Removing Obstacles To Eliminate Racial And Ethnic Disparities In Behavioral Health Care

Margarita Alegría[1],* **[professor of psychology]**, **Kiara Alvarez**[2] **[postdoctoral research fellow]**, **Rachel Zack Ishikawa**[3] **[project director]**, **Karissa DiMarzio**[4] **[research assistant]**, and **Samantha McPeck**[5] **[research assistant]**

[1]Department of Psychiatry at Harvard Medical School and chief of the Disparities Research Unit, Department of Medicine, at Massachusetts General Hospital (MGH), both in Boston.

[2]Disparities Research Unit, Department of Medicine, at MGH.

[3]Disparities Research Unit, Department of Medicine, at MGH.

[4]Disparities Research Unit, Department of Medicine, at MGH.

[5]Disparities Research Unit, Department of Medicine, at MGH.

Abstract

Despite decades of research, racial and ethnic disparities in behavioral health care persist. The Affordable Care Act expanded access to behavioral health care, but many reform initiatives fail to consider research about racial/ethnic minorities. Mistaken assumptions that underlie the expansion of behavioral health care risk replicating existing service disparities. Based on a review of relevant literature and numerous observational and field studies with minority populations, we identified the following three mistaken assumptions: improvement in health care access alone will reduce disparities, current service planning addresses minority patients' preferences, and evidence-based interventions are readily available for diverse populations. We propose tailoring the provision of care to remove obstacles that minority patients face in accessing treatment, promoting innovative services that respond to patient needs and preferences, and allowing flexibility in evidence-based practice and the expansion of the behavioral health workforce. These proposals should help meet the health care needs of a growing racial/ethnic minority population.

According to the 2014 National Healthcare Quality and Disparities Report, racial/ethnic disparities in access to mental health and substance use disorder treatment changed little between 2008 and 2012.[1] In 2012 black (62.1 percent) and Latino (55.6 percent) adults were less likely than whites (72.0 percent) to receive treatment for depression, compared to 56.1% of blacks, 57.4% of Latinos, and 71.8% of whites in 2008.. For the twenty-three million people who needed substance use disorder treatment in 2012, all racial/ethnic groups were equally unlikely to enter treatment . Blacks and Latinos were less likely than whites to complete treatment for alcohol and drugs, while Native Americans were less likely to complete alcohol treatment[2]—highlighting that even those racial and ethnic minority patients who receive treatment do not have their treatment needs met adequately . Similarly,

*Corresponding author, malegría@mgh.harvard.edu.

blacks who used services had significantly lower odds of receiving adequate depression care, compared with whites.[3]

Disparities in care lead to excess morbidity and disease burden for racial/ethnic minorities. Given evidence that access to care and high-quality interventions can improve the course of behavioral health conditions, the primary goal of the Action Plan to Reduce Racial and Ethnic Health Disparities of the Department of Health and Human Services (HHS) is to transform the health care system through initiatives to reduce access and quality disparities. [4] However, prospects for reducing racial/ethnic disparities, particularly in behavioral health care, are uncertain at best.

Many of the thirty-two million people expected to gain health insurance through Medicaid expansions or subsidized plans offered through the Marketplaces[5] as part of the Affordable Care Act (ACA) are low-income and previously uninsured racial/ethnic minorities[5] with limited English proficiency; previous experiences of poor access,[6] low-quality care,[7] or coerced care (such as involuntary commitment or court-mandated services);[8] and low expectations about the value of behavioral health care.[9] The ACA seeks to improve health equity through the expansion of insurance coverage, health care delivery provisions (for example, related to health homes and workforce training support), data collection requirements (such as requiring race and ethnicity data to be linked to reporting), and population health improvements (for example, community prevention initiatives).[10] But the policy levers intended to improve health care delivery systems may not be well aligned to the actions needed to reduce disparities.

Multiple conceptual frameworks for service disparities (see online Appendix 4)[11] divide the "mechanisms" of disparities into the following three levels: macro level (the larger health and social policy or environmental context), meso level (interactions between formal organizations, lay sectors, and communities), and micro level (interactions between provider and caregiver, patient, or both). At the macro level, low Medicaid reimbursement payments mean racial/ethnic minorities who depend on public insurance must struggle to find behavioral health service providers who accept Medicaid and are multilingual, which causes access disparities. A lower percentage of psychiatrists accepted Medicaid (43.1 percent) in 2009–10, compared to other physicians (73.0 percent).[12] At the meso level, minority communities' stigma about and distrust of behavioral health treatments may discourage patients' prioritization of care over other matters such as housing and employment security. At the micro level, limited institutional support for providers to adopt evidence-based treatments can lead to disparities in high-quality care, since poorly funded health care systems are the least likely to implement new treatments. Compared to the majority white population[please provide], racial/ethnic minority populations are more often affected by discrimination, racism, and poverty, which affect interactions with clinicians and health care institutions and lead to premature dropping out of behavioral health treatment and poor behavioral health outcomes.

In this article we discuss how current approaches might inadvertently reinforce racial/ethnic disparities in access to and quality of care even in the context of well-intended reform

initiatives, because the initiatives may not address the central dynamics discussed above. Our focus is on behavioral health care (see Appendix 1).[11]

Overview

This article draws on the literature and our experience with two observational studies, four studies with national data, and five clinical trials with patients who were diverse in terms of race/ethnicity, age, language use, immigration status, and clinical presentation (see Appendix 5 and 6). [11] These studies and trials were conducted to understand the mechanisms involved in service disparities or to increase access to and the quality of behavioral health care for racial/ethnic minorities.

We posit that the persistence of behavioral service disparities is partly due to the planning of service delivery systems without consideration of research findings, and consequently, with faulty assumptions. Lessons and challenges encountered in these studies illustrate how outmoded assumptions may inhibit the implementation of equitable behavioral health care access and high-quality care. We next identify three faulty assumptions that we have consistently encountered, after which we make recommendations.

Mistaken Assumptions

Expanding Insurance Coverage

The first mistaken assumption is that a universal approach to improving access to care by itself will reduce disparities in behavioral health services. The HHS *Action Plan* recommends expanding insurance coverage and integrating behavioral health services into primary care, initiatives promoted by the ACA.[4]

While expanding insurance is an important part of a disparities reduction strategy, studies suggest that insurance fails to eliminate behavioral health service disparities between blacks and whites, which may be a result of less availability of the services in predominantly black neighborhoods, compared to majority white neighborhoods.[13] These factors may help explain why black Medicaid patients are half as likely as whites to receive follow-up care within thirty days of an inpatient discharge.[14]

Strategies to increase engagement can be effective. Many evidence-based interventions explicitly address service barriers, including Assertive Community Treatment (multidisciplinary care for individuals diagnosed with severe mental illness, which involves service delivery in their community),[15] screening for and treating mental illnesses in nonmedical settings, and training front-line workers such as peer navigators (see Appendix 3).[11] But these require substantial effort and funding and are not of widespread use in communities of color. For example, in one study of depression care, low-income women (approximately 70 percent of whom were Latina, African American, Asian American, or Native American and 30 percent of whom were white) needed to be contacted an average of ten times before attending an initial therapy appointment,[16] an unrealistic practice in the present funding environment.

In our studies, persistent recontacting and rescheduling of sessions have been the rule, not the exception, to ensure that minority patients receive an adequate treatment dose. For example, we have found thus far in the International Latino Research Partnership study that it takes over twenty weeks to deliver 10–12 sessions(see Appendix 6). [11] Persistent outreach, which we see as necessary for retention, conflicts with the standard clinical practice of dropping patients after several missed appointments.

We also found that telephone-based cognitive behavioral therapy was as effective as face-to-face intervention for reducing depression among low-income Latino patients and was associated with greater engagement in treatment. However, billing restrictions hamper the expansion of telehealth service delivery.[17]

A systematic review of evidence-based strategies for improving behavioral health care engagement found only ten studies that either analyzed results by race/ethnicity or included a sample containing more than 50 percent racial/ethnic minorities.[18] Even these studies did not generally examine effects for separate racial/ethnic groups or by language use. The only engagement approach studied more than once and found to be as efficacious for Latino and African-American patients as for white patients was collaborative care for depression. [18] Effective approaches are needed to address the needs of Asian, Native American, and other minority populations and to treat patients experiencing psychiatric illnesses other than depression in languages besides English and Spanish.

Responding To Diverse Populations

The second mistaken assumption is that planning of behavioral health service delivery addresses minority patient preferences. . While providing patient-centered care is a laudable goal, the reality is that the behavioral health care patient population in the United States is characterized by what Mary-Jo Good and Seth Hannah describe as "hyperdiversity"—the vast range of nationalities, races, ethnicities, immigration status, and nativity represented in the United States.[19] Responding to the unique needs of diverse racial/ethnic minority populations is enormously challenging for providers.[19]

Sensitivity and responsiveness to cultural pluralism requires ascertaining what matters most to the patient,[20] weighing his or her choices in treatment,[21] improving communication, increasing the patient's role, and incorporating his or her preferences in care.[22] Although these principles hold for any patient, they are particularly relevant when patient and provider do not share the same cultural or contextual background.

Training providers in cultural competence is not enough. While the majority of behavioral health providers perceive themselves as culturally competent, more studies that involve observer ratings are needed to determine the prevalence and effectiveness of culturally competent provider behaviors. Providers also need an infrastructure that supports cultural competence.[23] Yet few systems of care coach and support providers in shared decision making, improved communication, and interpersonal relationships with racial/ethnic minorities. Interpersonal factors within the provider-patient interaction matter—in particular, language compatibility, shared understanding, the provider's familiarity with the patient's

cultural preferences, and whether or not the provider speaks to the patient in egalitarian terms.[24]

Patient preferences in behavioral health care vary across racial/ethnic groups.[20,25] A qualitative study of patient preferences in the behavioral health patient-provider encounter found that the following three themes were consistently described for African-American, Latino, and white patients: listening, understanding, and managing differences between patients and providers.[26] However, descriptions of the themes varied across the groups. For African-American patients, listening involved the provider's recognizing the patient as the expert on him- or herself. For Latino patients, it meant clearly paying attention to what the patient is saying, and for white patients, it meant making the patient comfortable enough to express his or her feelings.

Even when preferences are similar, the same treatment options are not available to all patient groups. Like most members of the general population,[27] minority patients prefer psychotherapy to medication, but they have fewer options than white patients for accessing those treatments, even when referred from primary care.[28]

When asked about barriers to care, more than half of Latino immigrants cited a desire to handle a problem on their own, two-fifths reported thinking that treatment would not work, and almost half reported being unsure of where to go for treatment.[9] Additional obstacles include a system that requires face-to-face engagement while disregarding the personal costs of transportation,[9] time demands (for example, having an irregular work schedule or no paid sick leave), and lack of linguistic and cultural competence.[29] Many of these barriers would apply to any low-income patient,[30] but barriers rooted in the lack of linguistic or cultural competence or in differences in interpersonal dynamics differentially affect specific racial/ethnic minority groups.

Medical practices that integrate behavioral health services into primary care services [please provide] confront limitations on obtaining reimbursement for services that address social determinants of behavioral health (for example, coaching patients to advocate for themselves in eviction hearings or providing care coordination to assist patients in addressing contextual issues such as food or employment insecurity). Insurance plans may be particularly stringent in their application of "medical necessity" criteria for behavioral health care. Twenty-nine percent of respondents in a national survey reported that they or a family member were denied behavioral health care based on medical necessity criteria, compared to 14 percent who reported being denied general medical care.[31] Such restrictions imply low payments for behavioral health services,[32] and therefore disincentives for providers to meet the needs of racial/ethnic minority patients.

Evidence-Based Practices

The third mistaken assumption is that evidence-based interventions are readily available for uptake in settings serving diverse populations, with a trained workforce prepared to offer them. Though the behavioral health field has emphasized evidence-based practices over the past three decades, implementation of these practices in real-world settings has proven to be challenging. (see Appendix 2).[11] While a focus on evidence-based practices is

theoretically consistent with providing high-quality care to patients, these practices have been criticized for equating efficacy with carefully screened patients in research conditions to efficacy with complex patient populations in real-world settings.[33] Given the severe underrepresentation of racial/ethnic minorities in controlled trials of behavioral health interventions,[34] this problem is especially salient.

Evidence indicates that adapting treatments for racial/ethnic minorities adds value.[35] Options include using client manuals that reinforce the strategies learned after treatment has ended and using clinician manuals that provide scripts for bilingual clinicians to use without having to improvise. Relying on the clinician to translate concepts and materials ad hoc is a substantial burden on the clinician, involving unreimbursed time, and can lead to unintended changes in the protocol. Yet most evidence-based practices, which utilize treatment manuals for clinicians and handouts for patients, have not been translated into multiple languages or tested with different racial/ethnic populations, much less been culturally adapted for them (see Appendix 2).[11]

Using culturally adapted interventions results in significantly improved outcomes across a range of conditions.[35] Although more programs are being developed with diverse populations, fewer explicitly describe cultural adaptations. Of the thirty-six new programs added since September 2015 to the National Registry of Evidence-Based Programs and Practices of the Substance Abuse and Mental Health Services Administration (SAMHSA), fourteen were developed with racially and ethnically diverse patients but only two described culturally adapted treatment.[36] From a policy and practice standpoint, tension exists between promoting quality of care via established scientific evidence and ensuring that evidence-based care is acceptable, feasible, and equally effective for most patients, including racial/ethnic minorities and low-income patients.[37]

The adaptation of intervention manuals is costly, involving multiple iterations of content, feedback integration, and testing.[38] Adapting treatment to more than one racial/ethnic minority population requires attention to culture, language, age, and other characteristics, including differences within groups. The use of manualized protocols may also be complicated by low education and literacy levels. Nearly one-third of the participants in the Comparative Effectiveness Research for Eliminating Disparities study and the Positive Minds–Strong Bodies study (see Appendix 6) [11] had fewer than six years of formal education. In the latter study, many elderly Chinese participants were unable to read Chinese text, which required considerable adaptation to a less verbal version of the participants' intervention workbook. Without this kind of flexibility in response to implementation challenges, the elders would have likely become less engaged in treatment.

Finally, uptake of culturally adapted evidence-based practices is inhibited by having an unprepared, minimally diverse behavioral health workforce.[39] Minority providers are more likely than nonminority providers to practice in underserved areas and serve patients of color, but minority providers represent only a fraction of providers (for example, 12.9 percent of social workers and 7.8 percent of psychologists).[34] While ethnic matching is not essential to treatment effectiveness, many minority patients prefer minority clinicians, [40] and nonnative English speakers prefer treatment in their native language.[41]

Additionally, over half of US counties, particularly in rural areas, lack any practicing psychiatrists, psychologists, or social workers.[42] Overall workforce shortages make workforce diversification even more difficult to achieve.

There are numerous challenges to diversifying and expanding the behavioral health workforce, and the high turnover of paraprofessional staff is a particular problem. The Positive Minds–Strong Bodies study showed a turnover rate of 54 percent among community health workers trained in behavioral health care, a rate consistent with that among home health aides, case managers, and other entry-level behavioral health staff members (see Appendix 6). [11] Turnover is costly in terms of training and replacement expenses, and it is disruptive to the therapeutic relationship. It can be particularly disruptive to efforts to implement evidence-based practices. When institutional capacity is lost with departing staff members, the competency to perform the interventions as intended diminishes.

In addition, paraprofessionals are a more diverse workforce thanpeople in other health professions (for example, 35 percent of community health workers are Latino, 15.5 percent are African American, 5 percent are Native American, and 4.6 percent are Asian or Pacific Islander).[43] Consequently, lack of retention represents a threat to diversification efforts.

Recommendations

There is an urgent need to resolve persistent disparities in behavioral health care. We next identify recommendations to ensure that racial/ethnic minorities receive essential behavioral health treatment. Some of these approaches have a strong evidence record; others are novel proposals that should be tested for viability in addressing the problems raised above.

Tailor The Provision Of Care To Remove Obstacles

To address the assumption that universal approaches to improving access will reduce disparities, we propose expanding outreach beyond clinic walls, with a focus on engaging racial/ethnic minority groups. We discuss here promising programs that could be tailored to the reduction of behavioral health disparities.

Several promising interventions could improve access to behavioral health care. The 2,000 medical mobile clinics in the United States target hard-to-reach populations such as the homeless and the uninsured, and the clinics have recently begun adding behavioral health screening and outreach.[44] Widespread deployment of mobile clinics for behavioral health screening and brief interventions would enable confidential, language-specific treatment that eliminated some of the stigma associated with clinic-based treatment (for alternative treatment models, see Appendix 3).[11] Mobile clinics reduce the numbers of emergency department visits and save money.[45] Challenges to this approach include the limited space in mobile vans for confidential discussions and regular treatment visits.

Other options to increase access include the use of mobile technology that can help patients who are not proficient in English conduct confidential self-assessments of symptoms and that can refer them to linguistically compatible clinicians. Outcomes research evaluating the

efficacy of mobile technology for behavioral health is still in its infancy.[46] In theory, linguistically and culturally appropriate technology that utilizes culturally normative concepts, imagery, and recommendations could increase awareness of symptoms and available providers for diverse racial/ethnic groups.

Language barriers decrease the odds of using behavioral health services.[41] To provide direct language-matched treatment even when geographic distance might preclude face-to-face sessions, we recommend telephone- and video-based treatments (see Appendix 3).[11] Such treatments—including assessments, care management, referral services, medication consultation and management, and therapy—facilitate care continuity and scheduling flexibility. Paying for these services would require a change for most insurers.

Access may also be facilitated by integrating behavioral health services into programs that provide housing, employment, or other social services, such as Housing First and Recovery College (see Appendix 3).[11] Low-income patients are more likely to adhere to behavioral interventions when these are combined with community resources that attend to basic social needs.[47]

Widespread social marketing and culturally relevant campaigns developed with input from minority groups are needed to promote access to behavioral health care. Such strategies can address issues of stigma and mistrust. Examples include Minnesota's "Make It OK" and "El Silencio Duele" campaigns, which destigmatize treatment and encourage minorities to seek behavioral health care. SAMHSA has disseminated multifaceted strategies that combine social marketing with community outreach to inform racial/ethnic minorities about their insurance eligibility and enrollment. We recommend that these strategies be used not only to provide general information but also to offer information on locally accessible treatment options such as behavioral health screening, multilingual services, or mobile interventions.

Respond To Patient Needs And Preferences

To tackle obstacles described in the section "Responding To Diverse Populations," we recommend that health care providers collect data on patient preferences in terms of behavioral health care needs, treatment options, and barriers to care. We also suggest that providers use this information to inform inform administrators of reimbursement programs and state policy-makers about the needs of minority behavioral health consumers. This would help Medicaid agencies and state minority health offices to collaborate in creating behavioral health services that address the preferences of minority patients.

We recommend that patient activation interventions—such as those that were part of the Effectiveness of DECIDE In Patient-Provider Communication Therapeutic Alliance, and the Care Continuation trial (see Appendix 6) [11]—and decision aids in multiple languages (that is, tools to improve decision quality and personalize health care options [48]) be built into Medicaid contracts with integrated provider organizations. Examples of decision aids include the Agency for Healthcare Research and Quality's Effective Health Care Program, the Ottawa Hospital Research Institute's Patient Decision Aids, and the Shared Decision Making National Resource Center's Depression Medication Choice tool. [49]

Expanded use of patient and family advisory boards, which are already required in federally qualified health centers and hospital systems, may also help increase the engagement of minority patients. We recommend that boards with a diverse membership of patients and community advocates provide feedback on disparities reduction initiatives, suggest ways for staff to recognize minority patient concerns, and help design strategies to reach new behavioral health care consumers.

Payers should hold provider groups financially accountable for addressing disparities.[50] The Centers for Medicare and Medicaid Services (CMS) currently requires health care organizations to address ethnic/racial disparities when they draft quality improvement goals. [51] However, in the case of accountable care organizations, only one quality measure required by CMS relates to behavioral health.[52]

We recommend that CMS as well as Medicaid payers expand disparities reduction initiatives while concurrently expanding the use of behavioral health quality measures that can be stratified by racial/ethnic groups. CMS reimbursements should be contingent upon providers' demonstrating acceptable levels of racial/ethnic minority engagement by reporting the demographic breakdown of patients who began and continued treatment, and through a similar breakdown of outcomes and patient satisfaction measures organized by patient demographics. This approach would help integrated care organizations become vehicles for disparities reduction and could prevent them from avoiding at-risk or low-income patients, practices that would exacerbate disparities.[53]

Be Flexible In Using Evidence-Based Practices And Expanding The Workforce

To address the challenges outlined in the section "Evidence-Based Practices," we recommend adapting these practices to the target communities through partnerships among researchers, clinicians, and community leaders. Adapting evidence-based practices requires familiarity with the target population and an understanding of the opportunities and barriers to behavioral health service engagement in that population. These partnerships are also vital to the sustainability of behavioral interventions. Indeed, engaging community agencies in planning the delivery of behavioral health interventions is more predictive of positive health outcomes than is providing evidence-based practices at the individual program level alone. [54] The primary challenges in these collaborations are finding available funding and staff time to develop and sustain the partnerships.

We also recommend expanding the behavioral health care workforce to treat patients newly eligible for Medicaid. In part, this can be done by providing behavioral health training to some of the more than 120,000 community health workers now employed in clinics and community-based organizations (see Appendix 3).[11] (Community health workers are lay public health workers who often come from the communities they serve and are more typically trained in physical instead of behavioral health services.) Equipping them to provide quality assessments and behavioral health care would require rigorous training and supervision by experienced behavioral health professionals. Minimizing turnover among community health workers would involve careful hiring practices, ongoing support, rewards for optimal performance, and efforts to foster a sense of empowerment.

Ensuring appropriate training and supervision could be accomplished through implementation of comprehensive certification standards. Currently, qualifications for community health worker training and certification vary across states, with only seventeen states having any certification standards, training programs, or Medicaid payment provisions for community health workers.[55]

New federal and state funding to support behavioral health service employers and community partners will also be needed. An effective model with greater fidelity to evidence-based practices can be found in a multistate implementation of Assertive Community Treatment in which state health authorities provided financial support, quality monitoring, technical assistance, and human resource support to implementing agencies.[15]

Conclusion

Behavioral health care providers, researchers, and policymakers can reduce service disparities by adopting strategies that have proved successful but have not been widely adopted or by testing approaches that have improved access and quality of care for other health conditions. Strategies to increase the availability, accessibility, and quality of behavioral health care for racial/ethnic minorities work best if they also address social determinants that affect health care. A systematic commitment at the levels of policy, health care delivery, and community practice could create real and lasting improvements in behavioral health status for all Americans.

Acknowledgment

Appendix 1: Health and Behavioral Health Disparities

Selected references

Alegría M, Canino G, Shrout PE, Woo M, Duan N, Vila D, et al. Prevalence of mental illness in immigrant and non-immigrant US Latino groups. Am J Psychiatry. 2008;165(3): 359-69.

Alegría M, Woo M, Takeuchi D, Jackson J. Ethnic and racial group-specific considerations. In: Ruiz P, Primm AB: Disparities in psychiatric care. Philadelphia: Lippincott Williams & Wilkins; 2012. p. 306-319.

Alegría M, Perez DJ, Williams S. The role of public policies in reducing mental health status disparities for people of color. Health Aff. 2003 Sep;22(5):51-64.

Alegría M, Vallas M, Pumariega AJ. Racial and ethnic disparities in pediatric mental health. Child and Adolesc Psychiatr Clin Am. 2010 Oct;19(4):759-774.

Alegría M, Carson NJ, Goncalves M, Keefe K. Disparities in treatment for substance use disorders and co-occurring disorders for ethnic/racial minority youth. J Am Acad Child Adolesc Psychiatry. 2011 Jan;50(1):22-31.

Benz JK, Espinosa O, Welsh V, Fontes A. Awareness of racial and ethnic health disparities has improved only modestly over a decade. Health Aff. 2011 Oct;30(10):1860-1867.

Braveman PA, Kumanyika S, Fielding J, LaVeist T, Borrell LN, Manderscheid R, et al. Health disparities and health equity: the issue is justice. Am J of Public Health. 2011 Dec; 101(S1):S149-S155.

Breslau J, Kendler KS, Su M, Gaxiola-Aguilar S, Kessler RC. Lifetime risk and persistence of psychiatric disorders across ethnic groups in the United States. Psychol Med. 2005;35(03):317-27.

Busch AB, Lehman AF, Goldman H, Frank RG. Changes over time and disparities in schizophrenia treatment quality. Med Care. 2009 Feb;47(2):199-207.

Cook BL, Doksum T, Chen CN, Carle A, Alegría M. The role of provider supply and organization in reducing racial/ethnic disparities in mental health care in the US. Soc Sci Med. 2013 May;84:102-109.

Cook BL, Alegría M. Racial-ethnic disparities in substance abuse treatment: the role of criminal history and socioeconomic status. Psychiatr Serv. 2011 Nov;62(11):1273-1281.

Cook BL, McGuire TG, Lock K, Zaslavsky AM. Comparing methods of racial and ethnic disparities measurement across different settings of mental health care. Health Serv Res. 2010 Jun;45(3):825-847.

Cook BL, McGuire T, Miranda J. Measuring trends in mental health care disparities, 2000-2004. Psychiatr Serv. 2007;58(12):1533-40.

Diez Roux AV. Investigating neighborhood and area effects on health. Am J Public Health. 2001 Nov;91(11):1783-9.

Farmer MM, Ferraro KF. Are racial disparities in health conditional on socioeconomic status? Soc Sci & Med. 2005 Jan;60(1):191-204.

Gamble VN, Stone D. US policy on health inequities: the interplay of politics and research. J Health Polit Policy Law. 2006 Feb;31(1):93-126.

Gee GC, Payne-Sturges DC. Environmental health disparities: a framework integrating psychosocial and environmental concepts. Environ Health Perspect. 2004 Dec;112(17): 1645-1653.

Hogan MF. Achieving the promise: Transforming mental health care in America: final report, July 2003: President's New Freedom Commission on Mental Health; 2003.

Imel ZE, Baldwin S, Atkins DC, Owen J, Baardseth T, Wampold BE. Racial/ethnic disparities in therapist effectiveness: a conceptualization and initial study of cultural competence. J Couns Psychol. 2011 Jul;58(3):290-298.

Institute of Medicine. Unequal treatment: confronting racial and ethnic disparities in health care. Washington, DC: The National Academies Press; 2002.

Jimenez, DE, Alegría, M, Chen Cn, Chan D, Laderman M. Prevalence of psychiatric illnesses in older ethnic minority adults. J A Geriatr Soc. 2010 Feb;58(2):256-264.

Koh HK, Graham G, Glied SA. Reducing racial and ethnic disparities: the action plan from the Department of Health and Human Services. Health Aff. 2011 Oct;30(10):1822-1829.

Maxwell J, Cortés DE, Schneider KL, Graves A, Rosman B. Massachusetts' health care reform increased access to care for Hispanics, but disparities remain. Health Aff. 2011 Aug; 30(8):1451-1460.

McGuire TG, Alegría M, Cook BL, Wells KB, Zaslavsky AM. Implementing the Institute of Medicine definition of disparities: an application to mental health care. Health Serv Res. 2006 Oct;41(5):1979-2005.

McGuire TG, Miranda J. New evidence regarding racial and ethnic disparities in mental health: policy implications. Health Aff. 2008 Mar;27(2):393-403.

McNiel DE, Binder RL, Robinson JC. Incarceration associated with homelessness, mental disorder, and co-occurring substance abuse. Psychiatr Serv. 2014.

Miranda J, Cooper LA. Disparities in care for depression among primary care patients. J Gen Intern Med. 2004 Feb;19(2):120-126.

Miranda J, McGuire TG, Williams DR, Wang P. Mental health in the context of health disparities. Am J Psychiatry. 2008 Sep;165(9):1102-1108.

Myers HF. Ethnicity-and socio-economic status-related stresses in context: an integrative review and conceptual model. J Behav Med. 2009 Feb;32(1):9-19.

Ngo-Metzger Q, Sorkin DH, Phillips RS, Greenfield S, Massagli MP, Clarridge B, et al. Providing high-quality care for limited English proficient patients: the importance of language concordance and interpreter use. J Gen Intern Med. 2007 Nov;22(2):324-330.

Robert Wood Johnson Foundation. How does the Affordable Care Act address racial and ethnic disparities in health care. 2011.

Rogers WA. Evidence based medicine and justice: a framework for looking at the impact of EBM upon vulnerable or disadvantaged groups. J Med Ethics. 2004 Apr;30(2):141-145.

Sentell T, Shumway M, Snowden L. Access to mental health treatment by English language proficiency and race/ethnicity. J Gen Intern Med. 2007 Nov;22(2):289-293.

Smedley BD. The lived experience of race and its health consequences. Am J of Public Health. 2012 May;102(5):933-935.

Sturm R, Ringel JS, Andreyeva T. Geographic disparities in children's mental health care. Pediatrics. 2003 Oct 1;112(4):e308.

Tomlinson M, Rudan I, Saxena S, Swartz L, Tsai AC, Patel V. Setting priorities for global mental health research. Bulletin of the World Health Organization. 2009;87(6):438-46.

National Institutes of Health. Understanding and reducing disparities in health: behavioral and social sciences research contributions. Proceedings of the NIH Conference on Understanding and Reducing Disparities in Health: Behavioral and Social Sciences Research Contributions. Bethesda, MD: National Institutes of Health. 2006 Oct 23-24.

US Public Health Service. Mental health: culture, race and ethnicity—A report of the Surgeon General. Washington, DC: US Department of Health and Human Services. 2001.

Valentine A, DeAngelo D, Alegría M, Cook BL. Translating disparities research to policy: A qualitative study of state mental health policymakers' perceptions of mental health care disparities report cards. Psychol Serv. 2014 Nov;11(4):377.

Van Ryn M, Fu SS. Paved with good intentions: do public health and human service providers contribute to racial/ethnic disparities in health? Am J Public Health. 2003 Feb; 93(2):248-255.

Wells K, Klap R, Koike A, Sherbourne C. Ethnic disparities in unmet need for alcoholism, drug abuse, and mental health care. Am J Psychiatry. 2001 Dec; 158(12):2027-2032.

Whiteford M, Rudan I, Saxena S, Swartz L, Tsai AC, Patel V. Setting priorities for global mental health research. Bulletin of the World Health Organization. 2009;87(6)438-446.

Williams DR, Collins C. US socioeconomic and racial differences in health: patterns and explanations. Ann Rev Sociol. 1995 Jan;21:349-386.

Williams DR, Gonzalez HM, Neighbors H, Nesse R, Abelson JM, Sweetman J, et al. Prevalence and distribution of major depressive disorder in African Americans, Caribbean blacks, and non-Hispanic whites: results from the National Survey of American Life. Arch Gen Psychiatry. 2007;64(3):305-15.

Williams DR, Jackson PB. Social sources of racial disparities in health. Health Aff. 2005 Mar;24(2):325-334.

Williams DR, Mohammed SA. Discrimination and racial disparities in health: evidence and needed research. J Behav Med. 2009 Feb;32(1):20-47.

Woolf SH, Braveman P. Where health disparities begin: the role of social and economic determinants—and why current policies may make matters worse. Health Aff. 2011 Oct; 30(10):1852-9.

Zuvekas SH, Taliaferro GS. Pathways to access: health insurance, the health care delivery system, and racial/ethnic disparities, 1996–1999. Health Aff. 2003 Mar;22(2):139-53.

Appendix 2: Evidence-Based Practice and Cultural Adaptation of Treatment

Selected references

Anderson NB. Evidence-based practice in psychology. Am Psychol. 2006;61(4):271-85.

Bernal GE, Domenech Rodríguez MM. Cultural adaptations: Tools for evidence-based practice with diverse populations. Washington, DC: American Psychological Association; 2012.

Bernal G, Jiménez-Chafey MI, Domenech Rodríguez MM. Cultural adaptation of treatments: A resource for considering culture in evidence-based practice. Prof Psychol: Research and Practice. 2009;40(4):361.

Brown CH, Sloboda Z, Faggiano F, Teasdale B, Keller F, Burkhart G, et al. Methods for synthesizing findings on moderation effects across multiple randomized trials. Prevention Science. 2013;14(2):144-56.

Castro FG, Barrera Jr M, Martinez Jr CR. The cultural adaptation of prevention interventions: Resolving tensions between fidelity and fit. Prevention Science. 2004;5(1): 41-5.

Chambless DL, Hollon SD. Defining empirically supported therapies. J Consul Clin Psychol. 1998 Feb;66(1):7.

Chambless DL, Ollendick TH. Empirically supported psychological interventions: Controversies and evidence. Annual review of psychology. 2001 Feb;52(1):685-716.

Drake RE, Goldman HH, Leff HS, Lehman AF, Dixon L, Mueser KT, Torrey WC. Implementing evidence-based practices in routine mental health service settings. Psychiatr Serv. 2001 Feb 1.

Hoagwood K, Burns BJ, Kiser L, Ringeisen H, Schoenwald SK. Evidence-based practice in child and adolescent mental health services. Psychiatr Serv. 2001 Sep 1.

Holden K, McGregor B, Thandi P, Fresh E, Sheats K, Belton A, Mattox G, Satcher D. Toward culturally centered integrative care for addressing mental health disparities among ethnic minorities. Psychol Serv. 2014 Nov;11(4):357.

Huey Jr SJ, Polo AJ. Evidence-based psychosocial treatments for ethnic minority youth. J Clin Child & Adolesc Psychol. 2008 Mar 3;37(1):262-301.

Kaltman S, Pauk J, Alter CL. Meeting the Mental Health Needs of Low-Income Immigrants in Primary Care: A Community Adaptation of an Evidence-Based Model. Am J Orthopsychiatry. 2011;81(4):543-51.

Kazdin AE. Evidence-based treatment and practice: new opportunities to bridge clinical research and practice, enhance the knowledge base, and improve patient care. Am Psychol. 2008 Apr;63(3):146.

Miranda J, Bernal G, Lau A, Kohn L, Hwang WC, LaFromboise T. State of the science on psychosocial interventions for ethnic minorities. Annu. Rev. Clin. Psychol.. 2005 Apr 27;1:113-42.

Miranda J, Duan N, Sherbourne C, Schoenbaum M, Lagomasino I, Jackson-Triche M, et al. Improving care for minorities: Can quality improvement interventions improve care and outcomes for depressed minorities? Results of a randomized, controlled trial. Health Serv Res. 2003 Apr; 38(2), 613-630.

Stirman SW, Matza A, Gamarra J, Toder K, Xhezo R, Evans AC, et al. System-Level Influences on the Sustainability of a Cognitive Therapy Program in a Community Behavioral Health Network. Psychiatr Serv. 2015.

Torrey WC, Drake RE, Dixon L, Burns BJ, Flynn L, Rush AJ, Clark RE, Klatzker D. Implementing evidence-based practices for persons with severe mental illnesses. Psychiatr Serv. 2014 Oct 8.

Wells KB. Treatment research at the crossroads: the scientific interface of clinical trials and effectiveness research. Am J Psychiatry. 2014 Oct 7.

Wells KB, Sherbourne C, Schoenbaum M, Duan N, Meredith L, Unützer J, Miranda J, Carney MF, Rubenstein LV. Impact of disseminating quality improvement programs for depression in managed primary care: a randomized controlled trial. JAMA. 2000 Jan 12;283(2):212-20.

Wells K, Sherbourne CD, Miranda J, Tang L, Benjamin B, Duan N. The cumulative effects of quality improvement for depression on outcome disparities over 9 years: Results from a randomized, controlled group-level trial. Med Care. 2007 Nov; 45(11): 1052-1059.

Whaley AL, Davis KE. Cultural competence and evidence-based practice in mental health services: a complementary perspective. Am Psychol. 2007 Sep;62(6):563.

Appendix 3: Alternative Behavioral Health Treatment Models

Selected references on models referred to in the text

Backhaus A, Agha Z, Maglione ML, Repp A, Ross B, Zuest D, et al. Videoconferencing psychotherapy: A systematic review. Psychol Serv. 2012;9(2):111.

Batastini AB, King CM, Morgan RD, McDaniel B. TelePsychol Serv With Criminal Justice and Substance Abuse Clients: A Systematic Review and Meta-Analysis. Psychol Serv. 2015.

Fortney JC, Pyne JM, Mouden SB, Mittal D, Hudson TJ, Schroeder GW, Williams DK, Bynum CA, Mattox R, Rost KM. Practice-based versus telemedicine-based collaborative care for depression in rural federally qualified health centers: a pragmatic randomized comparative effectiveness trial. Am J Psychiatry. 2013 Apr;170(4).

Hill C, Zurakowski D, Bennet J, Walker-White R, Osman JL, Quarles A, et al. Knowledgeable Neighbors: a mobile clinic model for disease prevention and screening in underserved communities. Am J Public Health. 2012;102(3):406-10.

Hutchinson DS, Gagne C, Bowers A, Russinova Z, Skrinar GS, Anthony WA. A framework for health promotion services for people with psychiatric disabilities. Psychiatric Rehabilitation Journal. 2006;29(4):241.

Mosley AM, McCabe OL, Everly Jr GS, Gwon HS, Kaminsky MJ, Links JM, Lating JM. The tower of ivory meets the house of worship: psychological first aid training for the faith community. Int J Emerg Ment Health. 2008;9(3):171-80.

O'Reilly R, Bishop J, Maddox K, Hutchinson L, Fisman M, Takhar J. Is telepsychiatry equivalent to face-to-face psychiatry? Results from a randomized controlled equivalence trial. Psychiatr Serv. 2007 Jun;58(6):836-43.

Rog DJ, Marshall T, Dougherty RH, George P, Daniels AS, Ghose SS, et al. Permanent supportive housing: assessing the evidence. Psychiatr Serv. 2014.

Rosenthal EL, Brownstein JN, Rush CH, Hirsch GR, Willaert AM, Scott JR, et al. Community health workers: part of the solution. Health Aff. 2010;29(7):1338-42.

Ruiz Y, Matos S, Kapadia S, Islam N, Cusack A, Kwong S, et al. Lessons learned from a community–academic initiative: The development of a core competency–based training for community–academic initiative community health workers. Am J Public Health. 2012;102(12):2372-9.

Wells KB, Jones L, Chung B, Dixon EL, Tang L, Gilmore J, Sherbourne C, Ngo VK, Ong MK, Stockdale S, Ramos E. Community-partnered cluster-randomized comparative effectiveness trial of community engagement and planning or resources for services to address depression disparities. J Gen Int Medicine. 2013 Oct 1;28(10):1268-78.

Viswanathan M, Kraschnewski J, Nishikawa B, Morgan LC, Thieda P, Honeycutt A, Lohr KN, Jonas D. Outcomes of community health worker interventions. AHRQ Evidence Reports, No.181. Rockville, MD: Agency for Healthcare Research and Quality. 2009.

Appendix 4: Health Disparities Frameworks

Selected references on frameworks referred to in the text

Alegría M, Alvarez, K, Pescosolido, B. A., & Canino, G. A sociocultural framework for mental health and substance abuse service disparities. In: Sadock BJ, Sadock VA, Ruiz P, editors. Kaplan and Sadock's Comprehensive Textbook of Psychiatry. Philadelphia, PA: Lippincott Williams & Wilkins; in press.

Betancourt JR, Green AR, Carrillo JE, Ananeh-Firempong 2nd O. Defining cultural competence: a practical framework for addressing racial/ethnic disparities in health and health care. Public health reports. 2003;118(4):293.

Gee GC, Payne-Sturges DC. Environmental health disparities: a framework integrating psychosocial and environmental concepts. Environmental Health Perspectives. 2004:1645-53.

Lipscomb HJ, Loomis D, McDonald MA, Argue RA, Wing S. A conceptual model of work and health disparities in the United States. Int J Health Serv. 2006;36(1):25-50.

Myers HF. Ethnicity-and socio-economic status-related stresses in context: an integrative review and conceptual model. J Behav Med. 2009;32(1):9-19.

Schulz A, Northridge ME. Social determinants of health: implications for environmental health promotion. Health Educ Behav. 2004;31(4):455-71.

Appendix 5: References for studies listed in Appendix 6

Selected references for studies referred to in Appendix 6

Alegría M, Mulvaney-Day N, Woo M, Torres M, Gao S, Oddo V. Correlates of past-year mental health service use among Latinos: Results from the National Latino and Asian American Study. Am J Public Health. 2007 Jan;97(1):76-83.

Abe-Kim J, Takeuchi DT, Hong S, Zane N, Sue S, Spencer MS, Appel H, Nicdao E, Alegría M. Use of mental health-related services among immigrant and US-born Asian Americans: results from the National Latino and Asian American Study. Am J Public Health. 2007 Jan; 97(1):91-8.

Alegría M, Polo A, Gao S, Santana L, Rothstein D, Jimenez A, Hunter ML, Mendieta F, Oddo V, Normand SL. Evaluation of a patient activation and empowerment intervention in mental health care. Med Care. 2008 Mar;46(3):247.

Cortes DE, Mulvaney-Day N, Fortuna L, Reinfeld S, Alegría M. Patient–provider communication: Understanding the role of patient activation for Latinos in mental health treatment. Health Educ Behav. 2008 Apr 15.

Alegría M, Nakash O, Lapatin S, Oddo V, Gao S, Lin J, Normand SL. How missing information in diagnosis can lead to disparities in the clinical encounter. Journal of public health management and practice: JPHMP. 2008 Nov;14(Suppl):S26.

Alegría M, Lin JY, Green JG, Sampson NA, Gruber MJ, Kessler RC. Role of referrals in mental health service disparities for racial and ethnic minority youth. J A Acad Child & Adolesc Psychiatry. 2012 Jul 31;51(7):703-11.

Green JG, Gruber MJ, Kessler RC, Lin JY, McLaughlin KA, Sampson NA, Zaslavsky AM, Alegría M. Diagnostic validity across racial and ethnic groups in the assessment of adolescent DSM-IV disorders. Int J Methods Psychiatr Res. 2012 Dec 1;21(4):311-20.

Alegría M, Ludman E, Kafali EN, Lapatin S, Vila D, Shrout PE, Keefe K, Cook B, Ault A, Li X, Bauer AM. Effectiveness of the Engagement and Counseling for Latinos (ECLA) intervention in low-income Latinos. Med Care. 2014 Nov;52(11):989-97.

Falgas I. RZ, Herrera L., Qureshi A., Chavez L., Bonal C. , McPeck, S., Wang, Y., Cook B., & Alegría, M. Barriers to and Correlates of Retention in Behavioral Health Treatment among Latinos in Two Different Host Countries: U.S. and Spain. J Public Health Manag Pract. Forthcoming 2016.

Alegría M, Green JG, McLaughlin KA, Loder S. Disparities in child and adolescent mental health and mental health services in the US. New York, New York: William T. Grant Foundation. 2015.

Appendix 6: Table of Referenced Behavioral Health Disparities Studies

List of Referenced Behavioral Health Disparities Studies[a]

Title	Recruitment Dates	Number Enrolled	Participant Ethnicity (Percent of enrolled sample)					Type	Description
			Non-Hispanic White	Latino/Hispanic	African American	Asian	Other		
National Latino and Asian American Study (NLAAS; U01 MH62209)	2001 - 2003	4,649	-	55%	-	45%	-	Epidemiological Study	Comprehensive survey providing national information on the similarities and differences in mental illness and service use of Latinos and Asian Americans.[a]
The Right Question Project – Mental Health (RQP-MH; DECIDE Efficacy; P60 MD002261)	2004 - 2006	231	10%	80%	5%	-	5%	Clinical Trial	Intervention aimed at improving quality of care by assisting patients in learning how to formulate and ask questions of their health care providers.[a]
Improving the Quality of Depression Treatment for Ethnic/Racial Minorities (Treatment Quality; Robert Wood Johnson Foundation Grant #58678)	2006 - 2008	10,556	42%	29%	7%	20%	2%	Analysis of Nationally Representative Surveys	Study addressing issues of quality, patient-centeredness, and economic costs relevant for depression treatment for ethnic/racial minorities.[a]
Patient-Provider Encounter Study (PPES; 1 P50 MH073469)	2006 - 2008	129 Patients 47 Clinicians	Patients: 50%; Clinicians: 53%	Patients: 39%; Clinicians: 36%	Patients: 12%; Clinicians: 9%	Patients: 0%; Clinicians: 2%	-	Epidemiological Study	Study aimed at helping clinicians decrease clinical uncertainty, diagnose diverse patients with more accuracy, and improve the matching of clinical services to the treatment needs of non-white patients.[a]
Unraveling Differences for Clinical Services (NLASS II; U01 MH-062209)	2006 - 2009	19,944	39%	18%	31%	11%	-	Analysis of Nationally Representative Surveys	Study seeking to investigate the risk of psychiatric illness and mental health service disparities among Asian Americans and Latinos as compared to non-Latino Whites and African Americans.[a]
Reducing Ethnic and Racial Bias in Screening for Psychiatric Disorders in Adolescents (Screening; RC1MD004588)	2009 - 2012	9,244	66%	14%	15%	-	5%	Analysis of Nationally Representative Surveys	Study designed to improve the effectiveness of identification, referral and screening for mental health disorders associated with ethnic/racial disparities in adolescent receipt of mental health care.[a]
Comparative Effectiveness Research for	2011 - 2012	257	-	100%	-	-	-	Clinical Trial	Trial focused on alternative approaches to outreach and provide evidence based

Title	Recruitment Dates	Number Enrolled	Participant Ethnicity (Percent of enrolled sample)					Type	Description
			Non-Hispanic White	Latino/Hispanic	African American	Asian	Other		
Eliminating Disparities (CERED; P60 MD002261)									depression care for Latinos.[a]
Effectiveness of DECIDE in Patient-Provider Communication, Therapeutic Alliance, and Care Continuation (DECIDE; CD-12-11-4187)	2013 - 2016 (ongoing)	278 Patients 48 Clinicians	Patients: 38%; Clinicians: 65 %	Patients: 38%; Clinicians: 17 %	Patients: 9%; Clinicians: 2%	Patients: 14%; Clinicians: 16%	Patients: 1%; Clinicians: 0%	Clinical Trial	Effectiveness trial aiming to increase shared decision making among patients and their providers and to improve patient-centered quality of care and providers' receptivity to patient activation.[b]
International Latino Research Partnership (ILRP; R01DA034952)	2014 - 2017 (ongoing)	288	-	100%	-	-	-	Clinical Trial	International trial testing a behavioral health intervention for migrant Latinos with co-occurring substance use and mental health problems in Madrid, Barcelona, and Boston.[a]
Positive Minds - Strong Bodies: Building Community Capacity for Disability Prevention for Minority Elders (PM-SB; R01AG046149)	2015 - 2018 (ongoing)	38	14%	18%	8%	60%	-	Clinical Trial	Study examining how to successfully build collaborative research for the provision of evidence-based mental health and disability prevention treatments in community-based organizations.[b]
Mechanisms Underlying Racial/Ethnic Disparities in Mental Disorders (Mechanisms; R01MD009719)[b]	2015 - 2019 (ongoing)	34,535	50%	17%	25%	8%	-	Analysis of Nationally Representative Surveys	Study investigating mechanisms that may explain ethnic/racial disparities in mental health outcomes and mental health service delivery.[b]

[a] Please consult Appendix 5 for references from this table.

[b] These studies are in progress and have not published results.

Bios for 2016-0029_Alegria

Bio 1: Margarita Alegria (malegria@mgh.harvard.edu) is a professor of psychology in the Department of Psychiatry at Harvard Medical School and chief of the Disparities Research Unit, Department of Medicine, at Massachusetts General Hospital (MGH), both in Boston.

Bio 2: Kiara Alvarez is a postdoctoral research fellow in the Disparities Research Unit, Department of Medicine, at MGH.

Bio 3: Rachel Zack Ishikawa is project director in the Disparities Research Unit, Department of Medicine, at MGH.

Bio 4: Karissa DiMarzio is a research assistant in the Disparities Research Unit, Department of Medicine, at MGH.

Bio 5: Samantha McPeck is a research assistant in the Disparities Research Unit, Department of Medicine, at MGH.

Notes

1. Agency for Healthcare Research and Quality. 2014 national healthcare quality and disparities report [Internet]. AHRQ; Rockville (MD): May. 2015 [cited 2016 May 4]. (AHRQ Publication No. 15-0007). Available from: http://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/nhqrdr/nhqdr14/2014nhqdr.pdf

2. Saloner B, Lê Cook B. Blacks and Hispanics are less likely than whites to complete addiction treatment, largely due to socioeconomic factors. Health Aff (Millwood). 2013; 32(1):135–45. [PubMed: 23297281]

3. Alegría M, Chatterji P, Wells K, Cao Z, Chen CN, Takeuchi D, et al. Disparity in depression treatment among racial and ethnic minority populations in the United States. Psychiatr Serv. 2008; 59(11):1264–72. [PubMed: 18971402]

4. Department of Health and Human Services. HHS action plan to reduce racial and ethnic health disparities: a nation free of disparities in health and health care [Internet]. HHS; Washington (DC): [cited 2016 May 4]. Available from: http://minorityhealth.hhs.gov/npa/files/plans/hhs/hhs_plan_complete.pdf

5. DeParle, N-A. The Affordable Care Act helps America's uninsured. White House Blog [blog on the Internet]. Sep 16. 2010 [cited 2016 May 4]. Available from: https://www.whitehouse.gov/blog/2010/09/16/affordable-care-act-helps-america-suninsured

6. How, SKH.; Shih, A.; Lau, J.; Schoen, C. Public views on U.S. health system organization: a call for new directions. Commonwealth Fund; New York (NY): Aug. 2008

7. Agency for Healthcare Research and Quality. 2013 national healthcare disparities report [Internet]. AHRQ; Rockville (MD): May. 2014 [cited 2016 May 4]. (AHRQ Publication No. 14-0006). Available from: http://www.ahrq.gov/sites/default/files/publications/files/2013nhdr.pdf

8. Link B, Castille DM, Stuber J. Stigma and coercion in the context of outpatient treatment for people with mental illnesses. Soc Sci Med. 2008; 67(3):409–19. [PubMed: 18450350]

9. Falgas IRZ, Herrera L, Qureshi A, Chavez L, Bonal C, McPeck S, et al. Barriers to and correlates of retention in behavioral health treatment among Latinos in two different host countries: U.S. and Spain. J Public Health Manag Pract. (Forthcoming).

10. Hanlon, C.; Giles, B. State policymakers' guide for advancing health equity through health reform implementation [Internet]. National Academy for State Health Policy; Portland (ME): Aug. 2012 [cited 2016 May 4]. Available from: http://www.nashp.org/wp-content/uploads/sites/default/files/advancing.equity.health.reform.pdf

11. To access the Appendix, click on the Appendix link in the box to the right of the article online.

12. Bishop TF, Press MJ, Keyhani S, Pincus HA. Acceptance of insurance by psychiatrists and the implications for access to mental health care. JAMA Psychiatry. 2014; 71(2):176–81. [PubMed: 24337499]

13. Alegria M, Lin J, Chen CN, Duan N, Cook B, Meng XL. The impact of insurance coverage in diminishing racial and ethnic disparities in behavioral health services. Health Serv Res. 2012; 47(3 Pt 2):1322–44. [PubMed: 22568675]

14. Carson NJ, Vesper A, Chen CN, Lê Cook B. Quality of follow-up after hospitalization for mental illness among patients from racial-ethnic minority groups. Psychiatr Serv. 2014; 65(7):888–96. [PubMed: 24686538]

15. Mancini AD, Moser LL, Whitley R, McHugo GJ, Bond GR, Finnerty MT, et al. Assertive community treatment: facilitators and barriers to implementation in routine mental health settings. Psychiatr Serv. 2009; 60(2):189–95. [PubMed: 19176412]

16. Miranda J, Chung JY, Green BL, Krupnick J, Siddique J, Revicki DA, et al. Treating depression in predominantly low-income young minority women: a randomized controlled trial. JAMA. 2003; 290(1):57–65. [PubMed: 12837712]

17. Whitten P, Buis L. Private payer reimbursement for telemedicine services in the United States. Telemed J E Health. 2007; 13(1):15–23. [PubMed: 17309350]

18. Interian A, Lewis-Fernández R, Dixon LB. Improving treatment engagement of underserved US racial-ethnic groups: a review of recent interventions. Psychiatr Serv. 2013; 64(3):212–22. [PubMed: 23203442]

19. Good MJ, Hannah SD. "Shattering culture": perspectives on cultural competence and evidence-based practice in mental health services. Transcult Psychiatry. 2015; 52(2):198–221. [PubMed: 25480488]

20. Katz AM, Alegría M. The clinical encounter as local moral world: shifts of assumptions and transformation in relational context. Soc Sci Med. 2009; 68(7):1238–46. [PubMed: 19201074]

21. Patel SR, Bakken S, Ruland C. Recent advances in shared decision making for mental health. Curr Opin Psychiatry. 2008; 21(6):606–12. [PubMed: 18852569]

22. Street RL Jr, Makoul G, Arora NK, Epstein RM. How does communication heal? Pathways linking clinician-patient communication to health outcomes. Patient Educ Couns. 2009; 74(3):295–301. [PubMed: 19150199]

23. Huey SJ Jr, Tilley JL, Jones EO, Smith CA. The contribution of cultural competence to evidence-based care for ethnically diverse populations. Annu Rev Clin Psychol. 2014; 10:305–38. [PubMed: 24437436]

24. De Jesus M, Earl TR. Perspectives on quality mental health care from Brazilian and Cape Verdean outpatients: implications for effective patient-centered policies and models of care. Int J Qual Stud Health Well-being. 2014; 9(1):22839. [PubMed: 24461570]

25. Mulvaney-Day NE, Horvitz-Lennon M, Chen CN, Laderman M, Alegría M. Valuing health in a racially and ethnically diverse community sample: an analysis using the valuation metrics of money and time. Qual Life Res. 2010; 19(10):1529–40. [PubMed: 20680690]

26. Mulvaney-Day NE, Earl TR, Diaz-Linhart Y, Alegría M. Preferences for relational style with mental health clinicians: a qualitative comparison of African American, Latino and non-Latino white patients. J Clin Psychol. 2011; 67(1):31–44. [PubMed: 20939021]

27. McHugh RK, Whitton SW, Peckham AD, Welge JA, Otto MW. Patient preference for psychological vs pharmacological treatment of psychiatric disorders: a meta-analytic review. J Clin Psychiatry. 2013; 74(6):595–602. [PubMed: 23842011]

28. Ishikawa RZ, Cardemil EV, Alegría M, Schuman CC, Joseph RC, Bauer AM. Uptake of depression treatment recommendations among Latino primary care patients. Psychol Serv. 2014; 11(4):421–32. [PubMed: 24512538]

29. Ponce NA, Hays RD, Cunningham WE. Linguistic disparities in health care access and health status among older adults. J Gen Intern Med. 2006; 21(7):786–91. [PubMed: 16808783]

30. Sareen J, Jagdeo A, Cox BJ, Clara I, ten Have M, Belik S-L, et al. Perceived barriers to mental health service utilization in the United States, Ontario, and the Netherlands. Psychiatr Serv. 2007; 58(3):357–64. [PubMed: 17325109]

31. National Alliance on Mental Illness. A long road ahead: achieving true parity in mental health and substance use care [Internet]. NAMI; Arlington (VA): Apr. 2015 [cited 2016 May 6]. Available from: https://www.nami.org/About-NAMI/Publications-Reports/Public-Policy-Reports/A-Long-Road-Ahead/2015-ALongRoadAhead.pdf

32. Kathol RG, Butler M, McAlpine DD, Kane RL. Barriers to physical and mental condition integrated service delivery. Psychosom Med. 2010; 72(6):511–8. [PubMed: 20498293]

33. Westen D, Novotny CM, Thompson-Brenner H. The empirical status of empirically supported psychotherapies: assumptions, findings, and reporting in controlled clinical trials. Psychol Bull. 2004; 130(4):631–63. [PubMed: 15250817]

34. Santiago CD, Miranda J. Progress in improving mental health services for racial-ethnic minority groups: a ten-year perspective. Psychiatr Serv. 2014; 65(2):180–5. [PubMed: 24178249]

35. Griner D, Smith TB. Culturally adapted mental health intervention: a meta-analytic review. Psychotherapy (Chic). 2006; 43(4):531–48. [PubMed: 22122142]

36. Substance Abuse and Mental Health Services Administration. National Registry of Evidence-Based Programs and Practices (NREPP) [Internet]. SAMHSA; Rockville (MD): [last updated 2016 Jan 7; cited 2016 May 6]; Available from: http://www.samhsa.gov/nrepp

37. Borntrager CF, Chorpita BF, Higa-McMillan C, Weisz JR. Provider attitudes toward evidence-based practices: are the concerns with the evidence or with the manuals? Psychiatr Serv. 2009; 60(5):677–81. [PubMed: 19411357]

38. Ramos Z, Alegría M. Cultural adaptation and health literacy refinement of a brief depression intervention for Latinos in a low-resource setting. Cultur Divers Ethnic Minor Psychol. 2014; 20(2):293–301. [PubMed: 24588455]

39. Eden, J.; Maslow, K.; Le, M.; Blazer, D. The mental health and substance use workforce for older adults: in whose hands?. National Academies Press; Washington (DC): 2012.

40. Cabral RR, Smith TB. Racial/ethnic matching of clients and therapists in mental health services: a meta-analytic review of preferences, perceptions, and outcomes. J Couns Psychol. 2011; 58(4):537–54. [PubMed: 21875181]

41. Kim G, Aguado Loi CX, Chiriboga DA, Jang Y, Parmelee P, Allen RS. Limited English proficiency as a barrier to mental health service use: a study of Latino and Asian immigrants with psychiatric disorders. J Psychiatr Res. 2011; 45(1):104–10. [PubMed: 20537658]

42. Hoge, MA.; Morris, JA.; Daniels, AS.; Stuart, GW.; Huey, LY.; Adams, N. (Annapolis Coalition on the Behavioral Health Workforce, Cincinnati, OH). An action plan for behavioral health workforce development [Internet]. Substance Abuse and Mental Health Services Administration; Rockville (MD): 2007. [cited 2016 May 6]. Available from: http://annapoliscoalition.org/wp-content/uploads/2013/11/action-plan-full-report.pdf

43. Health Resources and Services Administration. Community health worker national workforce study [Internet]. HRSA; Rockville (MD): Mar. 2007 [cited 2016 May 6]. Available from: http://bhpr.hrsa.gov/healthworkforce/reports/chwstudy2007.pdf

44. Gibson BA, Ghosh D, Morano JP, Altice FL. Accessibility and utilization patterns of a mobile medical clinic among vulnerable populations. Health Place. 2014; 28:153–66. [PubMed: 24853039]

45. Song Z, Hill C, Bennet J, Vavasis A, Oriol NE. Mobile clinic in Massachusetts associated with cost savings from lowering blood pressure and emergency department use. Health Aff (Millwood). 2013; 32(1):36–44. [PubMed: 23297269]

46. Harrison V, Proudfoot J, Wee PP, Parker G, Pavlovic DH, Manicavasagar V. Mobile mental health: review of the emerging field and proof of concept study. J Ment Health. 2011; 20(6):509–24. [PubMed: 21988230]

47. Haas JS, Linder JA, Park ER, Gonzalez I, Rigotti NA, Klinger EV, et al. Proactive tobacco cessation outreach to smokers of low socioeconomic status: a randomized clinical trial. JAMA Intern Med. 2015; 175(2):218–26. [PubMed: 25506771]

48. O'Connor AM, Wennberg JE, Legare F, Llewellyn-Thomas HA, Moulton BW, Sepucha KR, et al. Toward the "tipping point": decision aids and informed patient choice. Health Aff (Millwood). 2007; 26(3):716–25. [PubMed: 17485749]

49. What you need to know about shared decision making [Internet]. Informed Medical Decisions Foundation; Boston (MA): [Please provide author][please provide publication date] [cited 2016 May ??]. Available from: http://www.informedmedicaldecisions.org/patient-resources/

50. Lewis VA, Larson BK, McClurg AB, Boswell RG, Fisher ES. The promise and peril of accountable care for vulnerable populations: a framework for overcoming obstacles. Health Aff (Millwood). 2012; 31(8):1777–85. [PubMed: 22869656]

51. Kessell E, Pegany V, Keolanui B, Fulton BD, Scheffler RM, Shortell SM. Review of Medicare, Medicaid, and commercial quality of care measures: considerations for assessing accountable care organizations. J Health Polit Policy Law. 2015; 40(4):761–96. [PubMed: 26124294]

52. Bao Y, Casalino LP, Pincus HA. Behavioral health and health care reform models: patient-centered medical home, health home, and accountable care organization. J Behav Health Serv Res. 2013; 40(1):121–32. [PubMed: 23188486]

53. Pollack CE, Armstrong K. Accountable care organizations and health care disparities. JAMA. 2011; 305(16):1706–7. [PubMed: 21521853]

54. Wells KB, Jones L, Chung B, Dixon EL, Tang L, Gilmore J, et al. Community-partnered cluster-randomized comparative effectiveness trial of community engagement and planning or resources for services to address depression disparities. J Gen Intern Med. 2013; 28(10):1268–78. [PubMed: 23649787]

55. Association of State and Territorial Health Officials. Community health workers (CHWs) training/certification standards [Internet]. ASTHO; Arlington (VA): [last updated 2015 Oct 23; cited 2016 May 6]; Available from: http://www.astho.org/Public-Policy/Public-Health-Law/Scope-of-Practice/CHW-Certification-Standards/Updated-10-23-15/