







Health is a State of Mind: Addressing Behavioral Health Disparities

October 28, 2015

2015 Conference Packet

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Health is a State of Mind: Addressing Behavioral Health Disparities

October 28, 2015

CONFERENCE AGENDA

7:00 AM – 8:00 AM	REGISTRATION AND HEALTHY BREAKFAST
	WELCOME
8:00 AM – 8:45 AM	Arlee Wallace, Acting Director, Maryland Office of Minority Health and Health Disparities
	OPENING & GREETINGS
	The Honorable Shirley Nathan-Pulliam, Senate, District 44, Maryland General Assembly Van T. Mitchell, Secretary, Maryland Department of Health and Mental Hygiene Annelle B. Primm, MD, MPH, Senior Psychiatrist Advisor, Urban Behavioral Associates (Conference Moderator)
8:45 AM -	SETTING THE STAGE ADDRESSING BEHAVIORAL HEALTH DISPARITIES
9:15 AM	Jacquelyn Duval-Harvey, PhD, Executive Director, Mayor's Office of Human Services
	SHIRLEY NATHAN-PULLIAM HEALTH EQUITY LECTURE
9:15 AM - 10:30 AM	INTRODUCTION OF AWARD RECIPIENT Stephen B. Thomas, PhD, Professor, Health Services Administration, University of Maryland School of Public Health and Director, Maryland Center for Health Equity, University of Maryland, College Park
	AWARD RECIPIENT & KEYNOTE ADDRESS
	Brian D. Smedley, PhD, Executive Director, National Collaborative for Health Equity
10:30 AM - 10:45 AM	BREAK
	BEHAVIORAL HEALTH NEEDS OF SERVICE MEMBERS, VETERANS AND THEIR FAMILIES
10:45 AM – 12:00 PM	Moderator Shauna Donahue, Director, Maryland's Commitment to Veterans, Behavioral Health Administration, Maryland
	Department of Health and Mental Hygiene
	Panelists David Galloway, Central Regional Resource Coordinator, Maryland's Commitment to Veterans CH(MAJ) Michael Clancy, State Family Program Director, Maryland Army National Guard Erika N. White, PhD, Clinical Psychologist, Team Leader, PTSD Clinical Team, VA Maryland Health Care System
12:00 PM- 1:00 PM	LUNCH (Location: Embassy Room)

	CONCURRENT BREAKOUT SESSIONS (will repeat at 2:30 p m)			
1:00 PM — 2:15 PM	A: Mental Health First Aid / Crisis Services (Location: Camelia Terrace Room)			
2:15 PM – 2:30 PM	Sandy O. Washington, Co-Founder and Executive Director, Lifestyles, Inc. BREAK AND TRANSITION			
2.30 F IVI	CONCURRENT BREAKOUT SESSIONS (recurrence from 1:00 p.m.)			
2:30 PM – 3:45 PM	A: Mental Health First Aid / Crisis Services (Location: Camelia Terrace Room) B: Recognition and Prevention Strategies in Minority Communities (Location: Maryland Room) C: Community-Based Behavioral Health Initiatives (Location: Wayne Room)			
3:45 PM – 4:00 PM	CLOSING & NEXT STEPS (Location: Camelia Terrace Room)			

Co-sponsored by the Maryland Behavioral Health Administration's Office of Workforce Development and Training

The Maryland Behavioral Health Administration's Office of Workforce Development and Training is an approved sponsor of the Maryland Board of Social Work Examiners for **5** Continuing Education Units (Category I) for licensed social workers in Maryland; as a sponsor of **5** Continuing Education Units acceptable to the Maryland Board of Examiners of Psychologists; and **5** Continuing Education Units (Category A) by the Maryland Board of Professional Counselors and Therapists, and the Maryland Addiction and Behavioral-health Professionals Certification Board upon completion of this training and a completed evaluation. The Office of Workforce Development and Training maintains responsibility for this program.



Dr. Brian D. Smedley 2015 Award Recipient

5th ANNUAL SHIRLEY NATHAN-PULLIAM **HEALTH EQUITY LECTURE SERIES**

Presented by

Maryland Department of Health and Mental Hygiene Office of Minority Health and Health Disparities **University of Maryland School of Public Health Center for Health Equity**

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r. Brian D. Smedley Research Director and co-founder is co-founder and **Executive Director** of the National Collaborative for Health Equity (www.nationalcollaborative.org), a project that connects research, policy analysis, and communications with on-the-ground activism to advance health equity. In this role, Dr. Smedley oversees several initiatives designed to improve opportunities for good health for people of color and undo the health consequences of racism. From 2008 to 2014, Dr. Smedley was Vice President and Director of the Health Policy Institute of the Joint Center for Political and Economic Studies in Washington, DC, a research and policy organization focused on addressing the needs of communities of color.

Formerly, Dr. Smedley was

of a communications, research and policy organization, The Opportunity Agenda (www.opportunityagenda.org), which seeks to build the national will to expand opportunity for all. Prior to helping launch The Opportunity Agenda, Dr. Smedley was a Senior Program Officer in the Division of Health Sciences Policy of the Institute of Medicine (IOM), where he served as Study Director for the IOM reports, In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce and Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care, among other reports on diversity in the health professions and minority health research policy. Dr. Smedley came to the IOM from

the American Psychological

Association, where he worked on a wide range of social, health, and education policy topics in his capacity as Director for Public Interest Policy. Prior to working at the APA, Dr. Smedley served as a Congressional Science Fellow in the office of Rep. Robert C. Scott (D-VA), sponsored by the American Association for the Advancement of Science. Among his awards and distinctions, in 2013 Smedley received the American Public Health Association's Cornely Award for social activism; in 2009 Smedley received the Congressional Black Caucus Congressional Leadership in Advocacy Award; in 2004 he was honored by the Rainbow/PUSH coalition as a "Health Trailblazer" award winner; and in 2002 he was awarded the Congressional Black Caucus "Healthcare Hero" award.









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SELECTED SPEAKER BIOGRAPHIES

Van T. Mitchell Secretary Department of Health and Mental Hygiene State of Maryland

Van Mitchell serves as the Secretary for the Maryland Department of Health and Mental Hygiene (DHMH), appointed by Governor Larry Hogan on January 21, 2015. Van previously served as a Government Relations Specialist from 2007 – 2015 for Manis Canning & Associates. He was appointed Principal Deputy Secretary of the DHMH from 2004-2007 where he was a member of the Interagency Disabilities Board, Homeland Senior Policy Group and the Maryland Commission on Disabilities. Van served as a



member of the Maryland House of Delegates for three terms from 1995 – 2004. During his tenure in the legislature he sat on both the Economic Matters and Appropriations Committees. During this time he was a member of the Unemployment Insurance Subcommittee; Real Property Subcommittee; House Chair of the Workers' Compensation Subcommittee; House Chair Workers' Compensation Benefit and Insurance Oversight Committee; Joint Committee on Administrative, Executive and Legislative Review; member Capital Budget Subcommittee; Oversight Committee on Pensions; Chair of the Health and Human Resources Subcommittee; House Chair Joint Audit Committee; and Chaired both the Charles County and Southern Maryland Delegations.

Since 1985, Van has served as President/CEO of MSI, Inc., a building supply company which operated in Charles County, MD for forty-nine years. He has also served on many boards such as the University of Maryland Charles Regional Medical Center (formerly Civista Medical Center), College of Southern Maryland Board of Trustees and is a Co-Founder & Board Member of County First Bank. Van attended Campbell University.

The Honorable Shirley Nathan-Pulliam Senate, District 44 Maryland General Assembly

Senator Shirley Nathan-Pulliam, who served in the Maryland House of Delegates since 1994, was elected to her first term as senator, in 2015. She is the first Caribbean-born person and the first African-Caribbean registered nurse elected to the Maryland General Assembly. Nathan-Pulliam has dedicated her career to ensuring that all Marylanders have access to health care, regardless of social demographics. She has utilized her nursing experience and leadership to create a political platform for developing a multitude of laws aimed to improve quality and access to care.



Annelle B. Primm, MD, MPH Senior Psychiatrist Advisor, Urban Behavioral Associates

Annelle B. Primm, M.D., MPH, is a community psychiatrist currently serving as the Senior Psychiatrist Advisor Urban Behavioral Associates and several other organizations in the Baltimore-Washington area. Dr. Primm was a physician executive at the American Psychiatric Association (APA) from 2004-2015 a period during which she led APA's Division of Diversity and Health Equity and served as Deputy Medical Director. Prior to her service at the APA, Dr. Primm was Medical Director of the Johns Hopkins Hospital Community Psychiatry Program where she oversaw a variety of mental health services for adults.

Well known for her leadership of community collaborations, Dr. Primm is the Convener and Chair of the All Healers Mental Health Alliance, a national network of mental health professionals, health advocates and faith community leaders that facilitates culturally competent responses to the mental health needs of people affected by disasters. Dr. Primm has lectured and written widely on public mental health and is a co-editor of the 2012 book, Disparities in Psychiatric Care. She is an adjunct Associate Professor of Psychiatry at Howard University College of Medicine and the Johns Hopkins School of Medicine.

Arlee Wallace Interim Director, Maryland Office of Minority Health and Health Disparities

Arlee Wallace was appointed Interim Director of the Office of Minority Health and Health Disparities within the Maryland Department of Health and Mental Hygiene in July 2014. MHHD was established in statue in 2004 with the charge to promote the reduction of ethnic and racial health disparities. As Interim Director, Arlee provides supervisory management the day-to-day operations of the office personnel as well as the fiduciary obligation for procurements and financial oversight of 18 Local Health Disparities Programs designed to address minority health disparities. The grant programs annual budget addresses cardiovascular disease, infant mortality, and cancer and tobacco disparities. Arlee is the principal investigator for MHHD's five-year \$1 million grant from the federal Office of Minority Health.



Prior to her appointment as Interim Director, Arlee began her state service in 2004 as Deputy Director at Maryland Department of Health and Mental Hygiene, Office of Minority Health and Health Disparities and the Cigarette Restitution Fund Program providing oversight of the cancer, tobacco and academic research grants. She provides oversight and management of the Minority Outreach and Technical Assistance Program and the Minority Adult Cardiovascular Disease and Infant Mortality Reduction Demonstration projects.

Arlee's professional career began at Arkansas Department of Health and Human Services in the Division of Child and Family Services as a family service caseworker in 1989, resigning in 1993 as a family service worker II supervisor responsible for the county foster care division. In 1994, President William Jefferson Clinton appointed Arlee to serve as an Intergovernmental Relations Specialist at the U.S. Department of Housing and Urban Development to outreach and educate constituencies on the impact of Quality Housing and Work Responsibility Act, Elderly Housing, Disabled Housing, HOPE VI, Family Self-Sufficiency and other housing initiatives. Arlee is a graduate of Arkansas State University with a Bachelor of Arts degree in social work.

Jacquelyn Duval-Harvey, PhD Executive Director, Mayor's Office of Human Services

Dr. Jacquelyn Duval-Harvey is the newly appointed Executive Director for the Mayor's Office of Human Services in Baltimore City. In this capacity she has oversight of Head Start, Homeless Services, Community Action Center Partnerships and Re-entry Services. From April 2014 to February 2015, Dr. Duval-Harvey served as the Interim Health Commissioner for Baltimore City. Prior to the interim position, Dr. Duval-Harvey served as Deputy Commissioner for the Division of Health Promotion and Disease Prevention, a position she held since February, 2008. In that former role, she had oversight for the Bureau of School Health Programs, the Bureau of Maternal and Child Health Programs, the Office of Youth Violence Prevention, the Office of Chronic Disease Prevention and the Office of Field Health Services.



Dr. Duval-Harvey has worked primarily with youth and families in urban communities. Her professional career began in community mental health, as a staff psychologist and program administrator at Metropolitan Hospital Center in New York. At Metropolitan she was responsible for all of the psychiatric programs for children including an adolescent coed inpatient unit, a day hospital program, a 450 client outpatient program and a therapeutic day nursery program for mothers with a mental health diagnosis and their children. Dr. Duval-Harvey came to Maryland in 1998 and was on the faculty at the Johns Hopkins Medical Institutions, in the Department of Psychiatry and Behavioral Health in the School of Medicine. Her career at Hopkins began in 1998 until 2008, at which time she was the Director of the Community Mental Health Outpatient Programs for Children in the Department of Psychiatry and Behavioral Services. Dr. Duval-Harvey has also taught at the graduate level in New York, Virginia, and in the Schools of Education and Counseling at Johns Hopkins.

Dr. Duval-Harvey is a licensed clinical psychologist. She received her bachelor's degree in Psychology from Hofstra University in New York and her master's and doctoral degree from the Pennsylvania State University. Dr. Duval-Harvey completed her clinical internship with the Mount Sinai School of Medicine in New York.

Stephen B. Thomas, PhD
Professor, Health Services Administration
University of Maryland School of Public Health
Director, Maryland Center for Health Equity
University of Maryland, College Park

Stephen B. Thomas, PhD, is Founding Director of the Maryland Center for Health Equity and Professor of Health Services Administration in the School of Public Health at the University of Maryland in College Park. Dr. Thomas is one of the nation's leading scholars on 4th Generation Disparities Research, an approach focused on translation of biomedical and public health advancements into scientifically sound and culturally tailored community based interventions designed to eliminate racial and ethnic health disparities to achieve health equity.



He is Joint Principal Investigator, with Dr. Sandra C. Quinn, of the Center of Excellence on Race, Ethnicity and Health Disparities Research funded by the NIH-National Institute on Minority Health and Health Disparities (NIMHD). This five-year \$5.9M grant award, launched in August 2012, includes teams of scientists conducting targeted research on obesity, vaccine acceptance and Black men's health.

Before joining the faculty at the School of Public Health, Dr. Thomas served as the Philip Hallen Professor of Community Health and Social Justice at the University of Pittsburgh's Graduate School of Public Health (2000-2010). In 2010, he received the Dorothy Nyswander Social Justice Award from the Society for Public Health Education. He was awarded the 2005 David Satcher Award from the Directors of Health Promotion and Education for his leadership in reducing health disparities through the improvement of health promotion and health education programs at the state and local levels and received the 2004 Alonzo Smyth Yerby Award from the Harvard School of Public Health for his work with people suffering the health effects of poverty. In 2011, he was the inaugural recipient of the Shirley Nathan-Pulliam Health Equity Leadership Award.

CONFERENCE SESSIONS WORKSHEET

October 28, 2015

Following the discussion of each Session, please identify 1 or more Action Items that you plan to work on within your organization, workplace, community, etc.

Behavioral Health Needs of Veterans and Their Families

Action Items (who, what, when, where, how)

Breakout Session A: Mental Health First Aid / Crisis Services

Action Items (who, what, when, where, how)

Breakout Session B: Recognition and Prevention Strategies in Minority Communities
Action Items (who, what, when, where, how)
Breakout Session C: Community-Based Behavioral Health Initiatives
Action Items (who, what, when, where, how)
Contact Information (not required)
Name & E-mail Address:
Other Comments

Thank you for your feedback!



Maryland Office of Minority Health and Health Disparities



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Conference Evaluation Form

Please indicate how well the following learning objectives were met.

Scale: 1=Not met 2= Not very well met 3=Somewhat met 4=Well met 5=Very well met

Scale: 1-1vot met 2-1vot very wen met 3-somewhat met 4-ven met 3-very wen met					
Understand the state of behavioral health disparities and behavioral health needs in Maryland's diverse populations	1	2	3	4	5
Discuss behavioral health needs of Maryland's Veterans and their families	1	2	3	4	5
Learn about Mental Health First Aid	1	2	3	4	5
Recognize and identify prevention strategies in minority communities	1	2	3	4	5
Learn about community-based behavioral health initiatives	1	2	3	4	5

Please rate each session that you attended
Scale: 1=Very Poor 2=Poor 3=Fair 4=Good 5=Excellent NA=Not Applicable

Scale: 1=Very Poor 2=P		Good 5=Excelle	ent NA=Not App	olicable
Activity	Presenter Knowledge of Subject Matter	Quality of Presentation	Useful Information	Comments
Setting the Stage				
Shirley Nathan-Pulliam Health Equity Lecture Series - Keynote Address				
Behavioral Health Needs of Veterans and Their Families				
Concurrent Session A: Mental Health First Aid / Crisis Services				
Concurrent Session B: Recognition and Prevention Strategies in Minority Communities				
Concurrent Session C: Community-Based Behavioral Health Initiatives				
Evalua	ation continu	es on other sid	le →	



Maryland Office of Minority Health and Health Disparities



Please check you	ır major affilia	ation(s):			
\square Healthcare Professional \square Government \square Priv	ate Citizen	☐ Health In	nsurer [☐ Policy Ma	ıker
☐ Community-Based Group ☐ Health Educator/Comm	unity Outreach	□ Acade	emic Institut	ion 🗆 St	udent
☐ Business Industry ☐ Community Health Worker ☐	DHMH (specif	fy administr	ation)		
□ Other:	•				
Other:					
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Are you Hispanic or Latino? \square Yes \square No If YES ,	please specify of	origin			
Please specify your race (choose all that apply)? \Box Black	ck or African An	nerican \square	Asian 🗆 V	White	
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What is your gender? □ Male □ Female					
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Registration Process	1	2	3	4	5
Location	1	2	3	4	5
Quality of Facility	1	2	3	4	5
Quality of Lunch/Refreshments	1	2	3	4	5
Quality of Speakers/Panelists	1	2	3	4	5
Overall Quality of Conference	1	2	3	4	5
st three ways the conference can be improved					
-99-21 amar tobres of memor mar you would like to					
dditional argaestians/somress-to					
dditional suggestions/comments					

Please Return Completed Forms to the Evaluation Drop Box. Thank you!









Maryland's 12th Annual Health Disparities Conference

Health is a State of Mind: Addressing Behavioral Health Disparities

October 28, 2015 Baltimore, Maryland

CONFERENCE PLANNING TEAM

Mr. Van T. Mitchell	Ms. Shauna Donahue	Ms. Namisa Kramer
Dr. Gayle Jordan-Randolph	Ms. Michelle Darling	Ms. Vanessa Jordan
Ms. Arlee Wallace	Ms. Alexandra Cirillo	Dr. Moira A. Lawson
Dr. Annelle B. Primm	Ms. Stephanie Hall	Dr. David A. Mann
Dr. Jean W. Smith	Ms. Kimberly Hiner	Ms. Diane D. Walker

Dr. Stephen B. Thomas

GUEST PRESENTERS AND SPEAKERS:

Ms. Arlee Wallace	Mr. David Galloway	Dr. Kim B. Kim
Senator Shirley Nathan-Pulliam	CH(MAJ) Michael Clancy	Mr. Carlos Hardy
Mr. Van T. Mitchell	Dr. Erika N. White	Dr. Enrique Olivares
Dr. Annelle B. Primm	Dr. Jean W. Smith	Ms. Susan M. Doyle
Dr. Jacquelyn Duval-Harvey	Ms. Jennifer B. Treger	Ms. Donna Wells
Dr. Stephen B. Thomas	Ms. Madge Pat Mosby	Ms. Jan A. Desper
D., D., D. C., 11	M., D., 1 I I-1	M - 17 - 41-1 D -1-1 4

Dr. Brian D. Smedley Mr. Brandon J. Johnson Ms. Kathleen Rebbert-Franklin Ms. Shauna Donahue Ms. Marian Bland Ms. Sandy O. Washington

EXHIBITORS: Please see included list for participating exhibitors

VOLUNTEERS

Thank you to the many volunteers and staff who have assisted in making Maryland's 12th Annual Health Disparities Conference a success!

PARTNERING ORGANIZATIONS

Maryland's Commitment to Veterans

Co-sponsored by the Maryland Center for Health Equity

Co-sponsored by the Maryland Behavioral Health Administration's Office of Workforce Development and Training

The Maryland Behavioral Health Administration's Office of Workforce Development and Training is an approved sponsor of the Maryland Board of Social Work Examiners for 5 Continuing Education Units (Category I) for licensed social workers in Maryland; as a sponsor of 5 Continuing Education Units acceptable to the Maryland Board of Examiners of Psychologists; and 5 Continuing Education Units (Category A) by the Maryland Board of Professional Counselors and Therapists, and the Maryland Addiction and Behavioral-health Professionals Certification Board upon completion of this training and a completed evaluation. The Office of Workforce Development and Training maintains responsibility for this program.

Office of Minority Health and Health Disparities — Maryland Department of Health and Mental Hygiene

201 West Preston Street, Room 500, Baltimore, MD 21201 Phone: 410-767-7117 Fax: 410-333-7525

E-mail: dhmh.healthdisparities@maryland.gov Web: http://dhmh.maryland.gov/mhhd

Like us on Facebook at www.facebook.com/MarylandMHHD

Chapter 126

(Senate Bill 321)

AN ACT concerning

Baltimore City and Baltimore County – Police Mental Behavioral Health Units – Pilot Program

FOR the purpose of requiring, to the extent practicable, on or before a certain date, the Baltimore City and Baltimore County police departments to establish mental behavioral health units; requiring a mental behavioral health unit to consist of at least a certain number of officers who are specially trained to understand the needs of mentally ill individuals with mental health, substance use, or co-occurring mental health and substance use disorders and in cultural sensitivity and cultural competency; requiring the training to be developed in consultation with the Behavioral Health Administration in the Department of Health and Mental Hygiene; establishing the purpose and goals of a mental behavioral health unit; requiring the Baltimore City and Baltimore County police departments to report to the General Assembly on or before a certain date; providing for the construction of this Act; requiring the Baltimore City Police Department to complete a certain study and make certain recommendations; providing for the termination of this Act; and generally relating to police mental behavioral health units.

BY adding to

Article – Public Safety Section 3–510 Annotated Code of Maryland (2011 Replacement Volume and 2014 Supplement)

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That the Laws of Maryland read as follows:

Article - Public Safety

3-510.

- (A) ON TO THE EXTENT PRACTICABLE, ON OR BEFORE JUNE OCTOBER 1, 2016, THE BALTIMORE CITY POLICE DEPARTMENT AND THE BALTIMORE COUNTY POLICE DEPARTMENT EACH SHALL ESTABLISH A MENTAL BEHAVIORAL HEALTH UNIT.
- (B) A <u>MENTAL</u> <u>BEHAVIORAL</u> HEALTH UNIT SHALL CONSIST OF AT LEAST SIX OFFICERS WHO ARE SPECIALLY TRAINED:

- (1) TO UNDERSTAND THE NEEDS OF MENTALLY ILL INDIVIDUALS WITH MENTAL HEALTH, SUBSTANCE USE, OR CO-OCCURRING MENTAL HEALTH AND SUBSTANCE USE DISORDERS; AND
 - (2) IN CULTURAL SENSITIVITY AND CULTURAL COMPETENCY.
- (C) TRAINING FOR OFFICERS IN A MENTAL BEHAVIORAL HEALTH UNIT SHALL BE DEVELOPED IN CONSULTATION WITH THE BEHAVIORAL HEALTH ADMINISTRATION IN THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE.
- (D) THE PURPOSE OF A <u>MENTAL</u> <u>BEHAVIORAL</u> HEALTH UNIT IS TO RESPOND TO EMERGENCY CALLS INVOLVING AN INDIVIDUAL SUSPECTED OF HAVING A MENTAL <u>HLINESS</u> <u>HEALTH</u>, <u>SUBSTANCE USE</u>, <u>OR CO-OCCURRING MENTAL HEALTH</u> AND SUBSTANCE USE DISORDER.
 - (E) THE GOAL GOALS OF A MENTAL BEHAVIORAL HEALTH UNIT IS ARE TO:
- (1) DIVERT MENTALLY ILL INDIVIDUALS WITH MENTAL HEALTH, SUBSTANCE USE, OR CO-OCCURRING MENTAL HEALTH AND SUBSTANCE USE DISORDERS INTO TREATMENT INSTEAD OF THE CRIMINAL JUSTICE SYSTEM; AND
- (2) PREVENT AND REDUCE UNNECESSARY USE OF FORCE AND LOSS OF LIFE IN SITUATIONS INVOLVING INDIVIDUALS WITH MENTAL HEALTH, SUBSTANCE USE, OR CO-OCCURRING MENTAL HEALTH AND SUBSTANCE USE DISORDERS.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act may not be construed to interfere with or replace any existing crisis intervention team programs in Baltimore City or Baltimore County.

SECTION 3. AND BE IT FURTHER ENACTED, That, on or before December 1, 2015, the Baltimore City Police Department shall complete a study and make recommendations regarding the establishment of a behavioral health unit, including recommendations on the structure, size, cost, potential funding sources, and timeline for establishing the behavioral health unit.

SECTION $\stackrel{?}{=}$ 4. AND BE IT FURTHER ENACTED, That, on or before October 1, 2018, the Baltimore City Police Department and the Baltimore County Police Department shall report to the General Assembly, in accordance with § 2–1246 of the State Government Article, on the number of emergency calls that their $\frac{\text{mental}}{\text{mental}}$ behavioral health units responded to in 2016, 2017, and 2018, and the disposition of those calls.

SECTION 3. 5. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 2015. It shall remain effective for a period of 3 years and 9 months and, at the

end of June 30, 2019, with no further action required by the General Assembly, this Act shall be abrogated and of no further force and effect.

Approved by the Governor, May 12, 2015.

Maryland Office of Minority Health and Health Disparities

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Selected Conference Resource List

Behavioral Health Administration, Maryland Department of Health and Mental Hygiene - http://bha.dhmh.maryland.gov/

Behavioral Health Equity, Substance Abuse and Mental Health Services Administration - http://www.samhsa.gov/behavioral-health-equity

Behavioral Health System Baltimore - http://www.bhsbaltimore.org/

Black Mental Health Alliance - http://www.blackmentalhealth.com/

Carroll County Health Department - http://www.carrollhealthdepartment.dhmh.md.gov/

Community Behavioral Health Association of Maryland - http://www.mdcbh.org/

Howard County Mental Health Authority - http://www.hcmha.org/

Korean Resource Center - http://ikorean.org/

Lifestyles of Maryland Inc. - http://www.lifestylesofmd.org/

Maryland Addictions Directors Council (MADC) - http://madc.homestead.com/

Maryland Center for Health Equity, University of Maryland, College Park - http://sph.umd.edu/center/che/

Maryland Coalition of Families for Children's Mental Health - http://www.mdcoalition.org/

Maryland's Commitment to Veterans, Behavioral Health Administration, Maryland Department of Health and Mental Hygiene - http://veterans.dhmh.maryland.gov

Maryland Department of Health and Mental Hygiene - http://dhmh.maryland.gov/dhmh/home.html

Maryland Health Connection - www.marylandhealthconnection.gov

Maryland National Guard - http://www.md.ngb.army.mil/

Maryland Office of Minority Health and Health Disparities, Department of Health and Mental Hygiene - http://dhmh.maryland.gov/mhhd

Maryland Recovery Organization Connecting Communities - http://www.m-rocc.org/

Mayor's Office of Human Services, City of Baltimore - http://humanservices.baltimorecity.gov/

Mental Health First Aid Maryland - http://mhfamaryland.org/

Mental Health Association of Maryland - https://www.mhamd.org/

MentalHealth.gov, United States Departmental of Health and Human Services - http://www.mentalhealth.gov/

National Alliance for Mental Illness - http://namimd.org/

National Collaborative for Health Equity - http://www.nationalcollaborative.org/

National Network to Eliminate Disparities in Behavioral Health - http://nned.net/

Overdose Response Program, Maryland Department of Health and Mental Hygiene -

http://bha.dhmh.maryland.gov/NALOXONE/SitePages/Home.aspx

Maryland Office of Minority Health and Health Disparities 12th Annual Health Disparities Conference Health is a State of Mind: Addressing Behavioral Health Disparities

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Screening, Brief Intervention and Referral to Treatment, Maryland Department of Health and Mental Hygiene - http://bha.dhmh.maryland.gov/SitePages/SBIRT.aspx

State Drug and Alcohol Abuse Council, Maryland Department of Health and Mental Hygiene -

http://bha.dhmh.maryland.gov/State%20Drug%20and%20Alcohol%20Abuse%20Council/SitePages/Home.aspx

Suicide and Violence Prevention, Behavioral Health Administration -

http://www.dhmh.maryland.gov/suicideprevention

United States Department of Veterans Affairs - Mental Health - http://www.mentalhealth.va.gov/

Urban Behavioral Associates - http://urbanbehavioralhealth.org/

ValueOptions - http://maryland.valueoptions.com/

Select Reports, Articles and Other Resources

A Journey Toward Health and Hope: Your Handbook for Recovery After a Suicide Attempt, Substance Abuse and Mental Health Services Administration, 2015 - http://www.samhsa.gov/

Behavioral Health Barometer, United States 2013, Substance Abuse and Mental Health Services Administration - http://store.samhsa.gov/product/Behavioral-Health-Barometer-2013/SMA13-4796

Health IT Policy Making, Regulation and Strategy, Behavioral Health, HealthIT.gov -

https://www.healthit.gov/policy-researchers-implementers/behavioral-health

2015 Kelly Report: Health Disparities in America, Congresswoman Robin L. Kelly -

http://robinkelly.house.gov/sites/robinkelly.house.gov/files/2015%20Kelly%20Report.pdf

2014 National Healthcare Quality and Disparities Reports, Agency for Healthcare Research and Quality - http://www.ahrq.gov/research/findings/nhqrdr/index.html

Promoting Emotional Health and Preventing Suicide: A Toolkit for Senior Citizens, Substance Abuse and Mental Health Services Administration, 2015 -

http://store.samhsa.gov/product/Promoting-Emotional-Health-and-Preventing-Suicide/SMA10-4515

Strategies for Behavioral Health Organizations to Promote New Health Insurance Opportunities in African American Communities, Substance Abuse and Mental Health Services Administration, 2014 -

http://store.samhsa.gov/product/Strategies-for-Behavioral-Health-Organizations-to-Promote-New-Health-Insurance-Opportunities-in-African-American-Communities/SMA14-4819

Strategies for Behavioral Health Organizations to Promote New Health Insurance Opportunities in American Indian and Alaska Native Communities, Substance Abuse and Mental Health Services Administration, 2014 -

http://store.samhsa.gov/product/Strategies-for-Behavioral-Health-Organizations-to-Promote-New-Health-Insurance-Opportunities-in-American-Indian-and-Alaska-Native-Communities/SMA14-4821

Strategies for Behavioral Health Organizations to Promote New Health Insurance Opportunities in Asian American, Native Hawaiian, and Pacific Islander Communities, Substance Abuse and Mental Health Services Administration, 2014 - http://store.samhsa.gov/product/Strategies-for-Behavioral-Health-Organizations-to-Promote-New-Health-Insurance-Opportunities-in-Asian-American-Native-Hawaiian-and-Pacific-Islander-Communities/SMA14-4818

Strategies for Behavioral Health Organizations to Promote New Health Insurance Opportunities in Latino and Hispanic Communities, Substance Abuse and Mental Health Services Administration, 2014 -

http://store.samhsa.gov/product/Strategies-for-Behavioral-Health-Organizations-to-Promote-New-Health-Insurance-Opportunities-in-Latino-and-Hispanic-Communities/SMA14-4820

Are you aware of other resources? Help us build our resource list. E-mail dhmh.healthdisparities@Maryland.gov

Maryland's 12th Annual Health Disparities Conference Health is a State of Mind: Addressing Behavioral Health Disparities

Exhibitors

Maryland Office of Minority Health and Health Disparities

Overview: The Maryland Department of Health and Mental Hygiene, Office of Minority Health and Health Disparities envisions a state in which health care services are organized and delivered in a manner designed to eliminate health disparities among all populations, thereby leading to health equity for all Marylanders. In fulfillment of the Department's mission to promote health equity for all Maryland citizens, the Office of Minority Health and Health Disparities (MHHD) works to focus the Department's resources on eliminating health disparities through assessment of the health status of all populations, demonstrating and promoting promising practices, engaging local communities and partnering with government and private sector programs in the State. The Office shall focus its efforts of promoting health equity to African Americans, Hispanic/Latino Americans, Asian Americans, Native Americans and all other groups experiencing health disparities.

Contact: Arlee Wallace **Phone**: 410-767-7117

E-mail: <u>DHMH.HealthDisparities@Maryland.gov</u>

Address: 201 West Preston Street, Room 500, Baltimore, MD 21201

Website: www.dhmh.maryland.gov/mhhd

Center for Health Equity, School of Public Health, UMD, College Park

Overview: Located within the School of Public Health at the University of Maryland in College Park, the main focuses of the Center for Health Equity are to eliminate racial and ethnic disparities to achieve health equity among residents in the state of Maryland; and increase the inclusion of racial and ethnic minorities in health research through our Building Trust initiative.

Contact: Shawnta Jackson, MPH

Phone: 301-405-8859 **E-mail:** sjack1@umd.edu

Address: 4200 Valley Drive, College Park, MD 20742

Website: http://sph.umd.edu/center/che/

DHMH Behavioral Health Administration

Overview: The Behavioral Health Administration (BHA) is responsible for all publically funded specialty mental health and substance related disorders services in the public behavioral health system (PBHS). The PBHS is managed in collaboration with local behavioral health entities referred to as Core Service Agencies (CSAs) and Local Addiction Authorities (LAAs).

Contact: Cynthia Petion **Phone**: 410-402-8473

E-mail: Cynthia.petion@maryland.gov

Address: 55 Wade Ave., Spring Grove Hospital Center, Catonsville, MD 21228

Website: http://bha.dhmh.maryland.gov

Black Mental Health Alliance for Education and Consultation, Inc.

Overview: The Black Mental Health Alliance for Education and Consultation, Inc. (BMHA) has a thirty-one year history of public education and provision of resource and referrals. BMHA provides education around mental health issues through trainings, webinars and symposiums designed to increase awareness regarding delivery of culturally competent mental health services to people of color. To facilitate resource and referral, BMHA maintains a data base of mental health professionals and service provision to address inquires received from those seeking assistance in the Baltimore Metropolitan and surrounding areas.

Contact: Jan Desper Peters, Executive Director

Phone: 410-338-2642

Address: 201 West Preston Street, Room 501, Baltimore, MD 21201

Website: www.blackmentalhealth.com

Prevention and Health Promotion Administration Infectious Disease Prevention and Health Services Bureau

Overview: The mission of the Prevention and Health Promotion Administration is to protect, promote and improve the health and well-being of all Marylanders and their families through provision of public health leadership and through community-based public health efforts in partnership with local health departments, providers, community based organizations, and public and private sector agencies, giving special attention to atrisk and vulnerable populations. The Prevention and Health Promotion Administration envisions a future in which all Marylanders and their families enjoy optimal health and well-being.

Contact: Carmi Washington-Flood

Phone: 410-767-5252

E-mail: <u>carmi.washington-flood@maryland.gov</u>

Address: 500 North Calvert Street, Baltimore MD 21202

Maryland Attorney General, Health Education and Advocacy Unit (HEAU)

Overview: Health Education and Advocacy Unit (HEAU) of the Maryland Attorney General's Office offers a free mediation service to consumers who have billing disputes with a health care provider and coverage disputes with their HMO or private health insurance company. HEAU also assists consumers who have been denied enrollment in a qualified health plan or been denied tax credits or cost-sharing reductions by Maryland Health Connection.

Contact: Jeannine Robinson **Phone**: 410-576-7205

E-mail: jrobinson@oag.state.md.us

Address: 200 Saint Paul Place, 16th Floor, Baltimore, MD 21202

Website: www.marylandcares.org

Maryland's Commitment to Veterans

Overview: Maryland's Commitment to Veterans is a DHMH initiative to assist Veteran, family members and community provider's find the resources necessary to successfully transition to civilian life. We also help to educate the community and providers to assist them in helping veterans in their communities.

Contact: David Galloway, Central Regional Resource Coordinator

Phone: 410-258-2513

E-mail: DGalloway.MCV@gmail.com

Address: 201 W. Preston Street Baltimore, MD 21201

Website: veterans.dhmh.maryland.gov

Maryland Health Benefit Exchange, Maryland Health Connection

Overview: The Maryland Health Connection is the Maryland's official health insurance marketplace for individuals and families to compare and enroll in health insurance and determine eligibility for Medicaid and other assistance programs, federal tax credits and cost-sharing reductions.

Contact: Jenny Garrison, Outreach Coordinator

Phone: 410-547-6323

E-mail: jenny.garrison@maryland.gov

Address: 750 E. Pratt St, 16th Floor, Baltimore, MD 21202 https://www.marylandhealthconnection.gov/

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Mental Health First Aid Maryland

Overview: Mental Health First Aid is a groundbreaking public education program that helps the public identify, understand, and respond to signs of mental illnesses and substance use disorders. Mental Health First Aid, offered as an interactive 8-hour course for helping both adults and youth, introduces participants to the risk factors and signs/symptoms of mental health problems, builds understanding of their impact, and overviews common treatments. Those who complete the course certify as Mental Health First Aiders, having learned a 5-step action plan encompassing the skills, resources and knowledge to help an individual connect with appropriate professional, peer, social, and self-help care.

Mental Health First Aid USA is managed, operated and disseminated nationally by the National Council for Behavioral Health, Missouri Department of Mental Health and the Maryland Department of Health and Mental Hygiene, in partnership with the Mental Health Association of Maryland.

Contact: Jennifer Treger, Director

Phone: 410-235-1178

Website: www.mhfamaryland.org

Maryland Insurance Administration

Overview: The Maryland Insurance Administration is the state agency that regulates the insurance industry in the State of Maryland.

Contact: James Mobley **Phone:** 410-468-2024

E-mail: James.mobley@maryland.gov

Address: 200 St. Paul Place, Suite 2700, Baltimore, MD 21202

Website: www.Insurance.Maryland.gov

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U.S. Office of Minority Health

Overview: The Office of Minority Health is dedicated to improving the health of racial and ethnic minority populations through the development of health policies and programs that will help eliminate health disparities.

Contact: Info Specialist **Phone:** 1-800-444-6472

E-mail: info@minorityhealth.hhs.gov

Address: P.O. Box 37337, Washington, DC 20013-7337

Website: <u>www.minorityhealth.hhs.gov</u>









SETTING THE STAGE -- ADDRESSING BEHAVIORAL HEALTH DISPARITIES

Jacquelyn Duval-Harvey, PhD, Executive Director, Mayor's Office of Human Services

Health is a State of Mind

Addressing Behavioral Health Disparities

Maryland's 12th Annual Health Disparities Conference October 28, 2015

SETTING THE STAGE

Addressing Behavioral Health Disparities

Jacquelyn Duval-Harvey, Ph.D Licensed Psychologist

Behavioral Health in Context

In Maryland:

- 7/1/1997: As a result of Managed Care, Maryland opted to have mental health services carved out into an Administrative Services Organization.
- As a result, mental health services were no longer managed by local grants but rather through utilization management in an ASO model.
- Utilization of outpatient services has steadily increased since then.

State and Local Systems

In Baltimore City:

• 10/1/2013 – Baltimore Mental Health Systems and Baltimore Substance Abuse Systems merged to become Behavioral Health Systems Baltimore.

State Level:

- 7/1/2014: ADAA and MHA merged into the Behavioral Health Administration
- 1/1/2015: Outpatient SUD services for Medicaid recipients carved out into the ASO
- 7/1/2015 Identified date for outpatient SUD services to be taken out of the local authority budgets and moved to the ASO. This is still pending.

New Terminology

- Mental Health and Substance Abuse: Behavioral Health
- Local authorities are CSAs Core Service Agencies for Mental Health
- LAAs Local Addiction Authorities for SUD
- LBHAs for merged entities Local Behavioral Health Authorities

OPPORTUNITY:

- Given the focus on Behavioral Health Services
 - Important to ensure that clinicians are, and remain competent
 - Necessary for clinicians to be able to engage clients in treatment
 - Clinicians need to know how to translate their theoretical modalities and academic knowledge into a language clients can understand





Behavioral Health is Essential To Health



Prevention Works







People Recover

SAMHSA Contact Info

Individuals interested in getting more information on SAMHSA's Trauma Informed Care should contact:

Joan Gillece, PhD SAMHSA National Center for Trauma Informed Care Joan.gillece@nasmhpd.org 703-682-5195

Slides provided in this presentation are part of the public domain as are most SAMHSA documents

ISSUE:

What do people say about mental health professionals?

Mental Health professionals:

- Ask too many personal questions
- Always want to know how you feel about things
- Want to do research and study you
- Want you to work on your "issues"
- Think everybody needs treatment/therapy
- Don't really help you anyway

Behavioral Health Treatment

- Do people seek out treatment
- There has been an almost 10% increase in the unduplicated number of clients receiving SUD services since 2011 with 19,669 individuals receiving services in FY 13.
- Outpatient services account for the large majority of substance use services provided with Opioid Maintenance Treatment being the level of care with the highest numbers.

FY'14 Public System Data

- The mental health system continues to expand in terms of the number of individuals served (7% over the last three years to 48,768).
- There has been a continued increase in Medicaid consumers, 4% from FY 13 to FY 14, and 8% over the last three years.
- Outpatient services account for the large majority of services

Behavioral Health Treatment

- Do people believe it works?
- Do clinicians understand treatment from a client perspective?
- What is the average number of sessions?

Title:

Traumatic Stress and the Implications: Understanding the Impact on Young Children and their Families.

Step 1: Making it real/relevant

New Title:

What looks like "crazy" on television and what you should know about it.







Step 2: Building on what the client knows and the things that are of interest to them

What is Trauma?

Individual trauma results from an <u>event</u>, series of events, or set of circumstances that is <u>experienced</u> by an individual as physically or emotionally harmful or life threatening and that has lasting adverse <u>effects</u> on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.

In Other Words...

Things that have happened to you can prevent you from being the kind of parent, spouse, partner, friend or person that you want to be....

The Three E's in Trauma

Events

Experience

Effects

Events/circumstances cause trauma

An individual's experience of the event determines whether it is traumatic.

Effects of trauma include adverse physical, social, emotional, or spiritual consequences.

Things to Remember



Underlying question =

"What happened to you?"

Symptoms =

Adaptations to traumatic events

Healing happens

In relationships

Potential Traumatic Events

Abuse

- Emotional
- Sexual
- Physical
- Domestic violence
- Witnessing violence
- Bullying
- Cyber-bulling
- Institutional

Loss

- Death
- Abandonment
- Neglect
- Separation
- Natural disaster
- Accidents
- Terrorism
- War

Chronic Stressors

- Poverty
- Racism
- Invasive medical procedure
- Community trauma
- · Historical trauma
- Family member with substance use disorder

Experience of Trauma

Experience of trauma affected by:

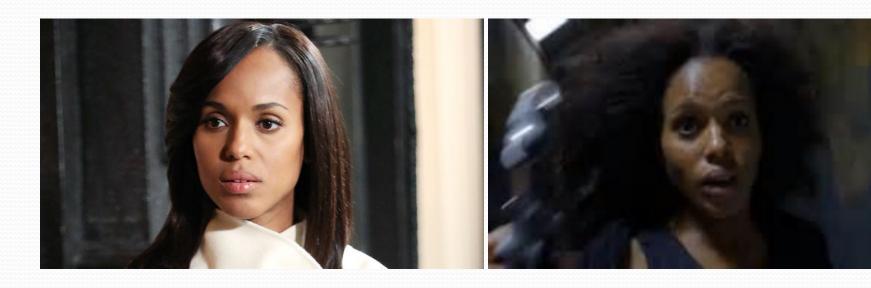
How

When

Where

How Often

What happened to her?



What happened to her?





In closing:

- Understand what it means for a client to voluntarily seek out treatment
- Explore the beliefs or perceptions clients have about "therapy"
- Frame your work together in manner that makes sense to the client
- Be aware of your limitations or challenges
- Seek out support or assistance
- BE OPEN TO DOING THINGS DIFFERENTLY









SHIRLEY NATHAN-PULLIAM HEALTH EQUITY LECTURE

Brian D. Smedley, PhD, Executive Director, National Collaborative for Health Equity

Place, Race, and Disease:

Addressing the Roots of Behavioral Health Disparities

Brian D. Smedley, Ph.D National Collaborative for Health Equity

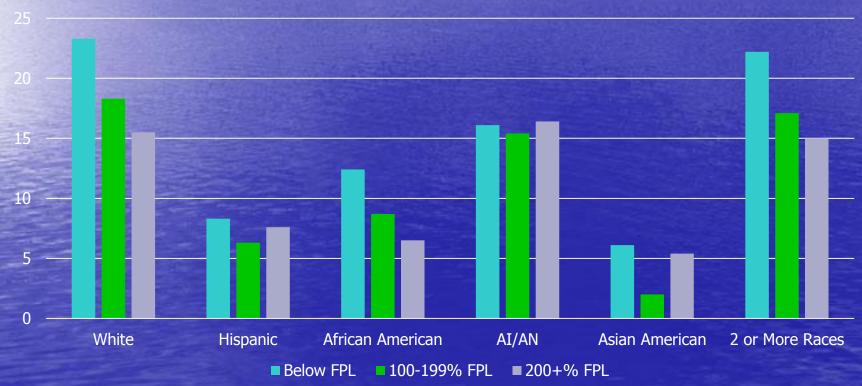
www.nationalcollaborative.org

Behavioral Health Disparities

- People of color are over-represented among those experiencing risk factors for poor mental and behavioral health
- People of color face an array of geographic, cultural, linguistic, and financial barriers to accessing behavioral health services
- People of color may experience symptoms that are undiagnosed, under-diagnosed, or misdiagnosed for cultural, linguistic, or historical reasons

Mental Health Service Use in the Past Year among Adults, by Race/Ethnicity and Poverty Status, 2008-2012

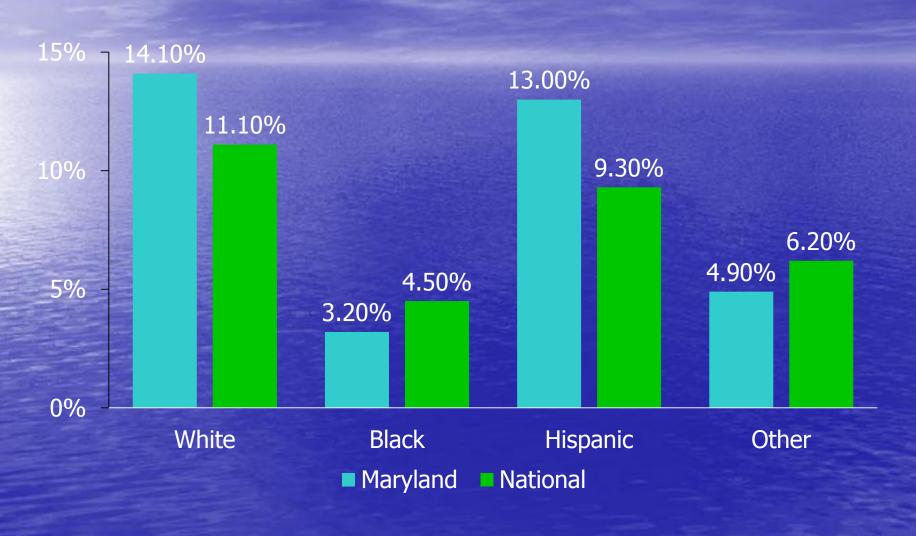




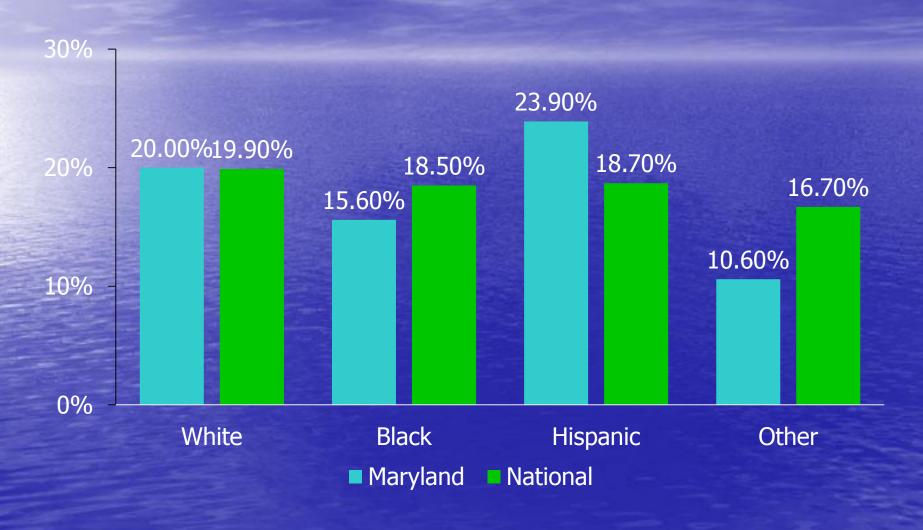
"Disparities in use of mental health services persist for Black and Latino children"

- "About 10% of white youth are using mental health care compared to 4 - 5% of Black and Latino youth"
- "That 2-to-1 ratio is giant disparity compared to other areas of health care"
- Money spent for MH care increased for white children; decreased significantly for Latino children (2002-2003 and 2006-2007)
- "...the amount of dollars the system is spending on Latino users relative to white users is shrinking."
- But, when strategies are used to engage these families ->
 access to MH care increases.
 - B. Cook, Health Services Research, 2012; Dataset: 30,000 youth, Medical Expenditure Panel Surveys.

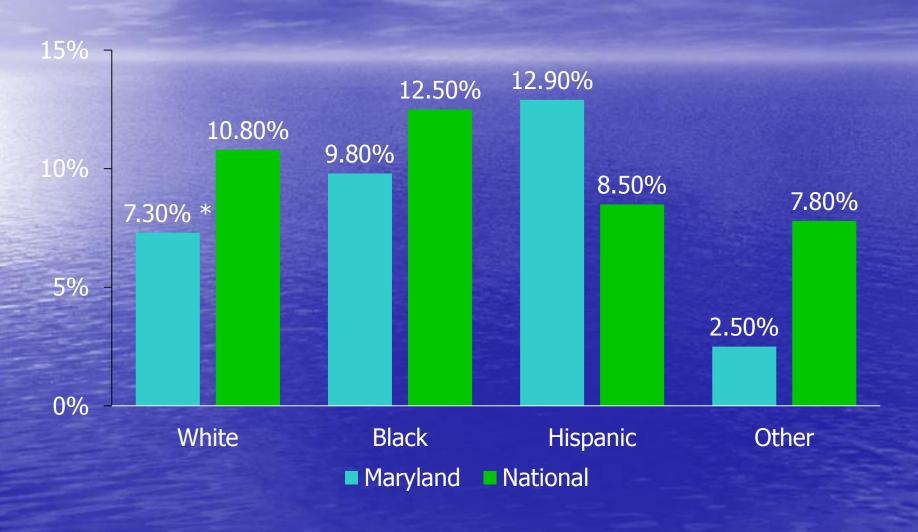
Past month binge drinking (2006-2009) 12-17 year olds



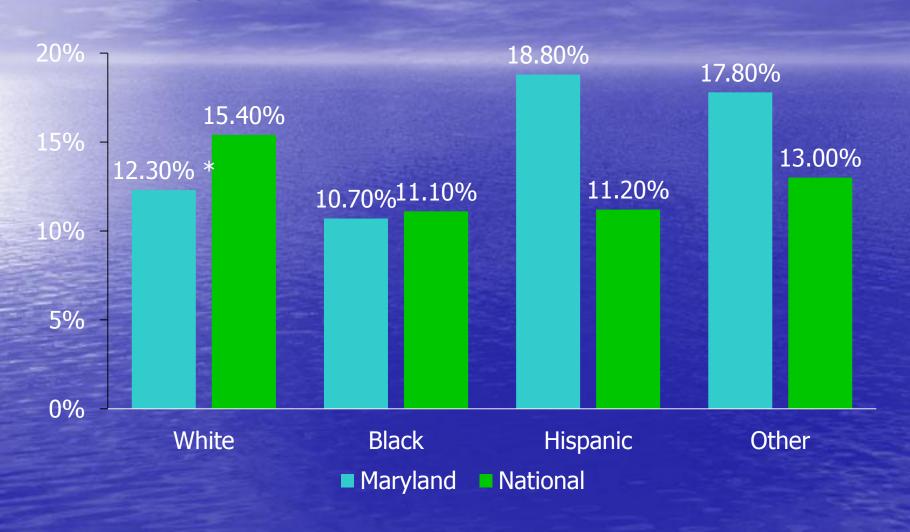
Past year illicit drug use (2006-2009) 12-17 year olds



Past year illicit drug use (2006-2009) 26+ year olds



Lifetime Major Depressive Episode 18-25 year olds (2006-2009)



The Role of Segregation

Racial Residential Segregation – Apartheidera South Africa (1991) and the US (2010)

Source: Frey 2011; Massey 2004; Iceland et al 2002



Negative Effects of Segregation on Health and Human Development

- Racial segregation concentrates poverty and excludes and isolates communities of color from the mainstream resources needed for success. African Americans are more likely to reside in poorer neighborhoods regardless of income level.
- Segregation also restricts socio-economic opportunity by channeling non-whites into neighborhoods with poorer public schools, fewer employment opportunities, and smaller returns on real estate.

Negative Effects of Segregation on Health and Human Development (cont'd)

- African Americans are *five times less likely* than whites to live in census tracts with supermarkets, and are *more likely* to live in communities with a high percentage of fast-food outlets, liquor stores and convenience stores
- Black and Latino neighborhoods also have fewer parks and green spaces than white neighborhoods, and fewer safe places to walk, jog, bike or play, including fewer gyms, recreational centers and swimming pools

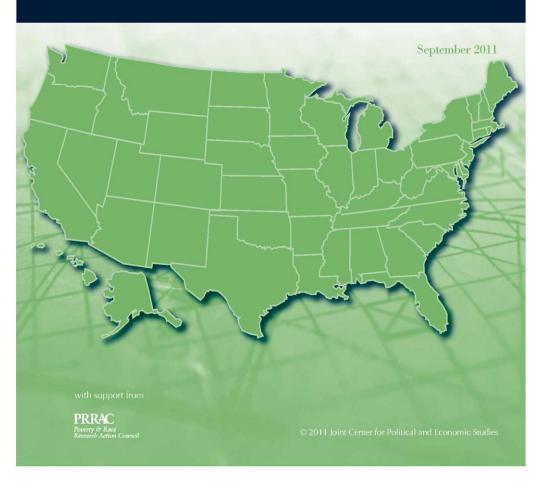
Negative Effects of Segregation on Health and Human Development (cont'd)

- Low-income communities and communities of color are *more likely to be exposed* to environmental hazards. For example, in 2004 56% of residents in neighborhoods with commercial hazardous waste facilities were people of color even though they comprised less than 30% of the U.S. population.
- The "Poverty Tax:" Residents of poor communities pay more for the exact same consumer products than those in higher income neighborhoods— more for auto loans, furniture, appliances, bank fees, and even groceries.

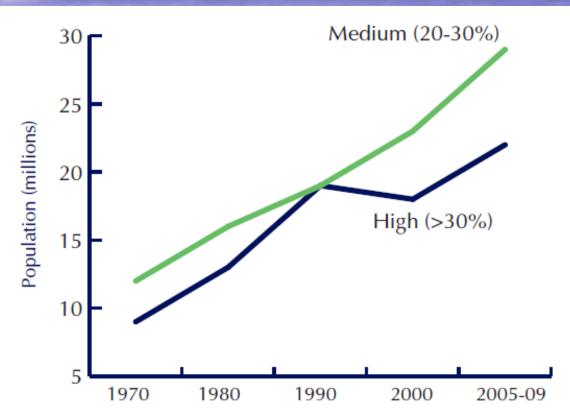
Trends in Poverty Concentration

A Lost Decade: Neighborhood Poverty and the Urban Crisis of the 2000s



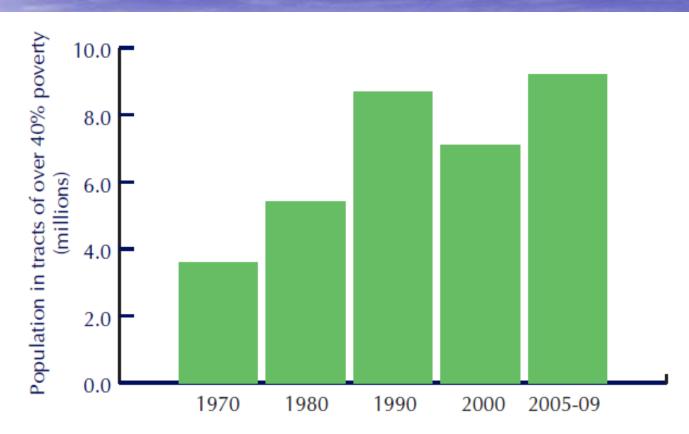


Steady rise in people in medium, high-poverty neighborhoods



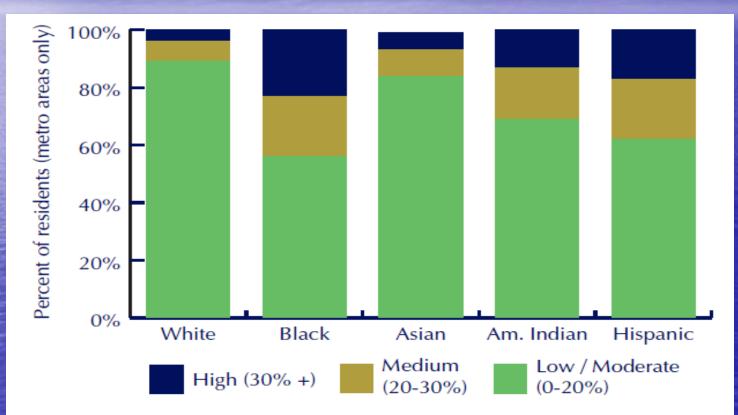
Source: U.S. Census Bureau, Decennial Censuses of Population and Housing and American Communities Survey five-year estimates, based on authors' calculations.

2000s: Population soars in extreme-poverty neighborhoods



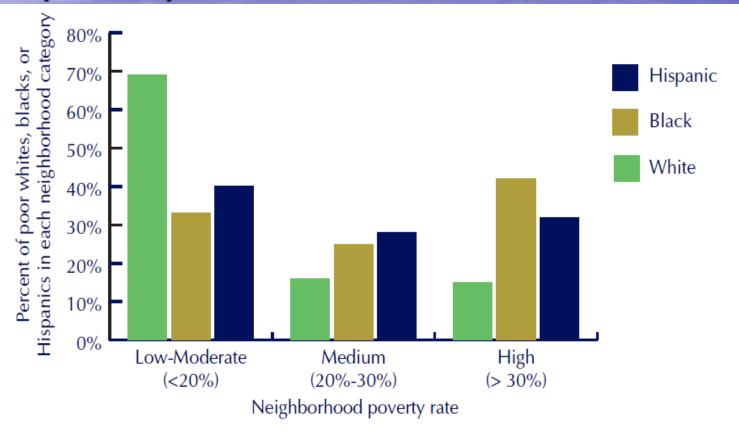
Source: U.S. Census Bureau, Decennial Censuses of Population and Housing and American Communities Survey five-year estimates, based on authors' calculations.

Blacks, Hispanics, Amer. Indians overconcentrated in high-poverty tracts



Source: U.S. Census Bureau, Decennial Censuses of Population and Housing and American Communities Survey five-year estimates, based on authors' calculations.

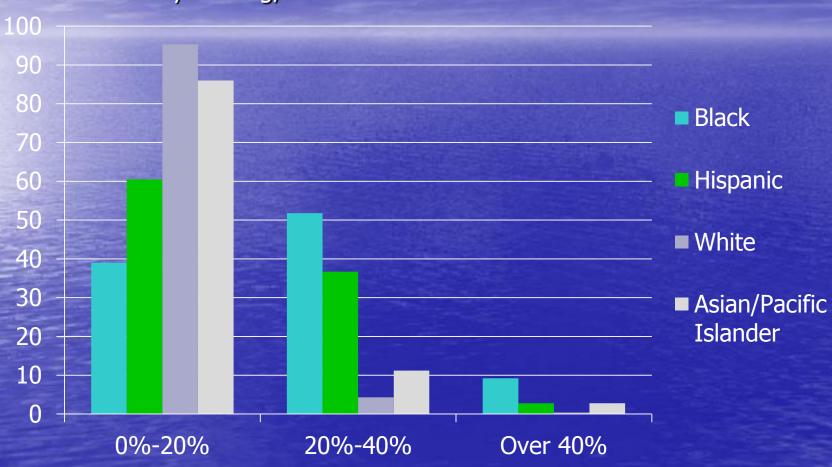
Poor blacks and Hispanics are more likely than poor whites to live in medium- and high-poverty tracts



Source: U.S. Census Bureau, Decennial Censuses of Population and Housing and American Communities Survey five-year estimates, based on authors' calculations.

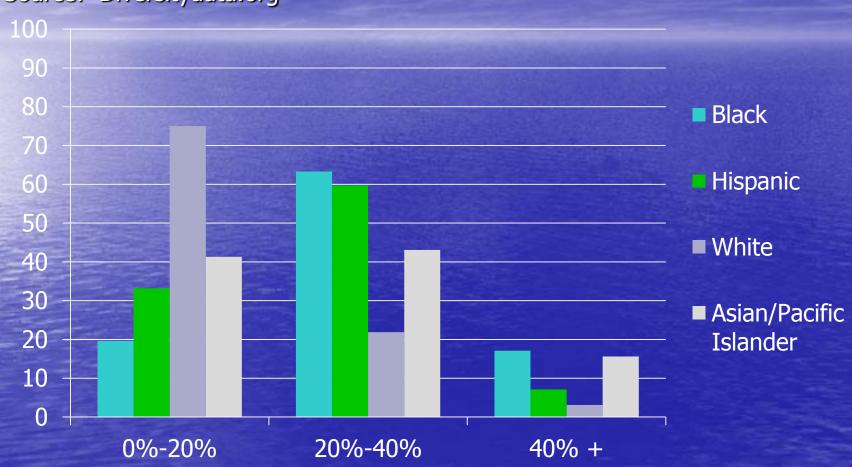
Metro Detroit: Poverty Concentration of Neighborhoods of All Children

Source: Diversitydata.org, 2011



Metro Detroit: Poverty Concentration of Neighborhoods of Poor Children

Source: Diversitydata.org



Science to Policy and Practice—What Does the Evidence Suggest?

 A focus on prevention, particularly on the conditions in which people live, work, play, and study

Multiple strategies across sectors

Sustained investment and a long-term policy agenda

Science to Policy and Practice—What Does the Evidence Suggest?

 Place-based Strategies: Investments in Communities

People-based Strategies: Investing in Early Childhood Education and Increasing Housing Mobility Options

Create Healthier Communities:

- Improve food and nutritional options through incentives for Farmer's Markers and grocery stores, and regulation of fast food and liquor stores
- Structure land use and zoning policy to reduce the concentration of health risks
- Institute Health Impact Assessments to determine the public health consequences of any new housing, transportation, labor, education policies

Improve the Physical Environment of Communities:

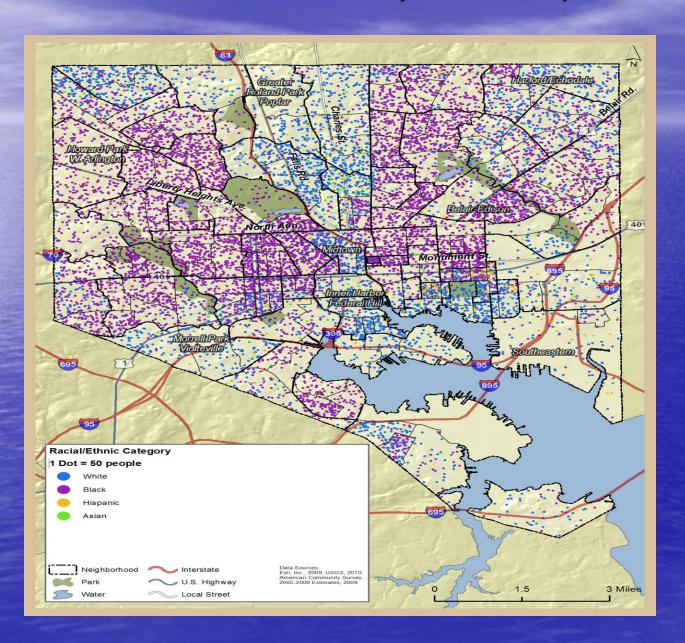
- Improve air quality (e.g., by relocating bus depots further from homes and schools)
- Expand the availability of open space (e.g., encourage exercise- and pedestrian-friendly communities)
- Address disproportionate environmental impacts (e.g., encourage Brownfields redevelopment)

Expanding Housing Mobility Options:

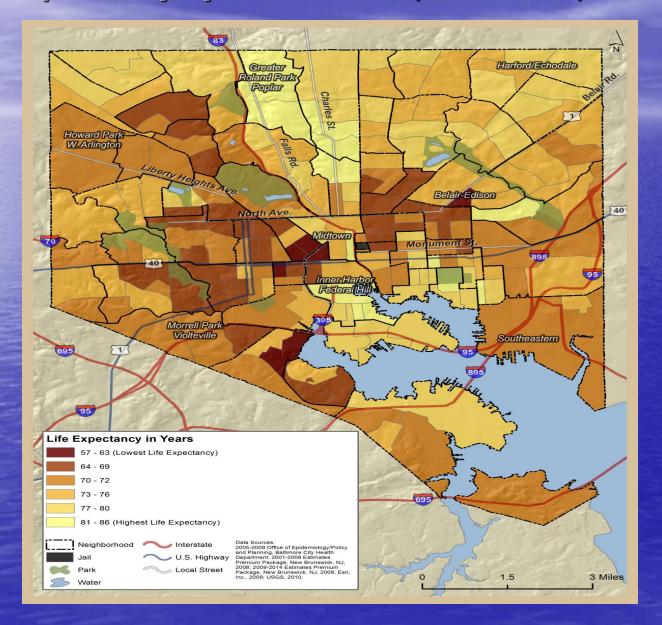
Moving To Opportunity (MTO)

- U.S. Department of Housing and Urban Development (HUD) launched MTO demonstration in 1994 in five cities: Baltimore, Boston, Chicago, Los Angeles, and New York.
- MTO targeted families living in some of the nation's poorest, highest-crime communities and used housing subsidies to offer them a chance to move to lower-poverty neighborhoods.
- Findings from the follow up Three-City Study of MTO, in 2004 and 2005, answer some questions but also highlight the complexity of the MTO experience and the limitations of a relocation-only strategy.
- Away from concentrated poverty, would families fare better in terms of physical and mental health, risky sexual behavior and delinquency?
 Adolescent girls benefited from moving out of high poverty more than boys.

Racial and Ethnic Distribution, Baltimore, 2005-2009



Life Expectancy by Census Tract, Baltimore, 2005-2009



The Health Equity Leadership & Exchange Network (HELEN)

HELEN is a collaborative effort between the National REACH Coalition, Morehouse School of Medicine, and the National Collaborative for Health Equity, designed to bolster leadership and the exchange of ideas and information among communities of color and other vulnerable populations to advance health equity in laws, policies, and programs



Welcome, Cathy!

- Dashboard
- · Polls &
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CAMPAIGN FOR HEALTH EQUITY

We envision the HELEN forum as a national network exchange

- · comprehensively, trans-disciplinarily, and collaboratively coordinates and strengthens health equity leadership,
- · shares timely and essential information,
- · and, actualizes health equity strategies and approaches at the local, state, regional, and national level.

Support HELEN by making a donation today





NOW AVAILABLE ONLINE: HELEN PRESENTS: HEALTH EQUITY AND THE IMPACT OF THE 2014 MIDTERM ELECTIONS

Webinar: Health Equity and the Impact of the 2014 Mid-Term Elections...



AN OPEN LETTER OF WELCOME FROM DANIEL DAWES, JD., AND BRIAN SMEDLEY, PHD.

Dear Friends,... Welcome to the Health Equity Leadership and Exchange Network (HELEN)!... HELEN is launching at a crucial time in our country's history and will work to advance health equity by connecting people, ideas, and information....

HELEN is a national network designed to bolster leadership and the exchange of ideas and information among health equity champions relative to the advancement of equity in health laws, policies, and programs.

QUICK LINKS ABOUT US MEET THE TEAM HELEN MEMBERSHIP FAQ NEWS CONTACT

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CONNECT WITH US SUBSCRIBE TO OUR NEWSLETTER Welcome, Cathy Morales

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The HELEN Monitor - Vol. 5



NC 130A-33.43 et. seq. Minority Health Advisory Council



NC 130A-33.43 et. seq. Minority Health Advisory Council

FORUM ACTIVITY

New NHeLP Issue Brief on Medicaid Coverage for Women Living with HIV 1 view 1 reply Last post 02-09-2015

The President's Budget - What health equity items to look for

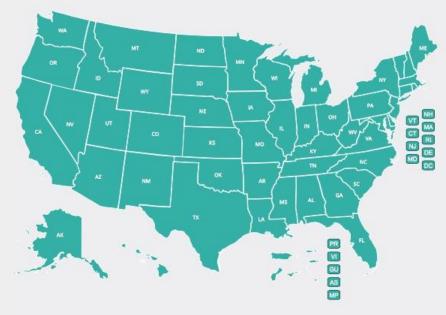
11 views 1 reply Last post 01-28-2015

DATA for minorities

146 views 6 replies Last post 11-25-2014

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Click on any state to find documents and other HELEN members in that state.



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Welcome, Cathy Morales

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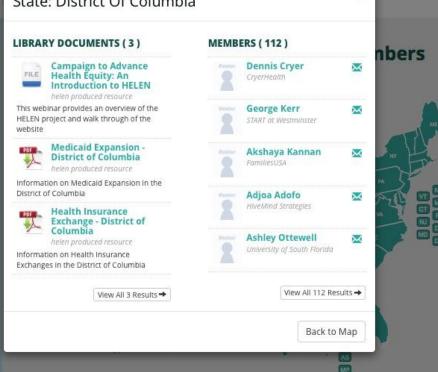
NC 130A-33.43 et. seq. Minority Health Advisory Council

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TOPIC

cultural or linguistic competency data collection dental health information technology medically underserved area

POPULATION GROUP

african american american indian asian american children elderly

Resource Library

Total results: 363.

str.	FILE	TITLE	PUB. DATE	COMMENTS	STATE	TYPE	TOPIC	JURIS.	POP. GROUP
**	**	The HELEN Monitor - Vol. 5 The Health Equity Leadership & Exchange Network (HELEN) provides frequent updates on health equity-related policies, laws and programs through The HELEN Monitor. This resource is readily accessible and is available in the Resource Library. The HELEN Monitor contains legislative and regulatory updates, recent governmental and non-governmental reports & publications, funding opportunities, a special HELEN member spotlight and upcoming events in health equity.	Feb 2015	0		funding opportunities, helen produced resource, law, legislation, nongovernmental report or study, proposed legislation, regulations, the helen monitor, updates		National	
tr .	***	The HELEN Monitor • Vol. 4 The Health Equity Leadership & Exchange Network (HELEN) provides frequent updates on health equity-related policies, laws and programs through The HELEN Monitor. This resource is readily accessible and is available in the Resource Library. The HELEN Monitor contains legislative and regulatory updates, recent governmental and non-governmental reports & publications, funding opportunities, a special HELEN member spotlight and upcoming events in health equity.	Feb 2015	0		funding opportunities, helen produced resource, law, legislation, nongovernmental report or study, proposed legislation, regulations, the helen monitor, updates		Federal	
dr .	269.17 KB	Medicaid Expansion - Tennessee Information on Medicaid expansion in Tennessee	Jan 2015	0	TN	helen produced resource		State	
\$r		The HELEN Monitor - Vol.3 The Health Equity Leadership & Exchange Network (HELEN) provides frequent updates on health equity-related policies, laws and programs through The HELEN Monitor. This resource is readily accessible and is available in the Resource Library. The HELEN Monitor contains legislative and regulatory updates, recent governmental and non-governmental reports & publications, funding opportunities, a special HELEN member spotlight and upcoming events in health equity.	Jan 2015	0		funding opportunities, helen produced resource, law, nongovernmental report or study, proposed legislation, the helen monitor, updates		National	and the second
dr.	15.03 MB	Health Disparities and Disability Presentation on health disparities in people with disabilities by CDC funded researcher Dr. James Rimmer (Lakeshore Fd & UAB) to the National Academy of Science, October 2012.	Oct 2012	0		presentation		National	people with disabilities
år.	T.	Disparities in chronic conditions and health status by type of disability Study examining the differences in chronic conditions and health status	Oct 2013	0		nongovernmental report or study		National	people with disabilities





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Discussion

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Forum Name	Topics	Replies	Latest Post Info
Rules / Conduct for the HELEN Forum Guidelines and Rules for the HELEN Forum	1	0	Guidelines and Rules for the HELEN Forum Author: Gary Reckard, 09-25-2014 04:50 PM
HELEN Announcements Occasional announcements from the HELEN website team to our members.	1	0	"Got Language Access: Culture, Collaboration, and Solutions," Summit Author: Cathy Morales, 10-10-2014 06:36 PM

Discussion

Forum Name	Topics	Replies	Latest Post Info
Effective Health Equity Policy Strategies	4	7	New NHeLP Issue Brief on Medicaid Coverage for Women Living with HIV Author: Jamille Fields, 02-09-2015 12:05 PM
ACA Enrollment	1	1	Lessons Learned from ACA first enrollment period Author: Gilda Pedraza, 11-25-2014 10:18 AM
HIT and Health Equity	1	0	Technology to further Health Equity Author: Angelica Alton, 10-08-2014 04:22 PM
Health Equity Provisions under ACA and ARRA	1	1	ACA and ARRAHealthy Equity Provisions? Author: Megan Douglas, 11-25-2014 02:54 PM

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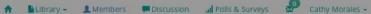










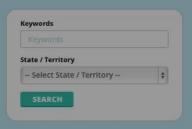


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Member Search

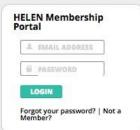
Total results: 713.

NAME +	ORGANIZATION	STATE	00
Rachel Abramson	HealthConnect One	IL	*
Adjoa Adofo	HiveMind Strategies	DC	E
Ngozi Afulezi	Consultant	GA	*
Evelyn Aissa	NH Voices for Health	NH	×



Karen Anderson	Institute of Medicine	DC	×
Norman Anderson	American Psychological Association	DC	×
Marie Anderson	Student	DC	₩.
Lauri Andress	West Virginia University	wv	*
Antoinette Angulo	NRC	WA	∞
Angela Ankoma	RI Department of Health	RI	×
Renaisa Anthony	Center for Reducing Health Disparities	NE	*
Elizabeth Aparicio	University of Hawaii at Manoa	н	×
Tomas Aragon	San Francisco Department of Public Health	CA	×







HOME ABOUT US HELEN MEMBERSHIP FAQ NEWS CONTACT SEARCH

CAMPAIGN FOR HEALTH EQUITY

The HELEN project will include members of various organizations, coalitions and associations committed to the elimination of health disparities and serve as a national forum for health equity champions to share information about timely, relevant and pressing policy issues impacting health equity.

HELEN Membership will provide:

- Access to an interactive online forum for bidirectional exchange of ideas, and information
- Access to information about relevant and pressing proposed policy issues impacting health equity
- Increased understanding of the economic, policy and legal impact of existing and proposed policies on health equity
- Membership in a national network of health equity champions

Take this opportunity to become part of a network that uses a health equity lens to analyze health laws and polices for education and outreach efforts. Members will actively inform, participate in, and monitor the development, implementation, and impact of health equity laws, policies and programs at the federal state and local levels. We encourage you to become a member of HELEN today.

BECOME A MEMBER NOW

Last Name*	26		
Email Address*			
Organization*			
Job Title			
Password*			
8			
Confirm Password®			
B			
Street Address			
Street Address			
Street Address			<u>\</u>
	State /	Territory *	5
Street Address City	State /	Territory *	

"[I]nequities in health [and] avoidable health inequalities arise because of the circumstances in which people grow, live, work, and age, and the systems put in place to deal with illness. The conditions in which people live and die are, in turn, shaped by political, social, and economic forces."

World Health Organization Commission on the Social Determinants of Health (2008)









BEHAVIORAL HEALTH NEEDS OF SERVICE MEMBERS, VETERANS AND THEIR FAMILIES

David Galloway, Central Regional Resource Coordinator, Maryland's Commitment to Veterans





Overview

- Maryland's Commitment to Veterans (MCV)
 Introduction
 - About MCV
 - Who eligible & how works
- Community Provider Training
- Mental Health First Aid
- Contact Information & Questions



About MCV

- A collaboration between Maryland's Department of Health and Mental Hygiene; United States Department of Veterans Affairs; Maryland Department of Veterans Affairs as well as other state agencies and community providers.
- Assist veterans and their families with coordinating behavioral health services for the veteran, including mental health and substance abuse services- either with the VA or DHMH Behavioral Health Administration.
- Facilitate and cover transportation costs to behavioral health appointments for veterans.
- Provide information and referrals related to employment, education, housing, VA benefits.
- Outreach: educate residents, veterans (i.e. Maryland National Guard) and community groups about MCV.

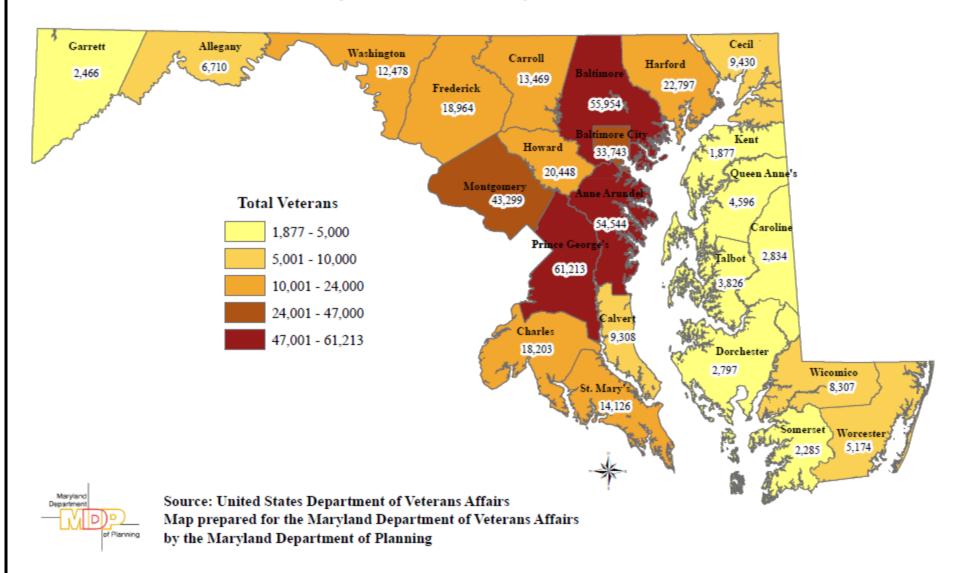


Who is eligible?

- An individual, male or female, with prior active duty service (other than for training), regardless of service era
- For behavioral health services: veterans discharged or released under conditions 'other than dishonorable'
- For information and referral: all veterans regardless of discharge and their families

Projected Number of Veterans in Maryland - 2015

Projected Veterans in Maryland: 428,861





How does MCV work?

- •Referrals accepted 24 hours a day, 7 days a week
- •1-877-770-4801
- Referral sources are unlimited
- A connection is made with a Regional Resource Coordinator (RRC)
- •One RRC per region Central, Southern, Western, Eastern
- A personal relationship is built

Once a veteran is linked to an RRC, they will always speak to the same person. Once a relationship is built, the veteran will ideally feel heard and understood, opening up the lines of communication so needs can be met, and stability can be achieved.



MCV Regions

- Western: Carroll, Frederick, Montgomery, Washington, Allegany, Garrett
- Southern: Prince Georges, Calvert, St. Mary's, Charles
- <u>Eastern:</u> Cecil, Kent, Queen Anne's, Caroline,
 Talbot, Dorchester, Wicomico, Somerset,
 Worcester
- <u>Central:</u> Baltimore, Harford, Anne Arundel, Howard, Baltimore City



Behavioral Health Coordination

- Mental health and substance abuse counseling services are initially attempted through the VA Maryland Health Care System
- For information about enrolling VA health care call 1-800-463-6295 ext. 7324
- If services are not available within a two week time frame, uninsured veterans are provided with services via DHMH Behavioral Health Administration through Value Options
- Veterans designated as special population under DHMH Behavioral Health Administration which means they do not need to meet typical eligibility requirements like income



Information and Referral

Information and referrals are provided to address additional needs, such as:

- Employment
- Housing
- Benefit Information
- Financial Assistance
- Community Support

MCV links veterans to resources – helping them to navigate the system.



Fun FY 2015 MCV Facts

- Since October 2008 (program inception) through June 2015 MCV has assisted 8,354 veterans and their families. FY 2015 MCV responded to 1,383 calls from veterans and their families, community providers, VA Maryland Health Care, and civic organizations.
- 60% of MCV callers were veterans, 26% were veteran family members, 4% callers were VA representatives, state agencies or civic organizations.
- There were at least two needs for every MCV caller total of 3,117 needs for 1,383 callers
- 15% of callers were connected with behavioral health services either through the Behavioral Health Administration, VA Health Care System or Community providers.
- Top Services provided by MCV 44% Information and Referral (612 total callers) 36% Behavioral Health transportation (506), 10% Advocacy (134)
- Top MCV Referral Sources FY 2015 27% VA SSVF Providers (375), 16% Department of Social Services (221), 18% Maryland Department of Veteran Affairs and the MDVA Trust Fund(133 and 113 respectively) 12% US Department of Veteran Affairs Behavioral Health Services (167)



Community Provider Training

- Fall 2012 nearly 3,300 behavioral health and primary care providers completed an online needs assessment survey. Found majority of community providers do not have experience working with veterans and nearly half do not screen for veteran status.
- Based on needs assessment responses developed training. Five training programs throughout the state with a total attendance of more than 1,000 Maryland behavioral health and primary care providers. Training titles included:
 - Treating Veterans and their Families in Primary Care Settings (3/20/2013)
 - Promising Practices for Addressing Behavioral Health Issues Facing Maryland Veterans (3/22/2013)
 - Treating Behavioral Health Challenges of Women Veterans (4/4/2014)

Military Cultural Competency and Treating Behavioral Health Needs of Service Members, Veterans and Their Families

Wednesday, October 21, 2015

The Conference Center at the Maritime Institute, 692 Maritime Blvd, Linthicum Heights, MD

MID
<u>Agenda</u>
8:00-8:30 Registration and Continental Breakfast
8:30-8:45 Welcome and Updates (Auditorium)
Al Zachick, Acting Executive Director, Behavioral Health
Administration Maryland Department of Health and Mental Hygiene
8:45-10:15 Plenary Military Culture, Lisa French, PsyD, Assistant Director of Military Training Programs
Center for Deployment Psychology.
10:15–10:30 Break
10:30-12:00 Plenary Unique Challenges of Military Families, Lisa French, Speed
12:00-1:00 Lunch (Dining Room)
1:00-2:30 Plenary Moral Injury in Veterans, Paula Domenici, PhD, Director of Civilian Training
Programs Center for Deployment Psychology
2:30-2:45 Break
2:45- 4:00 Plenary Assessment and Management of Anger in Service Members and Veterans
Paula Domenici, PhD
4:00 Adjourn (Evaluation and CEU/COA's)

On-line registration:
http://trainingcenter.umaryland.edu/register/registerMilitaryCulturalCompetency2015.asp



Mental Health First Aid

- New to MCV All four RRCs certified Mental Health First Aid Instructors – FY 2015 104 people working with veterans were trained on Mental Health First Aid.
- Training those working with veterans and their family members
- MCV led courses for Taylor Made Transportation,
 Alliance and US Vets (VA SSVF providers) as well as
 Garrett County law enforcement
- "This course will help me with my work with veterans as well as my personal life at home – my husband is a veteran."



MCV Feedback

"MCV was the first direct contact I found. Our MCV Regional Resource Coordinator (RRC) was not only accessible, but also knowledgeable and personable. We were in a crisis situation and I was beginning to think that no one knew where to go, who to contact or what to do until I spoke with MCV. Just the fact that I was able to speak directly with a person was comforting and when I realized the RRC not only was compassionate and helpful but also very knowledgeable I realized I had found a gold mine. MCV was able to direct us to valuable resources without delay and maintained contact with us during and after our family crisis. I feel that MCV is our key to a system that may not be broken but is sadly in need to repair. Without a doubt, MCV is a very valuable resource."

- Mother of a U.S. Marine



For more information.....

Visit our website:

veterans.dhmh.maryland.gov

Or call our hotline:

1-877-770-4801





Staff Contact Information

Shauna Donahue, Director Maryland's Commitment to Veterans Shauna.donahue@maryland.gov or 410.767.5934

Resource Coordinators

<u>Western Region</u>: Melissa Barber <u>mbarber.mcv@gmail.com</u>, 410-725-9971

<u>Central Region</u>: David Galloway <u>dgalloway.mcv@gmail.com</u>, 410.258.2513

Southern Region: Rick Reed rreed.mcv@gmail.com, 410.725.9993

Eastern Region: Dina Karpf dkarpf.mcv@gmail.com, 410.725-9996



Questions?









BEHAVIORAL HEALTH NEEDS OF SERVICE MEMBERS, VETERANS AND THEIR FAMILIES

CH(MAJ) Michael Clancy, State Family
Program Director, Maryland Army
National Guard



12th Annual Health Disparities Conference "Health is a State of Mind: Addressing Behavioral Health Disparities"

Behavioral Health Needs of Service Members, Veterans and their Families

CH(MAJ) Michael Clancy, LCPC, LCADC MDARNG State Family Program Director Family Life Chaplain 28 October 2015







BACKGROUND

Since September 11, 2001, more than 2.2 million members of the U.S. Armed Forces have served in the Operation Enduring Freedom (OEF) in Afghanistan and Operation Iraqi Freedom (OIF) in Iraq.

Many service members return from deployments with ongoing psychological health problems, including post-traumatic stress disorder, depression, and substance use problems.

Of the military members deployed to Iraq and Afghanistan as of 2010, roughly half have been members of the Army; with the Reserve Component (RC), specifically Army National Guard (ARNG) and Army Reservists (AR), comprising almost 44% of Army deployments.

(Harris et al, Military Medicine, 10:1090, 2014)



BACKGROUND - 2

21.6 million living veterans in America today. While the total number of living veterans will decline over the next 20 years to 15.7 million, the percentage of the total that post-9/11 veterans comprise will increase over the same time period from 10.8% to 26.2%

More than 200,000 Service Members will transition from active duty each year over the next five years.

In Aug 2014, the 8-24 year old veteran unemployment rate was 14.2% compared to a non-veteran rate of 12.0%. DOD paid over \$780M in unemployment benefits in FY13

Mental Health: A review of studies focused on "US combat Veterans" (those that deployed in support of combat operations) and PTSD noted a prevalence range of 2-17%.

In comparison, a study following Hurricane Katrina found that PTSD prevalence was 19% for police officers and 22% for firefighters 26% of American adults are affected by some mental health disorder each year with anxiety disorders contributing some 18%.

(Joint Chiefs of Staff, Veteran Reintegration, Oct 2014)







Post-9/11 Military Caregivers Differ from Other Caregivers

5.5 million military caregivers in the United States:

19.6 percent (1.1 million) are caring for someone who served in the military after the terrorist attacks of September 11, 2001

Military caregivers helping veterans from earlier eras tend to resemble civilian caregivers in many ways; by contrast, post-9/11 military caregivers differ systematically from the other two groups.

Post-9/11 caregivers are more likely to be:

- younger (more than 40 percent are between ages 18 and 30)
- caring for a younger individual with a mental health or substance use condition
- nonwhite
- a veteran of military service
- employed
- not connected to a support network (53%)

(Ramchand et al, Hidden Heroes: America's Military Caregivers, RAND, 2014)





Transitional Assistance Advisors (TAA)

TAAs primarily support uniformed service members and their families by ensuring they understand the services available through the Veteran Affairs and the military health system.

Additionally, TAAs coordinate resources for these members and their families with the myriad of service programs provided by the VA, TRICARE, Veterans Service Organizations and other supporting agencies.

Edward Graham - 410-370-6916







National Guard Psychological Health Program

Is in every State, Territory, and the District of Columbia.

Information and contacts to help, build resiliency, including education to support overall wellness, support for Family members and Friends, and immediate access to help if you are experiencing troubling symptoms.

Army: Mercia Cummings – 443-379-1779

Air: Susan Starnes, LCSW-C - 410-918-6558







Family Assistance Centers (FACs)

"One Call Does it All"

Provide support and assistance to Soldiers and their Families by offering information about military, federal, State, and local resources.

FACs provide a variety of services, including: legal resources & referrals, financial resources & referrals, crisis intervention & referrals, TRICARE resources & referrals, ID cards & Defense Enrollment Eligibility Reporting System (DEERS), and community information & outreach.

FACs are located throughout each State, making it easier for Soldiers and their Families to receive support and assistance during the entire deployment cycle.

FAC Coordinator: Amy Preston: 410-825- 2858







MilitaryOneSource

Non-Medical Counseling, Financial Counseling, Disability Consultation, Resources, Special Needs Consultation, Health and Wellness, Language Translation, & More.....

1-800-342-9647







Survivor Outreach Services (SOS)

Survivor Outreach Services is a "one" Army program. Regardless of your loved one's Army component, duty status, location, or manner of death, Survivor Outreach Services Support Coordinators and Financial Counselors are here to provide dedicated outreach and support when, and for as long as you desire.

Glen Beares - 410-576 - 2991





Family Life Chaplains and Military Chaplains

Specially-trained chaplains to provide pastoral counseling to families with an emphasis on marriage and family issues. The training and counseling provided is professional, 100% confidential, and distinctively pastoral.

Partners in Care Program

Local partnerships with congregations willing to provide goods and services for National Guard members and Family members. Current in Maryland there are 99 congregations serving every county of Maryland. An example of faith based community partnerships.









Strong Bonds

Strong Bonds mission is to increase Soldier and Family readiness through relationship education and skills training.

Offsite retreat format designed to maximize relationship training, "get away" provides an emotionally safe and secure training environment in which to address the effect of military lifestyle stressors.









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CONTACTS

CH(MAJ) Michael Clancy 410-576-2992 Michael.w.clancy2.mil@mail.mil









BEHAVIORAL HEALTH NEEDS OF SERVICE MEMBERS, VETERANS AND THEIR FAMILIES

Erika N. White, PhD, Clinical Psychologist, Team Leader, PTSD Clinical Team, VA Maryland Health Care System

BEHAVIORAL HEALTH NEEDS OF SERVICE MEMBERS, VETERANS, AND THEIR FAMILIES

Erika N. White, Ph.D.

VA Maryland Health Care System

October 28th, 2015

A LITTLE CONTEXT

- VA training experiences
- Connection with Veteran population
 - Trauma work
- Baltimore VA PTSD Clinical Team (PCT)
- Team Leader role

FROM WHERE I SIT

- Military culture/Veteran culture
 - Difficulty with "sick role"
- Effective engagement is key
 - Motivational interviewing
 - Validation/support
 - Meeting the Veteran where he/she is
- Collaboration with other providers
 - Symptoms rarely operate in a vacuum
- Veteran as an individual
- Engagement of spouse/significant other

COMMON INTERACTIONS WITH VETERANS

- Orientation session
- Assessment
- Individual therapy
 - Typically PE or CPT
- Group therapy
- Supervision of trainees









Mental Health First Aid / Crisis Services

Jennifer B. Treger, Director, Mental Health First Aid Maryland, Mental Health Association of Maryland



MENTAL HEALTH FIRST AID™

www.MentalHealthFirstAid.org

Jennifer Treger Mental Health First Aid of MD Maryland Health Disparities Conference October 28, 2015







Mental Health First Aid is the help offered to a person developing a mental health problem or experiencing a mental health crisis. The first aid is given until appropriate treatment and support are received or until the crisis resolves.





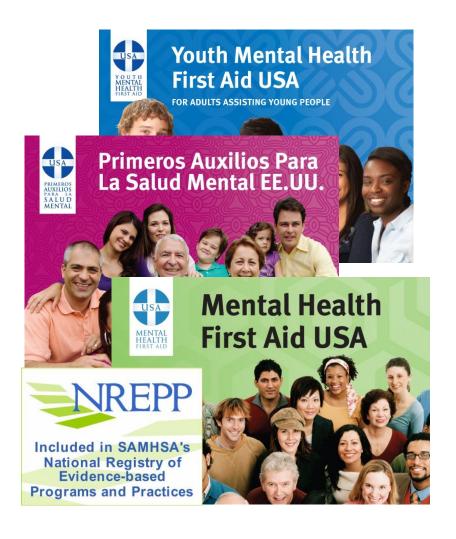






Mental Health First Aid





- Origins in Australia and currently in 20 countries
- Adult MHFA course for individuals 18 years of age and older; available in both Spanish and English
- Youth MHFA is designed to teach caring adults how to help an adolescent (age 12-18) who is experiencing a mental health or addictions challenge or is in crisis
- Included in SAMHSA's National Registry of Evidence-based Programs and Practices
- Partnership with Maryland and Missouri State Governments

Why Mental Health First Aid?



- Mental health problems are common
- Stigma is associated with mental health problems
- Professional help is not always on hand
- Individuals with mental health problems often do not seek help
- * Many people...
 - > are not well informed about mental health problems
 - > do not know how to respond





- Risk factors and warning signs of mental health concerns.
- Information on depression, anxiety, trauma, psychosis, and substance use.
- A 5-step action plan to help someone developing a mental health concern or in crisis.
- Available evidence-based professional, peer, and self-help resources.



What Participants Learn





What Participants Learn

- Prevalence of Mental Health Problems
- Signs and Symptoms of Depression
- Crisis First Aid for:
 - > Traumatic Events
 - > Acute Psychosis
 - > Overdose and Withdrawal

MHFA Action Plan





Assess for risk of suicide or harm



Listen nonjudgmentally



Give reassurance and information



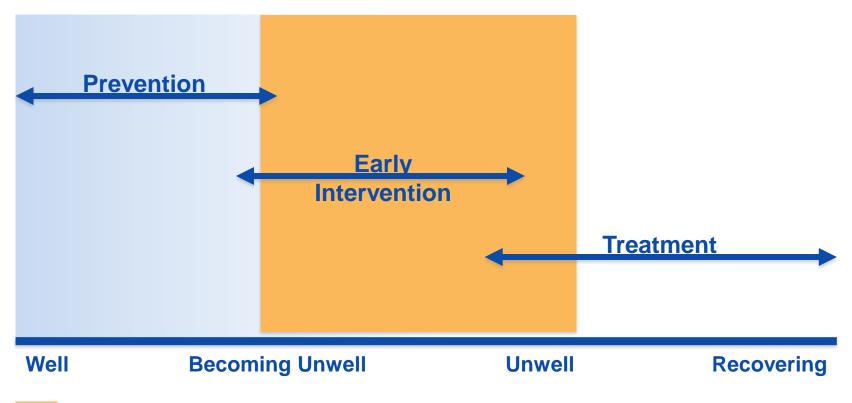
Encourage appropriate professional help



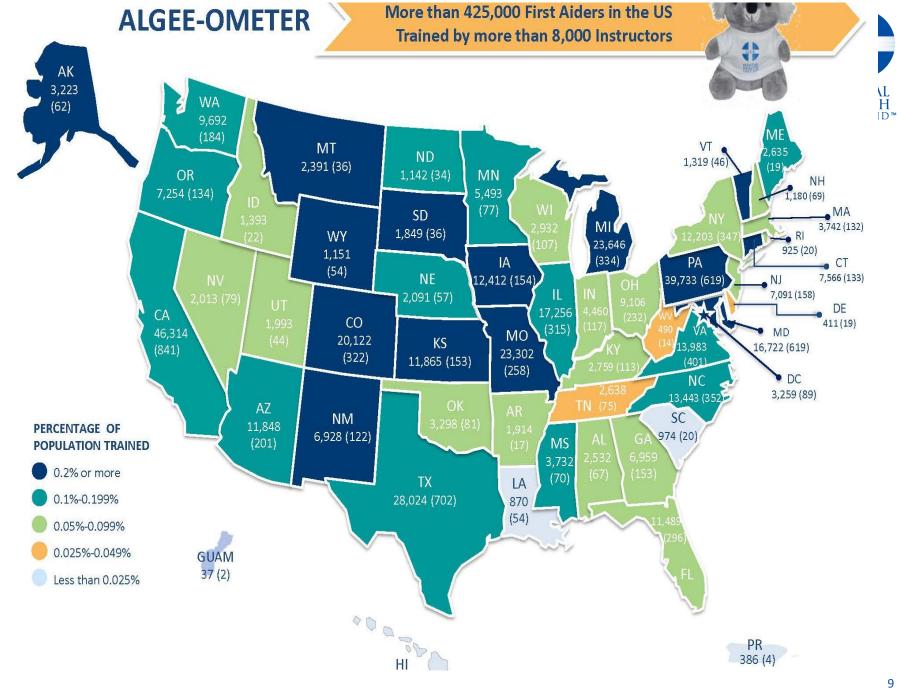
Encourage self-help and other support strategies

Where Mental Health First Aid Can Help





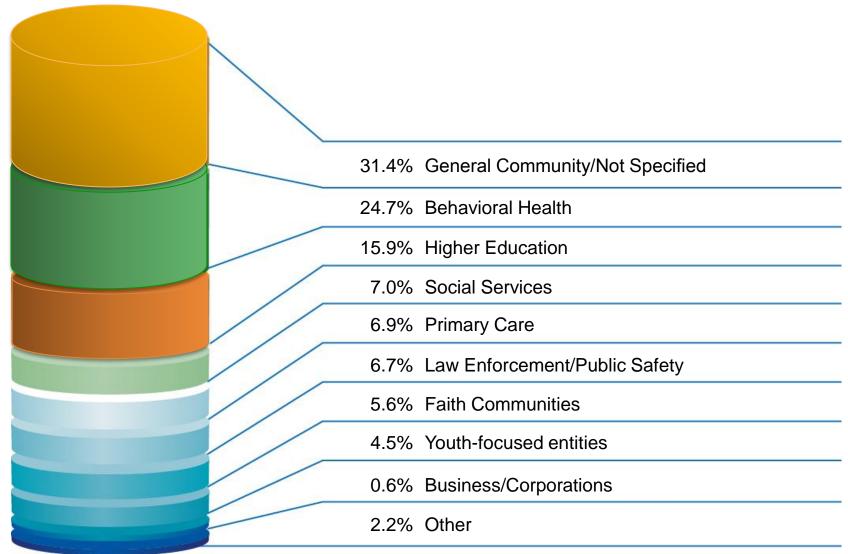
Where Mental Health First Aid can help on the spectrum of mental health interventions



Audiences

12,600 Courses (through April 2014)





Evidence

Mental Health First Aid





Mental Health First Aid in the News





The Washington Post



THE HUFFINGTON POST



January 8, 2014 | by Jennie Grabel

What has changed since Jan. 8, 2011, in Tucson and beyond?

January 2, 2014 | by Patrick Skahill

A "First-Aid" Response to Mental Illness

December 27, 2013 | by Kathleen Megan

After Newtown, Building A Stronger System Of Mental Health Services

October 13, 2013 | by T. Rees Shapiro

Mental Health Program Helps Fairfax County Teens Cope

March 12, 2012 | by Kim Painter

Classes Teach 'First Aid' for Mental Health Crises

October 18, 2011 | For Your Health



What people are saying...

N.Y.U. has also added a **mental** health first aid training course. Employees who work in campus hot spots learn to identify mental illness symptoms as well as how to defuse a tense situation until help arrives. A hot spot is any place prone to frustrate, including the financial aid office, the bursar's office, and the registrar's office.

Attend a traditional first aid class, and you will learn checklists for assessing and responding to cuts, burns and strokes. [In **Mental Health First Aid**] students consider how they would respond to...a stranger having a panic attack, a friend expressing hopelessness, or a client distressed over an illness.

The New York Times

January 23, 2011



Take a Course. You could be the help someone needs.



Contact Us: Jennifer Treger jtreger@mhamd.org













Mental Health First Aid / Crisis Services

Brandon J. Johnson, MHS, State Coordinator, Suicide and Violence Prevention, Behavioral Health Administration



Suicide Prevention in Maryland: Promoting Hope & Prevention

Brandon J. Johnson, M.H.S.

State Coordinator, Suicide and Violence Prevention

Behavioral Health Administration



SUICIDE

IS A

MAJOR PUBLIC HEALTH CONCERN

THAT AFFECTS PEOPLE OF ALL AGES AND BACKGROUNDS

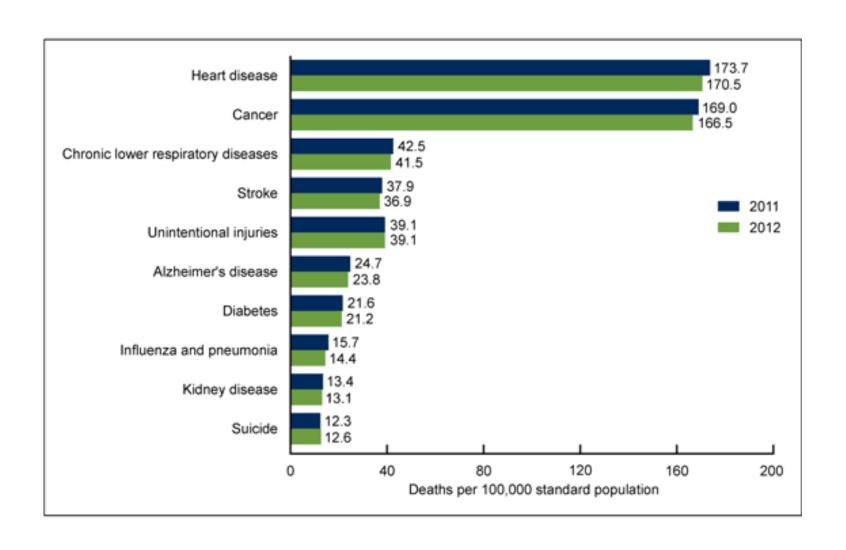
#EndSuicideMD



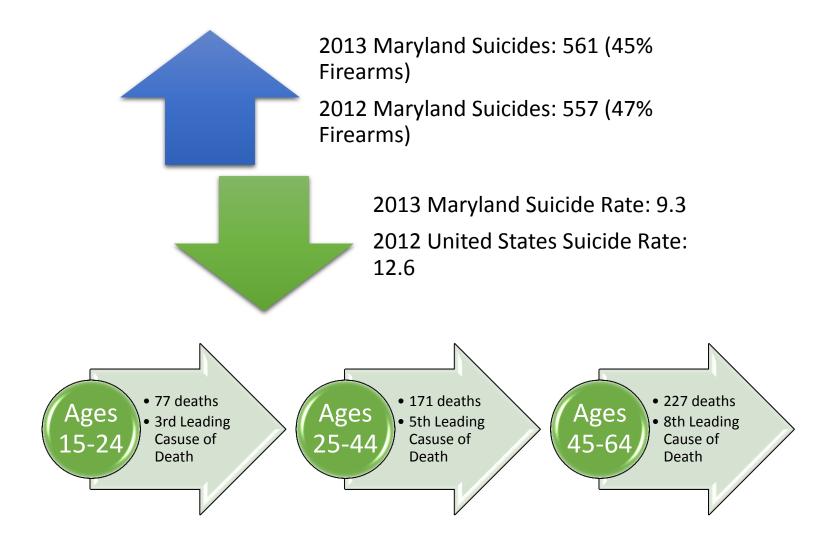
Major Public Health Problem

- Suicide was the 10th leading cause of death for all ages in 2012.
- There were 40,600 suicides in 2012 in the United States—an average of 111 each day.
- The total suicide rate for 2012 was 12.6 per 100,000 people, a slight increase from 2011 (12.3)
- People with depression are 20% more likely to attempt suicide
- About 2/3 of every person who completes a suicide is depressed at the time of death

10 leading causes of death: US, 2012



Maryland Suicide Statistics



10 Leading Causes of Death by Age Group, United States - 2012

	Age Groups										
Rank	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65+	Total
1	Congenital Anomalies 4,939	Unintentional Injury 1,353	Unintentional Injury 743	Unintentional Injury 807	Unintentional Injury 11,908	Unintentional Injury 15,851	Unintentional Injury 15,034	Malignant Neoplasms 48,028	Malignant Neoplasms 113,130	Heart Disease 477,840	Heart Disease 599,711
2	Short Gestation 4,202	Congenital Anomalies 501	Malignant Neoplasms 440	Malignant Neoplasms 472	Suicide 4,872	Suicide 6,216	Malignant Neoplasms 11,337	Heart Disease 35,265	Heart Disease 71,228	Malignant Neoplasms 403,497	Malignant Neoplasms 582,623
3	SIDS 1,679	Malignant Neoplasms 392	Congenital Anomalies 167	Suicide 306	Homicide 4,614	Homicide 4,342	Heart Disease 10,489	Unintentional Injury 20,394	Unintentional Injury 15,822	Chronic Low. Respiratory Disease 122,375	Chronic Low. Respiratory Disease 143,489
4	Maternal Pregnancy Comp. 1,507	Homicide 339	Homicide 138	Homicide 173	Malignant Neoplasms 1,574	Malignant Neoplasms 3,674	Suicide 6,758	Liver Disease 8,877	Chronic Low. Respiratory Disease 15,212	Cerebro- vascular 109,127	Cerebro- vascular 128,546
5	Unintentional Injury 1,169	Heart Disease 154	Heart Disease 67	Congenital Anomalies 160	Heart Disease 956	Heart Disease 3,231	Homicide 2,705	Suicide 8,862	Diabetes Mellitus 12,553	Alzheimer's Disease 82,690	Unintentional Injury 127,792
6	Placenta Cord. Membranes 1,018	Influenza & Pneumonia 93	Chronic Low. Respiratory Disease 63	Heart Disease 108	Congenital Anomalies 423	HIV 652	Liver Disease 2,469	Diabetes Mellitus 5,747	Cerebro- vascular 11,230	Diabetes Mellitus 52,881	Alzheimer's Disease 83,637
7	Bacterial Sepsis 566	Septicemia 62	Benign Neoplasms 47	Chronic Low Respiratory Disease 56	Diabetes Mellitus 196	Diabetes Mellitus 646	Diabetes Mellitus 1,867	Cerebro- vascular 5,654	Cerebro- vascular 11,070	Unintentional Injury 44,698	Diabetes Mellitus 73,932
8	Respiratory Distress 504	Cerebro- vascular 56	Influenza & Pneumonia 44	Cerebro- vascular 51	Cerebro- vascular 183	Liver Disease 597	Cerebro- vascular 1,730	Chronic Low. Respiratory Disease 4,533	Suicide 6,929	Influenza & Pneumonia 43,355	Influenza & Pneumonia 50,636
9	Circulatory System Disease 492	Benign Neoplasms 55	Cerebro- vascular 34	Influenza & Pneumonia 41	Complicated Pregnancy 169	Cerebro- vascular 535	HIV 1,345	HIV 2,582	Septicemia 4,982	Nephritis 37,740	Nephritis 45,622
10	Neonatal Hemorrhage 422	Chronic Low Respiratory Disease 51	Septicemia 26	Benign Neoplasms 40	Influenza & Pneumonia 147	Congenital Anomalies 401	Septicemia 757	Septicemia 2,340	Nephritis 4,765	Septicemia 27,022	Suicide 40,600

Data Source: National Vital Statistics System, National Center for Health Statistics, CDC. Produced by: National Center for Injury Prevention and Control, CDC using WISQARS™.



10 Leading Causes of Injury Deaths by Age Group Highlighting Violence-Related Injury Deaths, United States – 2012

	Age Groups										
Rank	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65+	Total
1	Unintentional Suffocation 965	Unintentional Drowning 415	Unintentional MV Traffic 339	Unintentional MV Traffic 407	Unintentional MV Traffic 6,910	Unintentional Poisoning 7,737	Unintentional Poisoning 7,899	Unintentional Poisoning 10,340	Unintentional Poisoning 5,431	Unintentional Fall 24,190	Unintentional Poisoning 36,332
2	Homicide Unspecified 170	Unintentional MV Traffic 357	Unintentional Drowning 141	Suicide Suffocation 195	Homicide Firearm 3,931	Unintentional MV Traffic 5,949	Unintentional MV Traffic 4,620	Unintentional MV Traffic 5,359	Unintentional MV Traffic 4,543	Unintentional MV Traffic 6,378	Unintentional MV Traffic 34,935
3	Unintentional MV Traffic 68	Homicide Unspecified 153	Unintentional Fire/Burn 74	Homicide Firearm 124	Unintentional Poisoning 3,175	Homicide Firearm 3,427	Suicide Firearm 2,924	Suicide Firearm 4,113	Suicide Firearm 3,747	Suicide Firearm 4,796	Unintentional Fall 28,753
4	Homicide Other Spec., Classifiable 43	Unintentional Suffocation 138	Homicide Firearm 67	Unintentional Drowning 109	Suicide Firearm 2,218	Suicide Firearm 2,760	Suicide Suffocation 2,054	Suicide Suffocation 2,029	Unintentional Fall 2,168	Unintentional Unspecified 4,664	Suicide Firearm 20,666
5	Unintentional Drowning 43	Unintentional Fire/Burn 101	Unintentional Suffocation 34	Suicide Firearm 104	Suicide Suffocation 1,882	Suicide Suffocation 2,085	Homicide Firearm 1,887	Suicide Poisoning 1,974	Suicide Poisoning 1,485	Unintentional Suffocation 3,403	Homicide Firearm 11,622
6	Undetermined Suffocation 41	Unintentional Pedestrian, Other 98	Unintentional Other Land Transport 24	Unintentional Suffocation 45	Unintentional Drowning 540	Suicide Poisoning 852	Suicide Poisoning 1,251	Unintentional Fall 1,344	Suicide Suffocation 1,172	Unintentional Poisoning 1,655	Suicide Suffocation 10,088
7	Homicide Suffocation 26	Unintentional Struck by or Against 52	Unintentional Poisoning 21	Unintentional Other Land Transport 43	Homicide Cut/Pierce 386	Undetermined Poisoning 557	Undetermined Poisoning 640	Homicide Firearm 1,181	Unintentional Suffocation 677	Adverse Effects 1,639	Suicide Poisoning 6,729
8	Undetermined Unspecified 26	Homicide Other Spec., Classifiable 46	Homicide Unspecified 18	Unintentional Fire/Burn 36	Suicide Poisoning 364	Homicide Cut/Pierce 437	Unintentional Fall 458	Undetermined Poisoning 881	Homicide Firearm 589	Unintentional Fire/Burn 1,021	Unintentional Suffocation 6,238
9	Unintentional Natural/ Environment 19	Homicide Firearm 45	Unintentional Pedestrian, Other 18	Unintentional Poisoning 30	Undetermined Poisoning 247	Unintentional Drowning 433	Unintentional Drowning 370	Unintentional Drowning 533	Unintentional Fire/Burn 493	Suicide Poisoning 799	Unintentional Unspecified 5,915
10	Unintentional Fire/Burn 17	Unintentional Natural/ Environment 39	Unintentional Struck by or Against 17	Unintentional Firearm 22	Unintentional Fall 218	Unintentional Fall 319	Homicide Cut/Pierce 351	Unintentional Suffocation 451	Undetermined Poisoning 467	Suicide Suffocation 667	Unintentional Drowning 3,551

Data Source: National Center for Health Statistics (NCHS), National Vital Statistics System. Produced by: National Center for Injury Prevention and Control, CDC using WISQARS™.



At-Risk Populations

- Youth (Bullying)
- Males
- Unemployed
- Lesbian, gay, bi-sexual, transgendered, questioning
- Older adults
- Victims of human trafficking



Risk Factors

- Depression
- Difficult life events (loss of a loved one, divorce, accident etc.)
- Previous suicide attempt
- Substance abuse
- History of physical, sexual, and/or emotional abuse
- Stressful home environments
- Family history of depression
- Access to firearms
- Poor adaptability (Youth)
- Mental Illness
- Member of LGBTQ community

Comorbidities and Chronic Mental Illness

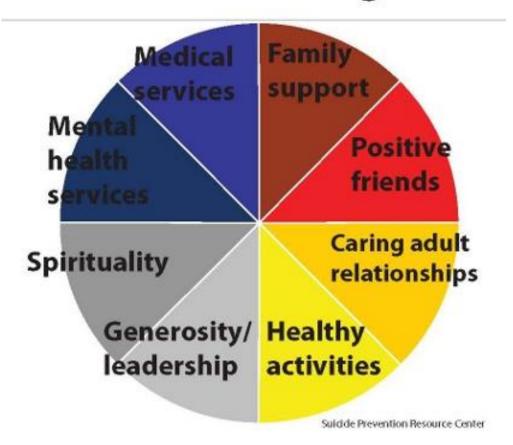
- Major Depression increases risk of suicide and is often a common comorbidity to suicide
- Post-traumatic stress disorder (PTSD)

 (especially after event causing TBI) increases a person's risk for suicide
- Substance abuse increases risk of suicide
 - Alcohol is a depressant
 - Substance use increases impulsivity
 - Drastic increase in substance use is an indicator of suicidal ideation

SUICIDE IS PREVENTABLE!!!

Network of Support

Sources of strength



Know the Signs!

Behavioral Signs

- Previously attempted suicide
- Increased substance abuse
- Increased talk around death and dying
- Removing themselves from friends and social activities
- Giving away prized possessions
- Becoming very irritable or aggressive
- Becoming reckless or impulsive
- Drastic change in mood or demeanor

Know the Signs!

Verbal Cues

- "I don't want to keep living."
- "You all would be better off without me."
- "I wish I could just disappear."
- "You won't have to worry about me much longer."
- "Who cares if I'm dead anyway?"
- "I feel like I want to kill myself."

How to Help...

Ask the question!

- "What you said just worried me...are you thinking about hurting yourself?"
- "Do you wish you could go to sleep and not wake up?"
- "Have you been extremely unhappy with life lately?"
- "Are you planning to kill yourself?"
- Be direct in your questioning
- Ask if there is a plan in place

State Initiatives and Practices

Governor's Commission on Suicide Prevention

- Created in 2009, first State Plan created in 2012
- New State Plan coming before the end of 2015
- New target populations
 - Disconnected Youth
 - Bullying Prevention
 - Co-occurring substance use disorders
 - Individuals with lived experience (loss & attempt)
- Continued work with
 - Veterans
 - LGBTQ
 - Youth through school-based initiatives



Suicide Prevention and Early Intervention Network

SAMHSA funded grant for 2014-2019 \$735,000/year

Goal of MD-SPIN:

Reduce premature loss of lives from suicide by increasing the number of at-risk youth who are identified, referred and receive quality behavioral health services.

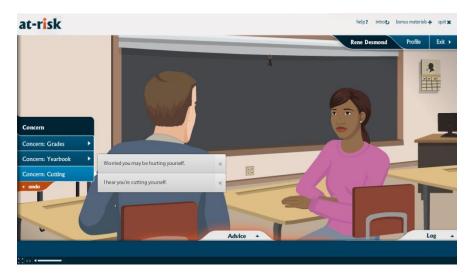
Kognito Training

- Online Avatar based interactive training
- Evidence-based practice
- Various versions available to train faculty, staff and students and different population groups
- 30-60 minute trainings
- Available at no cost to user during this project
- http://kognito.com/maryland

At-Risk Suite for K-12 Educators



- Online 24/7; 50 60 minutes
- Virtual role-play conversations with at-risk "emotionally active" student avatars
- Created in collaboration with school and mental health experts and educators
- Deliberate practice and personalized feedback
- Listed: SPRC/AFSP Best Practice Registry



- Listed: National Registry of Evidence-Based Programs and Practices (HS only)
- Effectiveness demonstrated in national empirical studies (HS only)
- Widespread adoption over 100,000 teachers in Texas, NY, Arizona, Ohio (HS only)

Suicide Prevention Resources

Maryland Crisis Hotline
 Network: 1-800-422-0009

 National Suicide Prevention Lifeline: 1-800-273-8255

 Suicide Prevention Website http://dhmh.maryland.gov/suic ideprevention/SitePages/Home .aspx





Maryland Social Media for Suicide Prevention

Facebook:

www.facebook.com/MDS uicidePrevention



Twitter: twitter.com/MDSuicidePr ev



Behavioral Health Administration Office of Child and Adolescent Services

Brandon J. Johnson, M.H.S.

State Coordinator, Suicide and Violence Prevention

Phone: 410-402-8313

brandon.johnson@maryland.gov









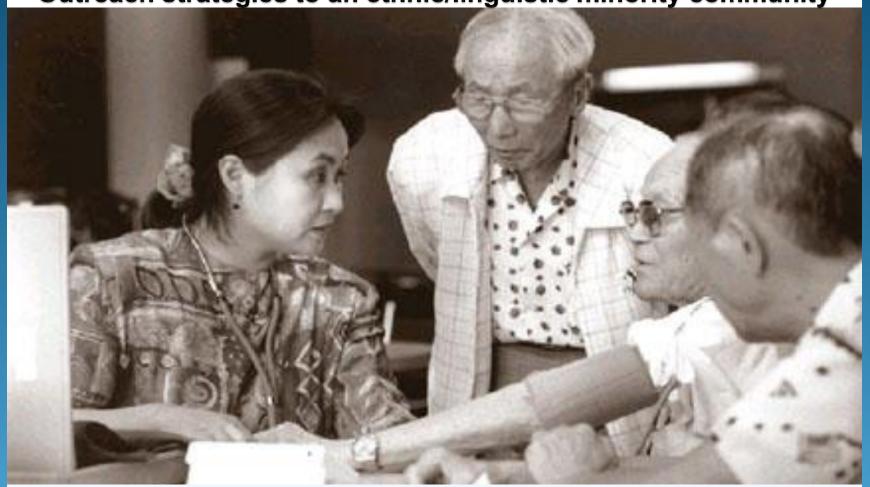
Recognition and Prevention Strategies in Minority Communities

Kim B. Kim, PhD, CEO/President, Korean Resource Center

innovative Community

Engagement

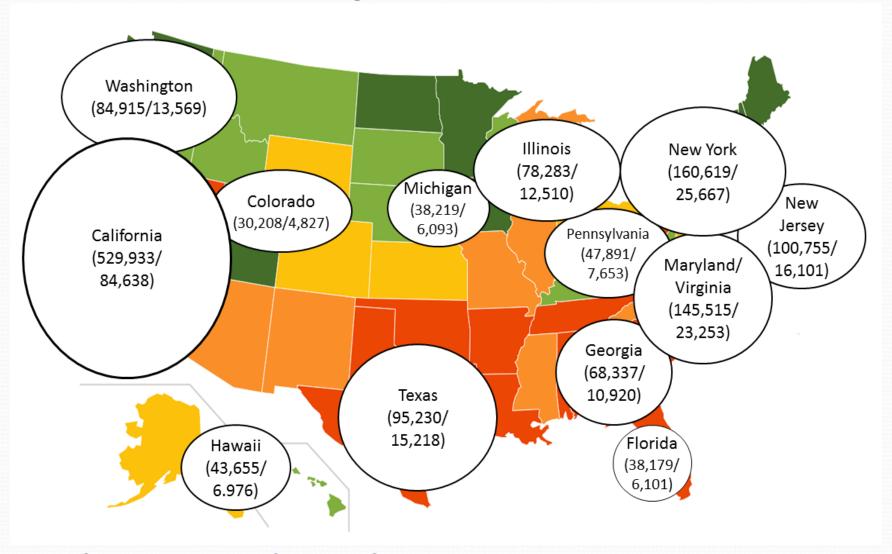
Outreach strategies to an ethnic/linguistic minority community



Maryland Department of Health and Mental Hygiene
2016 Health Disparities Conference
October 28, 2015
Martin's West, Baltimore

Kim B. Kim, Ph.D Korean Resource Center 10328 Baltimore National Pike, Ellicott City, MD 21042 Email: kbkim@ikorean.org

States with Largest Korean Americans



Data Source: The American Community Survey, 2008-2012

Korean Americans in Maryland

- More than 60,000 (1% Marylanders) (Montg., Howard, PG, BC, AA, B-City)
- 1st generation immigrants
- Family owned/operated small business (
- grocery, carry-out, dry cleaner, liquor, mechanic)
- > 15.5% of the total Asian Americans (3rd)
- Before ACA, 30%-45% adults without health insurance, (now est. 15-20%)

Studies Indicate...

- High prevalence of chronic conditions (hypertension, diabetes, depression, etc.)
- Low healthcare utilization (KA: lowest among ethnic groups)
- Many KA seniors not qualified for Medicare/ Medicaid (lack of points) & left out without a health insurance
- Lack of institutional support/cultural understanding of this linguistic/ethnic minority

Barriers to Adequate Health Care

Individual

- Language
- Transportation
- Fear or being intimidated by main health care system



Care

Psychological

- Feeling of marginalization
- Loss of self-confidence
- Role conflict/dependency on others
- "Do not want to be a burden to family"Depression



Environmental/financial

- Safety
- Cost of medication
- Access to health care

Innovative Community Engagement

-Korean Resource Center-

- Leading community-based agency for healthcare research/ education
- <u>Mission</u>: To reduce health disparities and to improve quality of life in the Korean American community
- Goals: To find best-practice community-based management solutions to chronic disease (diabetes, hypertension, CVD, depression, cancer screening, smoking/drugs) -> culturally/individually tailored self-help management solution
- Theoretical Framework: Community-based participatory research (CBPR), Translational Research & Self-help
- Strategies: (1) Partnership with universities/public agencies; (2) community health workers (CHWs) training and empowerment



KA Community Assets

- 176 faith-based organizations
- 19 Sunday schools
- 173 healthcare clinics
- 9 supermarkets
- 25 trade associations
- 33 hobby/social clubs

Outreach! Outreach! Outreach

In partnership with faithbased/community-based organizations, and associations in KA community



Education in the Community



Community Health Workers (CHW)



Clinical Trials/Research Projects (selected)

2009-2016	Better Diabetes Care for Korean Americans (R18). Funding agency: NIH National Institute of Diabetes, Digestive and Kidney
2009-2014	Breast/Cervical Cancer Screening for Korean American Women (RO1). Funding agency: National Cancer Institute)
2006-2012	Better Hypertension Care for Korean American Seniors (RO1). Funding agency: NIH National Heart, Lung and Blood Institute
2008-2012	Depression and Dementia Surveillance Study. Funding Agency: American Alzheimer Association
2007-2009	Better Diabetes Care for Korean Americans: a Pilot Study (R34). Funding agency: Agency for Healthcare Research and Quality
2004-2006	<u>Hypertension Care for Korean American Seniors</u> (R21). Funding agency: Agency for Healthcare Research and Quality
2005-2006	Women's Health Initiative (Breast/Cervical Cancer) (R21). Funding Agency: American Cancer Society

Education/Service Projects (selected)

2013-2017	Health Insurance Education and Enrollment Assistance. Sponsors: Maryland Department of Health and Mental Hygiene, the Healthy Howard
2002-2015	Smoking Cessation Initiative in the Korean American Community. Sponsors: American Legacy Foundation, Howard County Health Department, Baltimore City Health Department, Harford County Health Department, Baltimore County Health Department
2006-2008	Innovative Smoking Cessation Program. Sponsor: American Legacy Foundation
2012-2014	Korean Meals on Wheels. Sponsor: Meals on Wheels of Central Maryland
2005-2013	Free Prescription Drug for Low-Income and Uninsured Family. Sponsor: Maryland MedBank
2005-2011	Medical Interpreter Training for Korean Americans. Sponsors: General Hospitals in Maryland
2008-Present	t CPR Training for Korean Americans. Sponsors: Red Cross of Central Maryland
2003-2006	Business and Educational English for Korean American Businee and Parent. Sponsor: Baltimore County Community College

Publications (Selected from 32 Articles)

- Kim MT, Kim KB (Corresponding Author), Huh B, Nguyen T, Han HR, Bone L, Levine D. (2015). The effect of a community-based multimodal behavioral self-help intervention program in Korean Americans with type 2 diabetes. Am Journal of Preventive Medicine. (In Press).
- Kim MT, Kim KB (Corresponding Author), Han HR, Huh BY, Nguyen T, Lee HB. (2015). Prevalence and Predictors of Depression in Korean American Elderly: Findings from the Memory and Aging Study of Koreans (MASK). American Journal of Geriatric Psychiatry. Online ahead of print: doi:10.1016/j.jagp.2014.11.003
- **Kim KB**, Han HR, Huh BY, Nguyen T, Lee HB, Kim MT. (2014). The effect of a community-based self-help multimodal behavioral intervention in Korean American seniors with high blood pressure. American Journal of Hypertension. 27(9): 1199-1208.
- Han HR, Park SY, Song HJ, Kim MT, **Kim KB**, Lee HB. (2013). Feasibility and validity of dementia assessment by trained community health workers based on Clinical Dementia Rating. Journal of the American Geriatrics Society. Jul;61(7):1141-5. Epub 2013 Jun 3.
- Lee HB, Han HR, Huh BY, **Kim BK**, Kim MT. (2013). Mental Health Service Utilization among Korean Elders in Korean Churches: Preliminary Findings from the Memory and Aging Study of Koreans in Maryland (MASK-MD). Aging and Mental Health, 2014; 18:1, 102-109.

Educational Materials (Selected)

- <u>Diabetes Care Manual</u> (225p, English/Korean)
- <u>Diabetes Care Training Presentation</u> (6 sessions for 12 hours, English/Korean)
- Community Health Worker Training Manual (150p, English/Korean)
- High Blood Pressure Self-Care Manual (140p, English/Korean)
- Smoking Cessation Manual (185p, Korean)
- Medicare & Me (Korean, annual update)

A Showcase of CBPR

"Better Diabetes Care for Korean Americans"

- A comparative effectiveness clinical trial funded by the National Institute of Diabetes and Digestive and Kidney Diseases (R18 DK083936) (PI: Miyong T. Kim; Site PI: Kim B. Kim), 2009-2016
- Enroll 250 KAs with type 2 diabetes (HbA1c ≥ 7.0%) in MD,
 Northern VA
- <u>Intervention</u>:
 - 1. 6 sessions of 2 hour each (total 12 hours) classroom education on health literacy, DM management skills (diet, exercise, medication, stress management)
 - 2. Home monitoring of blood sugar (for 12 months)
 - 3. Telephone motivational counseling by a team of RNs/CHWs (once a month for 12 months)

Recruitment/Enrollment

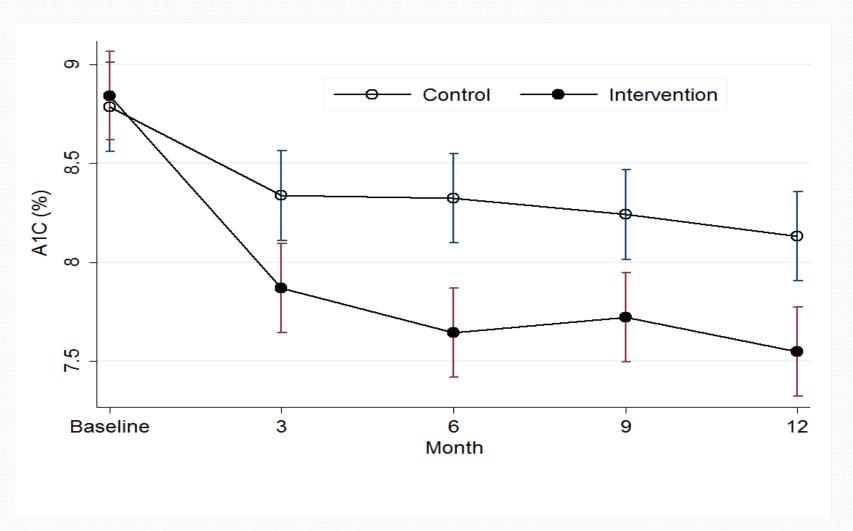
- Used 3-phase screenings
- 1. RBS
 - 35 times to 32 churches (1,986 RBS tests)
 - 2 trade meetings (57 tests)
 - 1 Korean festival (75 tests)
 - A screening booth at a supermarket (86 days- 2,414 RBS tests)
 - Walk-ins
- A1C+ Now
- ICTR lab test of HbA1c

Recruitment/Enrollment Outreach (n=4,457) RBS Media campaign 32 Churches (n= 1,986) Referral (PCP) 86 outreach to a supermarket (n=2,414) Screening Word of mouth 2 outreach to trade assoc. meetings (n=57) Call/Walk in KRC: Having DM/on RBS >200 after meal/fasting RBS A1C DM medication (n=189) >120/on DM medication (n=408) + MON Ineligible (A1c< 6.8) (263) Screened (n= 597) Spouse already enrolled (2) Refuse to give personal info (3) No ride (2); In other program (1) Screened (n= 303) Out of contact (2) Dementia (2); Sick (2) Ineligible (A1c<7.0) (47) Too busy (3) Abnormal lab report (2) Mission trip/travel (2) Refuse (4) Refuse (12) Randomization (n=250)

Source: Kim MT, **Kim KB, et al.** The effect of a community-based multimodal behavioral self-help intervention program in Korean Americans with type 2 diabetes. Am Journal of Preventive Medicine. 2015 (in Press.) doi:10.1093/ajh/hpu041

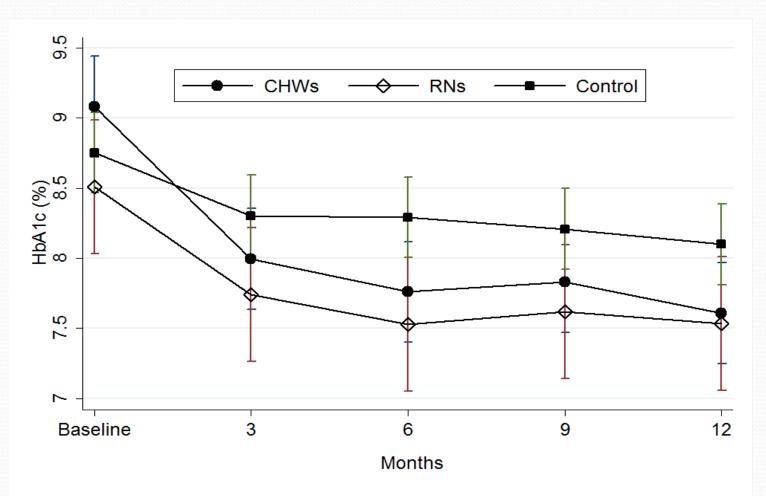
Outcomes

Figure. Changes in HbA1c Level for 12 months



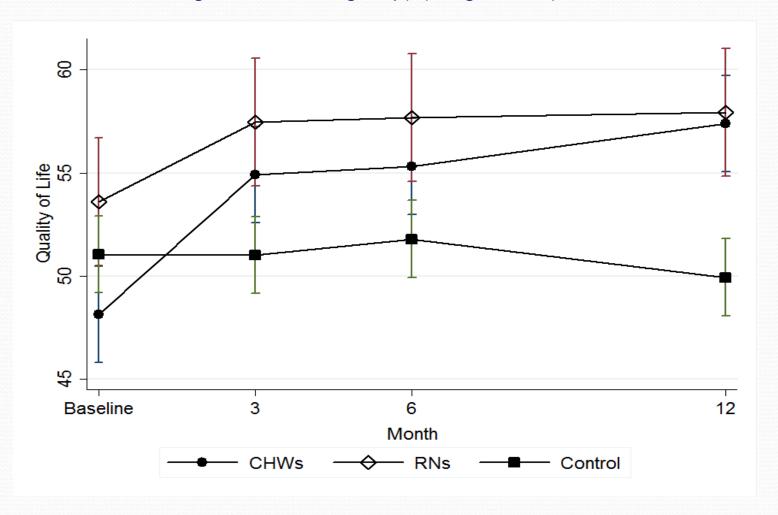
Outcomes

Figure. Changes in HbA1c Level for 12 months (RN-counseling, CHW-counseling, and control group)



Outcomes

Figure. Changes in quality of life score for 12 months (RN-counseling, CHW-counseling, and control group) (range: 0-75)



Lessons Learned & Promises

Keys to Innovative Community Engagement

- Equitable partnership (shared decision-making, equal resource sharing)
- Empower CHWs as a case manager

Are we ready?

- To empower clients/community to be the owner of their health (i.e., responsible for their health)
- To ascertain "Freedom from the fear of illness!"

Session Resource Kim B. Kim, PhD, CEO/President, Korean Resource Center

The Effect of a Community-Based Self-Help Multimodal Behavioral Intervention in Korean American Seniors with High Blood Pressure

Kim B. Kim, ¹ Hae-Ra Han, ² Boyun Huh, ³ Tam Nguyen, ⁴ Hochang Lee, ⁵ and Miyong T. Kim⁶

Source: American Journal of Hypertension 27(9) September 2014

Background: Great strides have been made in improving heart health in the United States during the last 2 decades, yet these strides have not encompassed many ethnic minority populations. There are significant health disparity gaps stemming from both a paucity of valid research and a lack of culturally sensitive interventions. In particular, many Korean Americans with chronic illnesses encounter difficulty navigating the healthcare system because of limited health literacy.

Methods: The effect of a multimodal Self-Help Intervention Program on the Control of High Blood Pressure (HBP) was tested in a community-based clinical trial for Korean American seniors. Of 440 seniors enrolled, 369 completed the study (184 in the intervention group and 185 in the control group; mean age = 70.9 ± 5.3 years). The intervention group received 6 weekly educational sessions on HBP management skill building, including health literacy training, followed by telephone counseling and home blood pressure (BP) monitoring for 12 months.

Results: Findings support that the Self-Help Intervention Program on the Control of HBP was effective in controlling BP in this ethnic/linguistic minority

population. The BP control rates for the intervention and control groups were 49.5% vs. 43.2% at baseline, 58.5% vs. 42.4% at 6 months, 67.9% vs. 52.5% at 12 months, and 54.3% vs. 53.0% at 18 months. Significant changes were observed over time in some psychobehavioral outcomes, including self-efficacy for BP control, medication adherence behavior, HBP knowledge, and depression.

Conclusions The study findings suggest that the multimodal Self-Help Intervention Program on the Control of HBP is effective at promoting optimal HBP control for this ethnic/linguistic minority population.

The Effect of a Community-Based Self-Help Intervention Korean Americans with Type 2 Diabetes

Miyong T. Kim, PhD, RN,¹ Kim B. Kim, PhD,² Boyun Huh, PhD, RN,³ Tam Nguyen, PhD, RN,⁴ Hae-Ra Han, PhD, RN,⁵ Lee R. Bone, MPH, BSN,⁶ David Levine, MD⁷

Source: Am J Prev Med 2015;49(5):726-737

Introduction: Korean Americans are one of the most underserved ethnic/linguistic minority groups owing to cultural and institutional barriers; there is an urgent need for culturally competent diabetes management programs in the Korean American community for those with type 2 diabetes. The purpose of this study was to test the effectiveness of a community-based, culturally tailored, multimodal behavioral intervention program in an ethnic/linguistic minority group with type 2 diabetes.

Design: An RCT with waitlist comparison based on the Predisposing, Reinforcing, and Enabling Constructs in Education/environmental Diagnosis and Evaluation (PRECEDE)—Policy, Regulatory, and Organizational Constructs in Educational and Environmental Development (PROCEED) and self-help models. Data were collected between September 2010 and June 2013 and were analyzed in August—December 2014. Statistical significance was set at po0.05. Setting/participants: In a naturally occurring community setting, a total of 250 Korean Americans with type 2 diabetes were randomized into an intervention group (n½120) or a control group (n½130).

Intervention: The intervention consisted of key self-management skill-building activities through 12 hours of group education sessions, followed by integrated counseling and behavioral coaching by a team of RNs and community health workers.

Main outcome measures: Primary (clinical) outcomes were hemoglobin A1c, glucose, total cholesterol, and low-density lipoprotein at baseline and at 3, 6, 9, and 12 months. Secondary (psychosocial and behavioral) outcomes included diabetes-related quality of life, self-efficacy, adherence to diabetes management regimen, and health literacy.

Results: During the 12-month project, the intervention group demonstrated 1.0%–1.3% (10.9–14.2 mmol/mol) reductions in hemoglobin A1c, whereas the control group achieved reductions of 0.5%–0.7% (5.5–7.7 mmol/mol). The differences between the two groups were statistically significant. The intervention group showed statistically significant improvement in diabetes-related self-efficacy and quality of life when compared with the control group.

Conclusions: RN/community health worker teams equipped with culturally tailored training can be effective in helping an ethnic/linguistic minority group manage diabetes in the community.

Prevalence and Predictors of Depression in Korean American Elderly: Findings from the Memory and Aging Study of Koreans (MASK)

Miyong T. Kim, Ph.D., Kim B. Kim, Ph.D., Hae-Ra Han, Ph.D., Boyun Huh, Ph.D., Tam Nguyen, Ph.D., Hochang B. Lee, M.D.

Source: Am J Geriatr Psychiatry 23:7, July 2015

Objectives: To estimate the prevalence and identify the predictors of depression among community-dwelling Korean American elderly (KAE).

Design: A crosssectional descriptive epidemiological survey using a two-step sampling strategy to obtain a representative community sample.

Setting: The authors recruited study participants at religious, service, and business establishments in the KA community (26 churches, 6 senior centers, 2 medical daycare centers, 1 supermarket).

Participants: Community-dwelling first-generation KAE (N ¼ 1,118; mean age SD: 70.5 7.0 years; female: 67.2%).

Measurements: Trained bilingual nurses and community health workers interviewed participants face-to-face for demographic information, chronic conditions, and depression using the Korean versions of the Patient Health Questionnaire (PHQ-9K).

Results: 30.3% of KAEs were classified as having either mild (PHQ-9K score 5e9; N ½ 218, 19.5%) or clinical depression (PHQ-9K score 10; N ½ 120, 10.8%), respectively. One of seven KAE (N ½ 164, 14.7%) endorsed thoughts of death or self-injury, but only 63 (5.7%) reported utilizing mental health services. The authors also identified several predictors of depression, including living arrangement (living alone versus living with family/spouse); having chronic conditions such as diabetes, arthritis, digestive disorders, or chronic bronchitis; years of education; and cognitive impairment.

Conclusions: The authors' findings reveal a high prevalence of depression among KAE and a low level of mental health service utilization. Because there are urgent needs for culturally and contextually relevant interventions, the authors also discuss the feasibility of community-based interventions to reduce the burden of depression, which should be incorporated into a management system for multiple chronic conditions.









Recognition and Prevention Strategies in Minority Communities

Annelle B. Primm, MD, MPH, Senior Psychiatrist Advisor, Urban Behavioral Associates

Prevention and Social Determinants of Mental Health in Diverse and Underserved Populations

Maryland Office of Minority Health and Health Disparities 12th Annual Health Disparities Conference

Health is a State of Mind: Addressing Behavioral Health Disparities

October 28, 2015
Martin's West

Annelle B. Primm, M.D., MPH
Senior Psychiatrist Advisor
Urban Behavioral Associates
Baltimore, Maryland
Former Deputy Medical Director
American Psychiatric Association

Outline

- Population profiles and other indices by race
- Social determinants of mental health
- Examples of prevention strategies

Population Characteristics

	Baltimore City	Baltimore County	Maryland	US
Population	621,000	805,000	5.8 million	317 million
Black or African American (a)	64%	26%	29%	13%
Hispanic or Latino (b)	4%	4%	8%	17%
White (a) (White alone, not Hispanic)	30%	65%	58%	78% (63%)
Two or More Races	2%	2%	3%	2%
Asian (a)	2%	4%	6%	5%

⁽a) Persons reporting only one race (b) Hispanics may be of any race, so also are included in applicable race categories. (c) American Indian and Alaska Native and Native Hawaiian and Other Pacific Islander – less than 1%. Sources: US Census

Population Characteristics

	Zip 21215	Zip 21216	Zip 21217
Population	60,161	32,071	37,111
Black or African American (a)	82%	97%	87%
Hispanic or Latino (b)	2%	1%	1%
White (a) (White alone, not Hispanic)	15%	1%	10%
Two or More Races	1%	2%	2%
Asian (a)	1%	<1%	1%

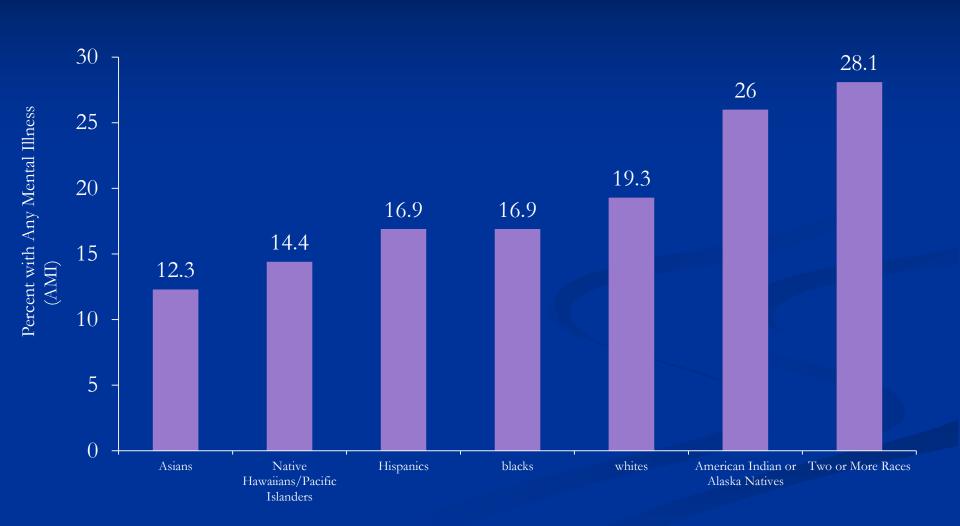
⁽a) Persons reporting only one race (b) Hispanics may be of any race, so also are included in applicable race categories. (c) American Indian and Alaska Native and Native Hawaiian and Other Pacific Islander – less than 1%. Sources: US Census

Population Characteristics

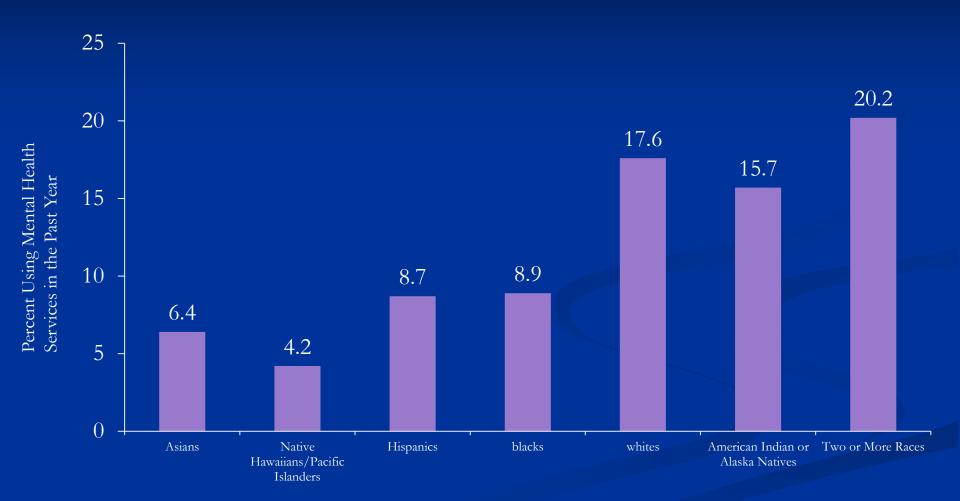
	Zip 21215	Zip 21216	Zip 21217	Balt. City	Balt. Co.	MD
Persons under 18	23%	18%	26%	22%	22%	23%
Persons 65 and older	17%	15%	11%	12%	15%	12%
Foreign born	10%	1%	3%	7%	11%	14%
High school graduate or higher	78%	77%	74%	80%	90%	89%

Source: US Census, 2010

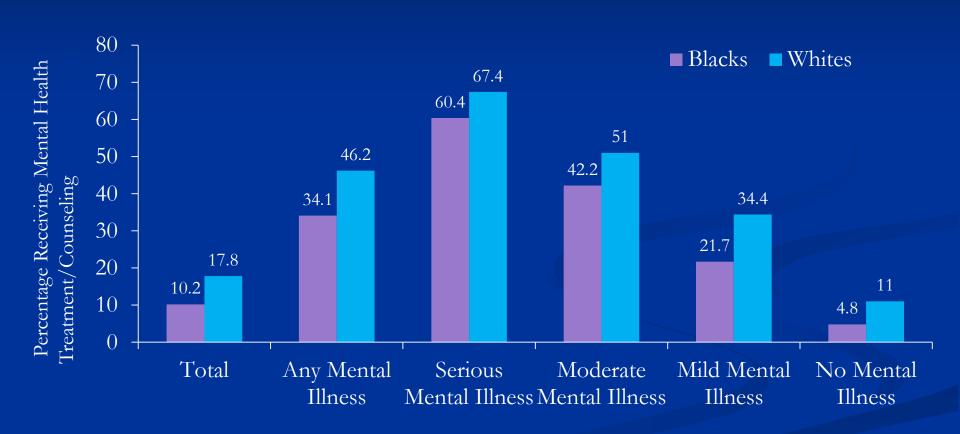
Percentage of Any Mental Illness in the Past Year Among Adults Aged 18 or Older by Race or Ethnicity: 2013



Percentage of Adults Aged 18 or Older Using Mental Health Services in the Past Year by Race or Ethnicity: 2013



Received Mental Health Treatment/Counseling in the Past Year among Blacks and Whites, Aged 18 or Older, by Past Year Level of Mental Illness Percentages, 2012



Percent with Unmet Mental Health Care Needs in Past 12 Months

Baltimore City, 2009

23%
33.4 %
8.5 %
28.6 %
7.8 %

Source: 2009 Baltimore City Community Health survey

	2012
	Percent
Baltimore City	22.96%
Maryland	15.76%
Black	26.54%
White	14.66%
Men	23.28%
Women	22.72%
<hs< th=""><th>44.65%</th></hs<>	44.65%
HS Grad or Equiv	26.92%
College Graduate	9.80%
Income <\$15,000	40.05%
\$15,000-24,999	39.39%
\$25,000-49,999	26.88%
\$50,000-74,999	10.38%
>=\$75,000	6.52%

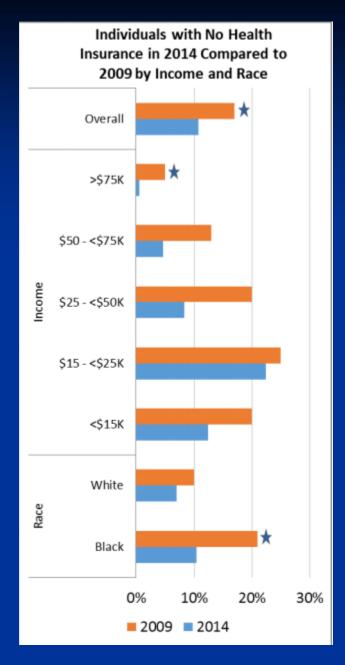
Fair or Poor Health Status

Baltimore City Health Disparities Report Card, 2013; data from Maryland Behavior Risk Factor Surveillance System

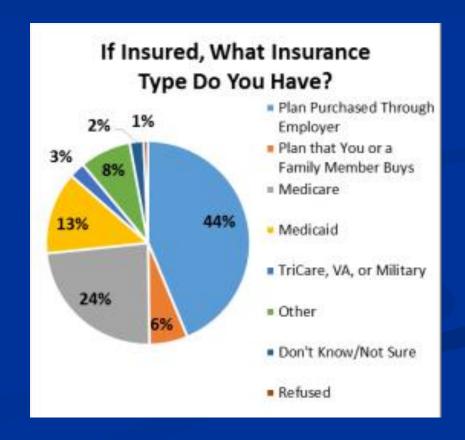
	2012
	Percent
Baltimore City	15.54%
Maryland	13.79%
Black	16.40%
White	14.58%
Men	6.52%
Women	22.40%
<hs< th=""><th>13.87%</th></hs<>	13.87%
HS Grad or Equiv	18.77%
College Graduate	10.99%
Income <\$15,000	27.11%
\$15,000-24,999	21.31%
\$25,000-49,999	7.63%
\$50,000-74,999	18.08%
>=\$75,000	8.57%

Mental Health Not Good

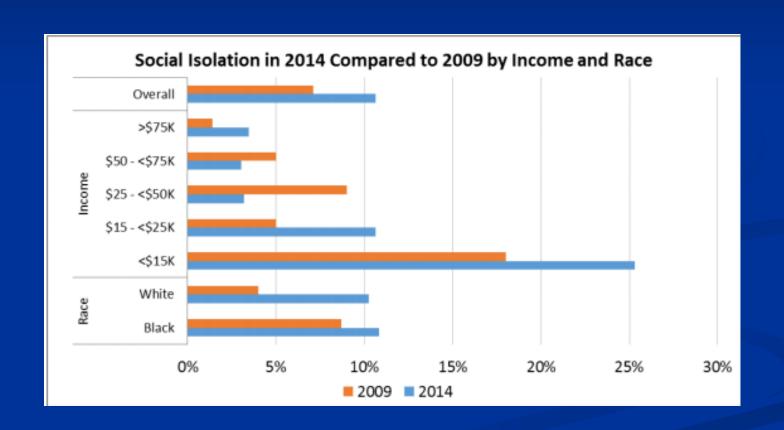
Baltimore City Health Disparities Report Card, 2013; data from Maryland Behavior Risk Factor Surveillance System



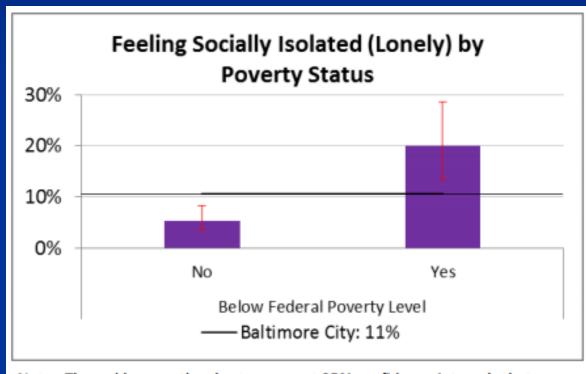
Health Insurance – Baltimore City



Social Isolation-Baltimore City



Social Isolation-Baltimore City



Income is a strong predictor of social isolation

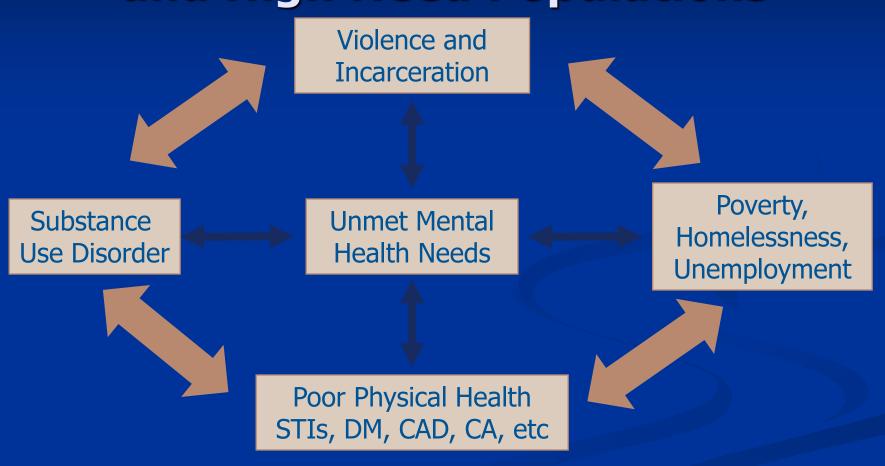
Note: The red bars on the chart represent 95% confidence intervals that estimate the precision of each calculation.

Social Determinants of Mental Health

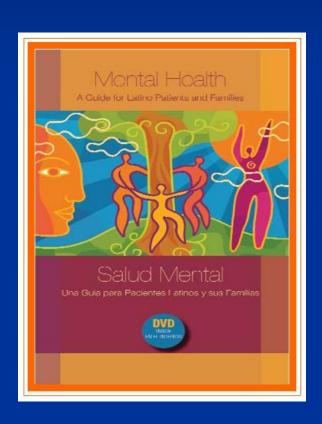
- Discrimination and Social Exclusion
- Adverse early life experiences
- Poor education
- Unemployment, underemployment and job insecurity
- Income inequality, poverty and neighborhood deprivation
- Food insecurity
- Poor housing quality and housing instability
- Adverse features of the built environment
- Poor access to health care

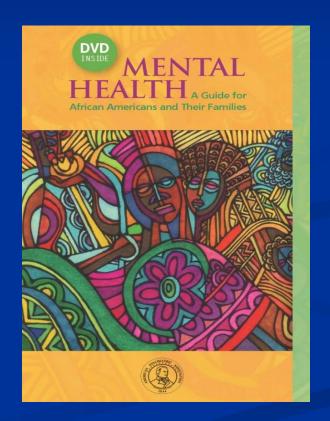
Compton MT, Shim RS, The Social Determinants of Mental Health, 2015, American Psychiatric Press

Vicious Cycle Social Determinants of Health and High Need Populations



Prevention Strategies: Public Education Tools





Community-Based Prevention Strategy

- Emotional Emancipation Circles developed by the Community Healing Network, www.communityhealingnet.org
- Helping members of the black community cope with the trauma associated with racism and related stressors

Examples of Prevention Strategies

- Oh Happy Day, Depression Support Group for African Americans, developed by Earlise Ward, PhD, Univ. of Wisconsin Milwaukee, supported by NIMHD
- Montefiore Health System Care Management and ACO focus on Hispanic and other groups
- Culturally Centered Integrative Care for Addressing Mental Health Disparities, Morehouse School of Medicine, Satcher Health Leadership Institute, (Holden et al, 2014)
- Charles B. Wang Community Health Center, Bridge Program, Chinatown, NYC mental health services in primary care
- Family Spirit Intervention utilizing community health workers to educate teen mothers (Barlow, et al 2015)

THANK YOU









Recognition and Prevention Strategies in Minority Communities

Carlos Hardy, MHS, Founder and Chief Executive Officer, Maryland Recovery Organization Connecting Communities





The Broader the Base....

The Higher the Pyramid

Maslow's Hierarchy of Need

/ self- \actualization

morality, creativity, spontaneity, acceptance, experience purpose, meaning and inner potential

self-esteem

confidence, achievement, respect of others, the need to be a unique individual

love and belonging

friendship, family, intimacy, sense of connection

safety and security

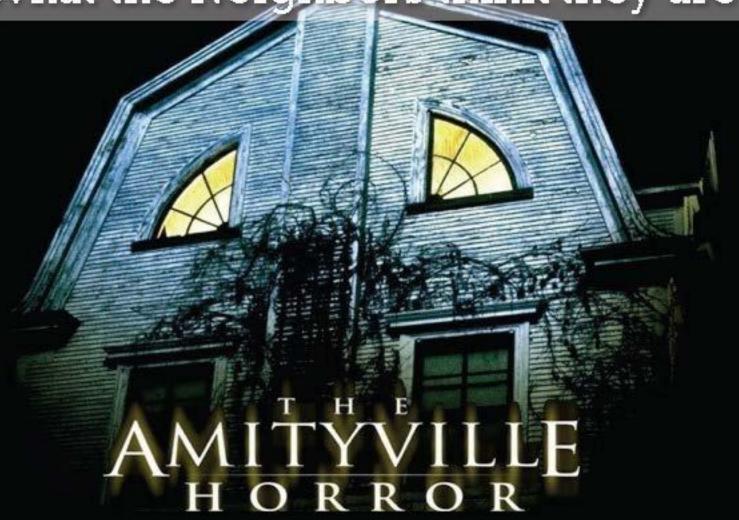
health, employment, property, family and social stability

physiological needs

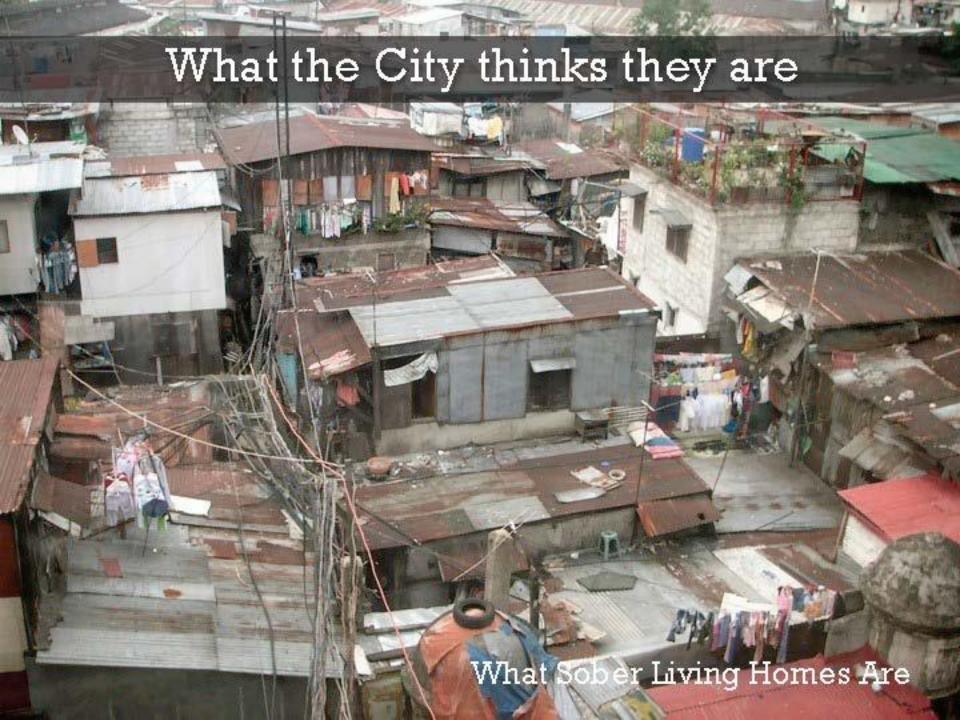
breathing, food, water, shelter, clothing, sleep

What do people think about sober housing?

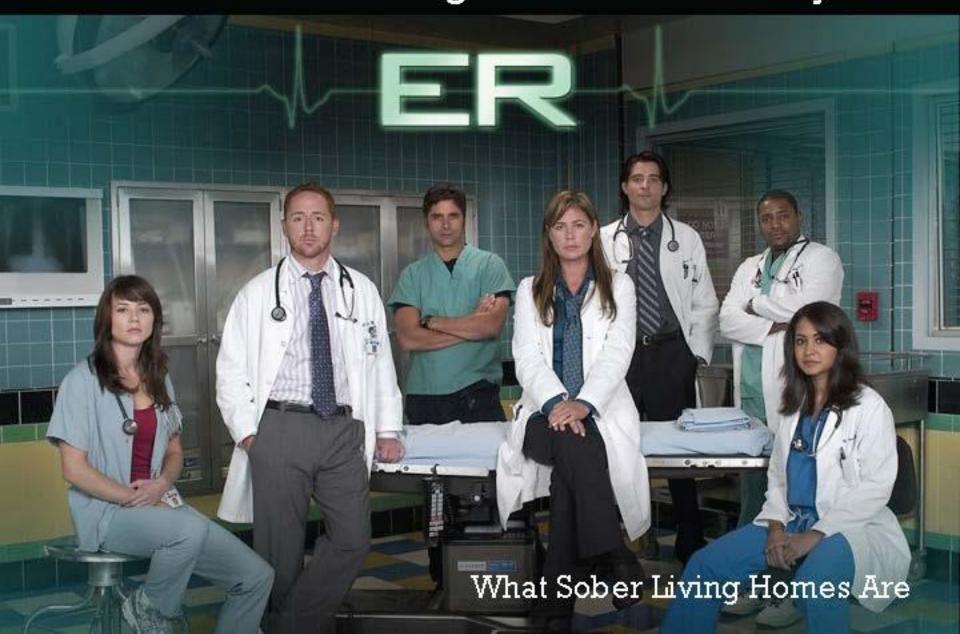
What the Neighbors think they are



What Sober Living Homes Are



What Placement Agencies think they are









Maryland State Association for Recovery Residences – (M-SARR)



Maryland State Association for Recovery Residences (M-SARR)





Maryland State Association for Recovery Residences (M-SARR)













Recognition and Prevention Strategies in Minority Communities

Enrique Olivares, MD, FAAP, Director of Addictions, ValueOptions

Behavioral Health and SUD Disparities Among Latino Populations: "Que Pasa?"

ENRIQUE B. OLIVARES, MD, FAPA, DABAM
DIRECTOR OF ADDICTION SERVICES
BEACON HEALTH OPTIONS

Objectives

Learn the geographical distribution and racial composition of the 3 main ethnic groups in Maryland: Mexicans, Central-Americans and Puerto-Ricans

Describe the main types of anxiety-disorders, mood disorders and substance abuse disorders and their epidemiology among the prevalent Latino groups in the State

Describe 3 culturally-appropriate interventions that will facilitate the treatment of Latinos in your practice or organization

Latinos in the US

Current percentage of the population 17.1% or 54 million. Projection for 2060 is 129 million or 31% of the population

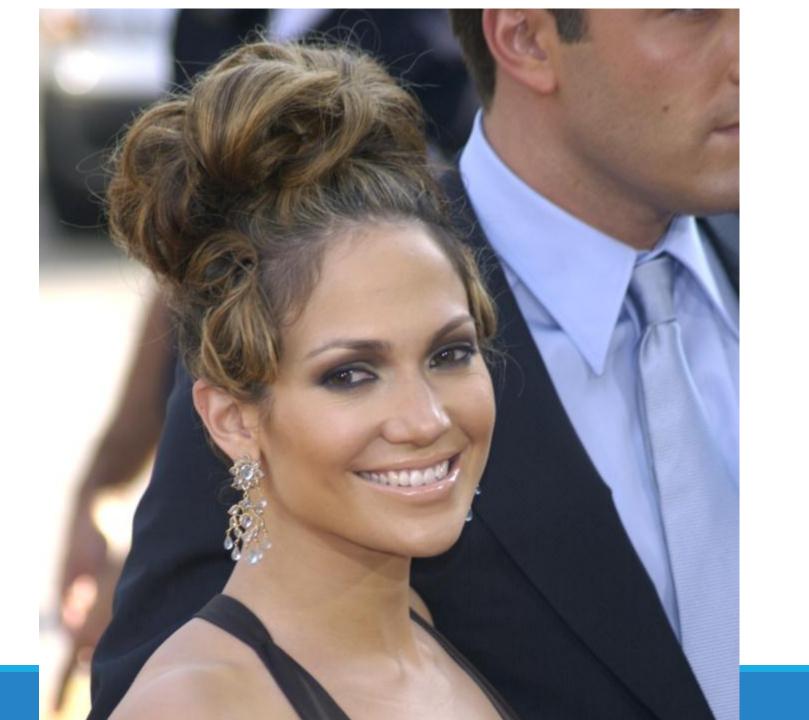
Of all the countries in the world, only Mexico has more Latinos than the US

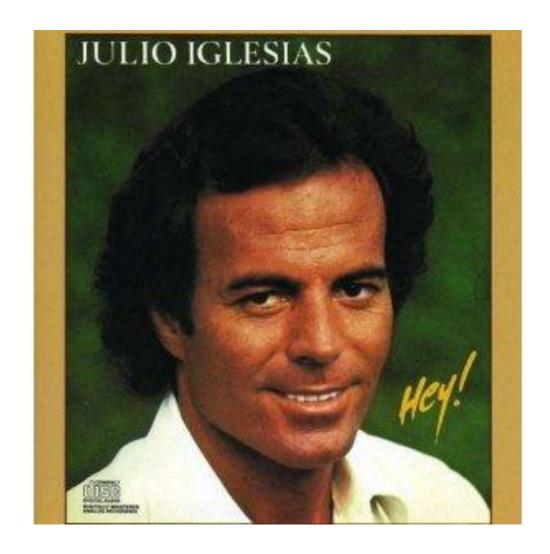
Texas, New Mexico and California concentrate the majority of Latinos in the US. 47% of the population of New Mexico are Latinos

In 2008, Latinos owned 8.3% of the firms in the US

63% of Latinos obtain a HS diploma, 13% graduate from college

1.2 million Latinos are veterans of the armed forces





Health Data Highlights

In 2010 Latinos in Maryland accounted for 8.2 % of the population

The population of Latinos in Maryland doubled from 2000-2010

Latinos are younger than the overall Maryland population

There are more Latino men than women

41% spoke English less than "very well"

40% were not US citizens

Leading causes of death: cancer, heart disease, stroke, accident and diabetes

Health Data Highlights II

Three times less likely to afford seeing a doctor
Latinos age 18-64 more obese, less physically active
HIV rates rate 3.6 higher than Non-Hispanic Whites
AIDS rates 4.7 times higher than Non-Hispanic Whites
Tuberculosis incidence 15 times higher than Non-Hispanic
Whites

In the 18-44% group, Latinos were 32% less likely than Non-Hispanic Whites to report having ever seen a provider for a MH problem.

Maryland Population Census 2010

Table 1. Maryland Population, 2010 U.S. Census by Race and Ethnicity (8.2% Hispanic population)

	All Ethnicity		Non-Hisp	anic	Hispan	ic
White	3,359,284	58.2%	3,157,958	54.7%	201,326	3.5%
Non-White	2,414,268	41.8%	2,144,962	37.2%	269,306	4.7%
Black	1,700,298	29.4%	1,674,229		26,069	
Asian Hawaiian/ Pac Isle	318,853 3,157	5.5% 0.1%	316,694 2.412		2,159 745	
American Indian	20,420	0.1%	13,815		6,605	
Some Other Race	206,832	3.6%	11,972		194,860	
Two or More Races	164,708	2.9%	125,840		38,868	
MD Total	5,773,552	100.0%	5,302,920	91.8%	470,632	8.2%

Source: 2010 Census Demographic Profiles, Department of Planning, Projections and Data Analysis/State Data Center, May 2011

Population Change

Figure 1. Hispanic Population Change in Maryland, 1990, 2000 and 2010

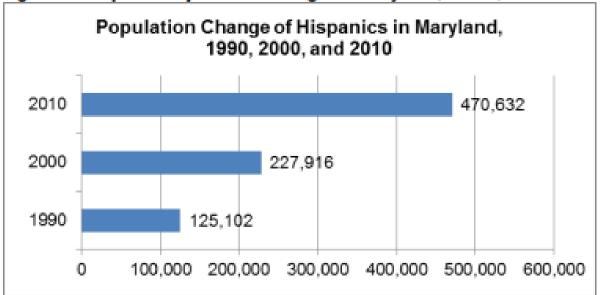
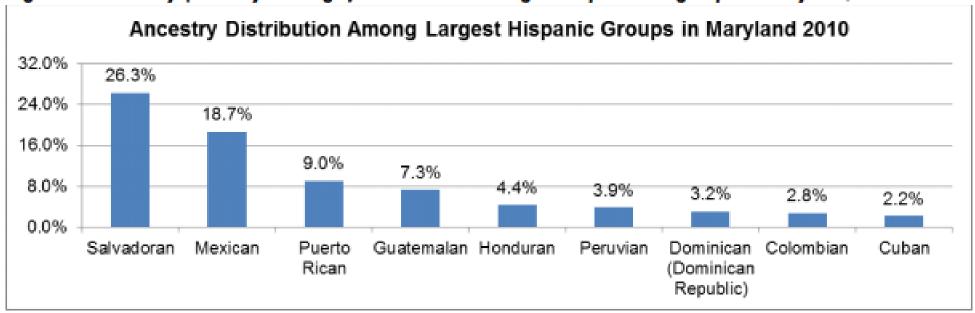


Figure 1 presents the Hispanic population change in Maryland across three decades. The Hispanic population in 1990 was 125,102, in 2000 was 227,916, and in 2010was 470,632. Over the past three decades, the Hispanic population in Maryland has more than tripled according to the estimates from the U.S. Census Bureau.

Source: U.S. Census 1990, 2000 and 2010

Figure 2. Ancestry (Country of Origin) Distribution of Largest Hispanic Subgroups in Maryland, 2010



Source: U.S. Census Bureau, SF2, March 1, 2012; Prepared by the Maryland Department of Planning

Age and Sex

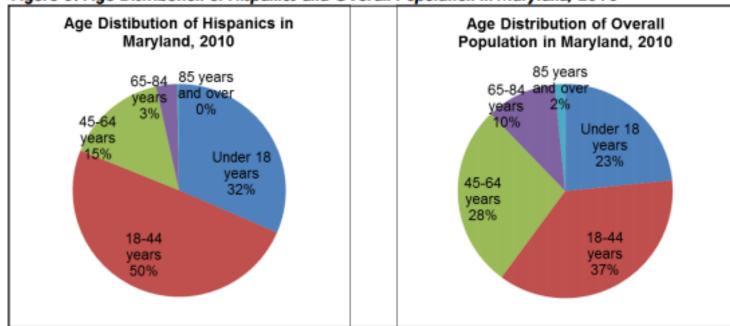


Figure 3. Age Distribution of Hispanics and Overall Population in Maryland, 2010

Figure 3 shows the comparison of age distribution between the Hispanic population and the overall population in Maryland. Generally, Hispanics in Maryland were younger than the overall population. Specifically, the Hispanic population 18 years and younger constituted 32% of the overall Hispanic population - 9% more than that of the overall population in Maryland; and Hispanics 18-44 years old constituted 50% of the overall

Where are the Latinos in Maryland?

Northwest Area	4.84%
----------------	-------

Baltimore Metro 4.59%

Montgomery County 17.02%

Prince George's County 14.94%

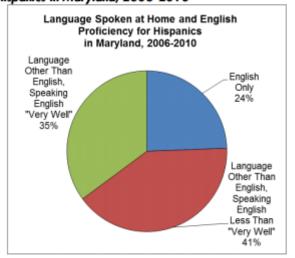
Southern Area 3.72%

Eastern Shore Area 3.95%

English Proficiency and Citizenship

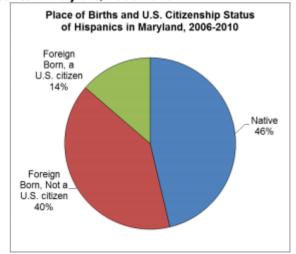
Language Use and English Proficiency

Figure 5. Language Spoken at Home and English Proficiency for Hispanics in Maryland, 2006-2010



Place of Births and Citizenship

Figure 6. Place of Births and U.S. Citizenship Status of Hispanics in Maryland, 2006-2010



Educational Attainment

Figure 7. Educational Attainment of Hispanics and Overall Population (25 years and older) in Maryland, 2009-2011

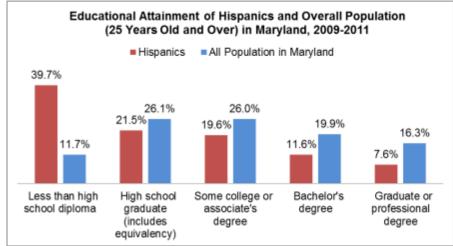


Figure 7 presents the educational attainment of Hispanics and the overall population in Maryland. The percentage of Hispanics who have obtained at least a bachelor's degree was less than half that of the overall population in the state.

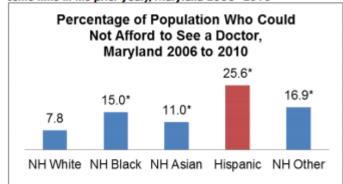
Additionally, the percentage of Hispanics with less than high school diploma was three times higher than that of the overall population.

Source: American Community Survey 2009-2011

Affordable Care and Insurance

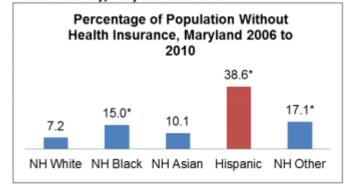
Affordable Care

Figure 8. Population Who Could Not Afford to See a Doctor (at some time in the prior year), Maryland 2006 -2010



Insurance

Figure 9. Population without Health Insurance (at the time of the survey) Maryland 2006-2010



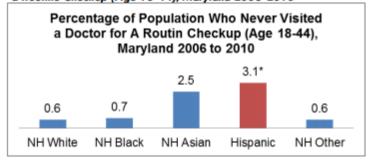
Source: Maryland BRFSS 2006-2010 NH=

NH=Non-Hispanic

*statistically significant vs. NH Whites

Percentage Who Have Never Seen a Doctor for a Routine Checkup

Figure 10. Population Who Have Never Visited a Doctor for a Routine Checkup (Age 18-44), Maryland 2006-2010



Binge Drinking

Binge Drinking

Figure 14. Binge Drinking, Maryland 2006-2010

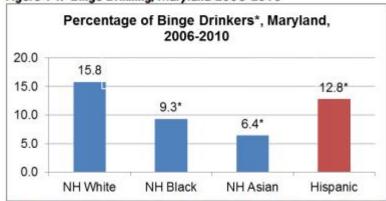


Figure 14 shows the percentage of binge drinking for residents in Maryland. Nearly 13% of Hispanics reported binge drinking. This figure was lower than the percentage for Non-Hispanic Whites, but higher than that of Non-Hispanic Blacks and Non-Hispanic Asians.

Source: Maryland BRFSS 2006-2010

NH=Non-Hispanic

*statistically significant vs. NH Whites

Note: Binge drinkers are defined as males having five or more drinks and females having four or more drinks on one occasion in the past month.

Smoking

Smoking



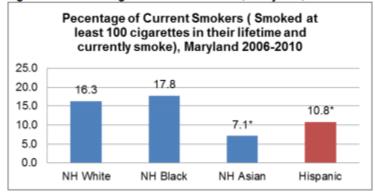


Figure 15 shows that the percentage of current smokers among Hispanics in Maryland was significantly lower than that of Non-Hispanic Whites and Non-Hispanic Blacks. Current smokers are defined here as individuals who smoked at least 100 cigarettes in their lifetime and were currently smoking.

*statistically significantly vs. Non-Hispanic Whites NH=Non-Hispanic

Source: Maryland BRFSS 2006-2010

Utilization of MH Resources

Table 7. Percent of Maryland Adults Reporting Seeing a Provider For a Mental Health Problem, By Race/Ethnicity, 2001-2002

Percent Reporting Ever Seeing a Provider for a Mental Health Problem By Race and Ethnicity, Maryland BRFSS 2001 and 2002 Pooled

	NH White	NH Black	NH Other	NH Multiracial	Hispanic
Age 18-44	24.8%	13.4%*	11.5%*	DNS	14.7%*
Age 45-64	24.7%	12.2%*	7.0%*	DNS	DNS
Age 65 +	13.3%	5.5%*	DNS	DNS	DNS

^{*} minority group is statistically significantly different from NH Whites

DNS = Data not sufficient to report a result

Source: Maryland BRFSS Data 2001 to 2002

Concept of Poor Mental Health

Poor Mental Health

Table 8. Percent of Maryland Adults Reporting 30 Days Of Poor Mental Health In The Previous Month, By Race/ Ethnicity, 2003-2007

Percent Reporting 30 days of Poor Mental Health in Previous Month By Race and Ethnicity, Maryland BRFSS 2003 to 2007 Pooled

	NH White	NH Black	NH Other	NH Multiracial	Hispanic
Age 18-44	3.9%	5.7%*	3.6%	6.2%	4.9%
Age 45-64	4.7%	5.6%	6.0%	13.1%*	5.4%
Age 65 +	3.2%	3.8%	2.2%	DNS	3.5%

^{*} minority group is statistically significantly different from NH Whites

DNS = Data not sufficient to report a result

Source: Maryland BRFSS Data 2003 to 2007

Latino Barriers to Care

Lack of health insurance

Lack of culturally and linguistically competent services

Eligibility issues (lack of understanding of eligibility requirements)

Unavailability of adequate transportation, limited hours of operation, continuity of care

Data limitations

Under-representation

Combination of sub-populations among Latinos

No distinction made among foreign-born, native-born and country of origin

Date incompleteness (missing, misclassified, inaccurate)

Mental Health Disorders Among Latinos

Depression:

- 17% lifetime prevalence (46% females, 19.6% males)
- In 1997 there was a 14.9% of suicide attempts in Latino adolescents (9.0% in AA, 13% NH-Whites)
- 30% of Latino female HS students have considered suicide
- Anxiety and depression tend to be described as body aches and pain
- -Youth with depression most likely to be diagnosed with anger problems or conduct disorder

Mental Health Disorders Among Latinos

Post Traumatic Stress Disorder:

- Many Latinos have been exposed to wars in their countries of origin
- Gang violence
- Mothers immigrate leaving small children behind, children reunite with them as adolescents, many conflicts arise
- Machismo and Domestic Violence

Culture-Bound Syndromes among Latinos

Ataque de nervios: out of consciousness state resulting from evil spirits. Symptoms: crying, trembling, uncontrollable shouting, physical and verbal aggression, intense heat in the chest moving to the head. Associated to stressful events i.e death of a loved one, divorce, witnessing an accident including a family member

Mal de Pelea (Puerto Ricans): A dissociative disorder involving outburst of violence and aggression or homicidal behavior at people or objects. A minor insult would precipitate this condition. Amnesia, exhaustion and persecutory ideas are often associated to this syndrome

Culture-Bound Syndromes among Latinos

Colera (rage): Anger and rage disturbing body balances leading to headache, screaming, stomach pain, loss of consciousness, and fatigue

Mal de ojo (evil eye): Medical problems as vomiting, diarrhea, fever and MH problems as depression/anxiety caused by another person. Condition is common among infants and children, adults can also experience the syndrome

Culture-Bound Syndromes among Latinos

Mal Puesto: Unnatural diseases and death resulting from the power of people who use evil spirits

Susto, Miedo, Espanto, Pasmo: Tiredness and weakness resulting from frightening and startling experiences

Wind or Cold Illness: A fear of cold and the wind; feeling weakness and susceptibility to illness resulting from the belief that natural and supernatural elements are not balanced

Substance Use Disorders Among Latinos

Rates of alcohol and drug abuse do not differ from those of the overall US population

Males tend to use more drugs and alcohol compared with females

Latinas are less likely to drink heavily and become alcohol dependent

English language proficiency associated to increase use of alcohol and drugs

US-born Latinos most likely to use cocaine and cannabis, compared with foreign-born Latinos

For Mexican-American, the presence of at least one US-born parent increases the risk of using alcohol or drugs

Treatment of SUD at Specialty Facilities 2003-2011

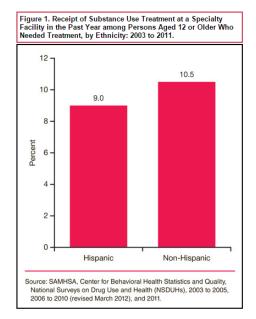


Figure 1 Table. Receipt of Substance Use Treatment at a Specialty Facility in the Past Year among Persons Aged 12 or Older Who Needed Treatment, by Ethnicity: 2003 to 2011.

Ethnicity	Percent
Hispanic	9.0%
Non-Hispanic	10.5%

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health (NSDUHs), 2003 to 2005, 2006 to 2010 (revised March 2012), and 2011.

Appropriate Interventions for Latino Patients

Learn about their countries of origin

Conduct a thorough social and cultural assessment at intake or first point of treatment

Whenever appropriate, engage a patient's family member

Take time to educate on mental health issues

Conduct outreach and educational awareness activities

Engage leaders of Latino communities

Become familiar with cultural syndromes

Appropriate Interventions for Latino Patients

Greet them in Spanish:

Hola: Hello

Como esta usted hoy dia?: How are you doing today?

Como se siente: How are you feeling?

Que gusto de verle: Nice to see you!!

Hasta la proxima visita: Until the next visit

Portese bien!!: Be good!!

You will get a laugh and the appreciation of your patients

The Latino Clinic at Arundel Lodge in Annapolis

- 2 front desk Spanish-Speaking staff
- 2 Spanish-Speaking counselors
- 1 Spanish and Portuguese-Speaking psychiatrist
- For medications, older than 16
- Contact Patricia Garcia 443-433-5900 for hours and availability

Resources

Partnerships and Resources

- > National Alliance for Hispanic Health: www.hispanichealth.org
- American Psychological Association: www.apa.org
- > American Psychiatric Association: www.psych.org
- > American Society of Hispanic Psychiatry: http://americansocietyhispanicpsychiatry.com/
- MANA A National Latina Organization: http://www.hermana.org/
- > National Association of Hispanic Nurses: http://www.thehispanicnurses.org/
- > National Council of La Raza: http://www.nclr.org/
- National Hispanic Medical Association: http://www.nhmamd.org/

Questions? Thanks!!











Community-Based Behavioral Health Initiatives

Jan A. Desper, Executive Director, Black Mental Health Alliance for Education & Consultation, Inc.

Black Mental Health Alliance

MARYLAND'S 12TH ANNUAL HEALTH DISPARITIES CONFERENCE OCTOBER 28, 2015

JAN DESPER PETERS, MPA

EXECUTIVE DIRECTOR

Our Mission

The primary mission of the BMHA is to provide a forum and promote a holistic, culturally relevant approach to the development and maintenance of optimal mental health programs and services for African Americans and other people of color.

Our History

The Black Mental Health Alliance for Education and Consultation, Inc. (BMHA) was founded on December 9, 1983 and received its Articles of Incorporation on January 1, 1984. BMHA is a private non-profit 501(C)3 organization which provides training, consultation, support groups, resource referral, public information, and educational resources regarding mental health and mental illness issues. The Guiding Principles of BMHA's mental health programs, trainings, and consultations are "Concern for Others, Integrity, Respect for Diversity, and Empowerment".

BMHA is a unique and well-rounded organization that has a history of direct service provision; including school based mental health services, tobacco education and prevention, fatherhood initiatives, summer camp and after school programs, and HIV/AIDS prevention initiatives.

Indicators of a Baltimore Uprising

THIS DIDN'T START WITH FREDDIE GRAY

MLK Riots of 1968

On April 6, 1968, just two days after the assassination of Martin Luther King Jr., riots broke out in Baltimore. When the dust settled on April 7, three people were dead, 70 were injured and more than 100 had been arrested, and numerous buildings were burned and destroyed, according to Baltimore magazine.



What's Happening In Baltimore . . . Didn't Just Start With Freddie Gray

The Maryland Crime Investigating Commission Report of the Baltimore Civil Disturbance of April 6 to April 11, 1968 later summed up the event in a few sentences that could have easily been written yesterday:

[S]ocial and economic conditions in the looted areas constituted a clear pattern of severe disadvantage for Negroes compared with whites... Our investigation arrives at the clear conclusion that the riot in Baltimore must be attributed to two elements -- 'white racism' and economic oppression of the Negro. It is impossible to give specific weights to each, but together they gave clear cause for many of the ghetto residents to riot.

Six Indicators of Unrest in Baltimore

1.White Flight

2. Loss of Factory Jobs

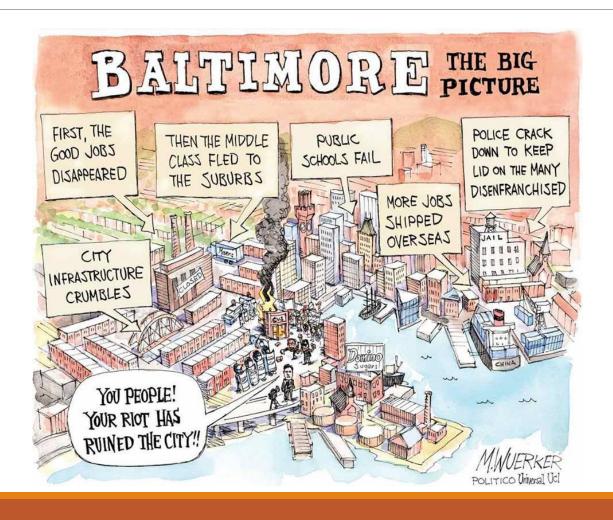
3.Illegal Drug Trade

4. Violence and Gang Activity

5. Predatory Mortgage Lenders

6.Police Brutality

Baltimore: The Big Picture





#BLACKMINDSMATTER

BALTIMORE RISING: SUMMONING THE VILLAGE

"THE HUMAN SPIRIT CAN ENDURE A SICK BODY, BUT WHO CAN BEAR A CRUSHED SPIRIT?" ~PROVERBS 18:14

What Are We Doing?

The Black Mental Health Alliance for Education & Consultation, Inc. (BMHA) has heard the cries of underserved communities over the years and has attempted to address those needs and make a difference. BMHA is committed to working to address the root causes and toxic levels of stress in the community which includes dealing with present and historical racial trauma.

BMHA will take action to initiate the first step toward healing which is acknowledging the racial trauma and stress that we are under and work to understand how it affects our feelings, our thinking and our actions.

Baltimore Rising



Summoning the Village





The Call

For over 30 years, BMHA has provided thousands of individuals and behavioral health professionals a forum for the development and maintenance of optimal mental health services for people of color and has provided a platform to continue the dialogue regarding the importance of culturally competent behavioral health counselling, direct service delivery, training, education and consultation.

BMHA accepts this current call to coordinate these efforts for such a time as this!

The Endorsement

As a Black mental health professional/community healer, I am committed to being an active participant in the healing of Baltimore's families, children and communities. As such, I support and endorse BMHA's efforts as outlined in this statement to work toward prevention and treatment of the trauma caused by toxic levels of stress in the community which include addressing present and historical racial trauma.

I will lend my time, talent and resources to assist BMHA in taking action to initiate the first step toward healing which is acknowledging the racial trauma and stress that Black families, children and communities are under and work to understand how it affects our feelings, thinking and actions, with the ultimate goal of creating a solutions focused model of prevention and treatment.

Our Methodology

Endorsement of BMHA efforts

Promote continuous and active BMHA membership

Augment Directory of BMHA professionals

Partner with
Community Healing
Network

12 Month Call to Action Series

Utilize Call to Action as a mental health model

Emerge as a thought leader in the mental health industry

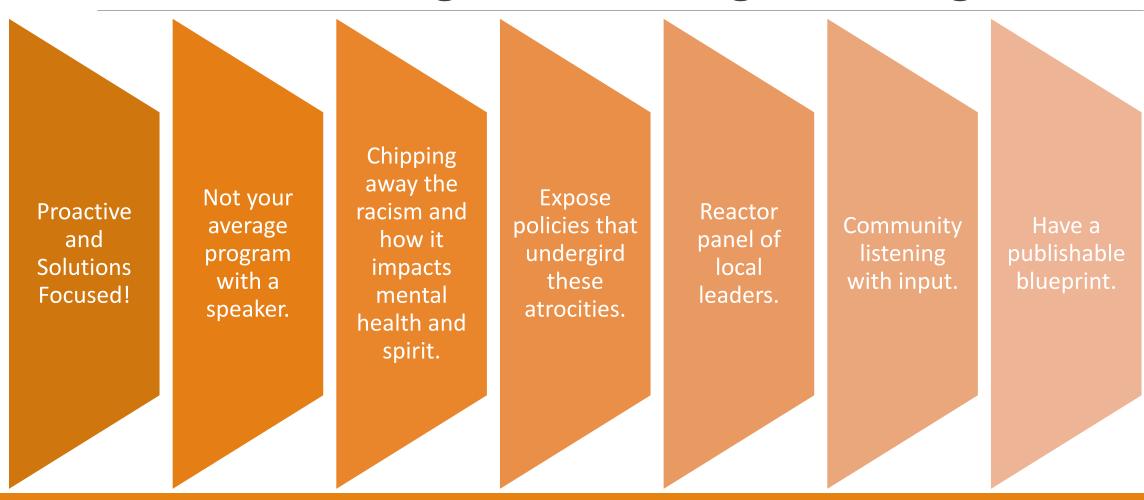
Solicit and challenge funders to support BMHA's mission

Research Baltimore City
Disaster Preparedness
and Trauma

Meet to enhance relationship with Baltimore Mayor, Health Commissioner & Police Department

Identify and solicit allies and partners

12 Month Call to Action Series #BlackMindsMatter Baltimore Rising: Summoning the Village



12 Month Call to Action Series ~ Process #BlackMindsMatter Baltimore Rising: Summoning the Village

Requires
Diverse
Advisory
Board

Need
Human and
Fiscal
Capitol

Allow the Process to be Fluid

Maximize
Every
Opportunity
to Share the
Story

Think outside of the Box and be Inclusive when it comes to partnerships

Call to Action July 2015

Contextual Framework for the Community Engagement Model Inaugural Keynote Speaker

Dr. Mindy Thompson Fullilove

Author of Urban Alchemy and best known for her work in treating entire cities of people in extreme environments. Dr. Fullilove helps cities neutralize the effects of policies detrimental to communities such as mass incarceration, planned shrinkage, disinvestment, and deindustrialization by undertaking deliberate actions to improve quality of life.



Call to Action August 2015 Race and Racism Keynote Speaker

Dr. Camara Jones

Camara Phyllis Jones, MD, MPH, Ph.D., is a family physician and epidemiologist whose work focuses on the impacts of racism on the health and well-being of the nation. She currently serves as Senior Fellow, Satcher Health Leadership Institute at Morehouse School of Medicine. Through the use of captivating stories, such as the Gardener's Tale, Dr. Jones explained how racism directly affects health through discriminatory policies that jeopardize the safety and well-being of communities of color.



Call to Action September 2015 Education Keynote Speaker

Dr. Lisa Delpit

Her extensive work on teaching and learning in urban schools and diverse cultural settings has documented "the elements of public education that conspire against the prospects of children of color, creating a persistent achievement gap during the school years- a gap that research shows is not present at birth." Dr. Delpit will share her blueprint for raising expectations for other people's children.



Call to Action October 2015 Black Women and Girls' Health Keynote Speaker

Dr. Gayle Porter

As a clinical psychologist, researcher, author and lecturer, Dr. Porter is also the Co-Director of The Gaston & Porter Health Improvement Center, Inc. (GPHIC). She co-authored the 2003 published book, Prime Time: The African American Woman's Complete Guide to Midlife Health and Wellness. Dr. Porter discussed major disparities in health outcomes, including the often neglected, physical and emotional health of Black women today. Dr. Porter offered specific strategies to reduce these disparities that included increasing knowledge, improving attitudes and changing behaviors.



Call to Action November 2015 The Crisis of Black Men and Boys Keynote Speaker

Dr. LaMarr Darnell Shields

Dr. LaMarr Darnell Shields is a social entrepreneur, inspirational speaker, and educator who loves to create and build with purpose. As the Co-Founder and Senior Director of Education and Innovation at the Cambio Group, Dr. LaMarr Darnell Shields has dedicated his life to inspiring adults and youth alike to pursue a higher purpose, achieve sustainable value for long-term success, and cope with adversity in order to create opportunities in their personal, professional and spiritual lives. Dr. Shields, the founder of PRAISE College Readiness Program (PCRP) a program that helps African-American Males in Baltimore to become competitive applicants to four-year colleges/universities.



•Developed by leaders of the Community Healing Network, Inc. and the Association of Black Psychologists to heal black people from the psychological and emotional chains of centuries of racism.

Enola G. Aird is the Founder and President of EED. She is an activist mother. A former corporate lawyer, Aird has worked at the Children's Defense Fund, leading its violence prevention initiative and serving as acting director of its Black Community Crusade for Children; is a past chair of the Connecticut Commission on Children; and was a visiting scholar at the Judge Baker Children's Center in Boston.

Dr. Cheryl Tawede Grills is a clinical psychologist with emphasis in Community Psychology. She is Professor of Psychology at Loyola Marymount University, Immediate Past President of The Association of Black Psychologists, and founder and director of Imoyase Community Support Services. She is principal investigator on several social justice projects related to education reform, mentoring African American youth. Dr. Grills consults nationally on issues regarding cultural competence, multiculturalism and Africentric interventions. She has also studied under traditional medical practitioners in Ghana, Nigeria, and Senegal.

- •An EEC is a support group organized by community leaders in which black people from all walks of life participate on a weekly or biweekly basis over an extended period of time.
- •Group members are guided through a variety of exercises, discussions, and affirmations designed to promote interconnectivity.
- •Infused throughout these activities is information presented to help participants understand the reality and impact of the following: racism and racial microaggressions, racial stress, psychological trauma, historical trauma, internalized racism, resiliency, and community healing and emotional emancipation. Ultimately, group members decide to work collaboratively to address a community challenge

Training organized by:

Black Mental Health Alliance

Experiential Workshops and Facilitators' Training

Friday and Saturday, June 26-27, 2015

30 people trained

Active Locations:

- ■1st Tuesday of Each Month from 6:00PM to 8:00PM Urban Business Center, 1200 West Baltimore Street, Baltimore, MD
- •2nd Saturday of Each Month from 11:00AM to 1:00PM
- Enoch Pratt Free Library, Pennsylvania and North Avenues, Baltimore, MD

Resources

Community Healing Network Website: http://www.communityhealingnet.org/#welcometochn

TED Talk by Dr. Cheryl Grills - http://tedxtalks.ted.com/video/Emancipation-from-Mental-Slaver

Dedicated to the liberation of the African mind, psychologist, Dr. Cheryl Tawede Grills, speaks on the crippling image of African and African-American people worldwide and offers solution through Emotion Emancipation.

Next Steps . . .

Continue the 12
Month Series

Continue to identify and solicit allies and partners

Continue "Community Walks" to collect data from those most impacted

Convene a Summit to Share Blueprint and Lessons Learned

Compile the Blueprint (i.e., Issue Briefs)

Continue to Fine Tune the Relationship with CHN to spread the EEC

Solicit and challenge funders to support BMHA's mission

Emerge as a thought leader in the mental health industry

Works Cited

http://www.huffingtonpost.com/2015/04/28/freddie-gray-baltimore-history_n_7161962.html

http://www.newsweek.com/baltimore-goes-beyond-freddie-gray-326109

http://www.ibtimes.com/baltimore-riots-2015-city-residents-struggle-under-poverty-income-inequality-mass-1899732

http://data.baltimoresun.com/bing-maps/homicides/index.php?show_results=UPDATE+MAP&range=2015&district=all&zipcode=All&cause=shooting&age=all&gender=all&race=black&article=all

http://fivethirtyeight.com/features/baltimores-toxic-legacy-of-lead-paint/



THANK YOU AND WE ARE HAPPY TO TAKE QUESTIONS???

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Community-Based Behavioral Health Initiatives

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Community-Based Behavioral Health Initiatives

Screening, Briefing Intervention, Referral to Treatment (SBIRT)

Screening, Brief Intervention, Referral to Treatment (SBIRT)

SBIRT is an evidence-based and cost-effective method for helping individuals reduce or stop alcohol and other drug use.

SBIRT can be adapted to be used in a variety of settings to screen people for various problems such as alcohol/drugs, physical/mental health, and HIV/sexually transmitted diseases.

SBIRT's Three Steps

Screening: A simple tool used to determine if a person is at risk for, or may have an alcohol or substance use disorder.

- 5 total questions for adults regarding frequency and amount of alcohol and drug use which indicate if patients are at low-, moderate- or high-risk for developing a substance use disorder (3 questions for alcohol, 2 for drug use).
- Adolescents are asked 3 pre-screening questions, then if any are positive, 6 additional questions.

Brief Intervention: Explanation of screening results, information on safe use, assessment of readiness to change, advice on change. The goal is to increase patients' understanding of the impact of substance use on health conditions, and to increase patients' motivation to reduce use if needed.

Referral to Treatment: Those with positive screening results may be referred for an evaluation to determine if individual has a substance use disorder

SBIRT Universal Principles

- SBIRT must become part of the agency's workflow for sustainability
- Must have leadership and line-staff buy-in
- Workflows must be analyzed
- Modifications to agency's EHR
- Staff Training, mentoring, monitoring
- Referral mechanisms to treatment must be clear and timely

SBIRT in Maryland

In August 2014, Maryland was awarded a 5 year, \$10 million grant from SAMHSA to implement SBIRT services in community health centers across Maryland.

MD intends to screen 90,000 patients over 5-years in 12 FQHCs with 45 locations, and in 2 hospitals across Maryland.

Goals

- Improve the health status of Marylanders through the integration of behavioral health and somatic health care services
- Increase identification of and intervention with individuals with risky substance use
- Demonstrate reduced substance use among individuals who received SBIRT services
- Reduce overdose deaths and promote health equality through the provision of universal behavioral health prevention and early intervention approaches
- Demonstrate increased capacity to treat SUD in underserved regions of Maryland
- Reduce health care costs
- Maryland simultaneously received a separate 3-year, \$1 million grant from the Conrad N.
 Hilton Foundation to implement SBIRT services for adolescents at SAMHSA-funded sites,
 3 large pediatric practices and 10 schools.

Why Implement SBIRT in Federally Qualified Health Centers (FQHCs)?

- Nationally, about 20% of primary care patients have moderate to high risk of developing substance abuse disorders.
- Primary care providers have trusted relationships with patients and can help patients understand the link between substance use and risk for medical problems.
- Nationally & in Maryland only about 25% of people who need treatment receive treatment.
- National studies show SBIRT is effective in reducing alcohol and drug use, health care and employer costs, hospitalizations, injuries, car crashes and arrests.
- Health care experts recommend early intervention and integrated behavioral health and medical care.
- Maryland's model for SBIRT implementation is nationally recognized as being financially and programmatically sustainable.

Maryland SBIRT Project Leadership

- DHMH/BHA is the SAMHSA grantee and lead State agency.
- Behavioral Health System Baltimore (BHSB), Baltimore City's behavioral health authority (mental health and substance abuse) was selected by BHA to administer the project.
- Policy Steering Committee (PSC) —is responsible for promoting and advising the project, and furthering efforts to institutionalize SBIRT in Maryland's health care facilities and health information technology plan.
- Implementation Team In addition to BHA and BHSB,
 - Mosaic Group Consulting firm with expertise in SBIRT and behavioral health program development, providing technical assistance, training, and quality monitoring at participating health centers.
 - Choice Research Project Evaluator

Maryland SBIRT Partners

- Selected Community Health Centers & Hospitals Selected health care organizations enter a 12-month contract with BHSB and work collaboratively to implement SBIRT services.
- Local health departments LHDs collaborate with selected community health centers, BHA and BHSB to ensure substance abuse treatment is available for patients who are identified through SBIRT as needing treatment.
- SBIRT experts, universities, professional membership associations University of Maryland provides SBIRT training and consultants with various areas of the project. MedChi (state medical society), Mid-Atlantic Association of Federally Qualified Health Centers and other organizations promote the project and co-sponsor SBIRT training.
- <u>Health Information Technology Experts</u> Maryland's Health Care Commission/CRISP are partners to plan how SBIRT services might be incorporated into Maryland's health information planning efforts to coordinate patient care and improve health outcomes.

Maryland SBIRT Project Activities

- 3-5 health centers selected to implement SBIRT services per year
 - Includes TA, training, and modification of EMR systems during first 2-3 months. Then, SBIRT is implemented, data is analyzed and centers instructed on quality improvement activities. SBIRT booster training provided for staff.
- Expand the availability of substance abuse treatment.
- Hold I-2 SBIRT trainings each year for "non-grantee" health care providers.
- Develop web-based SBIRT training program for medical professionals.
- Develop educational materials for staff and patients.
 - Website, brochure, posters.
- Develop Policy agenda to institutionalize SBIRT services throughout Maryland.
- Submit mandatory data collection and progress reports to SAMHSA.

SBIRT Year | Accomplishments August , 2014 through July, 2015

SBIRT services for adults were implemented in 4 FQHCs with 12 locations:

- Community Clinic Inc. 5 sites in Montgomery & I site in Prince George's Counties
- Health Care for the Homeless I site in Baltimore City
- Holy Cross 4 sites in Montgomery Count
- Owensville Primary Care I site in Anne Arundel County

8582 total patients were screened. Of those,

- 1,897 or 22% of patients had positive results
- 1,301 or 69% of patients with positive results received brief interventions
- 174 or 13% of patients who received brief interventions were referred to treatment

Training for 68 Non-Grantee Physicians was held June, 2015

Initiated workgroup to explore obstacles and make recommendations to expand SBIRT reimbursement.

Johns Hopkins Harriett Lane Clinic (large pediatric practice) and Center for Children in Calvert County (adolescent mental health provider) are implementing SBIRT services for adolescents as part of Conrad N. Hilton Foundation grant.

Future Plans and Policy Goals

- **Year 2** Access Carroll, Baltimore Medical Systems, Inc., I additional organization pending. Also, 2 schools will implement SBIRT for adolescents as part of Conrad N. Hilton Foundation grant.
- Year 3-5 Tentative I health center organization on Eastern Shore, 3 health center organizations in Western Maryland, 2 hospitals. Also, 8 additional schools and I-2 additional pediatric practices will implement SBIRT for adolescents as part of Conrad N. Hilton Foundation grant. Additional health care organizations are invited to participate.

Policy goals

- Expand reimbursement for SBIRT services delivered by non-physician medical and behavioral health professionals.
- Institutionalize SBIRT services in Maryland -
 - Advocate for SBIRT to be included in Maryland's value-based purchasing efforts, and in Maryland's health information technology and information sharing planning.
 - Advocate for SBIRT to be included in Federal "meaningful use" criteria for medical record systems.



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Thank you!

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Community-Based Behavioral Health Initiatives

Sandy O. Washington, Co-Founder and Executive Director, Lifestyles, Inc.



Community Based Behavioral Health Initiatives

Sandy O. Washington, Executive Director, LifeStyles of MD, Inc.

About Us



Highlights

- LifeStyles, Inc. is a Non-Profit Organization supporting people in crisis providing partnerships, provides referrals for health and human services needs.
- Serving Southern Maryland Community for over 19 years
- 2014 LS Supported 15,000 people in our community including the homeless and victims of domestic violence and their families.
- Established as a vital resource to those we serve

- Work to empower individuals and families providing:
 - Shelter and meals
 - Showers
 - Transitional Housing
 - 47 units next step in sustainable housing for homeless families
 - Domestic Violence Support
 - Transportation
 - Connection w/ resources
 - Emergency Services
 - Functional Kitchen Classroom
 - Training Center

About Us (Cont'd)



Who We Serve

- Low income
- Unbanked
- Unemployed or Under employed
- The Uninsured or under insured
- Chronically ill, (those with mental health diagnosis and those with undiagnosed mental illnesses)
- Those using substances that adversely impact their health and safety.



About Us (Cont'd)



Programs and Facilities

- Robert J. Fuller House
- Gayle's House
- Samaritan Project
- Southern Crossing
- Martha's
- Transportation
- Safe Nights
- Dana's Place



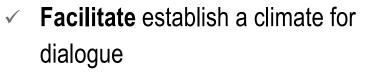
Behavioral Health In the Community

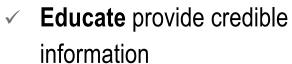


Behavioral Health Goals:

- To disseminate and apply prevention health knowledge effectively to a number of issues that impact the health and wellness of our community
- ✓ To identify and implement best practice preventive health strategies for diverse minority populations
- To de-stigmatize medication assisted treatment for substance use disorders

Methodology: FEEDE





- Engage establish support systems in the community i.e. faith-based, support groups, partners
- ✓ **Dispatch** Local initiatives underway or needed
- Evaluate Outcome/feedback impact on services





LifeStyles, Inc.

Contact Us:

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- •These links will take you directly to the LifeStyles website to learn more about LifeStyles:
- •Home Page: http://www.lifestylesofmd.org/ Click on the video to get an easy understanding of LS
- •About Us: http://www.lifestylesofmd.org/#!about-us/c1801 Another great video
- •Programs: http://www.lifestylesofmd.org/#!programs/cijb