtained from the NYS PCS for racial/ethnic age groups within and across regional sections of the State (Section III). Section IV examines inpatient service use in the State's psychiatric centers as well as in psychiatric units of article 38 general hospitals. Section V provides a report on rates of inappropriate prescribing among racial/ethnic groups on Medicaid, an assessment of quality of care in terms of medication use. Section VI provides the summary conclusions of the report with recommendations.

## II. National Literature Review

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### **Introduction**

The overall goal of this report is to identify unmet needs in New York State populations at high risk of needing mental health services. This report focuses on disparities. To set the stage for a discussion of disparities in New York State, this literature review provides an overview of the current state of knowledge of disparities in several high-risk groups: racial and ethnic minorities, children, rural populations, and gay, lesbian, bisexual and transgender (LGBT) individuals. As there are no published New York State-specific studies in the peer-reviewed literature on disparities in these populations, this literature review focuses on studies conducted nationally. As these studies are conducted in many states across the nation, persons may be receiving care under very different health care systems. The findings of this report are consistent with several prominent national reports, including the US Surgeon General's Report on *Mental Health: Culture, Race and Ethnicity*[1], the Institute of Medicine Report on *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*[2] and the *President's New Freedom Commission Report on Mental Health*[3]. All studies cited are national studies, unless otherwise specified.

### **Racial and Ethnic Disparities in Mental Health and Mental Health Care among US adults** *Disparities in Mental Health Prevalence for Adults*

Disparities can be defined in two ways: disparities in prevalence of mental health disorders and disparities in the receipt of mental health care. Disparities in the prevalence of mental health disorders are differences that occur by gender, race or ethnicity, education or income, disability, geographic location, or sexual orientation[4]. In the aggregate, mental health disorders do not discriminate; persons from all racial and ethnic groups are affected by mental health disorders. However, epidemiological studies are beginning to clarify the ways in which the distribution of mental health disorders varies across these diverse communities. It should be noted that prevalence of psychiatric disorders is higher in populations with low socioeconomic status, who are more likely to be served by public mental health systems[5, 6].

Prevalence rates vary across population subgroups, across types of disorder, and by acculturation. Prevalence rates of mood, substance use, posttraumatic stress disorder (PTSD) and certain anxiety disorders (panic attacks without agoraphobia, panic disorder, agoraphobia with panic disorder, social anxiety disorder, and generalized anxiety disorder)

have been shown to be similar to or lower for non-Hispanic blacks than for non-Hispanic whites [7-10]. However, rates of schizophrenia and other anxiety disorders (agoraphobia without panic disorder and panic attack after a traumatic event) have been shown to be higher among non-Hispanic blacks [9, 11]. Asian Americans tend to have lower rates of anxiety disorders, compared to non-Hispanic whites, Latinos, and African Americans [9, 12, 13]. Although data is limited on the American Indian/Alaska Native population (AI/AN), rates of some anxiety disorders have been shown to be higher than for non-Hispanic whites (panic disorder, social anxiety disorder and agoraphobia with panic disorder)[9] and rates of substance abuse disorders and suicide are high [1]. PTSD rates are higher among AI/AN Vietnam Veterans than their white, black or Asian counterparts [10]. Aggregate prevalence rates of anxiety and mood disorders have been shown to be lower for Latinos than for non-Hispanic whites [7, 9, 14, 15]. However, there is substantial data on the higher conditional risk of PTSD once exposed to trauma among Latinos, as compared to whites and African Americans [10]. The higher conditional risk of PTSD among Latinos has been observed among persons exposed to many types of trauma, including Vietnam Veterans [10, 16, 17], survivors of the September 11 attacks in New York City [18-20], and survivors of Hurricane Andrew in south Florida [21]. The higher conditional risk of PTSD among Latinos has also been observed in a study of survivors of physical trauma in Los Angeles County[22] and a study of urban police officers in New York City, Oakland and San Jose[23]. In addition, evidence suggests that, among Latinos and blacks with a psychiatric disorder, severity and persistence of the disorder may be greater than for non-Hispanic whites [7, 24]. Furthermore, prevalence rates vary among Latino groups. One study found that Puerto Ricans report higher risks of any psychiatric disorder, anxiety disorders, and substance use disorders, but no significant difference in risks of depressive disorders, compared to Mexicans and Cubans [15], while another found that Puerto Ricans have higher rates of suicidal ideation compared to other Latino groups [25].

New York State (NYS) is the state with the second-largest immigrant population in the United States; in 2009, 21% of NYS residents were foreign-born [26]. Thus, NYS is home to a large population of immigrants, as well as their second- and third-generation descendants. Scientific literature has identified an “immigrant paradox” where immigrants have lower rates of diagnosable mental illness than their descendants, despite facing higher social obstacles to economic progress [27]. The epidemiologic data provide greater insight into how the “immigrant paradox” applies to persons with specific mental health disorders. Among Latinos, the protective impact of foreign nativity was found for depressive and anxiety disorders for Mexicans, and for substance use disorders for Mexicans, Cubans, and other Latino groups, but not for Puerto Ricans [15, 28, 29]. Foreign-born Asian Americans report lower rates of all psychiatric disorders than their US-born counterparts [30]. However, variations by gender and nativity have been found. Nativity appears to be associated with mental disorders for women; immigrant Asian American women have lower rates of mental disorders compared to

US-born Asian women [13]. Nevertheless, for men, English proficiency rather than nativity was found to be associated with mental disorders; men who speak English fluently have lower rates of mental health disorders than men who do not speak English fluently, while nativity had no effect on mental disorders [13]. Gender and nativity variations have also been found among Afro-Caribbean immigrants. Afro-Caribbean men who immigrated to the US at age 35 or older report lower rates of mood, substance use or any disorder than second- or third-generation Caribbean men [29]. However, black women who immigrated to the US before age 13 report higher risks of mood and any disorder compared with US-born women [29]. Acculturation factors also come into play, as evidence suggests that once in the US, Latino immigrants experience similar risks of onset as US-born Latinos of a similar age [31]. However, Latino immigrants who come to the US before age 13 have higher rates of depressive, anxiety, substance use, and any psychiatric disorders than do persons who immigrate at older ages [31].

As shown in the literature described above, prevalence rates vary across racial and ethnic groups, by disorder, and by immigrant status. There is evidence that Latinos, Asians, and non-Hispanic blacks may have lower prevalence of some disorders than non-Hispanic whites; in that case, we would also expect treatment rates for those disorders to be lower. However, numerous factors may affect prevalence, such as nativity, gender, and age; some disorders have higher prevalence among racial and ethnic minorities than non-Hispanic whites. Even accounting for prevalence of psychiatric disorders, racial and ethnic minorities face numerous barriers in accessing care and disparities in quality of care.

### *Disparities in Mental Health Care Treatment for Adults*

Disparities in mental health care persist across the entire spectrum of mental health care from access and quality of care to utilization, retention, and outcomes. Mental health care disparities are defined as differences in the availability or quality of care that are not due to factors such as clinical needs or preferences for treatment [2]. In this report, we also discuss preferences for treatment, as low health literacy among racial and ethnic minority populations may contribute to the lack of preference for treatment, thus making preferences a dimension of disparity [32].

Numerous studies conducted across the United States have found that racially and ethnically underserved groups face decreased detection of mental disorders in primary care and have lower rates of entry into, adherence with, and retention in specialty mental health services [33-36]. Racial and ethnic disparities in mental health care persist even after controlling for socioeconomic factors [34-36]. Racial and ethnic minority groups are more likely to delay or avoid mental health care than Whites with similar mental health needs [37]. Among a population with health insurance, African Americans and Spanish-speaking

Hispanics were less likely to visit a mental health provider in the past year, compared to non-Hispanic Whites, even after controlling for the presence of a psychiatric condition [38]. Furthermore, a recent national study found that among people with depression, 69% of Asian Americans, 64% of Latinos, and 59% of African Americans did not access treatment within the past year, as compared to 40% of Whites [39]. In a survey of US adults with serious mental illnesses, African-Americans, Asians, Mexicans and Central and South Americans reported lower use of mental health care, and American Indians/Alaska Natives had higher rates of self-reported unmet need for mental health care, adjusting for socioeconomic factors [40]. In addition, linguistic minorities have to cope with severe limitations in the availability of linguistically appropriate services [41]. Asians and Latinos with limited English proficiency and a mental health need had lower rates of utilizing services than English-speaking Asians and Latinos [38, 42].

Once they access care, African Americans and Latinos are less likely to receive guideline-concordant mental health care and more likely to receive poor quality of care [43, 44]. Racial and ethnic minorities suffering from depression are less likely to be identified as depressed, to receive antidepressant prescriptions, and to receive newer medications than their White counterparts [45-47]. Of those with depression or anxiety, 34% of White individuals received appropriate care as compared to 24% of Hispanic individuals and just 17 % of African American individuals [44]. (In this study, appropriate care was defined as at least 2 months of appropriate psychotropic medication at an adequate dosage or at least 4 visits with a mental health specialist or a primary care provider that included counseling for mental health problems within prior 12 months.) In a different study of office-based psychiatric visits between 2001 and 2006, psychiatric visits by African American patients were 4.4 minutes shorter across all visits and 10.5 minutes shorter during first visits compared to White patients' visits [48]. African American women, African Americans who used Medicare, African Americans with a primary diagnosis of adjustment disorder, and African Americans who did not have mental health co morbidity had significantly shorter psychiatric visits than their White counterparts.

Poor quality of care can lead to mistrust of providers and lower engagement with health care providers. Compared to Whites, African Americans and Hispanics report greater distrust of their physicians [49]. In addition, the level of distrust among African Americans has been found to increase from pre- to post-visit. African Americans and Latinos are also less likely than Whites to view antidepressants as acceptable, fill antidepressant prescriptions, and take antidepressants [50]. Disparities in health literacy also exist. Limited health literacy – defined as the degree to which individuals can access and understand basic health information – presents additional obstacles to obtaining mental health care. Limited health literacy disproportionately impacts racial and ethnic minorities and is associated with lower medication-related knowledge, less access to pharmacy services, and worse health outcomes



including lower use of preventive services [51]. Stigma may also contribute to underutilization of mental health services and treatment. Among those with depression, stigma reduced desire for treatment more among immigrant women of color than among white women [52]. Perceived discrimination led to lower levels of satisfaction in mental health care for Latina and Asian women [53].

## **Racial and Ethnic Disparities in Mental Health and Mental Health Care among US Children and Adolescents**

### *Disparities in Mental Health Prevalence for Children*

One in five children in the United States has a mental illness[3]. Limited information is available on the prevalence of mental health disorders in this population, as the major epidemiological studies examining prevalence of psychiatric disorders do not include children [1]. In one of the few studies available, the Great Smoky Mountain Study (GSMS), a longitudinal study of children ages 9-13 living in rural North Carolina found similar prevalence of psychiatric disorders among African American and non-Hispanic white youth [54]. A study in Los Angeles County found that Latino teens report more depressive symptoms than white, African American or Asian American teens [55]. Findings from the GSMS indicate that rates of psychiatric disorders were also similar between AI/AN youth and non-Hispanic white youth, although AI/AN youth had higher rates of substance abuse [56]. Black and Latino adolescents have higher rates of engagement in physical fighting, early onset of substance abuse and higher rates of suicide attempts than white adolescents [57]. In addition, female Latina adolescents have higher rates of suicidal ideation, plans and behavior than non-Hispanic black and white female adolescents [58]. Further evidence suggests that African American adolescents are more likely to attempt suicide than Afro-Caribbeans [57].

### *Disparities in Mental Health Care Treatment for Children*

Racial and ethnic disparities exist in children's mental health service use across the United States. Among youth with mental health needs, 88% percent of Latino children and 90% of children from Other races did not receive mental health care, compared to 76% of White children and 77% of African American children [59]. However, a study in San Diego found that African American and Asian/Pacific Islander (API) high-risk youth are less likely to receive any mental health services and are less likely to receive outpatient mental health services as compared to their White counterparts, even after taking into account the effect of lower income, lack of insurance, and other predisposing social factors [60]. Among adolescents with depression, Black, Hispanic and Asian adolescents were significantly less likely than non-Hispanic whites to receive treatment for depression, to receive a prescription medication for depression, and to receive treatment from a mental health specialist, even

accounting for underlying mental health status [61]. Similarly, in a San Diego study, African American, API, and Latino youth were also more likely to report not receiving any school-based services, compared to White youth [62]. Among youth who contemplated or attempted suicide, African American and Latino youth were significantly less likely than White youth to use mental health services in the year of their ideation or attempt [63]. In addition, API and Latino youth who use mental health services begin to receive these services at an older age than non-Hispanic White youth [62].

Mental health care disparities among children and adolescents exist not only in access, but also in quality of mental health care. Among youth with past-year major depressive episodes, a significantly greater percentage of White youth (36%) received adequate mental health care compared to their Latino peers (27%) [64]. A study in southeastern Texas found that Latino adolescents receive significantly fewer mental health visits over their lifetimes compared to White adolescents [65]. A study conducted in a school district in the southeastern United States found that African American youth remain in mental health treatment for significantly shorter periods of time than White youth [66].

A variety of factors contribute to disparities in children's unmet mental health needs. Barriers such as inadequate insurance and lack of transportation reduce children's use of mental health services. Children who are uninsured are significantly less likely than those with public or private insurance to receive needed mental health services [59]. Similarly, children with no insurance were less likely to have received adequate mental health care for past-year major depressive episodes compared to children with insurance through Medicaid or the State Children's Health Insurance Program (SCHIP) [64].

Even when such barriers are taken into account, however, racial and ethnic disparities persist. One reason is that families' help-seeking behavior is influenced by cultural norms and preferences. White families are more likely to pursue formal avenues of support, such as specialty mental health services, while African American and Latino families are more likely to use informal supports, such as extended family and clergy [62, 67]. Similarly, parents' interpretations about the cause of their child's mental health problems vary culturally and influence help-seeking behavior. For example, racial and ethnic minority parents are less likely than non-Hispanic White parents to attribute children's mental health problems to physical health problems or trauma and more likely to attribute mental health problems to prejudice. The first kind of attribution (e.g., to physical causes) is associated with higher mental health service use, while the second kind of attribution (e.g., to prejudice) is associated with lower use [68]. Stigma also negatively impacts engagement in mental health care by leading parents to feel guilty or ashamed about their child's mental illness and causing families to avoid or delay accessing services [69]. Cultural mistrust of health professionals due to experiences of discrimination and legacies of racism also acts as a

barrier to engagement. Limited English proficiency and limited availability of bilingual, bicultural mental health professionals can impede LEP parents use of mental health services for their children [70].

Although effective treatments exist, approximately 80% of children between 6 and 17 who need mental health services do not receive them [59]. Left untreated, childhood mental disorders are associated with poorer academic performance and social functioning and increased family stress [71]. Early and adequate treatment of mental disorders can promote healthy functioning into adulthood.

### **Mental Health Disparities Among Rural Populations**

Rural residents are more likely to have low socioeconomic status, be in fair or poor health, and be uninsured compared to those who do not live in rural areas [72]. While the prevalence of psychiatric disorders is similar among rural and non-rural adults, their service utilization differs. Rural adults who report fair or poor mental health are significantly less likely to receive any type of mental health treatment than their non-rural counterparts, even after individual and financial characteristics were taken into account in the analysis [43, 72]. Rural residents with serious mental illness (SMI) receive fewer specialty services than those living in metropolitan areas [73]. Rural residents with SMI have worse symptom outcomes over time compared to non-rural residents with SMI, particularly among those with co-occurring substance abuse [73]. Rural populations are also more likely to be uninsured or underinsured [72]. The uninsured, especially those with psychiatric disorders, are less likely to use mental health services [72]. Limited evidence shows that rural residents may have higher copayments than non-rural residents [72].

Barriers such as lack of transportation, shortage of mental health providers, and concerns about confidentiality contribute to unmet mental health needs for rural populations [74]. Rural residents have to travel significantly farther to mental health specialty services and have fewer mental health specialists within thirty minutes of their home [73]. Distance to outpatient services has been negatively associated with the number of mental health visits and the likelihood of receiving adequate care [73]. Shortage of mental health providers also contributes to unmet mental health needs among rural populations [75]. In other words, the more rural the setting in the US, the higher the likelihood of unmet mental health need [76]. Individuals with depression living in rural areas tend to be less likely to seek mental health treatment, as they know that mental health care can be difficult to obtain [73]. As a result of shortages of rural specialty mental health providers, those living in rural areas are more likely to receive mental health care from primary care providers and to use general medical services to meet mental health needs [73]. In fact, an estimated 44% of low-income women seeking medical care at a community health center in the rural south were currently depressed [77]. In addition to shortages of mental health professionals, individuals in rural areas also perceive

less anonymity associated with engaging in mental health care compared to those who live in non-rural areas [73].

Rural individuals are more likely to receive medication than outpatient therapy services, which is problematic if persons are relying on medication due to the lack of availability of therapy services [78]. Individuals in rural settings have a higher rate of medication use and lower rate of having at least one office visit in the past year than those in urban settings [72]. Among those who have an office visit in the past year, rural residents have a significantly lower average number of visits per year compared to those in urban environments [72]. Additionally, individuals with psychiatric disorders who live in rural settings are more likely to be hospitalized as compared to those in non-rural settings [79].

## **Mental Health Disparities among Lesbian, Gay, Bisexual and Transgender Individuals**

### *LGBT Youth*

Lesbian, gay, bisexual, and transgender (LGBT) individuals face mental health and health care disparities compared to heterosexual individuals. As evidence for transgendered individuals is limited, most studies focus on lesbian, gay, and bisexual (LGB) individuals.

LGB youth are at increased risk of depression and suicidal ideation and behavior compared to heterosexual youth [80, 81]. Rates of smoking, alcohol consumption, and substance use are also higher among LGB youth as compared to heterosexual youth [81]. Limited research indicates that transgender youth face similar mental health disparities as LGB youth [81]. Youth with a same-sex orientation are more than twice as likely as peers without a same-sex orientation to report suicidal ideation and behavior and higher rates of alcohol abuse and depression even after individual and family characteristics are taken into account in the analysis[81].

A number of factors have been found to be associated with suicidal ideation and behavior among LGB youth. A study in San Francisco found that LGB youth who report high levels of family rejection have 8.4 times the odds of suicide attempts, 5.9 times the odds of current depressive symptoms, and 3.4 times the odds of illegal drug use, compared to LGB youth who describe low levels of family rejection [82]. Compared to their heterosexual peers, LGB youth report significantly higher rates of victimization, bullying, homophobic teasing, and perceived discrimination [82-85]. An analysis of the Centers and Disease Control's Youth Risk and Behavior Survey in Massachusetts and Vermont found that LGB youth with high rates of victimization at school also describe significantly higher rates of suicide attempts and use of alcohol, tobacco, marijuana, and other street drugs, compared to heterosexual youth with similarly high rates of victimization at school [83]. By contrast, LGB youth with low rates

of victimization at school report rates of suicide and substance use similar to their heterosexual peers [83]. Similarly, a study conducted in a large Midwestern county found that LGB youth who endure high rates of bullying and homophobic teasing have higher rates of depression and suicidality while LGB students who do not report such bullying have rates of depression and suicidality similar to heterosexual students [85]. A Boston study found that perceived discrimination on the basis of sexual minority status is also associated with higher rates of self-harm, suicidal ideation, and depressive symptoms among LGBT youth [84]. LGBT youth are also significantly more likely to be homeless than heterosexual youth [81]. Studies conducted in Seattle and Portland found that LGBT homeless youth have higher rates of anxiety, aggression, internalizing and externalizing behaviors than heterosexual homeless youth and are more likely to have used amphetamines and to have injected drugs than heterosexual homeless youth [86, 87]. Emerging research conducted in Minnesota indicates that the presence of caring adults and teachers, feelings of family connectedness, and feeling safe at school can serve as protective factors for LGB youth [88].

### *LGBT Adults*

Mental health disparities affecting the LGBT community continue into adulthood. LGB adults report higher rates of mood and anxiety disorders, smoking, alcohol use, substance use and substance use disorders and higher risk for suicidal ideation and behavior than heterosexual adults [80, 81, 89]. In studies of Black and Latino LGB adults in New York City, Blacks and Latinos had higher rates of suicide attempts than White persons [89, 90]. Limited research indicates that rates of suicidal ideation and attempts may also be elevated among transgender adults [81]. A study of Asian and Latino LGB found that gay or bisexual men were more likely than heterosexual men to have recently attempted suicide, and lesbian or bisexual women were more likely than heterosexual women to have a history of depressive disorders [91].

Research related to disparities in access to or quality of mental health care among LGBT adults remains very limited. Provider attitudes toward sexual-minority patients, inadequate training of health care providers, perceived discrimination, stigma, lack of health insurance, and lack of access to a same-sex partner's health insurance may act as barriers to care for LGBT individuals [81]. More research is necessary to understand disparities that LGBT adults may face in access to and quality of mental health care.

### **Summary**

This chapter provides a background on the current state of knowledge on disparities in mental health and health care at the national level in order to frame the limited data on New York State and help guide future research. We focused on four cultural groups for whom

national data is available: racial and ethnic minority adults and youth, and rural and LGBT populations.

## **Racial and Ethnic Minorities**

### *Adults*

- ❖ Mental illness does not discriminate. All racial and ethnic groups face mental disorders. Prevalence rates vary by disorder and across racial and ethnic groups, as well as by culturally relevant characteristics such as ethnic subgroup and acculturation level.
- ❖ Although there are very little data available in the published, peer-reviewed literature on service utilization in New York State, numerous studies conducted across the United States have found that racially and ethnically underserved groups have lower rates of entry into, adherence with, and retention in mental health care services than non-Hispanic whites, even after accounting for the impact of socioeconomic characteristics. For example, one recent national study found that among people with depression, 69% of Asian Americans, 64% of Latinos and 59% of African Americans did not access treatment within the past year, compared to 40% of Whites. These access data are largely unavailable for New York State.
- ❖ Once an individual does access care, numerous national studies have found that racial and ethnic minorities are more likely to receive poor quality of care and are less likely to be identified as depressed, receive antidepressant medications, and receive newer medications than their White counterparts. They are also more likely to meet other indicators of poor quality care. As will be demonstrated later in this report, however, in New York State, once a person has entered the public mental health system, available data on service utilization and psychotropic use showed limited quality-of-care differences across race and ethnicity. Overall, service utilization was similar across Whites, Blacks, and Hispanics, but there were some exceptions (e.g., Black adults with psychosis statewide, Black elderly in the NYC metropolitan area). Psychotropic medication utilization rates also showed very few differences, again with some exceptions (e.g., higher rates of high-dose antipsychotic use in Blacks, Asians, and “Other” race/ethnic groups). After accounting for the effect of socioeconomic variation across groups, other factors, such as cultural views of illness, treatment, and care must also be evaluated.

## **Children**

- ❖ Limited information is available on national prevalence rates for children, but as in the adult population, prevalence rates vary by disorder and across racial and ethnic groups. Limited information is available specifically for New York State.
- ❖ Nationally, racial and ethnic disparities exist in access to children's mental health care. In a study of high-risk youth in San Diego, African American and Asian/Pacific Islander youth are less likely to receive mental health care services than their White counterparts. A study in Texas found that Latino adolescents receive fewer mental health visits, while a study conducted in the southeastern United States found that African American youth remain in treatment for shorter time periods than their White peers. No data is available in the published peer-reviewed literature on disparities in access to children's mental health care in New York State. Interpretation of access data must take into account multiple determinants of access, including socioeconomic factors, preferences for care, and cultural understandings of what constitutes mental illness. As will be shown later in this report, once children in New York State enter mental health care, the available limited data on psychotropic utilization show very few differences in quality-of-care indicators across racial and ethnic groups.

## **Rural**

- ❖ Although disparities in prevalence of disorders have not been identified in rural adults, at the national level, rural adults experience disparities in access to care. Rural adults with mental health needs are less likely than their non-rural counterparts to receive specialty mental health services, because in many cases they are simply not available within an easy distance, if at all.
- ❖ National studies have identified numerous barriers to mental health care in rural areas, including distance from providers, lack of transportation, and shortage of mental health providers. Evidence from several studies suggests that persons living in rural areas are more likely to receive medication and less likely to receive therapy services.

## **LGBT**


- ❖ Evidence from national studies has shown that LGBT youth are at higher risk for depression and suicidal ideation compared to heterosexual youth, and report greater incidence of bullying and teasing.
- ❖ Evidence from national studies has shown that LGBT adults report higher rates of mood and anxiety disorders, substance abuse, and suicidal behavior than heterosexual adults. In studies conducted in New York City, Black and Latino LGB adults had higher rates of suicide attempt than White persons.

- ❖ Little is known about disparities faced by LGBT youth and adults in accessing mental health care. Provider attitudes toward LGBT patients and inadequate training of providers regarding the needs of the LGBT community may act as barriers to care.


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### **III. Access to and Use of non-Inpatient Services in the NYS Public Mental Health System by Racial/Ethnic Groups: Differences between Whites and other Racial/Ethnic Groups**

**Nathan Kline Institute (NKI) Center of Excellence in Culturally Competent Mental Health**

**Carole Siegel, Ph.D., Joseph Wanderling, M. S., Gary Haugland, M.A. , Eugene Laska, Ph.D., and Brady Case, M.D.**

**Introduction** New York State (NYS) has a long tradition of innovation in and generous support for public mental health services that are attuned to the needs of its population. The state population dynamically changes and continues to grow in its cultural diversity. While disconcerting disparities in mental health care for cultural groups have been documented in national studies (as reported in Section II), the extent to which these findings apply in NYS is examined here. Determining whether, for whom, and where disparities exist is a first step in targeting specific areas in which actions can be taken to improve the mental health care of all cultural groups of New York State.

The report summarizes the results of a large study undertaken to compare the larger racial/ethnic/age (R/E/A) groups of New York State (NYS) on access to and utilization of the non-inpatient services of the public mental health system (PMHS) -- the programs operated funded or certified by the NYS Office of Mental Health (NYSOMH). Access is measured by estimates of annual treated prevalence, the population based number of persons served. Use is measured by estimates of the average number of weeks in service per year for persons receiving services. Data from the NYSOMH Patient Characteristic Survey (PCS) were used to develop these estimates (Laska et al, 1988; Laska et al 2010) for Black non-Hispanics (herein referred to as Blacks), Hispanics and Asians and contrasted with that of White non-Hispanics (herein referred to as Whites). Differences in access and use between an R/E group and Whites are reported for those in the PMHS in 2009. Trends in access and use between 2003 and 2009 are also summarized.

The full report is available that contains detailed usage data on diagnostic/age groups and the use of specific service types for the state and its regions and is available at <http://cecc.rfmh.org>. Details on the construction of measures and the analyses conducted are contained there as well.



## Racial/Ethnic Statewide Data

**Defining racial and ethnic groups** The report is based on observed differences in access and use between Whites, a group that has historically enjoyed a majority status, and persons in broad racial and ethnic categories. Data availability both from NYSOMH and the US Census restricts analyses to broad racial and ethnic categories that encompass multiple cultural groups. Blacks include African Americans with longstanding history in the US, as well as Black persons who are recent immigrants primarily from Africa or Caribbean countries. Hispanics comprise individuals primarily from the Spanish-speaking countries in South and Central America. Asians come from a broad range of countries of origin, from China, Taiwan, Japan and the Philippines to Vietnam, Laos, Cambodia, Indonesia, and furthermore includes countries of the Indian subcontinent of India, Pakistan, and Sri Lanka. In calculating the number treated and treated prevalence rates, a small number of Pacific Islanders were added to the Asian category (the numerator of prevalence) as the population size (the denominator of prevalence) obtained from the US Census only provided an aggregated number for Asian/Hawaiian/ Pacific Islander group. In examining service use, Pacific Islanders were removed.

**Usage data** Figures 1-3 display respectively for racial/ethnic categories the number served in non-inpatient care in the public mental health system in 2009, annual treated prevalence rates and average number of weeks in service.

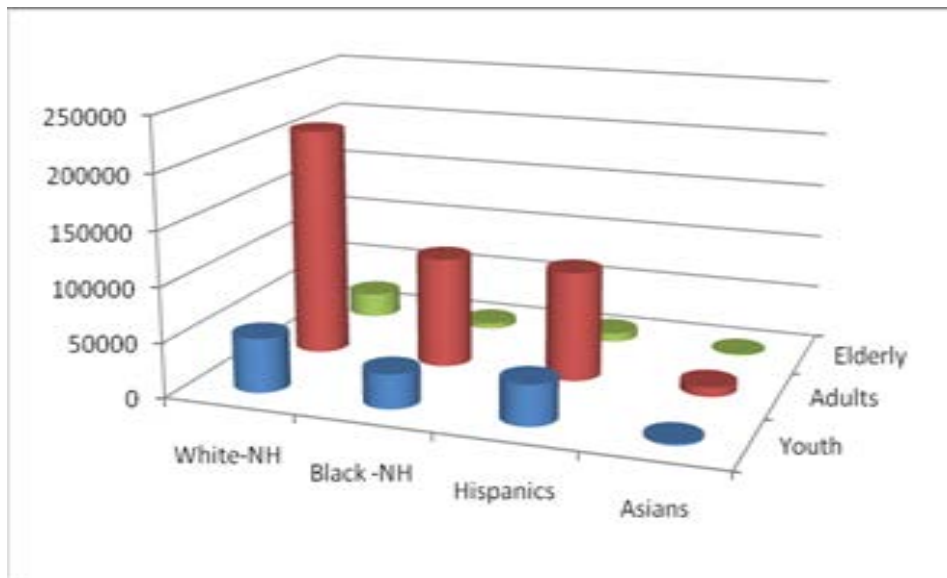


Figure 1: R/E/A Number in Non-Inpatient Services, Statewide 2009

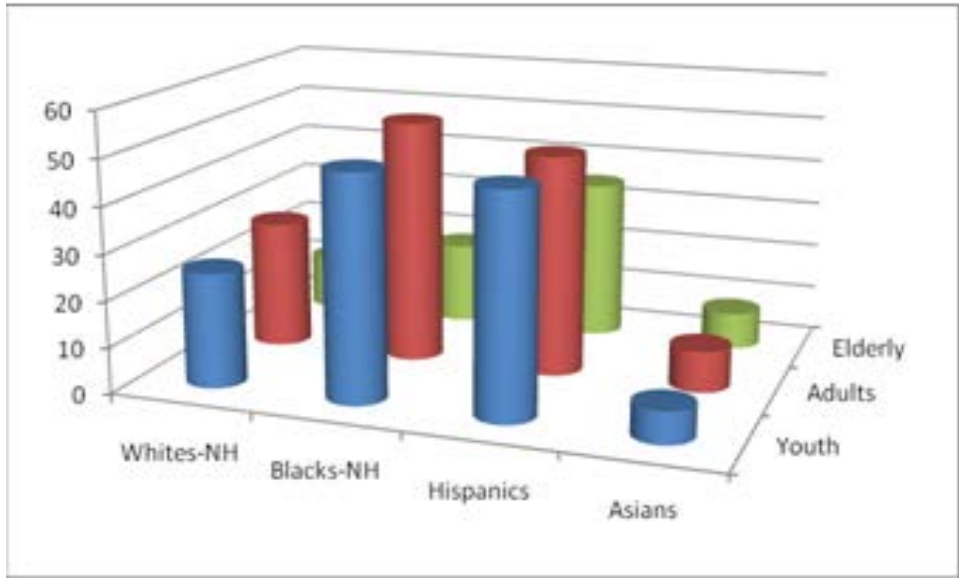


Figure 2: R/E/A Annual Treated Prevalence Rates. Statewide 2009

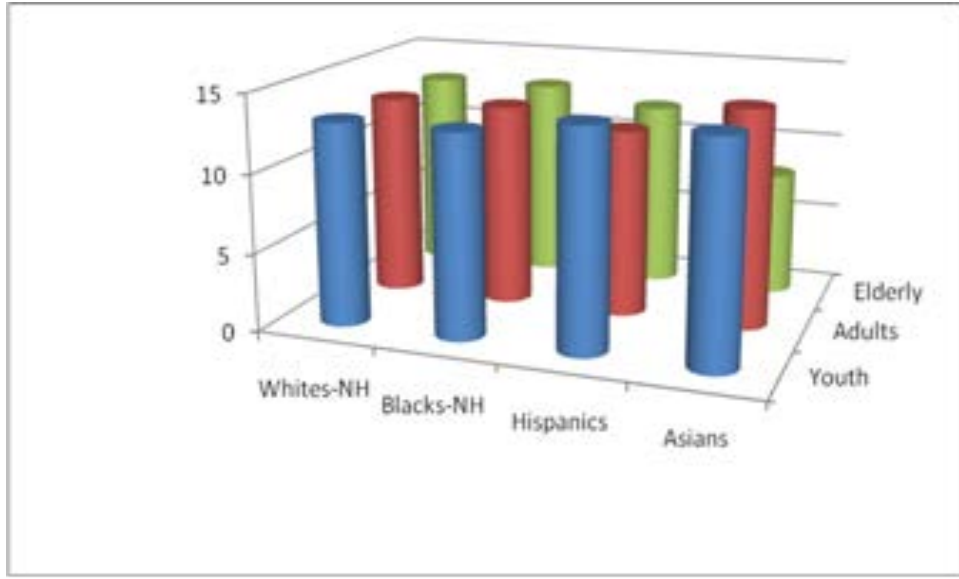


Figure 3: R/E/A Annual Average Service Rates. Statewide 2009

**White Non-Hispanics (Whites)** In 2009, there were 49,938 White children/youth, 211,463 White adults and 22,656 White elderly using non-inpatient services in the PMHS, representing 39% of children/youth service users, 48% of adult service users and 60% of elderly service users. In 2009, the modal diagnosis for White children/youth service users

was mood disorder (28%), followed by ADHD (21%). The modal (most common) diagnosis for White adults was depression (29%), followed by other/missing<sup>1</sup> (27%). The modal diagnoses for White elderly were depression (39%) and psychoses (28%), (See Table 1).

From 2003 to 2009, treated prevalence rates for non-inpatient care of White children/youth in the public mental health system (PMHS) remained steady at approximately 25 per 1000 for children/youth and 28 per 1000 for adults. Prevalence rates of the elderly, however, decreased somewhat from 15 per 1000 in 2003 to 12 per 1000 in 2009.

Annual service use rates for White children/youth in the PMHS increased from 11 weeks in 2003 to approximately 13 weeks in 2009. White adult rates remained steady at approximately 13 weeks. Elderly rates increased slightly from 12 weeks in 2003 to 13 weeks in 2009.

***Black Non-Hispanics (Blacks)*** In 2009, there were 31,607 Black children/youth, 101,336 Black adults and 5,146 Black elderly in the PMHS, representing 25% of children/youth service users, 23% of adult service users and 14% of elderly service users. In 2009, the modal diagnosis for Black children/youth service users was ADHD (26%), followed by disruptive behaviors (22%). The modal diagnosis for Black adult and elderly service users was psychoses (38% and 54% respectively).

From 2003 to 2009, the treated prevalence rates of Black children/youth remained steady at approximately 49 per 1000. The rates for adults declined approximately 15% from 61 in 2003 to 53 per 1000 in 2009. Prevalence rates for Black elderly declined approximately 18% from 22 per 1000 in 2003 to 18 per 1000 in 2009. In all years and for all age groups, prevalence rates of Blacks were higher than the prevalence rates of Whites. For children/youth and adults, the 2009 rates are approximately twice the White rates. Black elderly service rates are closer to White elderly rates. Annual service use rates of Blacks for all age groups increased slightly over time.

In 2009, both Blacks and Whites in all age groups across all diagnoses received on average between 12-13 weeks of non-inpatient services per year. In terms of specific services and/or diagnoses, Black children/youth receive community supports at lower rates than Whites. Black adult service users with psychoses receive two weeks less of services than Whites. Black elderly service users are more likely than White elderly to use emergency services.

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<sup>1</sup> The largest diagnostic group in this category was mood disorder, NOS.



Table 1. Most Common Diagnoses of R/E/A Groups:  
% Group with Dx.

	ADHD	Disruptive Disorders	Mood	Adjustment Disorders	Psychoses	Depression
Youth	W(21%) B (26%) H (25%) A (30%)	B (22%)	W (28%)	H(23%) A (28%)		
Adult					B (38%) A (39%)	W (29%) H (38%) A (20%)
Elderly					W (28%) B (54%) H (29%) A (26%)	W (39%) H (46%) A (50%)

- Whites: Depression (39%) and psychoses (28%)
- Blacks: Psychoses (54%) and other/missing (20%)
- Hispanic: Depression (46%) and psychoses (29%)
- Asian: Depression (50%) and psychoses (26%)

R/E/A group with higher prevalence of disorder than Whites

Black youth: Disruptive Disorders  
 Black and Asian adults: Psychoses  
 Hispanic adults: Depression  
 Black elderly: Psychoses  
 Hispanic, Asian elderly: Depression

**Hispanics** In 2009, there were 37,157 Hispanic children/youth, 100,361 Hispanic adults and 7,954 Hispanic elderly in the PMHS, representing 29% of children/youth service users, 23% of adult service users and 21% of elderly service users. In 2009, the modal diagnosis for Hispanic children/youth was ADHD (25%), followed by adjustment disorder (23%). The modal diagnosis for Hispanic adults was depression (38%), as it was for Whites, but proportionately fewer Whites (29%) received this diagnosis. Depression was also the modal diagnosis of elderly Hispanic and White service users (46% vs. 39%). Thirty percent of elderly Hispanics had diagnoses of psychoses, a proportion similar to Whites.

From 2003 to 2009, Hispanic adult treated prevalence rates declined approximately 13%, but in all years were higher than the prevalence rates of Whites. The 2009 rates for Hispanics per 1000 were: for children/youth 48; for adults 48; and for elderly 35. In all years and for all age groups, prevalence rates of Hispanics were higher than the prevalence rates of Whites. In 2009, the prevalence rates of Hispanic children/youth and adults were approximately twice the White rates. Elderly Hispanic treated prevalence rates were almost three times those of Whites.

Service usage rates of non-inpatient services for Hispanics in all age groups increased slightly over time. While Hispanic children/youth's service usage rates tended to exceed White rates, adult and elderly rates tended to be marginally lower than White rates.

In 2009, Hispanics across the State in all age groups and across all diagnoses received on average between 12-14 weeks of services. Hispanic children/youth received approximately 1 more week of services than Whites, while Hispanic adult and elderly rates received approximately 1 week less than Whites. In terms of specific service use and/or diagnoses, Hispanic children/youth service users are half as likely as Whites to use community support services. Hispanic adults with anxiety disorders receive fewer weeks in clinic services than Whites and those with depression a greater number of services. Elderly Hispanics with depression and those with anxiety disorders make less use of clinic services than Whites (12 vs. 15 and 8 vs. 15 respectively).

**Asians** In 2009, amongst Asian/Pacific Islanders there were 1992 children/youth, 8750 adults and 917 elderly representing 1% of children/youth service users, 2% of adult service users and 2% of elderly service users. In 2009, the modal diagnosis for Asian children/youth was ADHD (30%), followed by adjustment disorders (28%), a pattern similar to that of Hispanic children/youth. The modal diagnosis for Asian adults was psychoses (39%) as it was for Blacks. The modal diagnosis for elderly Asian service users was depression and the proportion of elderly Asians with this diagnosis (50%) was higher than the proportion for any other racial/ethnic group.

From 2003 to 2009, the treated prevalence rates of Asian/ Pacific Islanders for all age groups were substantially lower than that of all other racial/ethnic groups. Rates have fluctuated over time. For 2009, the rates per 1000 were for children/youth 7, for adults 9 and for the elderly 8.

While service usage rates for Asian children/youth and adults have increased over time (to 14 weeks), Asian elderly rates have fluctuated with a substantial rate dip in 2009 (to 8 weeks).

In 2009, Asian children/youth had rates comparable to White children/youth, adults had higher rates than Whites (14 vs. 12) and the elderly had 5 weeks less of service than Whites (8 vs. 13). In terms of specific services and/or diagnoses, youth/children service users have higher clinic visit rates, and adults with bipolar disorders higher community support rates. Asian elderly are more likely than Whites to use emergency services.

## Regional comparisons

The NYC Metropolitan Area, Upstate Metropolitan Areas and Upstate Non-Metropolitan Areas were compared on access and service utilization (See Table). We summarize the major regional findings by age group revealed in Table 2.

**Table 2: 2009 Regional Data on Annual Prevalence and Service Use**

	NYC Metro	Upstate Metro	Upstate non-Metro	State <sup>1</sup>
<b>CHILDREN/YOUTH</b>	W+B+H+A/PI N=68,598	W+B+H+A/PI N= 38,700	W+B+H+A/PI N=12,113	W+B+H+A/PI N=120,694
<b>2009 Prevalence/1000</b>				
Whites (W)	13.9	31.9	44.8	25.2
Blacks (B)	44.1 #	66.0 #	40.7	48.8 #
Hispanics (H)	46.9 #	57.6 #	41.0	48.2 #
Asians/Pacific Islanders (A/PI)	6.4 *	16.9	ne	7.5 *
<b>2009 Service use: weeks/yr</b>				
Whites	12.9	11.7	14.7	12.6
Blacks	13.5	9.7 *	15.9	12.4
Hispanics	14.3	10.5	16.0	13.9 #
Asians	15.0	ne	ne	13.6
<b>ADULTS</b>	W+B+H+A/PI N=243,991	W+B+H+A/PI N=134,134	W+B+H+A/PI N=38,151	W+B+H+A /PI N=421,910
<b>2009 Prevalence/1000</b>				
Whites	22.0	31.0	36.9	27.6
Blacks	44.7 #	89.7 #	73.5 #	53.3 #
Hispanics	44.0 #	84.2 #	58.0 #	48.1 #
Asians/Pacific Islanders (A/PI)	9.0 *	8.9 *	ne	9.0 *
<b>2009 Service use: weeks/yr</b>				
Whites	14.8	11.7	12.3	13.0
Blacks	13.6 *	11.2	13.4	12.9
Hispanics	12.9 *	9.7 *	13.8	12.4*
Asians	14.4	11.6	ne	14.3 #
<b>ELDERLY</b>	W+B+H+A /PI N=25,818	W+B+H+A/PI N= 7,720	W+B+H+A/PI N=2,671	W+B+H+A/PI N=36,673
<b>2009 Prevalence/1000</b>				
Whites	13.8	10.0	12.0	12.4
Blacks	18.2 #	17.1 #	ne	18.3 #
Hispanics	35.3 #	ne	ne	34.8 #
Asians/Pacific Islanders (A/PI)	8.1 *	ne	ne	7.7 *
<b>2009 Service use: weeks/yr</b>				
Whites	15.2	11.4	9.7	13.3
Blacks	12.2 *	12.9	ne	12.2
Hispanics	11.6 *	ne	ne	11.7 *
Asians	7.7 *	ne	ne	7.7 *

<sup>1</sup>= State total greater than sum of regional N's due to missing data on county code

# = Group rate > White rate, p<.05. ; \* = Group rate < White rate, p <.05; ne = non estimable

### ***Children/youth***

*Prevalence:* White prevalence rates increase as areas become less populated and rural. Black and Hispanic rates exceed White rates in the metropolitan areas and do not differ in the upstate non-metropolitan areas. Asian/Pacific Islander prevalence rates are lower than White rates in both downstate and upstate metropolitan areas. Black, Hispanic and Asian/Pacific Islander prevalence rates are highest in upstate metropolitan areas.

*Service Use:* Service rates for Whites are highest in the upstate non-metropolitan areas. Service rates of Blacks are significantly lower than that of Whites in upstate metropolitan areas. Black and Hispanic service rates are lowest in the upstate metropolitan area.

### ***Adults***

*Prevalence:* White prevalence rates increase as areas become less populated and rural. Black and Hispanic rates exceed White rates in all areas and are highest in upstate metropolitan areas. Asian/Pacific Islander prevalence rates are lower than White rates in both downstate and upstate metropolitan areas.

*Service Use:* Service rates for Whites are highest across areas in the NYC metropolitan area. In the NYC metropolitan area, Black and Hispanic service rates are significantly lower than Whites by 1 to 2 weeks. In upstate metropolitan areas, Hispanic rates are significantly lower than Whites. In metropolitan areas, Asians receive services at rates comparable to Whites.

### ***Elderly***

*Prevalence:* White prevalence rates across areas were highest in the NYC metropolitan area. In the NYC metropolitan area, Black and Hispanic rates exceed White rates and Asian/Pacific rates are lower than White rates.

*Service Use:* Service usage of elderly Whites in the upstate areas is less than in the NYC metropolitan area. In the NYC metropolitan area, Black, Hispanic and Asian rates are lower than White rates. In the NYC metropolitan area, Asians have the lowest service usage rate of all groups.

## **Report Conclusions**

While differences between racial/ethnic minority groups and Whites were observed, many of these can be reasonably accounted for by reasons that are not directly attributable to the mental health system. Nevertheless some can be addressed by mental health system

policies and procedures introduced centrally or within provider agencies. We highlight major findings.

**Annual Treated prevalence** Higher treated prevalence rates of Blacks and Hispanics in comparison to Whites represent their greater reliance on the public mental health system. Particularly in the downstate metropolitan area, Whites in addition to using the PMHS may make substantial use of private providers in the private sector. This may be a consequence of differentials in income and insurance between Whites, Hispanics and Blacks (DeNavas-Walt et al, 2004). A diminishing supply of private providers from downstate to upstate areas (Ellis et al, 2009) may explain the increasing prevalence rates of White adults and youth as they need to use public providers. Black and Hispanic treated prevalence rates of children/youths and adults are higher in the upstate metropolitan areas than in the NYC metropolitan area most likely reflecting higher poverty levels of these groups in upstate cities and greater reliance on the PMHS. The finding of no difference in treated prevalence rates of Black and Hispanic children/youths in upstate non-metropolitan areas may also be due to a dearth of private providers serving children/youth (Thomas et al, 2009) and to the lower income levels of Whites in these areas leading to their greater reliance on the PMHS.

In contrast, Asian treated prevalence rates for all age groups are substantially lower than Whites. While their lower prevalence in the PMHS may partially be explained by some use of private providers by those with higher incomes and insurance, other reasons are likely and may be strongly contributory. These include Asian views of mental illness in which mind and body are holistically viewed leading them to present symptoms of mental disorders somatically and to therefore seek help from primary care physicians (Yeung, et al, 2004). This particularly may be the case for those with depression. Additionally, Asian groups may experience stigma and family shame to a greater extent than other groups preventing them from seeking services (Kung et al, 2004). For the elderly, their limited English proficiency, and fewer contacts with agencies or providers who might triage them into needed services may keep them from receiving PMHS services.

**Annual Service Usage** Statewide, the average number of weeks in service did not substantially differ among White, Hispanic and Black service users. They all receive services for approximately three months in the year. An examination of age/diagnostic specific rates statewide and regional differences revealed some notable differences. For example, Black children/youth in upstate metropolitan areas receive two weeks less, Black adults with psychoses statewide two weeks less, and Black elderly in the NYC metropolitan area three weeks less of services than their White counterparts. Poverty-related community stressors facing Black children/youth leading to drug and alcohol use and involvement with the juvenile justice system may act to impede their use of services indicated in these data more so in upstate than downstate metropolitan area. Black adults with psychoses may be enrolled in

programs with limited cultural competency. Black elderly in NYC may have care-taker and transportation difficulties which may impede their ability to keep appointments.

Hispanic adults in upstate metropolitan areas receive two weeks less of services than Whites. Programs in these areas may need to increase their levels of linguistic and cultural competency.

Statewide, Asian children/youth and adults have service use rates comparable to Whites. However, Asian elderly receive one month less of services than Whites. This may be due to a lack of health information on the need to continue medication services and also, as is the case for Black elderly, transportation difficulties.

**Diagnoses** While the literature reports (Miranda, et al. 2008) comparable or even lower rates of mental disorders among racial/ethnic minority groups in the community, in the PMHS Black adults and Black elderly service users are more likely to receive diagnoses of psychoses than their White counterparts. This may reflect the well-noted problem (Barnes A, 2008) of the greater likelihood of clinicians diagnosing Blacks with psychoses than with affective disorders because of a failure to recognize their distinct cultural presentation of symptoms.

Another reason for the possible misdiagnosis of psychosis in Blacks may be that clinicians are getting insufficient information from their Black clients (Strakowski et al, 2007) in shorter interviews in contrast to fuller and longer interviews with white clients (Olfson, et al, 2009).

Cultural presentation of symptoms may also cause clinicians to miss depressive symptoms in Hispanics diagnosed as having anxiety disorders (Lewis-Fernández, et al, 2005) and may account for Hispanic adults and elderly with anxiety disorders receiving services at substantially lower rates than their White counterparts in contrast to those with depression receiving services at comparable rates to Whites.

Asian elderly service users are substantially more likely to receive diagnoses of depression than other groups. Low levels of acculturation and isolation from younger family members because extended family structures are no longer commonplace could contribute to situational depression.

## **Recommendations**

The following set of recommendations are based on noted difference in access or use by some cultural group but are framed to be applicable to all groups.

- **Cultural competency assessments:** Programs may not be linguistically and culturally competent, explaining lower rates of service use by certain cultural groups (observed in some areas for some age groups). Mandates to conduct organizational and program-level cultural competency assessments, particularly those that identify areas of needed improvement, should become part of quality of care assessments envisaged for health care reform.
- **Cross-system coordination:** Children/youth in some areas are at high risk for community-based problems, (e.g., Black children/youth in upstate metropolitan areas with lower service use rates may be at high risk for substance abuse and criminal justice system involvement). The need for cross-system coordination of services and supports used by children/youth is well recognized and is being addressed statewide in the NYS Children’s Plan (2011). Specific ways for parents to make linkages and coordinate with schools, other children/youth services and support systems are required to increase children/youth retention in needed mental health services.
- **Cultural competency clinician training:** Cultural competency clinician training is recommended that specifically addresses possible differences in the cultural presentation of illness symptoms, particularly with reference to psychoses in Blacks (Barnes, 2008) and depression and anxiety disorders in Hispanics (Lewis-Fernández, et. al, 2005).
- **Integration with primary care:** Since many cultural groups express mental disorders somatically and use primary care providers to treat their mental health problems (most likely accounting for the lesser use of PMHS by Asians), screening for mental disorders by primary care providers should be routine and ways for them to make referrals to programs in the PMHS facilitated. Primary care providers can also distribute mental health information to their patients.
- **Mental health information:**
  - To increase service use of less acculturated consumers, (e.g., Asian elderly), mental health information needs to be provided to them and their family members by the programs they are enrolled in, using languages and formats suitable to their cultures and acculturation levels on reasons for adhering to medications and the desirability of completing programs (Siegel, et al, 2011).
  - Community-based mental health information campaigns need to be mounted that are targeted to specific cultural groups and are geared to removing the shame and stigma of mental illness.

- **Assistance for elderly:** Assistance with transportation particularly for the elderly (as noted for Asians and Hispanics) consumers who are isolated or who have limited abilities to tap local resources by themselves (Leong, 2001; Mobley et al, 2006) would increase their lower levels of engagement in the system.

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#### IV. Utilization of Inpatient Psychiatric Care in New York State by Demographic Characteristics

##### OMH, Office of Performance Measurement and Evaluation

##### NKI Center of Excellence in Culturally Competent Mental Health

Data are presented on the population that utilized inpatient psychiatric care in New York State (NYS) in 2009 in State psychiatric centers and in Article 28 general hospitals, (i.e., hospitals with certified mental health units). Not included are private hospitals and general hospitals having only scatter beds for psychiatric care.

**Data sources** Data on the State psychiatric centers are from the NYSOMH MHARS system and on general hospitals from the NYS Department of Health SPARCS system. Denominator data for rates are from the US Census.

**Measures and tables** The average daily census (ADC) in a year for a racial/ethnic age and gender group, representing for a group, the average number of patients per day in the group in a hospital in a year is presented for the two inpatient setting types. The ADC's displayed are population based denominated to per 10,000 in the population. ADC rates cannot be used to estimate the unduplicated numbers seen in these sites. State-operated hospitals treat persons with the most severe and persistent mental illnesses, and persons there have longer hospitalizations than those served in general hospitals. Nevertheless there are discharges and new admissions every year so that the ADC is not an unduplicated patient count. In general hospitals, lengths of stay are shorter, and readmission rates are greater than in State hospitals, and without this knowledge, an unduplicated estimate cannot be made.

The rates are displayed in Tables 1-2. Tables 1 A-C display for each race/ethnic group the rates for the age and gender groups, Tables 1 A for general hospitals plus psychiatric settings, Table 1B for State psychiatric centers, and Table C for general hospitals. Tables 2 A-C provides the ADC for these settings in similar order for the total of each cultural group (i.e., across age and gender groups) for each of the OMH geographic regions. The tables also display an ADC ratio of a racial/ethnic minority's ADC to that of non-Hispanic Whites. This ratio provides information on the order of magnitude of differences between these groups, numbers greater than one indicating that the racial/ethnic group's ADC is greater than the White groups, and numbers less than one lower. No statistical tests were performed on this ratio, and we highlight only sizable differences.

**Definition of groups** For age groups, 'child' is a person under the age of 18, and 'adult' a person 18 or over. Adult therefore also includes the elderly. Racial/ethnic groups are Hispanic, Black non-Hispanic, Asian non-Hispanic and Other (representing all else). In these

tabulations, "Hispanics" are Hispanics alone or with any other race. Data are not presented in the tables for Other as the members of this group are diverse in terms of race/ethnicity.

## **Results**

The overall ADC for inpatient hospitals was 4.14 per 10,000 persons in NYS indicating that roughly 8,000 individuals were hospitalized in the studied settings for mental illness on any given day in 2009: 58% in general hospitals and 42% in state psychiatric centers. The ADC per 10,000 in the population did not differ between Whites and Hispanics, but was considerably higher for Blacks (3 times greater) and lower for Asians (about half) than Whites.

**Gender and Age Comparisons (Table 1)** Across all cultural groups, adult males had higher ADC rates than females, especially in State psychiatric centers where the overall ADC rates for male adults was more than two times that of females. Among children, this gender ratio is attenuated, with boys and girls having similar rates.

**Cultural group comparison (Table 1)** The overall ADC per 10,000 rate for White patients was 3.09 with the rate for children 1.28 and for adults 3.53. Black persons both children and adults were approximately three times more likely than Whites to be in hospital on a given day. Hispanic children were also more likely to be in hospitals than Whites in both settings but the difference is smaller. Among Asians the rates are considerably lower in total and for all age and gender groups compared to Whites in both setting types.

**Regional comparison (Table 2)** The overall ADC per 10,000 rate was highest in New York City (NYC) (5.19) compared to the other OMH regions (3.18-3.59). Black persons consistently had the highest rates in all regions. Asians continued to have the lowest hospitalization rates in each region and they were consistently lower than Whites.

Hispanic ADC ratios, however, varied somewhat by region when compared to White patients. State psychiatric center rates were higher in NYC and the Western region and similar in other regions. General hospital rates were higher in the Central region and similar or lower in other regions. When comparing the psychiatric hospital to the general hospital rates, there was an additional difference: Hispanics had lower rates of general hospital use in NYC compared to White patients (1.71 compared to 2.23) while their psychiatric center rates were higher (1.76 compared to 1.17).

## **Summary**

Black patients had the highest average daily census rates of hospitalization per Black capita. This finding is in line with national studies showing higher inpatient treatment prevalence rates for Blacks. Asians had the lowest rates regardless of hospital type, age, gender, or region. Hispanic patients present a more complex picture, with rates that are closer to the White comparison group but that vary according to hospital type, age, gender, and region. For all groups, New York City has the highest rates in the State. The concentration of hospitals in the city may make availability less of a barrier.

TABLE 1

## A: ADC per 10,000 All Inpatient Settings (State Psychiatric Centers and General Hospitals)

Race/Ethnicity	ADC-Child (Under 18 Years)		ADC Child Total	ADC Child Total	ADC-Adult (18 years and older)		ADC Adult Total	ADC Adult Total	ADC Grand Total	ADC Total Age
	F	M		Ratio	F	M		Ratio		Ratio
Asian Non-Hispanic	0.31	0.44	0.38	0.30	1.82	2.40	2.10	0.60	1.71	0.55
Black Non-Hispanic	3.24	4.04	3.65	2.85	7.37	15.72	11.13	3.15	9.20	2.98
Hispanic	1.70	1.59	1.64	1.28	2.59	4.95	3.75	1.06	3.13	1.01
White Non-Hispanic	1.28	1.27	1.28	1.00	3.07	4.03	3.53	1.00	3.09	1.00
Grand Total	1.75	1.90	1.82		3.76	5.97	4.82		4.14	

## B: State Psychiatric Centers

Race/Ethnicity	ADC-Child (Under 18 Years)		ADC Child Total	ADC Child Total	ADC-Adult (18 years and older)		ADC Adult Total	ADC Adult Total	ADC Grand Total	ADC Total Age
	F	M		Ratio	F	M		Ratio		Ratio
Asian Non-Hispanic	0.09	0.12	0.11	0.14	0.71	1.12	0.91	0.59	0.72	0.52
Black Non-Hispanic	1.88	2.21	2.05	2.53	2.89	8.17	5.27	3.44	4.44	3.19
Hispanic	1.11	0.98	1.04	1.29	0.97	2.76	1.85	1.21	1.62	1.16
White Non-Hispanic	0.83	0.79	0.81	1.00	1.20	1.88	1.53	1.00	1.39	1.00
Grand Total	1.02	1.02	1.02		1.39	2.83	2.08		1.84	

## C: General Hospitals (ADC per Mental Health Inpatient Treatment)

Race/Ethnicity	ADC Child (Under 18 Years)		ADC Child Total	ADC Child Total	ADC Adult (18 years and older)		ADC Adult Total	ADC Adult Total	ADC Total	ADC Total Age
	F	M		Ratio	F	M		Ratio		Ratio
Asian Non-Hispanic	0.22	0.32	0.27	0.57	1.12	1.28	1.19	0.60	0.98	0.58
Black Non-Hispanic	1.36	1.83	1.60	3.40	4.48	7.55	5.86	2.93	4.76	2.80
Hispanic	0.58	0.61	0.60	1.27	1.62	2.18	1.90	0.95	1.52	0.89
White Non-Hispanic	0.45	0.48	0.47	1.00	1.87	2.15	2.00	1.00	1.70	1.00
Grand Total	0.73	0.88	0.80		2.37	3.14	2.74		2.30	

Note: Other Non-Hispanic has been excluded from these tables

Data Sources: General Hospitals: SPARCS 2009; State Psychiatric Centers: MHARS 2009; NYS Population: 2009 US Census

**TABLE 2**

**Regional comparisons**

**A: ADC per 10,000: All Inpatient Settings (State Psychiatric Centers and General Hospitals)**

	Statewide		Central		Hudson River		Long Island		NYC		Western	
<b>Race/Ethnicity</b>	<b>Grand Total</b>	<b>Total Ratio</b>	<b>Grand Total</b>	<b>Ratio</b>	<b>Grand Total</b>	<b>Ratio</b>	<b>Grand Total</b>	<b>Ratio</b>	<b>Grand Total</b>	<b>Ratio</b>	<b>Grand Total</b>	<b>Ratio</b>
Asian Non-Hispanic	1.71	0.55	1.21	0.36	0.82	0.29	0.85	0.28	2.01	0.59	0.90	0.32
Black Non-Hispanic	9.20	2.98	8.61	2.58	8.07	2.83	8.92	2.94	9.76	2.87	6.92	2.45
Hispanic	3.13	1.01	3.84	1.15	2.46	0.86	1.67	0.55	3.47	1.02	3.26	1.16
White Non-Hispanic	3.09	1.00	3.34	1.00	2.85	1.00	3.04	1.00	3.40	1.00	2.82	1.00
Grand Total	4.14		3.59		3.36		3.32		5.19		3.18	

**B: State Psychiatric Centers**

	Statewide		Central		Hudson River		Long Island		NYC		Western	
<b>Race/Ethnicity</b>	<b>Grand Total</b>	<b>Total Ratio</b>	<b>Grand Total</b>	<b>Ratio</b>	<b>Grand Total</b>	<b>Ratio</b>	<b>Grand Total</b>	<b>Ratio</b>	<b>Grand Total</b>	<b>Ratio</b>	<b>Grand Total</b>	<b>Ratio</b>
Asian Non-Hispanic	0.72	0.52	0.81	0.42	0.44	0.36	0.44	0.31	0.82	0.70	0.33	0.23
Black Non-Hispanic	4.44	3.19	6.08	3.17	4.13	3.36	5.44	3.89	4.38	3.75	3.67	2.57
Hispanic	1.62	1.16	1.99	1.04	1.22	0.99	1.04	0.74	1.76	1.50	1.82	1.27
White Non-Hispanic	1.39	1.00	1.92	1.00	1.23	1.00	1.40	1.00	1.17	1.00	1.43	1.00
Grand Total	1.84		2.11		1.46		1.66		2.06		1.62	

**C: General Hospitals (ADC per Mental Health Inpatient Treatment)**

	Statewide		Central		Hudson River		Long Island		NYC		Western	
<b>Race/Ethnicity</b>	<b>Grand Total</b>	<b>Total Ratio</b>	<b>Grand Total</b>	<b>Ratio</b>	<b>Grand Total</b>	<b>Ratio</b>	<b>Grand Total</b>	<b>Ratio</b>	<b>Grand Total</b>	<b>Ratio</b>	<b>Grand Total</b>	<b>Ratio</b>
Asian Non-Hispanic	0.98	0.58	0.39	0.28	0.38	0.24	0.41	0.25	1.18	0.53	0.57	0.41
Black Non-Hispanic	4.76	2.80	2.53	1.78	3.94	2.45	3.48	2.12	5.38	2.41	3.24	2.33
Hispanic	1.52	0.89	1.85	1.30	1.24	0.77	0.64	0.39	1.71	0.76	1.44	1.04
White Non-Hispanic	1.70	1.00	1.42	1.00	1.61	1.00	1.64	1.00	2.23	1.00	1.39	1.00
Grand Total	2.30		1.49		1.90		1.66		3.13		1.56	

Data Sources: General Hospitals: SPARCS 2009; State Psychiatric Centers: MHARS 2009; NYS Population: 2009 US Census

## **V. Quality of Psychotropic Medication Prescribing by Race/Ethnicity in the New York State Medicaid Mental Health Population: the PSYCKES-Medicaid Program**

**Molly Finnerty, M.D., Edith Kealey, M.S.W., Emily Leckman-Westin, Ph.D., Veronica Hackethal, M.D., MSc, Roberto Lewis-Fernández, M.D., & Jennifer Humensky, Ph.D.**

In 2008, the Office of Mental Health (OMH) and the Department of Health began collaboration on a statewide Continuous Quality Improvement (CQI) initiative to improve the quality and safety of psychotropic prescribing for Medicaid recipients. The central vehicle of this initiative is PSYCKES-Medicaid, a HIPAA-compliant, web-based portfolio of tools designed to support quality improvement and clinical decision-making in the New York State (NYS) Medicaid mental health population. Community-based mental health providers with access to PSYCKES are able to review a portfolio of reports at the state, region, county, agency, site, program, and client levels to assess performance on quality indicators, identify individuals who could benefit from clinical review, and inform treatment planning.

OMH partnered with the Division of Mental Health Services and Policy Research (DMHSPR) of the New York State Psychiatric Institute and Columbia University to establish a Scientific Advisory Committee (SAC) consisting of experts who contribute regularly to the scientific literature on psychopharmacology. The SAC was charged with the task of identifying prescribing practices that may, under some circumstances, be considered clinically questionable. Six work groups were established: Schizophrenia, Bipolar Disorder, Depression, Youth, Older Adults, and Women. Indicator development was prioritized based on stakeholder input. From an initial list of over 60 quality concerns, four indicators were developed and implemented: psychotropic polypharmacy, cardiometabolic risk, high-dose prescribing, and risky psychotropic prescribing in youth.<sup>2</sup>

Before implementation, these indicators underwent detailed characterization analyses to identify the population most at risk for the quality concern. These analyses evaluated demographics (sex, age, race/ethnicity), diagnosis, and medications/service utilization of affected and unaffected recipients at the county, regional, and state level. Indicators were validated by chart review and revised as necessary.

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<sup>2</sup> For full technical specifications of these indicators see [http://www.omh.ny.gov/omhweb/psyckes\\_medicaid/quality\\_concerns/](http://www.omh.ny.gov/omhweb/psyckes_medicaid/quality_concerns/)

## Reducing Psychotropic Polypharmacy

Psychotropic polypharmacy as defined by the PSYCKES CQI project refers to a medication regimen that includes one or more of the following for longer than 90 days: 2 or more antipsychotics, 3 or more antipsychotics, 2 antidepressants from the same class or 3 antidepressants from all classes, 4 or more psychotropic medications in adults, or 3 or more psychotropic medications in youth.

Use of more than one medication to treat an individual with a psychiatric disorder has increased in the United States during the past decade.<sup>3</sup> There is minimal scientific evidence to support the effectiveness of combining psychotropics. In addition, psychotropic polypharmacy has serious potential risks:

- Polypharmacy increases the side effect burden for consumers, both acutely and long term.<sup>4,5</sup>
- There is a higher risk for adverse drug-drug interactions.
- Adherence decreases, with consequent risk of relapse.
- People prescribed polypharmacy may be receiving higher-than-necessary total doses within a drug class.
- It can also be difficult to determine which agent may be helping the client and which may be causing toxicity.
- Treatment costs are higher, without evidence of clinical benefit.

As a consequence, polypharmacy is recommended as an option only after adequate trials of monotherapy have proven unsuccessful.

## Cardiometabolic Risk

The PSYCKES CQI Cardiometabolic Risk set of indicators focuses on the risks that antipsychotic medications can pose to the health of consumers who have certain pre-existing cardiometabolic risk factors (hypertension, ischemic vascular disease, acute myocardial infarction [heart attack], hyperlipidemia, obesity, or diabetes/pre-diabetes). Among the major metabolic side effects of antipsychotics are weight gain and increased

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<sup>3</sup> Mojtabai R., Olfson M., National trends in psychotropic medication polypharmacy in office-based psychiatry. *Archives of General Psychiatry*, 2010. 67(1): p. 26-36.

<sup>4</sup> Sim, K., et al., Clinical correlates of antipsychotic polytherapy in patients with schizophrenia in Singapore. *Psychiatry Clin Neurosci*, 2004. 58(3): p. 324-9.

<sup>5</sup> Correll, C.U., et al., Does antipsychotic polypharmacy increase the risk for metabolic syndrome? *Schizophr Res*, 2007. 89(1-3): p. 91-100.



risk for diabetes, which are both already significant problems in the general population of the United States. These medical risks are magnified for consumers with psychiatric disorders. Obesity is twice as common in this population<sup>6</sup>, and diabetes rates are high.

The SAC identified a list of antipsychotics with high or moderate risk of cardiometabolic side effects. In adults, olanzapine was identified as being high risk; quetiapine, chlorpromazine, and thioridazine were identified as being moderate risk. In youth, olanzapine was identified as being the antipsychotic with the highest risk; quetiapine, paliperidone, and risperidone were identified as being higher risk; and all first-generation (conventional) antipsychotics with the exception of molindone were identified as being moderate risk. Reducing the use of these medications in consumers with pre-existing cardiometabolic risk factors is a major aim of the PSYCKES-CQI project.

### Higher-than-Recommended Doses of Psychotropic Medications

The PSYCKES CQI High-Dose indicator refers to a medication regimen that includes psychotropic medications at doses that are higher than recommended; this indicator applies to antipsychotics, antidepressants, mood stabilizers, anxiolytics, and stimulants. Maximum recommended doses were determined using a hierarchy of published recommendations, including the Federal Drug Administration (FDA)'s maximum doses, as indicated by the Physician's Desk Reference (PDR), 2009 recommendations of the Schizophrenia Patient Outcomes Research Team (PORT)<sup>7,8</sup>, the Texas report regarding the care of Foster Children (TEXAS)<sup>9</sup>, and a standard text for psychotropic prescribing in pediatrics.<sup>10</sup>

Despite decades of evidence that high doses of antipsychotics are more toxic and less effective than moderate doses, providers continue to prescribe high doses for a

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<sup>6</sup> Dixon, L., et al., The association of medical comorbidity in schizophrenia with poor physical and mental health. *J Nerv Ment Dis*, 1999. 187(8): p. 496-502.

<sup>7</sup> [Buchanan RW](#), [Kreyenbuhl J](#), [Kelly DL](#), [Noel JM](#), [Boggs DL](#), [Fischer BA](#), [Himmelhoch S](#), [Fang B](#), [Peterson E](#), [Aquino PR](#), [Keller W](#); [Schizophrenia Patient Outcomes Research Team \(PORT\)](#). The 2009 schizophrenia PORT psychopharmacological treatment recommendations and summary statements. *Schizophr Bull*. 2010 Jan;36(1):71-93.

<sup>8</sup> [Kreyenbuhl J](#), [Buchanan RW](#), Dickerson, FB, Dixon, LB. The Schizophrenia Patient Outcomes Research Team (PORT): Updated Treatment Recommendations 2009. *Schizophr Bul*. 2010 Jan;36(1):94-103.

<sup>9</sup> Texas Psychotropic Medication Utilization Parameters for Foster Children. Available at [http://www.hhsc.state.tx.us/medicaid/OCC/psychoactive\\_medications.html](http://www.hhsc.state.tx.us/medicaid/OCC/psychoactive_medications.html)

<sup>10</sup> *Pediatric Psychopharmacology: Principles and Practice*, second edition. Oxford: Blackwell Scientific Publications, 2011.

significant group of consumers. Higher-than-recommended doses of psychotropics place the consumer at increased risk for adverse outcomes.<sup>11,12</sup> High dosing is often associated with treatment non-response; clients who are least likely to respond to medications are often on the highest doses, and high doses are rarely reduced when there has been no clinical improvement. High doses of medication have been associated with decreased adherence, and increases in side effects at high doses are connected to increased dropout rates. Research suggests that children, youth, and the elderly are particularly vulnerable to adverse effects of psychotropic medication.<sup>13,14</sup>

## **Reducing Psychotropic Prescribing Risk for Youth**

The PSYCKES CQI Youth indicator set focuses on children and adolescents who are prescribed higher-than-recommended doses of psychotropics, who are on psychotropic polypharmacy, or who are receiving psychotropics and are less than 6 years old.

Higher doses of psychotropic medications are associated with increased risk of serious side effects and problems with adherence.<sup>15</sup> Little scientific evidence regarding high doses of medications exists for children and adolescents outside the FDA approval process; therefore, caution is needed when prescribing for this population. Although there is little empirical evidence to support its use, polypharmacy is becoming an increasingly frequent practice in the mental health treatment of youth. Polypharmacy in youth is associated with increased risk of serious drug interactions and adverse reactions, including delirium, serious behavioral changes, cardiac arrhythmias, and death.<sup>16</sup> During the past decade rates of prescription of psychotropic medications to preschool children have also risen.<sup>17</sup> The effectiveness, safety, and appropriate dosing

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<sup>11</sup> Elie, D., et al., Cognitive effects of antipsychotic dosage and polypharmacy: a study with the BACS in patients with schizophrenia and schizoaffective disorder. *J Psychopharmacol*, 2010. 24(7): p. 1037-44.

<sup>12</sup> *Morbidity and Mortality in Persons with Severe Mental Illness*, N.A.S.M.H.P.D.M.D. Council, Editor. 2006: Alexandria, VA

<sup>13</sup> Blader, J.C., et al., Stimulant-responsive and stimulant-refractory aggressive behavior among children with ADHD. *Pediatrics*, 2010. 126(4): p. e796-806.

<sup>14</sup> Hanlon, J.T., et al., Number and dosage of central nervous system medications on recurrent falls in community elders: the Health, Aging and Body Composition study. *J Gerontol A Biol Sci Med Sci*, 2009. 64(4): p. 492-8.

<sup>15</sup> Haas, M., Unis, A.S., et al., A 6-week, randomized, doubleblind, placebo-controlled study of the efficacy and safety of risperidone in adolescents with schizophrenia. *J. Child Adolesc. Psychopharm.* 2009. 19(6): 611-621.

<sup>16</sup> Safer, D.J., J.M. Zito, and S. DosReis, Concomitant psychotropic medication for youths. *Am J Psychiatry*, 2003. 160(3): p. 438-49.

of second-generation antipsychotics in preschool children remain unknown. Worrisome adverse effects have been documented even at low doses.

### Quality Indicator Analyses by Race/Ethnicity

Tables 1-4 show statewide performance by race/ethnicity as of June 1, 2010 on the four quality indicators noted above: Psychotropic Polypharmacy, Cardiometabolic Risk, High-Dose Prescribing, and Risky Psychotropic Prescribing in Youth. Preliminary descriptive analyses were conducted for the following categories: non-Hispanic Whites, non-Hispanic Blacks, Asians or Pacific Islanders, American Indians or Alaskan Natives, Hispanics, and patients of Other Race/Ethnicity. Specific tests of significance were not completed; however, given the robust sample size, it is expected that observed differences would be statistically significant.

Table 1 shows the rates of polypharmacy. Statewide, the proportions of Medicaid mental health recipients on psychotropic polypharmacy varied somewhat by race/ethnicity, but without a clear pattern of adverse indicators for a particular group. For several indicators (e.g.,  $\geq 4$  psychotropics/adults,  $\geq 3$  psychotropics/youth) the rates of polypharmacy were highest for non-Hispanic Whites. For other indicators (e.g., polypharmacy summary indicator,  $\geq 2$  and  $\geq 3$  antipsychotics), the “Other” race/ethnicity group had the highest rates. In general, rates for non-Hispanic Blacks, Asians/Pacific Islanders, and Hispanics were not higher than those for Whites, with some exceptions (e.g.,  $\geq 2$  antipsychotics for Asians/Pacific Islanders).

**Table 1: Psychotropic Polypharmacy Indicators by Race/Ethnicity**

Indicator	New York State		White (Non-Hispanic)		Black (Non-Hispanic)		Asian or Pacific Islander		American Indian or Alaskan Native		Hispanic		Other	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Psychotropic Polypharmacy Summary Indicator	86740	21.0	41434	21.9	20118	19.0	1559	20.1	838	18.4	13570	20.1	4637	22.0
$\geq 2$ Antidepressants	45172	1.4	22844	1.6	8588	0.9	753	1.6	440	1.4	8461	1.3	2273	1.3
$\geq 3$ Antidepressants	45172	0.5	22844	0.5	8588	0.5	753	0.3	440	0.5	8461	0.6	2273	0.2
$\geq 2$ Antipsychotics	47382	13.6	20306	12.3	12774	15.3	1062	18.1	439	13.4	6821	11.4	3088	18.7

<sup>17</sup> Olsson M, Crystal S, Huang C, Gerhard T. Trends in antipsychotic drug use by very young, privately insured children. *J Am Acad Child Adolescent Psychiatry*, 2010; 49(1):13-23.

Indicator	New York State		White (Non-Hispanic)		Black (Non-Hispanic)		Asian or Pacific Islander		American Indian or Alaskan Native		Hispanic		Other	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
≥3Antipsychotics	47382	0.6	20306	0.5	12774	0.7	1062	0.5	439	0.7	6821	0.3	3088	0.8
≥4Psychotropics (Adults)	69942	15.4%	33072	17.1	15873	11.6	1389	10.9	674	13.8	11750	16.9	4238	13.2
≥3Psychotropics (Youth)	16797	21.2%	8361	24.8%	4245	16.2	170	11.8	164	14.0	1820	17.1	399	15.0

Table 2 presents the Cardiometabolic indicator analyses. These data show that Hispanics and American Indians/Alaskan Natives tend to have the worst cardiometabolic characteristics for most of the indicators in this category. By contrast, Asians/Pacific Islanders tend to have the best. For at least one indicator, ischemic vascular disease/acute myocardial infarction, the prevalence among American Indians/Alaskan Natives (61.7%) was much higher than that among other racial/ethnic groups.

Indicator	New York State		White (Non-Hispanic)		Black (Non-Hispanic)		Asian or Pacific Islander		American Indian or Alaskan Native		Hispanic		Other	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Cardiometabolic Summary Indicator	33876	46.7	13443	46.5	9687	46.1	757	42.0	320	49.1	5588	50.6	2496	44.4
Diabetes	11745	41.9	4196	40.8	3484	41.4	276	39.1	93	38.7	2193	46.6	952	40.2
Hyperlipidemia	23108	46.5	9591	46.4	5912	45.8	588	40.0	222	51.4	3928	50.7	1780	44.4
Hypertension	21190	46.6	7906	46.2	6565	47.1	359	44.8	195	49.7	3534	49.7	1667	42.5
Ischemic Vascular Disease/Acute Myocardial Infarction	5910	47.9	2431	47.2	1558	50.0	92	34.8	60	61.7	1057	48.9	452	45.1
Obesity	11182	41.4%	4311	40.4	3402	40.4	168	41.7	94	40.4	1899	44.5	760	43.2

**Table 2: Cardiometabolic Risk Indicators by Race/Ethnicity**

Table 3 presents the High-Dose indicator analyses. Non-Hispanic Whites, in general, had slightly higher prevalences than other racial/ethnic groups for most indicators in this category. A notable exception is high-dose antipsychotics: non-Hispanic Blacks (8.4%), Asians/Pacific Islanders (7.6%) and other racial/ethnic groups (8.5%) had higher rates

than non-Hispanic Whites (7.3%), American Indians/Alaskan Natives (7.3%) and Hispanics (6.6%). Additionally, American Indians/Alaskan Natives had higher rates of anxiolytic/hypnotic use than non-Hispanic Whites (6.4% and 5.3%, respectively), and higher rates of mood stabilizers (1.6% and 1.1%, respectively). Other racial/ethnic groups also had higher rates of mood stabilizers than non-Hispanic Whites (1.3% and 1.1%, respectively).

**Table 3: High-Dose Indicators by Race/Ethnicity**

Indicator	New York State		White (Non-Hispanic)		Black (Non-Hispanic)		Asian or Pacific Islander		American Indian or Alaskan Native		Hispanic		Other	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
High Dose Summary Indicator	117346	10.2	57113	10.7	27115	9.7	2025	8.7	1144	9.3	17853	9.3	6083	9.8
Antidepressants	63400	5.2	31660	5.8	12929	4.0	1040	4.8	646	3.6	11750	4.9	2948	4.7
Antipsychotics	61014	7.8	26213	7.3	16847	8.4	1317	7.6	574	7.3	8909	6.6	3611	8.5
ADHD	20708	9.8	10597	10.4	5307	8.9	184	8.7	202	6.4	2160	10.0	557	8.6
Anxiolytics/Hypnotics	50661	4.6	27314	5.3	8362	3.5	629	2.4	452	6.4	9148	3.9	2707	3.9
Mood Stabilizers	29527	1.0	15261	1.1	6493	0.9	528	0.0	255	1.6	3880	0.8	1504	1.3

Regarding the youth indicators, non-Hispanic Whites had notably higher prevalences for several indicators, notably the youth summary indicator (22.9%), psychotropic prescribing among the very young (3.0%) and use of  $\geq 3$  psychotropics (24.8%). Specific prevalences for most indicators varied substantially by race/ethnicity (Table 4). For example, the youth summary indicator ranged from 9.3% among Asians/Pacific Islanders to 22.9% among non-Hispanic Whites.

**Table 4: Psychotropic Prescribing in Youth Indicators by Race/Ethnicity**

Indicator	New York State		White (Non-Hispanic)		Black (Non-Hispanic)		Asian or Pacific Islander		American Indian or Alaskan Native		Hispanic		Other	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Youth Summary Indicator	21620	19.0	10263	22.9	5799	14.4	236	9.3	223	11.7	2555	14.1	525	11.8
Youth High Dose	21472	11.0	10195	10.6	5754	11.1	237	7.2	223	7.2	2540	10.7	523	11.3
Very Young	21614	2.7	10262	3.0	5796	2.6	236	0.8	223	1.3	2554	1.9	525	0.4
$\geq 3$ Psychotropics (Youth)	16797	21.2	8361	24.8	4245	16.2	170	11.8	164	14.0	1820	17.1	399	15.0

The data presented here demonstrate that, among patients receiving psychotropic medications through the New York State Medicaid system, risk indicators for non-Hispanic Blacks, Asian/Pacific Islanders, and Hispanics are not higher than those for

non-Hispanic Whites, with some exceptions. Notably, Hispanics and American Indian/Alaskan Natives tend to have the worst cardiometabolic characteristics, while Asian/Pacific Islanders tend to have the best. It should be noted that this data only reflects utilization within the NYS Medicaid system and does not reflect persons who are uninsured, who are eligible for Medicaid but not receiving services, or those who are receiving care from other systems, such as Medicare or private insurers.

The PSYCKES Cultural Advisory Committee (CAC) will collaborate on follow-up analyses of these data and will advise on investigation of observed disparities. The aims of the CAC are to advise about changes in the PSYCKES application that would best promote awareness of race/ethnicity issues in conducting quality improvement and clinical review; identify culturally specific ways to increase the impact of each PSYCKES quality improvement project; and provide guidance on issues of cultural competence in analytical and evaluation plans.

## **VI. Report Conclusions:**

Mental health disorders do not discriminate: persons of all racial and ethnic groups face mental health disorders.

### **National studies**

Racially and ethnically underserved groups have lower rates of entry into, adherence with, and retention in mental health care services than non-Hispanic Whites, even after accounting for socioeconomic characteristics and prevalence of disorders.

Black and Latino adolescents have higher rates of suicide attempts than non-Hispanic whites. Furthermore, female Latina adolescents have higher rates of suicidal ideation, plans and behavior than non-Hispanic black and non-Hispanic white female adolescents.

Once they access care, racial and ethnic minorities are more likely to receive poorer quality of care than their non-Hispanic white counterparts.

Persons living in rural areas face barriers to treatment, including shortages of providers and lack of transportation to providers.

LGBT persons face high rates of mood disorders, substance abuse and suicidal behavior, and may have difficulty finding providers who understand the needs of the LGBT community.

## **Persons in the NYS PMHS**

### **Entry to services:**

Hispanics and non-Hispanic Blacks are more likely to rely on the PMHS than non-Hispanic Whites, who may be receiving services in the private sector.

Asians in all age groups have the lowest rates of entry into the PMHS.

Blacks with psychoses are seen in inpatient settings at greater rates than Whites.

### **Service use:**

With respect to non-inpatient services, all groups receive approximately 3 weeks of service, but there is considerable variation in this number among racial/ethnic minorities and Whites in diagnostic/age groups in different areas of the State.

- Hispanic adults and elderly with anxiety disorders receive services in substantially fewer weeks than Whites.
- Hispanic adult service usage rates are lower than those of Whites in metropolitan areas.
- Black children/youth service usage rates are lower than those of Whites in upstate metropolitan areas.
- Black children/youth with disruptive disorders have lower use of community supports
- Black adults with psychoses receive fewer weeks of service than Whites
- Among the elderly, statewide service usage rates for all racial/ethnic groups are lower than for Whites.
- Asian elderly have the lowest service use rate among all racial/ethnic groups.
- There is a greater reliance on the PMHS in rural areas than in urban areas by Whites so that racial/ethnic differences are not seen.

### **Quality of care:**

- Statewide the proportions of Medicaid mental health recipients on psychotropic polypharmacy were similar, except for Asians/Pacific Islanders and persons of "Other" race/ethnicity, for whom the prevalence of the  $\geq 2$  antipsychotic

polypharmacy indicator was higher (18.1% and 18.7%, respectively) than for the other racial/ethnic groups.

- Hispanics and American Indians/Alaskan Natives had worse cardiometabolic indicators of inappropriate medications compared to other groups.
- Non-Hispanic White youth were more likely than other groups to receive risky pharmacotherapy indicators.

## **VII. OMH Recommendations and Commitments:**

The New York State Office of Mental Health is concerned with the disparities experienced by the traditionally underserved and underrepresented populations and has implemented intentional measures to address these concerns. A multilevel approach has been implemented which includes hiring a Chief Diversity Officer who is part of the OMH executive team. The Chief Diversity Officer oversees the Division of Diversity Management which is comprised of the Bureau of Cultural Competence (BCC) and Diversity Planning and Compliance (DPC).

A key element of this approach is the establishment of the BCC which is charged with monitoring the compliance of Federal/State laws and regulations that ensure equitable access to behavioral health services for all New Yorkers. The NYS OMH funds research for the advancement of culturally competent services for diverse cultural groups through the Centers for Excellence for Cultural Competence at Nathan Kline Institute (NKI) and New York State Psychiatric Institute (NYSPI). To ensure our programs, policies and procedures consider cultural competence, we support local and statewide Multicultural Advisory Committees comprised of diverse cultural groups that advise the Commissioner. The BCC is responsible for oversight and coordination of both the Centers and the MAC.

In addition a statewide Cultural Competence Plan was developed with the purpose of creating systemic change and removing barriers for the traditionally underserved and underrepresented populations. This plan was developed in collaboration with CECCs, MAC and other internal stakeholders. The plan can be viewed in its entirety on the NYS OMH BCC website at

[http://www.omh.ny.gov/omhweb/cultural\\_competence/planning.html](http://www.omh.ny.gov/omhweb/cultural_competence/planning.html).

Below are recommendations to further improve the services delivered to cultural groups and are closely linked to CECC's research studies of persons in the NYS PMHS.



NYSOMH has undertaken several activities guided by the CC plan to improve the quality of care for diverse cultural groups. These are presented.

- **Cultural competency assessments:** Ongoing program assessment for linguistic and program cultural competence will help boost engagement of those groups that have traditionally been identified as underserved populations. Organizational and program-level cultural competency assessments, particularly those that identify areas of needed improvement, are extremely useful and support quality of care assessments envisaged for health care reform. OMH has already initiated some of these assessments.
  - BCC in conjunction with the NKI-CECC has already assessed the Children's Psychiatric Facilities, both inpatient and outpatient. This has lead to a targeted cultural competency improvement plan for the facilities and specific topics for CC training.
  - BCC and DPC are collaborating to establish Diversity and Cultural Competence Committees within the facilities to ensure services are culturally competent.
  - NKICECC has developed and is currently pilot testing a CC assessment instrument to measure the CC of a program. The selected items were based on stakeholder input and derived from an NKICECC study of three community defined evidence based programs: for Latinos, Chinese and multicultural youth.
  
- **Cross-system coordination:** Children/youth in some areas are at high risk for community-based problems (e.g., Black children/youth in upstate metropolitan areas with lower service use rates may be at high risk for substance abuse and criminal justice system involvement). Specific activities of cross-system coordination of services and supports used by children/youth needs articulation. Specific ways for parents to make linkages and coordinate with schools, other children/youth services, and support systems are required to increase children/youth retention in needed mental health services.
  - NYS OMH Children's Division addresses this need statewide with activities delineated in the NYS Children's Plan (2011).
  - NKICECC is preparing a program for dissemination that targets multicultural youth (PASS) with mental health challenges or with parents with mental health challenges that in addition to helping parents and youth improve communication skills, behaviors and functioning, teaches parents and youths how to use multiple systems, community supports and how to advocate for their needs.

- **Cultural competency clinician training:** Cultural competency clinician training is recommended that specifically addresses possible differences in the cultural presentation of illness symptoms, particularly with reference to psychoses in Blacks (Barnes, 2008) and depression and anxiety disorders in Hispanics (Lewis-Fernández, et. al, 2005). Training in the cultural adaptation of evidence-based interventions, when these are found to be necessary, should also be provided
  - In collaboration with NKI-CECC, NYSPI-CECC and other experts in the field, BCC provides webinars focused on engagement of specific cultural groups in behavioral health services. These webinars are ongoing and archived for future training opportunities:
    - Native Americans
    - In Our Own Voices/LGBTQ
    - HIV/AIDS
    - Suicide Prevention
    - Interpreter/ Language
    - Cultural Aspects of Children’s Services
    - Toolkit for Modifying EBP to Increase CC
    - LGBT Presentation on Engagement/Treatment
    - Improving the Physical Health of Latinos & African Americans
    - Latino Presentation on Engagement and Treatment
  - NSYPI-CECC also publishes and disseminates a quarterly publication “Cultural Competence Matters” to summarize latest advances in cultural competence research relevant to the mental health needs of NYS consumers.
  - NKICECC disseminates mental health information on many of the diverse cultural groups of NYS that can be incorporated into training programs. Cultural profiles are available through its website (<http://cecc.rfmh.org> ). Groups covered include African Americans, Latinos, Muslims, Southeast Asians, Chinese, Hasidim, Native Americans, Korean, Russian and the Deaf (using ASL), LGBTQI, and Rural persons.
  - NKICECC provides tools for the cultural adaptation of evidence-based interventions that include a manual and workbooks for adaptation and an, e-learning program.
- **Integration with primary care:** Many cultural groups face high stigma barriers to accessing mental health services and use primary care providers to treat their mental health problems (most likely accounting for the lesser use of PMHS by Asian Americans). In addition, persons with serious mental illnesses are at higher risk for modifiable health risk factors (such as obesity and diabetes). Therefore, ways to integrate mental and physical health services should be

pursued, including screening and basic treatment of mental disorders in primary care and physical conditions in mental health care. Revised reimbursement policies and incentives for shared electronic health records should also be evaluated.

- NYSPI-CECC has conducted research with consumers, providers, and other stakeholders to inform culturally competent models of integrated physical and mental health services. This work will inform the development and implementation of health homes and other models for integrating mental and physical health services for consumers with serious mental illness.
  - NKICECC is conducting a project to validate a primary care depression screening instrument for Mexican and Ecuadorean populations working with Bellevue primary care clinics. A suggested list of psychosocial stressors that could impact diagnosis is also being reviewed for relevance in depression screening
- **Language access:** New Yorkers with limited English proficiency depend on the availability and quality of interpretation and translation services. Level of access and quality of these services should be evaluated across clinical settings and patient language and diagnostic groups. Training of providers in the use of these interpretation/translation services should also be promoted.
    - BCC has translated OMH forms that require patient signature into the most frequent languages encountered at our facilities and outpatient programs. The 22 forms are available in Spanish, Chinese (Mandarin), Haitian Creole, Urdu, Korean, and Russian.
    - Ongoing training for interpretation/translation services is planned.
    - NYSPI-CECC is conducting a language assessment of OMH facilities and outpatient programs to assess the current status of interpreter utilization and access as well as barriers to its implementation.
    - NYSPI-CECC is developing a model to assist in the process of cultural brokering during the provider and consumer interaction for interpreters.
    - **Suicide prevention:** Black and Latino youth have high rates of suicidal behavior. While not yet well studied, this also appears to be the case for Native American male youths. OMH is working with health care providers and community partners to develop services and interventions to address suicidal behavior in these populations.
    - An NKI-CECC study addresses cultural and service usage reasons for high rates of suicidal behaviors in Native Americans.
    - NYSPI-CECC has partnered with Communilife, a community advocacy organization, to develop their Life is Precious program into an evidence-

- based practice; LIP seeks to reduce suicidal behavior in high-risk adolescents through culturally competent community-derived approaches.
- Other studies will be conducted by the CECCs to understand the higher rates of suicidal behavior in particular racial/ethnic groups.
  - **Mental health information:** To increase service use of less acculturated consumers, (e.g., Asian elderly), mental health information needs to be provided to them and their family members by the programs they are enrolled in, using languages and formats suitable to their cultures and acculturation levels on reasons for adhering to medications and the desirability of completing programs (Siegel, et al, 2011).
    - BCC designed a website for behavioral health information and resources for consumers and family members in Spanish Russian, Chinese Mandarin and Haitian(Creole).
    - NKICECC has developed outreach materials for use by both pulpit and lay clergy to help those engage persons in need from cultural groups into mental health services and to encourage ministers to serve as cultural brokers in the process.
  - **Assistance for elderly:** Assistance with transportation particularly for the elderly (as noted for Asians and Hispanics) and for consumers who are isolated or who have limited abilities to tap local resources by themselves (Leong, 2001; Mobley et al, 2006) would increase their lower levels of engagement in the system.

New York State Office of Mental Health Statewide Cultural Competence Strategic Plan  
[http://www.omh.ny.gov/omhweb/cultural\\_competence/planning.html](http://www.omh.ny.gov/omhweb/cultural_competence/planning.html).