

Mental Health Transformation- State Incentive Grant
Workgroup #3. Disparities in Mental Health Services are Eliminated
Minutes, Meeting #2

Date: Thursday, March 16, 2006

Time: 9:03 a.m. – 12:10 p.m.

Location: Connecticut Valley Hospital, Middletown, Page Hall Rm 213

Convener: Jose Ortiz

Guest: Barbara Bugella

Scheduled Agenda

1. Welcome to New Group Members
2. Group Rules Revisited
3. Timeline
4. Presentation: Eliminating Health disparities
5. Break
6. Breakout Groups
7. Group Discussion

Welcome to New Group Members & Introduction

Attendees introduced themselves, describing their professional position as well as ethnic/cultural backgrounds and interests in disparities.

Barbara presented an overview of the transformation grant and the workgroup. In October 2005 Connecticut was one of 7 states to be awarded the transformation grant from SAMHSA. Funding will be 13.7 million over 5 years, the first year being a planning year. Following the planning year will be implementation of the plans. The transformation grant targets not just DMHAS clients, but the larger population of CT across the life span and cultural groups. The grant brings together 14 state agencies and the judicial branch in order to reach the aim of transforming systems of care for persons with behavioral health problems.

There are 6 goals outlined in the *New Freedom Commission*; these goals form the basis of the 6 workgroups. There is a 7th workgroup focused on workforce development. This particular group is focused on eliminating disparities. We will develop recommendations that will be passed on to oversight committee. The recommendations will be incorporated into the comprehensive state plan, which will then be sent to SAMHSA for approval and then implementation. Funding will be dispersed based on the recommendations. The transformation grant is focused on interagency collaboration and issues relevant not only to DMHAS population, but also to all citizens of Connecticut. A website with the transformation information will be developed soon.

Jose mentioned that there is a parallel process with a needs assessment and evaluation conducted for the transformation grant. He suggested that the workgroup invite Yale staff to talk about the needs assessment. *Members agreed that would be helpful.*

Handouts

Jose passed out handouts:

- Meeting schedule for the next few months
- Timeline for when tasks need to be completed
- Revised group rules (this included the point that if people don't agree with group opinions, their views will be respected.)
- Mental Health Transformation Preliminary Goals sheet
- Contact List for the different workgroups

Timeline

A timeline was developed by Jose, after consulting with others. The plan is to continue doing group work this week, and over the next couple of weeks members will do “homework” in their agencies, which will help generate recommendations to the workgroup. After accumulating numerous recommendations, there will be a consensus-building process to refine the products into the final list of recommendations. The aim is to have a working draft by May 25th. Recommendations may or may not be approved, so it is important to generate the strongest recommendations.

The group expressed concern that the term “cultural competence” may exclude female-responsiveness and asked if our recommendations to the oversight committee could include gender specificity in overall statements and subgoals. Barbara said that gender is being included in documents. Other members mentioned the importance of specifying competence in terms of age, ability, and other characteristics of diversity. Some people with disabilities don't refer to their disability as a “culture”. It was mentioned that cultural competence is a broader concept. It was asked if subcultures, such as the psychiatric community, might be considered “communities” rather than cultures. Jose mentioned that it's often better to allow people to self-identify.

Presentation on Eliminating Health Disparities

A power-point presentation was provided that discussed the current status of health disparities as well as suggestions for future work. Members were invited to offer comments and ideas throughout the presentation, which created an atmosphere of discussion and generation of ideas. Members of the workgroup were actively engaged, asking questions and sharing their own views, experience, and knowledge of research findings. Barbara mentioned that these topics raised by the workgroup are critical, and that there is overlap in themes across the different workgroups. She mentioned that if the present workgroup decides not to “grab onto” some of the critical topics raised, these topics can be conveyed to the other workgroups.

The first part of the presentation focused on health disparities research. It was noted that the dialogue about disparities has been going on for a long time, but 3 documents made a strong impact in raising the national conversation about disparities:

1. *President's New Commission Freedom Report on Mental Health*, which discussed the disarray and gaps in behavioral health service systems. The document mentioned race/ethnicity, as well as issues relating to gender, children, elderly, and other specific groups.
1. Institute of Medicine's *Crossing the Quality Chasm* report, which focused on racial/ethnic inequalities in medical procedures provided and gaps in the healthcare system.
2. *Mental Health: Culture, Race, and Ethnicity: Supplement to the Surgeon's General Report*. This report discussed disparities in behavioral health in terms of: availability of services, access to services, quality of care, representativeness in behavioral health research, and greater disability of burden.

The definition of disparities was discussed and highlighted specific disparities prevalent in the behavioral health system (e.g., related to access, quality of care, and outcomes). Some of the theories and findings related to the causes of disparities, both systemic as well as at the individual/cultural level were reviewed. It was illustrated how behavioral health disparities intersect with disparities in so many other areas including medical, judicial, housing, employment, education, etc. The presentation then discussed solutions and interventions such as the need for culturally competent care, workforce development, data systems, fiscal alignment, policy alignment, and community support. Cultural competence was defined along with features of cultural competence at the systemic, organizational, programmatic, and individual levels. Other strategies for eliminating disparities include: linking primary care with behavioral health, creating integrative wrap around systems of care, and implementing cross-system, cross agency initiatives.

The presentation ended with the following questions for the workgroup to contemplate:

1. Are there specific disparities within societal or institutional systems that impact behavioral health disparities?
2. What cross system, cross agency initiatives or interventions can be developed to reduce disparities in the intersecting systems?

Issues discussed by workgroup members included:

- It should not be overlooked that one of the main root causes of these disparities is class structures and racism.
- Having difficulties in just one system area (i.e., housing, education, behavioral health, etc.) can negatively impact people, let alone being involved in the disparities related to so many different systems.
- Agencies do not do a good enough job of outreach and bringing people in to receive help; instead, the agencies depend on people to seek access on their own.
- Some of the agencies are evolving.
- The importance of language should not be overlooked.
- Some agencies need to distribute too many surveys, due to surveys required by multiple funding/administrative bodies. This can become tedious for clients. Also, in many cases the clients do not know how to read and write.

- There are differences in the ways that cultural groups experience and express stress. Cultural competence is needed in trauma programming in order to differentiate what is cultural and what are symptoms of a disorder.
- Evidence-based practices that are promoted by the agencies and state need to be examined to determine which groups were included in the evidence. Evidence-based practices are not effective for all groups.
- There is a need for more person-centered approaches that highlight the relationship between providers and clients.
- Examining the systemic intersections may be tedious, but it is an essential part of the process.
- A powerful moment for a consumer was when, after several years, a doctor finally asked him how it felt to take the medications.
- Persons of different income/insurance levels located on different floors, and people who are the most economically disadvantaged must use the back door. This is an example of a disparity.
- There is a need to bring state legislation to the table in order to support the workgroup's efforts. Barbara mentioned that the transformation funding is for infrastructure development, and therefore policy work can be included.
- Barbara encouraged the workgroup to think creatively in terms of including representatives from the broader educational system, or to find alternative ways to facilitate participation such as having people serve as external consultants to the process or having them come to one or two meetings.

Group Discussion

Group discussion was incorporated in the presentation.

Breakout Groups

Members were divided into the previous-week's workgroup, with new members joining the previous groups. Jose provided each group with a printout of their previous week's ideas. The breakout groups were asked to:

1. Develop more clear language from these ideas, using action terms in their recommendations
2. Write a general statement as a preface to their recommendations
3. Each group selected someone to be a "captain" to take notes, type up the group's outcomes, and e-mail it to Jose by Friday March 24th. Jose encouraged breakout group members to work on the document during the week by communicating by e-mail or phone. After he receives the e-mailed documents, Jose will then compile these notes so that they can be shared with the larger workgroup.

Homework

Jose asked each member to go back to their agencies and explore the following:

1. Identification of the disparities within the agency, or within the larger systems targeted by the agency. Information can be based on actual data or anecdotal experiences.
2. Recommendations for how to address these disparities. Previous documents and research reports may be useful in this process.
3. Identification of the intersections or links between these disparities and behavioral health issues.

At the next meeting, members will provide 5-10 minute presentations about their findings. Members can work in groups (for example, all representatives from a particular agency can do this homework together).

Barbara encouraged the workgroup members to think broadly of all citizens of Connecticut rather than just DMHAS clients, focus on infrastructure and not direct service, and include issues across the life span.

***** Next Meeting is Thursday March 30, 2006, CVH Page Hall Rm 213. *****