

Transformation Workgroup #3 Disparities in Mental Health Services are Eliminated

April 13, 2006
9:15 am – 12:00 pm

Attendance:

Convener: Jose Ortiz

Major Topics/Discussion Points:

- Attendees new to the workgroup meetings gave introductions.
- Jose provided reminders regarding the process of developing recommendations. If members have individual recommendations, those recommendations should go through the group process for consensus. The recommendations should not be focused on service – they should be about infrastructure across agencies and across life span. Although the transformation report emphasized race/ethnicity, we need to also include age appropriateness and gender. Also, we haven't responded to the second subgoal of the report which addresses access for the rural or geographically remote communities. One example of that might be the use of telemedicine.
- There will be stipends for consumers involved in the workgroup process.
- The agenda and breakout group process were reviewed. Groups will meet again today, and come up with final list of recommendations. Group facilitators will forward it to Jose, who will pull them all into one document. Next meeting the recommendations will be listed and we will discuss them and make decisions on which to keep and how to improve them. Then we will develop them according to a format provided by the Conveners group.
- Presentation by Chuck Nathan (Department of Public Health)
 - Progress: DPH has a staff person who works with U.S. Department of Health and Human Services (DHHS) to identify geographical areas in CT that are medically underserved populations with disparities in health services (including in mental health). The office on multicultural affairs started a project called "Meaningful Exchange" which included a one-day training for DPH staff aimed at having staff become more culturally competent aware. For many divisions and programs (e.g., AIDS division), the characteristics of population serviced are identified and services aim to be sensitive to that. Some programs survey community to ensure that the services are culturally competent.
 - Challenges: It is challenging to go through the steps to do gap analysis to identify underserved community. In order to receive designation as a health professional shortage area (HPSA) they need to sequentially build their own infrastructure (e.g., contacting social service agencies).
 - Recommendation: The process of underserved HPSA designation criteria can be examined. It may be helpful for the workgroup to know which specific areas have received the designation.
- Presentation by Pat Guerard (DMHAS)
 - Progress: Have bilingual unit for Spanish-speaking. We have a good idea on what needs to be addressed.

- Challenges: Need more cultural competence training for staff, managers, and eventually employees. Persons with mental illness might not be able to read or understand their medications. Staff with mental illness are also afraid to reveal it. Discrimination exists towards older persons, those with chronic illness (HIV), trauma victims, foreigners with different languages (telephone translation services have drawbacks), those with disabilities, those coming from criminal justice systems.
- Recommendations: Positive publicity (peer support programs, awareness), transportation (so people can go to offices, those in rural areas can have access), more language services (providers should speak the language of the persons served), interdepartmental communication (transfer information between providers).
- Presentation by Mary Scully (Khmer Health Advocates)
 - Khmer is a Cambodian American organization founded in 1982 at time of refugee movement. 30% of refugees are victims of torture, majority have trauma. Khmer Health was founded for that and became the only Cambodian health organization in the U.S.
 - Progress: They develop community health workers. They developed a Southeast Asian telemedicine project. This telemedicine system has video conferencing units in 3 sites and in people's homes; consumers like it and find it useful. This answers the need to reach people in geographically remote areas or in enclaves of underserved persons in cities and towns across the U.S. They have assessment tools that are bilingual, data entered in web database.
 - Challenges: Cambodians are a small population (about 3,000 in the state), resettled in cluster groups to keep from overimpacting specific areas, so therefore are spread across different catchment areas and difficult to reach them all to provide services. Also, they don't speak English, majority have had less than 3 years of education and don't read in their own language, have a cultural view of health and mental health that is very difficult from ours. Need to understand their trauma and torture experiences. It is a high risk population; mental health studies have found that about 62% have PTSD, 50-60% have depression. There are few professionals and need to rely heavily on paraprofessionals. Have overwhelming and growing demand for services as PTSD relates to poor health outcomes (e.g., diabetes, cardiovascular disease, stroke rate 2x Black Americans)
 - Recommendations: Take a look at telemedicine as a tool, especially for groups that are underserved with small distinct needs. Need to support development of ethnic community health workers. Important to have standards. Need to understand the population and its context, and have the flexibility to provide them with services they would need.
- Presentation by Joe Odell (DMHAS)
 - Joe reviewed DMHAS presentation describing cultural competence and system change (e.g., definitions, objectives, barriers, elements of change, etc.)
 - Progress: DMHAS has worked on many projects related to cultural competence over the years. Have multicultural advisory council. Used consultants to develop

curriculum. There is also cultural competence training for substance abuse counselors. There is a strategic plan, over the past few years met about 95% of goals and objectives. They work on helping agencies assess cultural competence and develop an agency plan. DMHAS has developed a Best Standard Practices and Implementation Guidelines. Multicultural advisory council is an agent for change for DMHAS, with coordination with other groups. The Council is diverse, and tries to impact executive decision-makers. Every DMHAS funded agency must have a cultural competence plan, and there are site visits to review that.

- Challenges: State agencies sometimes have trouble hiring diverse staff.
- Recommendations: Need to establish infrastructure to reach the cultural competence goals.
- Breakout groups met to discuss and further generate and refine recommendations. The group spokespersons will send it to Jose.

Other Ideas/Recommendations:

- CMS is offering an award to 5 states that have health care shortages; the term health shortage could be flexible in terms of what is emphasized (e.g., #s, cultural competence). It would be intensive technical assistance to 5 states helping to address the shortages.

To Do/Tasks:

- Question was asked for Medicaid auditing purposes, can treatment plans be written in Spanish? This would be a way to be more culturally competent.
- If facilitators e-mail breakout group members, please respond right away.
- Need to have more family, youth, and consumer input. Even if they can't come to the table, workgroup members can meet with families outside of the workgroup and bring their perspectives to the workgroup.
- Spokespersons from the breakout groups should e-mail Jose their updated recommendations list by next Friday, April 21.

Next Meetings:

Thursday, April 27th: 9:00 a.m. – 12:00 p.m., Room 213, Page Hall, CVH

Thursday, May 11th, 9:00 a.m. – 12:00 p.m., Room 213, Page Hall, CVH