Transforming Behavioral Health Services: Diversity, Accessibility, Flexibility

A virtual webinar presented by
the Massachusetts Behavioral Health Partnership (MBHP)
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[13:02:16] Right Hello everyone, we're going to start recording this webinar now.
[13:02:21] So, hi everyone thanks so much for joining us. My name is Kelsie Driscoll and I'm the director of Quality Management at Beacon and MBHP.
[13:02:32] And so I want to thank you for coming today's webinar, Transforming Behavioral Health Services, Diversity Accessibility and Flexibility. And we're thrilled to have you here.
[13:02:40] And our goal for the webinars that together.
[13:02:44] We're not only going to listen and learn but also reflect and share dialogue about how to address racial disparities and health, and to improve the health and wellbeing of all of our members.
[13:02:53] I first want to say thank you to everyone who has joined from the health and behavioral health systems and beyond. We really appreciate your time and dedication to this important mission of improving health equity, particularly in a time where COVID-19 has put a spotlight on the urgency of addressing behavioral health as a critical part of our overall health.
[13:03:13] Before we begin, I'm going to go over a few housekeeping items. So as you've seen in your chat, and all participants will be muted during the presentation.
[13:03:21] And you can use the Q&A option at the bottom of your screen to submit questions as they come up and throughout the presentation. We do want this to be interactive and collaborative, even in this virtual environment so fire off those questions, and we'll take the time after the presentation to explore them with our keynote. And additionally, links to the slides and recording will be sent out after the presentation, including a transcript as well.
[13:03:47] So today's webinar is a follow up to the MBHP 2020 virtual integration forum, The Impact of Race and Racism On Health, A Call to Action.
[13:03:56] Our keynote speaker today, Dr. Margarita Alegria, was a featured panelist at the forum, and we're very lucky that she's agreed to join us again for a more in-depth follow-up presentation.
[13:04:07] For those who are unable to attend that event last year, we have a full recording and transcript on the masspartnership.com website.
[13:04:16] So today we continue the conversation with an increased focus on attention on the action we can take to recognize measure and mitigate disparities and behavioral health outcomes.

[13:04:26] I'm a quality-focused person so my passion is using data and research to identify disparities and ultimately measure the impact of those strategies to address racial disparities.
[13:04:36] And that's because data speaks. Data from Substance Abuse and Mental Health Services Administration shows that among adults 26 to 34 years of age, 18% of white adults used behavioral health services in the past year, compared with only 8.5% of black adults, 5.1% of Asian adults and 6.6% of Hispanic adults.
[13:04:56] Further, even after controlling for factors like socio economic status, employment ,and education level, black, Hispanic, and Native American populations were significantly more likely to drop out of treatment compared to white populations, indicating that even when individuals access care to the behavioral health system, it is not appropriately meeting the needs of all populations equally.
[13:05:19] Because our own claims data shows that an under representation of behavioral health utilization among black, Asian, and Hispanic groups compared to their white counterparts, and an over representation of state hospital bed use among black populations compared to other racial groups.
[13:05:33] The Beacon and MBHP quality team's mission is to build an infrastructure that addresses racial health disparities by improving how we better collect measure and represent data in a meaningful way.
[13:05:44] And while we know that data is essential to shining a light on racial disparities, we also know that is incomplete without the action that it importance.
[13:05:52] And that is why I'm so excited to welcome Dr. Alegria today. Dr. Alegria is chief of the disparities Research Unit at Mass General Hospital, and a professor in the Department of Medicine and Psychiatry at Harvard Medical School.
[13:06:07] And she is also the Harry G. Lehnert, Jr. and Lucille F. Cyr Endowed chair at the Mass General Research Institute doctoral degree. Her research focuses on the improvement of healthcare service delivery for diverse racial and ethnic populations, conceptual and methodological issues with multicultural populations, and ways to bring the community's perspective into the design and implementation of health services.
[13:06:33] Thank you so much Dr. Alegria. We're thrilled to have you with us today.
[13:06:40] Thank you so much for having me. I'm delighted to be here and I'm really passionate about this same line of work, and mission. So let me thank Nancy, and also the Massachusetts Behavioral Health Partnership, because, I mean, the fact that you're being here means a lot. It means that we have a chance of changing the system. Let me share with you my screen. To start the presentation. I'm going to be speaking for around 45 minutes, and then I hope you give me a lot of questions so that we can really start the dialogue.

[13:07:19] I love the title, because it is really what I think we need to do, we have to transform it, we have to diversify it, we have to make it more accessible and really give more flexibility to the systems to innovate and accelerate the transformation to equity care. So let me start by saying I have no actual or potential conflicts of interest. No, companies, no nothing. So, I'm here to stay and do this work.

[13:07:48] I'm going to cover four major areas. I'm going to walk you through some of the issues and behavioral health inequities, and why I think it's so urgent to play, you know really accelerate the gas on changing the system would then we're going to move to building a diverse clinical staff what we need to do it, and I'm going to, you'll see that this is a little different than what you expect. I'm going to move quickly into improving access to and quality of behavioral health care what I think we know of what we need to do. And then finally, how can we innovate, to better address the behavioral health needs of the population.

[13:08:30] Let me start with the background of behavioral health inequities because, I mean, I would say that even though we know so much about this in equities, there has been so much written about it.

[13:08:43] The fact that we continue to have less access to behavioral health services that still, for example, youth especially our black and Latino youth are more likely to use emergency departments, and that we receive lower quality care is a tragedy in this country where we're 2021, and the fact that we've been having and talking about this for more than 50 years and not moving the needle. It's something that we have to take into account the fact is that we are suffering from it, we have escalating suicide death.

[13:09:22] We have increasing numbers of youth, but also adults and elderly with anxiety and depression, and that carries on to having underperformance in schools underperformance in work, but also in our the fabric of our communities.

[13:09:41] I want to show you this, people have talked and Kelsie mentioned this issue about coping, but I think what's really amazing about Corbett is that it's such a great X ray of the inequities in this country.

[13:09:54] If you look for example at this very quick slide you would see things that we didn't even talk before Native Hawaiian, Pacific Islanders, you know really contracting covert at rates that are unexpectedly high.

[13:10:11] The same for Alaskan Indian and American Indian and Alaska Native, as you can see here, Latinos and blacks. Look at the deaths for blacks, the death for American Indian is just astronomical showing you that this is an important issue that we have to definitely transcend let me see if I can move my slides.

[13:10:58] Okay, here we go. Sorry. So one of the things, by which we know the system is not working, is by how few people get access to, to meet their needs, you look at here the fact that even 2019.
[13:11:14] We have 45% of adults with mental illness that only those 45% received, you know, mental health services, meaning that less than half of people that need it, get it.
[13:11:27] But for substance abuse it's even worst 10% of people with a substance use disorder, receive treatment, and this is after all policy initiatives like we have done of achieving parity and financing, but still, there is so much to be done to change what we see.
[13:11:48] I wanted to show you this diagram that was done by meet them and he and her postdoc, showing how this is not unexpected, given that if you see here, there's the issue of how our society structures, who is a value, and who is not.
[13:12:09] And that's very related to the institutional racism I'm going to be talking about today about how our policies, create certain economic opportunities for some, including healthcare opportunities, and not for others, and how certain communities have more infrastructure and others have less, and the importance of interpersonal racism as being something in the clinical encounter that leads to give him more or less resources.
[13:12:40] And as a result, people confront specially marginalized blacks Latinos, Asian Americans that native and indigenous communities barriers to access barriers to quality that only two disparities in health.
[13:12:57] I want to bring one issue that I think it's so important because we tend to talk about healthcare, as the central determinant of what people need. But more and more, the more and more we keep seemed, we know that there are five areas that we need to address to make sure that we can improve our chances of recovery. One is economic stability it's hard for people to think about their mental health or behavioral health in aspects of economic instability.
[13:13:33] We need to think about the neighborhoods where people live and how they have such an important customer constellation of risk factors that can really erode your mental health and issues that have to do about the healthcare system, social, and community contacts your connections. Now we've seen the effects of social isolation, and it just shows you the importance of social connections, and even of education in trying to do better in terms of health.
[13:14:07] I also want to bring up work that has been done by Wasserman and Joni and and Michigan University, talking about how we need to do more research in areas such as role of the patient preferences, because, specially we tend not to know a lot about the preference that people have about clinical decision making about stereotypes and bias and stigma and about the importance of patient clinician interaction, so that we could do a better job of fulfilling the promise of good healing for our populations.

[13:14:47] I'm going to move quickly to talking about building a diverse clinical staff and creating a pipeline is going to take a long time. So I really want you to stay, think about this from a very different angle, and that angle is learning to be like, and think like the people that we are in having in front of us in the clinical encounter, getting to be in their skin to really be doing a better job.

[13:15:18] I want to really emphasize how the populations that we are having are going to be incredibly diverse in terms of race, culture, national origin, family composition, very different to our own.

[13:15:36] I want to tell you like the latest pq came out with 88% of the growth is going to be an immigrant populations. And that means that we are going to have a very different type of client coming from different places, not from Europe, as we did in the 19th century, but people that are coming from Latin America, the Caribbean, Asia, Africa, so it makes it a very different type of client, in terms of our skill sets and what we need to do to do a better job.

[13:16:15] They're going to be particularly and I want to emphasize this particularly cultural differences in how people will or will not recognize their mental illness, how they think about stigma, in terms of seeking help, but particularly how they think about what is the definition of the problem that they have. And this will require really a cognitive difference from providers to really try to understand from the skin of the patients, where are they coming from, how do they define their problem.

[13:16:54] And I have to say I mean there's a lot of courses and cultural sensitivity on awareness on recognizing diversity and inclusion, but I have to say, we know for a fact that it's very difficult for behavioral health professionals to get away from their own culture and truly try to understand how this family's that's children this adult things through a different cultural lens.

[13:17:22] It really means that we have to check our assumptions, check our norms, check our expectations of what people, we think people are thinking people are doing and why they're doing it to open the door to try to understand others.

[13:17:40] I want to show you how non diverse, is the for example that psychology workforce. And this is data, 2018. And you can see here, the very very small percentages of us psychology that are Asian black or Hispanic 86% are white health psychologist are even more white 88% are white. And if you look down the, you know, across the spectrum, you can see that it's very different than even the population, we have right now.

[13:18:20] And so it means that most likely a white provider is going to be servicing, a non white patient.

[13:18:29] I also want to bring into the equation the issue of language because mostly, we know that, for example one third of Latino populations in the US speak English, less than very well, and less than very well as what you need to have English proficiency. So it means that if you have less than very well. You speak left and very well. We have a very big percentage of people that are going to be

in the clinical encountering only getting part of the communication that they need to improve their health. This means that we need to think beyond the, the typical ways that we've been providing care to make sure that we can do a better job with those with limited English proficiency, and that includes, trying to think about how we can introduce professional interpreters, but also more importantly have people that speak the language that looked like them that talk like them, that understand they're under goings of daily living.

[13:19:38] And I mean it's true we have national standards for class for culturally linguistic appropriate services, but they're really not enforce, and we see the, we see the price of that.

[13:19:51] I want to move to the culture, or the organizational level culture that puts a lot of constraints in what can be done. Whether evidence based in interventions will be use, whether we are trained on them.

[13:20:07] And also, on to the desired outcomes they're looking, because there's the commercial aspect, the beneficial aspect of, you know, companies, including insurance companies, but there's also the organizational culture of how they want us to do our work, how they want us to service our clients and how that failed there's into how they recognize or not, the culture of our participants patients.

[13:20:37] I want to emphasize that culture is really a dynamic process that's why it's so hard to say, I'm going to take a course in trying to do better, you know, cultural responsiveness.

[13:20:51] I mean those courses help, but culture is really a dynamic process that it's influenced not only by us and employee, but by the families and youth you work with, and how the policies around working with them are really introduced into the equation.

[13:21:11] I also want to think about how you rate your organization they're starting to be great work on looking at the cultures organizations, and inequities in the culture of organizations.

[13:21:26] And that has to do with how your organization supports, or diminishes the support of diverse families and cultures.

[13:21:36] I also want to bring back the issue of neighborhoods, I talked before about neighborhoods, but I don't think we put enough emphasis on neighborhoods. In fact, I'm currently talking, doing some work where I'm trying to move resources, outside the clinic for providers to understand better the environments in which people live, because they have such a critical role in patients mental health outcomes. And by why, I mean by this for example living in a high-risk neighborhood has tremendous impact there's been great work done by David war, showing that if you live in an environment where there has been killings of black men.

[13:22:24] It really has an impact on that communities that neighborhoods, mental health, and I only, not want to talk about the negative I also want to talk about communities where there is a lot of social

interaction where there's very little isolation where people can socialize and have activities to meet each other, and how those things can be so can really help in terms of mental health.
[13:23:03] I also want to bring into the discussion, the issues that have to do with how when we think about health. We have to think about the community.
[13:23:22] And I really think that, you know, we should be thinking so much about the community, because how people adapt to expectations to norms to values to their event to their social position in their neighborhoods, it's really, really important.
[13:23:41] Most people including mental health providers have a really difficult time understanding cultures that are farther afield from there. And now I'm going to take you to a poll. Let me stop sharing and bring the poll question in.
[13:24:09] And here it goes to poll, which option best describes the role of community-based organizations in the community ecosystem.
[13:24:21] Are they undermining the guidance of medical professions, are they addressing gaps and need presence in underserved communities. Do they act as space for members of neighborhood communities to meet community members, or do they focus on research to inform federal policy level changes.
[13:24:42] And this is a hard one.
[13:24:49] And it's going to be even harder because it came a little bit before, what I'm going to present, but we'll see what you say.
[13:25:00] Let's see the results of the poll.
[13:25:08] Yes. See this this group is really bright it addresses gaps. Breastfeeding underserved communities right on. Very good. Okay, let me go back to share my screen and bring back the next one.
[13:25:33] So I also want to bring the issue of the culture at the family level because one of the areas where we could have a bigger expansion of the impact of what we do is really not only thinking about individuals but thinking about families, but rarely, rarely do we ask our participants our patients.
[13:25:57] How is the culture of their family, how would they describe it, what are the expectations the goals, the fit that that person has, in their family, and in their community and their family has in their community.
[13:26:12] And this is really important because how people think they fit into their family and into their communities. It's part of how they feel about themselves and how they feel about others.
[13:26:25] So that's important to know the attention to fitting in community and family also want to bring up the issue of how, in terms of mental health services.
[13:26:38] You know there's bigger costs for communities of color in this terms of services. For example, there's been great work that has been done actually by in Harvard, showing structural

inequities that are tied to people getting worse outcomes from having mental health or behavioral health conditions, and that's because they have less options to really recover. They have more stress die too unstable scheduling too low, low wages to benefits in their work.
[13:27:16] And also because typically people of color have differences in opportunities in really accessing this social determinants. And as a result, they have to deal with more overwhelming nature of their everyday life, and its own not only adults that suffer but their children to.
[13:27:37] This has been talked about a structural vulnerability and I want you to think about structural vulnerability from the area of when you talk to your patients when you talk to your clients.
[13:27:49] This is really how you define more practically that diverse forces, both external and internal in the clinical encounter that can sabotage to hell so patients, because we're not thinking about the, the limitations they confront in their opportunities are in their options to have health.
[13:28:13] So for example I want to think to you about the case, we were seeing a lot of patients from manufacturing in Massachusetts, that actually we couldn't comprehend why this, we had a lot of women that were working in a, in a manufacturing plant, and they were all showing. Not all, but many showing signs of anxiety, and it was really important to go and visit, where they work, biggest part of the problem was that all the facility was closed, without know windows, without being sitting down next to each constrained. And that had a tremendous impact in people's showing this anxiety of worrying about having a flyer, or having something and not being able to get out.
[13:29:08] So it shows you how their structure own vulnerabilities that need to be understood to be able to do a better assessment of where people are. and those vulnerabilities could be, transportation, they could be housing, They could be the their educational level, but they all translate into the health outcomes that then people are going to have. And that's why having this structural competency view or lens, when we look and attend to people's like conditions is so useful in not sabotaging their health.
[13:29:47] This are five points that mental enhance and talk about as being necessary points to try to understand better. Our clients. One is trying to see the structures that shaped the clinical interactions, how much time we have, how much you know extract clinical language we're using in our services, how much you know we articulation of cultural presentations we use in how we present what's happening to them, and also the imagination of what could be an equity intervention, something that we might do to actually move that person into thinking about it, not themselves as have been having flaws, but themselves as having structural areas of inequities that limit their thriving and flourishing.
[13:30:43] And then development of structural humility to try to better understand this.
[13:30:48] There's the, the model of factors contributing to health outcomes. And we typically talk about, you know, food and education and so forth. But more and more.

[13:31:00] I want you to concentrate when you are talking to your clients especially your minorities clients about social integration, whether they are really integrated in the fabric of their communities, whether they really supported by people in their community besides their family and peers and how much community engagement and discrimination is happening. That really is going to affect your health.

[13:31:33] This is a structural intervention for example we had a person came to us here inside the levels had really gone up increase, even though we were giving that person, a psychosocial intervention.

[13:31:48] And what we found was that that person was actually in the in the midst of being evicted. So, our structural intervention for equity was getting hair connected to a legal aid group that could help her with her addiction as a part of, you know, giving resources to that client.

[13:32:10] So, what do we do about increasing the workforce, how do we diversify it. I think we need to do more loan repayment programs that bring under represented minorities to the behavioral health field.

[13:32:26] We need to invest in training, the community health workers and fear, through the pipeline because they as, as we lead them to that pipeline, we can actually get them credits or get them scholarships to make sure that they move to the next level.

[13:32:44] And that can allow us to have a more diverse workforce.

[13:32:50] That really is going to take into account structural racism.

[13:32:56] Let me now go into talking about improving access and quality of behavioral healthcare, and we're going to discuss a few things. This could be a whole day workshop so I want to discuss some of the things that we have put, not only in our paper and transforming mental health and addiction services, but all seen in other works on innovation that we have written. I want to say that we were very fortunate to be asked by the National Academy of Medicine to write one of the papers on directions for health and healthcare priorities for 2021, and this was a papers that were going to be given to the new administration, and I was very lucky that together with my co authors, we were asked to write a paper on transforming mental health and addiction services, and this is in Health Affairs. One of the things we talk a lot in this paper is how we have to change the service paradigms, how the service paradigms that we have been using for the last 20 years are stuck on always that make it easy, but are actually might not be so effective. So we still have, you know, a service paradigm where people have to find treatment and rather than we finding people that need those treatments and getting to them, where we have to use paradigms that most proved intend to engage before starting treatment right and then letting people engaged and re engage when they think they needed the most.

[13:34:34] When they're giving choices of what they are willing to do, and preferences that align you know services that are aligned with their preference, so we can give them a range of offering, rather than give them one or two choices, and then services to add don't discharge people, when they leave care but actually re contact them, recognizing that relapse is a major, major thing in the disease process.

[13:35:04] So what can power professionals do we're using a lot of power professionals as our first entry point to connect with this communities. And what we're doing is, you know, not only as facilitators to connect people to services.

[13:35:22] But actually, we are training them as the healthcare workforce that can start to initiate a lot of things. And when we mean by power professionals we're talking about community health workers promo daughters late health workers, indigenous proper professionals, peer support specialist and natural helpers. So there's a lot of people that we could bring to create our village of healing. And this might be not only bridging you know between the community and the healthcare providers, but also providing care support, because there's a lot of more needs that, what can do in a 45-50 minute visit. And this is what where we are also using case management as a way to link people to their social determinants.

[13:36:14] And also it allows us to then use the professional workforce for very extreme cases, or for supervision of power professionals so we can expand the connections and expand the workforce.

[13:36:31] I want to say that there's evidence that workforce infrastructure alignments to service needs are better done when we have a more racially and ethnically make much work for us, for example, this is something we're seeing currently where some of our black, Latino, and Asian clients are asking for people have their same racial or ethnic background.

[13:36:59] And I think part of the issue, even though there's evidence that the outcomes don't differ has to do with how they feel that's my minimize the disparities, because they're delivering more culturally tailored programming.

[13:37:16] So what are we doing now, as any innovation, we're out reaching people we're not waiting for people to come to us, but actually we are going out to the communities in community-based organizations or a community clinics, and trying to identify people that need behavioral healthcare, but they don't recognize it. If you think about it, it takes a median of seven years for people to even for depression, go and seek help.

[13:37:49] By that time, we know that people have lost a lot of opportunities that people have sometimes lost their jobs. Sometimes lost their partners, or really have a lot of other issues.

[13:38:03] So we're doing a lot of community based organization outreach as a way to make sure that our staff, you know, has supervision of licensed professionals that can administer this preventive types of programs like First Aid, or Mental Health First Aid, or really go to trusted institutions that have

provided previous social services as a way to seek help. And also this is this our institutions or organizations that typically have non English speaking persons that can help us provide the care.
[13:38:47] Another thing that we're doing is home visits, we're definitely doing a lot of home visits, where people are actually going to the houses, because it really tells us what's happening the household, and we can be more have a more confidential private interaction with a participant. This has been done for example the meal delivery services to elders, but it also has been done for families in chaos, with small children.
[13:39:34] I also want to mention the importance of changing our focus in behavioral healthcare, we really been focused on reduction of symptoms and not that I think reduction of symptoms, is a bad thing, but I actually think we now have to move to what's called recovery capital. recovery capital sings about all the things that are needed, internal or external for people to actually get better. And it's, it includes you know how people are dealing with substance use and sobriety includes global psychological health, such as, you know, measuring psychological distress to try to mitigate it early on. It also means trying to get people earlier preventive care, either in infectious disease or cardiovascular disease, trying to see how we can get people involved in citizenship and community block involvement, providing social support and actually meaningful activities, we know that when people think they really are included and valued in society, it really affects their self-esteem and then all the other things that we see there.
[13:40:51] I want to go quickly to the innovations in behavioral healthcare because I want to leave enough time. obviously telehealth with COVID-19 really show how telehealth could be launch, specially for mental health and behavioral health.
[13:41:11] You can see here that in December of 2020. It was mental health conditions that really were the most popular for telehealth. So it shows you how mental health through telehealth and behavioral health, substance abuse care through telehealth.
[13:41:31] It's really an opening to arrive and outreach populations, a lot faster.
[13:41:38] There are issues however with telehealth. I mean, there's been some compatibility of some treatments, being the same in telehealth as there in person.
[13:41:50] I have to say that we're finding that for some populations, it's not exactly the same. For example, we are finding for some populations, particularly that distrust the government systems. They might feel less willing to disclose in telehealth than in person-to-person. We also think that telehealth is great for people that are homebound or that can leave the home, but it's also important to try to get that physical presence connection so that people feel it's a human talking to a human and make sure that they get reverse correctly.
[13:42:36] I want to show you how we know that there's very little computer types of resources for people that are specially I want to show you Hispanics, which have a very small chance of really

getting services, a third of Hispanics and we're seeing this particularly in young Hispanics, do not have a computer, or do not have broadband to get access to information, so it's it's really important to think of that and the same thing I want to show you for blacks were 36.4 according to the census, do not have broadband, or computers. So one of the things we have been able to do is to expand and give you know actually computers and tablets to make sure that people can get to the services and receive the interventions.

[13:43:38] The other thing is mobile health clinics, this is particular particularly important for the outreach and also for medication management, we can do then reach people during their lunch break during their early entry through their work and provide them with me medication management for behavioral health, without having them to leave their work, or leave their children to get medication. It's also super important in terms of accessibility and cost effectiveness in making sure that you are close to where they are and taking out the transportation hurdles that we hear so much about.

[13:44:21] The other thing is integrated care and there are many, many types of integrated care. I get worried because a lot of people are saying they have integrated care, but actually it's not so much integrated care if you really are not talking across providers and making sort of a wraparound services that includes, you know, behavioral health specially, especially with a primary care worker primary care provider, with maybe a case manager and maybe a community health worker.

[13:44:57] That's the type of integrated care that allows for people to do share the, the responsibilities and challenges of giving a complete services. And I think it's really important to think that this could have incredible potential savings, you know, according to the agency of healthcare quality.

[13:45:21] I also want to say that integrated systems have to deal with neighborhood level factors, we are hearing in work we're doing in New York, for example, that it's not the same to do an integrated healthcare system close to rural communities because there's a lot of the unlikelihood of having behavioral health specialists in the area. And so it's different to do what integrated care in rural communities, or in areas that have a shortage of behavioral workforce.

[13:45:59] So, this is where telehealth combined with good primary care, combined with case management and community health workers to navigate the system can be so useful.

[13:46:13] And so really move the needle in terms of behavioral health care.

[13:46:19] I want to say a few things that have been shown that are needed, if we're going to move behavior, integrated care to the next, you know, to the next century to the next generation of a good services.

[13:46:33] We need to try to replicate models in other service sectors like etc. in rural communities, or in communities that where they don't speak the language like indigenous communities.

[13:46:46] We need to try to see how we could use the flow of information because sometimes we hear that information is not share, and that creates silos, and therefore no one knows what the other person is doing or how they are coordinating across themselves.

[13:47:04] So this is where collaborative care systems are very useful to get people talking to each other and talking about the challenges, they're having but specially problem solving those challenge.

[13:47:19] And then there's needs to be more transparency, both in who's getting reimbursed for what and how things are being done.

[13:47:28] I think this is a call to action. We know a lot of things we need to do and can do it really requires to build into our organizational partnerships to connect a cross policy groups grassroots movements and advocacy to make it happen.

[13:47:48] But this transformation can be done it's definitely useful and can be done. I think a few things that we want to say in terms of connecting to resources we need to get more bilingual, bicultural clinicians that gets served as bridges, for training and retraining our power professionals. We need peers or people with live experience to become part of the workforce in supporting each other's recovery.

[13:48:22] We need to build better academic community partnerships with people that can talk about what's available in the evidence.

[13:48:34] In terms of research in terms of new treatments, but also people in the practice sector that can reciprocally say what will work and what will not work in this communities.

[13:48:47] There's also the importance of preventive treatments and community-based organizations (CBO), one of the things we're doing is we're moving a lot of our interventions, a lot of our services to this CBOs as a line of really getting quickly to get people where people are.

[13:49:09] I want to also say, you know, it's true that we need social determinants. But we need them in a way that's sustainable. So we need to work with people in the community, to not only give food one time because there's the pandemic, but to actually make sure that we could deal with the job instability that people are suffering and trying to see what can we do in terms of better jobs.

[13:49:39] What can we do in terms of better built environments that are safer, where people can feel that they have, you know, safety and talking to their neighbors in letting their children play.

[13:49:52] We have to really think about affordable housing initiatives. And this is not I want to emphasize sometimes gentrification is great, because in moves the income levels of people in their community.

[13:50:12] But for those that have to leave is terrible, it really you know extracts youth, and families, especially poor youth and minorities families from their ties.

[13:50:22] And so we need to think about how gentrification and segregation play a role in our communities. And lastly, I want to talk about school mental health services because they're

underfunded, they're needed, and we need to make sure that we get to us earlier than we have before.

[13:50:40] I want to say we need to work at the book I see we need to do more policy level interventions. I think that DACA was a great example of showing the difference of family of youth that received the DACA, and compared to use that were legible and then receive or use that, that did not receive it, because they were you know legible and the experience of showing better outcomes academic employment, wealth, everything. We also need to move more loans to minority-owned business, make sure that we have campaigns to really attract linguistically and culturally minority business to our communities. And then, as the National Academies American report said we need to deal with child poverty, it's enough.

[13:51:37] It's enough we need to really, you know, make a better effort to make sure that we eradicate child poverty.

[13:51:46] And finally, we need to strengthen Medicaid home and community based services, and they have, we have to put a lot more in pain in reimbursement, and making sure that we extend open and special enrollment.

[13:52:01] Thank you very much for sharing this time with me and I'm looking forward to hearing your questions.

[13:52:09] Thank you so much for that great presentation, and I'm happy to say testament to your presentation I believe we have a lot of questions so I'm going to try to get through as many as I can and of course we can kind of work from there but I've been organizing the questions as they come in in different areas and there's a lot have come in around workforce and workforce development.

[13:52:33] Obviously your slides really highlighted the lack of diversity and the behavioral health workforce so we've got a few people asking questions in that area, and one in particular was asking.

[13:52:46] Since there are less opportunities given to the BIPOC population, what can organizations do to increase hiring diverse staff and political members? Are there ways that we can address the socio economic disparities that might lead to the low percentage of BIPOC individuals represented in the BH workforce? and I kind of merge those two questions together but I think they relate.

[13:53:05] So let me say that we have found that we can find that by BIPOC population, sometimes not.

[13:53:13] Not all in the professional population but I think what really makes a big difference that we're finding is giving people a job, that is, with a sufficiently high wage that has security. And that has training opportunities so right now, for example, we paid and I've said this before, $40,000 for community health workers but we give them, professional and training opportunities.

[13:53:44] We make sure that they have insurance, and we make sure that they see this as a path to move forward in terms of their social mobility and we haven't had problems recruiting base on those characteristics.

[13:54:01] One of the things we do is we go to community colleges. We have referral networks that we get from, you know, let's say, Hispanic, institutions, or from Asian institutions, or from people in the communities that know that we do work with diverse population as the word gets, you know, spread around as people talk about how they like or don't like working with us, or working in this institution. We get a lot more resources and a lot more people applying.

[13:54:39] We have sometimes started with interns, so for example this summer, we'll get 11 interns, mostly by BIPOC interns, and those are the ones that keep on with us and then we'll move on to get diversifying the workforce.

[13:54:54] And then later on they go into medical school right now. Two of the people that work with us one went to medical school and the other one is going to a PhD program in public health at Harvard.

[13:55:06] So it's, it's an opportunity to really you know escalate the academic field by getting them young, but investing.

[13:55:23] That's great and kind of related to that topic, actually, have you thought about or has this come up in your work and kind of how to make behavioral health and mental health services appealing to young people and particularly young people of color who may not be considering entering the field.

[13:55:41] So I think the this internships really help, because people see healing from a different perspective. They see it as an opportunity to really make a difference in people's lives.

[13:55:55] They see people from their community suffering and seeing the potential changes that can be done by connecting them to services by connecting them to resources.

[13:56:06] People really, it really reframes, what can be done in behavioral health professions. And then the other thing that I think is really very useful. It's actually going and talking to people and really explaining differences of opportunity in behavioral health. I think sometimes. For example, I went once to give a talk and people were very distraught in that dating want to become pharmacologist, they want it to really have a face-to-face connection.

[13:56:39] And so we had a chance of showing, they're very different types of psychiatrists, for example, so you don't have to necessarily be one of those.

[13:56:50] That's really helpful and I know that's kind of why we all get into the field too so that's great to hear, and we do have someone who just asked if you would provide the name of the internship program that of the oh it's right, it said the disparities Research Unit and Mass General Hospital. And so we take, you know, people that are interested, many of them get either in colleges credits

sometimes they, they actually paid them a stipend, sometimes we pay them a stipend, and they work with us, sometimes during the summer and many of them. Sometimes decide to come back and work for us after they finish college.

[13:57:37] And, and this is a little bit of a deeper question but it's something that comes up a lot and actually we've talked about offline too but as we think about workforce diversity and behavioral health and thinking of the difference between kind of general cultural competency and provider training but also really just getting down to having providers who have the same race and ethnic background as the individuals that they're serving so this individual asked when we talk about matching clients to clinicians have similar culture and race. And is this racist thinking.

[13:58:15] Is this the only way to kind of be thinking about this. And what's the importance in your experience of.

[13:58:20] Yeah, actually, you know in work we have done more important that race has been language, you know, matching on language. We've tested that sometimes, you know, it's not a not race and actually we have some our of our community health workers that are, you know, working with people that are not from their racial, ethnic background and the same for clinicians, I think that there is ways like I was saying in the presentation. There are definitely people that are extremely good at doing it because they take that time, they actually get training the sense of really trying to learn from the community.

[13:59:04] Some people for example to give you how much people, the things people do to train themselves. One of my best clinicians actually went to when people died from that community they actually went to this. I don't know how you call it the cemetery and actually met the community saw how people interacted, others have done visits to the home to see, you know, the environment that person, you know one person, like I said, went to visit the employment, places of people. I think getting to know like how people live. What is their experience but even in the clinical encounter, even with limited time. There's so much that can be done by trying to connect to that person in what we call social identities, what are social identities that that person has that you want to learn about more as a way to be able to connect in terms, not only of empathy, but actually cognitively trying to understand how is that person thinking how is that person feeling.

[14:00:13] And I think that that actually is more important than anything else. But we typically don't spend enough time.

[14:00:23] You know, a lot of the compliance that we have to doing in in behavioral health, a lot of the paperwork, a lot of the epic. It's taking away from the time to really get to know people and I think, you know, epic, I, I think it's terrible.

[14:00:40] Because it really takes away from the Connect, even the eye contact connection that you need to have that person think that you are present and that you're hearing and listening what they have to say.

[14:00:56] Yeah, that makes total sense. And before we move away from the workforce. This one was just coming in from reading life.

[14:01:10] In the 1960s there was a social experiment between a social worker and game called the vice Lords would try to show kind of shortcut successful history providing social services and youth opportunities in Chicago neighborhood.

[14:01:16] Due to the politics and disapproval of the then Mayor Daley. This program was closed down. So the question is, do you have any thoughts on how we prevent politics from the funding future programs, and promising programs that can keep people engaged.

[14:01:32] Yeah, I think that's an excellent question I'm really glad they raised it.

[14:01:37] Unfortunately, pop, politics, really makes a difference and what I would say is one of the things that I think it's super important in doing this community academic policy partnerships is bringing people at the community level, your county officials that can advocate and say no in this community we really need this because in this community we found that actually it has worked really, really well.

[14:02:06] So I would say that getting people from that community policymaking is so important.

[14:02:14] For example, in the Netherlands, they've seen that only the this partnerships work best when policymakers from the community are involved in the discussions here what the members are saying here why they want certain things and not others.

[14:02:32] And I think that that's actually quite important too. So I would definitely get.

[14:02:38] Try to get county level officials. If possible, involved.

[14:02:44] Yeah, thank you and I know that's something that that we're really interested in speaking as well so hopefully we can talk more about doing that future.

[14:02:53] And so we have, like I said many more questions so I'll move into and kind of the category of some of the research you shared around disparity so sorry, the beginning of the presentation.

[14:03:03] One of our early questions was, if you have any additional information on the reason behind the low rates of covert infection and death in Asian Americans compared to other racial populations during COVID-19.

[14:03:18] Well I mean I think there are several.

[14:03:20] I mean I think people are still trying to figure that one out. So, I am going to say just this is a hypothesis I have, but many Asian families are intergenerational and have lived in very close environments and they take a lot of precautions to actually try to deal with the possibility of, you know, when there are infectious diseases. For example, I mean masks were used in many Asian countries, way before the pandemic.

[14:03:54] And so they are used to using, I mean I saw them in airports for example I used to see them in. Sometimes people with mass, even before the pandemic. So I think they are more used to, because they have been, you know, sometimes living in close environments and intergenerational II and are afraid about their elders, older people getting sick. They're very cautious on certain things. I also think, you know, the other reason I'll say is has to do with Asians have one of the highest levels of education.

[14:04:30] And we know that education is something that helps in health, because you know health literacy is one of the areas that we need to invest more, and we haven't we really haven't invested.

[14:04:42] And then I think Lastly, I think, you know, sometimes we really think it might be geographically related. So there might be issues of geography, that that make a difference. So those are some of the ones that we, we could explore.

[14:05:04] Yeah, thank you for sharing what you you've known so far.

[14:05:08] And, and another question related is 1% asked, Are there different areas in the US, that have shown successful in being more inclusive and behavioral health field and having more diverse workforce I kind of assuming.

[14:05:23] But the question has been more inclusive and where does Massachusetts stand compared to other states.

[14:05:28] Oh, I have to say, let me start with the second one, Massachusetts have one of the highest disparities. we're in the fourth quartile.

[14:05:37] With regards to disparities if you divide the nation into cartels, with the first court they'll be in the best and the fourth cup court they'll be in the worst Massachusetts in the worst gay meeting, we have very high disparities, meaning the difference between what white person's get versus black Latinos, is a lot different. In Massachusetts, which is very tragic, given that we have one of the best. We have some of the best access and quality care in the nation to with regards to areas where there's really good. There are some areas that surprisingly are doing quite good, because they I think they, there's less difference whether that's good or bad, depends on the quality.

[14:06:31] But for example we're finding areas in in areas that have to do with the overall like for example one area is in Maine. They're actually showing a pretty good. In terms of. There's almost no disparities, but that might be also because they have a very limited number of racial ethnic minorities. So there are areas where they're more services, right on when people come in for example for refugees and asylum people.

[14:07:07] There are areas where there's less resources for black populations and by populations overall. In terms of the distribution in, in terms of clinical and healthcare resources so that's, I think part of it is the resources but part of it is the investment.

[14:07:29] Yeah, that makes a lot of sense.

[14:07:31] And so the next set of questions are kind of around treating individuals and perceptions and kind of generally categorize, but, um, so one that just came in was a as providers to our bilingual or bicultural mental health conditions.
[14:07:52] And do you have any recommendations on best ways to start helping or getting reaching out to offer your services for those clinicians for us a way to offer, could you read kind of strangely, so those direct question is what is the best way to start helping or who can we reach out to offer our services as bilingual, bicultural mental health clinicians and help minority population.
[14:08:17] oh I think that ideally you would connect with faith organizations with community-based organizations that serve that population, because they are really great organizations that serve, you know, those organizations and then put your name out as someone that is offering those services. I also think it's important to get into radio and programs where that population might be listening, because that's a way to say you know there's availability, you can do a program, talking about, you know, the work that you would like to do and that could be a way. And then the last thing I'll say is writing a blog or an article in in the newspapers, that servicing that population where you could, you know, talk about an important issue and make yourself known and then put your name out there as someone that is offering services.
[14:09:28] Yeah, and that's kind of another opportunity of kind of meeting people where they are and all of the themes are really highlighted so that's an interesting, an interesting stuff I hadn't thought of.
[14:09:45] How can you engage a client who responds, but they are unsure or have never thought about their how their culture affects their mental health concerns.
[14:09:54] Are there any screenings or other tools that might be helpful guide for starting those conversations. I think the best one is the diagnostic form cultural formulation, that's in the DSM.
[14:10:08] I really think it's a really, really useful way of starting the conversation about culture, because it asked about how you really perceive your feelings, what do you think causes those symptoms that you're having or what really is bothering you.
[14:10:25] What is your hypotheses about what that's happening.
[14:10:29] I think that did the cultural formulation guide that was developed by Roberto Lewis with, you know, obviously, a Harvard professor who I'm blocking. I think, you know, that is a great way of trying to get to the issues of culture. I also think questions regarding family life routines that people do, how they spend time.
[14:10:55] What are the things they value, what is their way of thinking about, you know, what they value the most and how they spend their time, those are things that definitely are very helpful in terms of controlling what is the culture of that person.
[14:11:13] Yeah, thank you.

[14:11:16] And, a related question that someone had asked was, do you have any recommendations for when a clinician is working with a family who continues to work with racist or discriminatory or discriminatory providers, through systems like DCF, and who are unwilling to recognize that organizational racism.

[14:11:38] Yeah, I am also very appreciative of that comment because I'm actually working with one of my mentees is actually trying to do an intervention in welfare systems to try to change the racism that sometimes happens by people misinform doing assumptions and just doing a really poor job in answer to the question to person. I really think it's very important to try to change providers if they find a race of providers that are tweeting them, and alternatives to that is really trying to see if their community-based organizations that are better suited to serve them, rather than, you know, going through the welfare system, if they have to work through the welfare system because you know for some reason they have to, then I think getting community advocates is one way to deal better with it. You know there's great community advocates that have gone together to well for visits or have gone together to other types of visits school, this is for example, where families find themselves being treated by racist organizations, you know making assumptions about them and that's a way to counteract the structural racism, very helpful.

[14:13:16] And another person had asked.

[14:13:22] As members of an individual's outpatient team, how can we help families, engage the stressors of their housing or manage I'm sorry the stressors of their housing situations.

[14:13:33] Yeah, I think that one of the things we have really spent time is actually having that case manager care manager that spends time with a person trying to see what are the needed steps to try to deal with our housing.

[14:13:52] So for example helping them feeling, you know, sometimes the application for vouchers, or helping them see if they're, you know, public housing kind of feel the application. Sometimes it is actually being able to talk to landlords, about, you know, how they're the it's unacceptable some of the things people are going through.

[14:14:17] So having that time from my case manager or care manager that we have really has people find it very helpful. It takes out some of the steam some of the anger some of the frustration.

[14:14:32] Some of the hopelessness that people feel because their life circumstances are getting worse and worse and no one seems to care. So I want to emphasize the importance of making sure that this resources are in place.

[14:14:46] I actually think we don't put enough resources for our patients to have those resources. And at the end, this is so critical, because if you feel frustrated, angry, If you feel hopeless.

[14:15:04] If you are in despair, there's very little you can do as a clinician to really try to move this person forward.

[14:15:14] Yeah, and I know that housing is a big issue that we kind of talked about a lot that can be difficult to move since there's so limited resources so it's really great to go from kind of a, what can we do perspective.

[14:15:47] Do you believe that services should be provided in the neighborhoods community centers, schools, Boys and Girls Clubs, senior centers, etc., that, which could serve as a more approachable place that might be for individuals who might be reluctant to seek mental health services to do feeling stigmatized can other services such as recreational programs for youth are elderly help others to network with others and interview girls.

[14:16:02] I couldn't agree more. That's why, for example, I think you services, use recreational services are excellent way to put behavioral health in schools, because that's where kids might be willing to talk to refer, but also to, to actually integrate one of the things I want to emphasize and I was trying to emphasize in recovery capital is this issue of integrating people that are left behind, or that feel socially isolated feel like they have no future.

[14:16:40] And kids you know one of the things I'm very concerned about is hearing so much suicidality in use today.

[14:16:48] And not seeing like kids are not going to go to their parents and tell them you know I actually feel I don't want to live anymore. So this is an area where having conversations when having appears we're really talking about how, you know, the and the isolation caused by the pandemic has made many people feel like that, you know, making it a natural thing that has happened, and that it's not only you that are overwhelmed and then talking about, for example Mental Health First Aid, talking about ways of taking care of your yourself, you know, meditation, breathing strategies to come back and society, you know, and then trying to bring people.

[14:17:40] Yeah, that's, that's fantastic. And I think it kind of circles back to the earlier questions about kind of changing perceptions of behavioral health in order to stigmatize for both providers and individuals seeking services and thinking of behavioral health, fitness, wellness and wellbeing too. Yeah, and I have for example I was going to say also employment support services, that would be the other one that's really important. Because, you know, there's so many people in our communities that are under employed or unemployed, sometimes that this is a way to really connect them to, you know, services to employment, and also to make them feel like there is an opportunity there is a way to get out of this hole. And, and also to feel better about themselves.

[14:18:34] Yeah, that's, That makes a lot of sense.

[14:18:38] And I know we have just a couple more questions, and probably only have time for a couple more questions but these specifically around telehealth so the first question was, regarding telehealth, is there any evidence of its efficacy and ongoing treatment for substance use issues, and even the efficiency or the advocacy for those clients who have recently discharged from the hospital.

[14:19:05] For there is evidence for substance use, I mean, but it really depends. Let me, let with a caveat. It really depends what type of substances are we talking about and it also depends very much on the severity of the substance use, I mean I think there is evidence of people doing for example, brief impatient, and then doing telehealth and finding specially for example, there are some studies in rural communities that it has proven to work for people to do a lot better and sustained remission for time period. There are, however, you know, we don't know for example about my faith that means there's a. We know very little about how we can treat it by telehealth. There are others. It really depends on the severity and also the comorbidities that that person might have. So, it is not a straight forward answer I'm sorry to say, because it really depends.
[14:20:20] What we are recommending doing is people really having a clinician, assess is this person ready for telehealth or do they need more in person treatment for a while, to really get the trust the connection.
[14:20:39] And then also have a better sense of where they are. And so it, you have to calibrate it based on that.
[14:20:50] Yeah, that's helpful and the second part was about hospital discharges and connecting to telehealth. Yeah, I think in terms of hospital discharges, absolutely.
[14:21:04] Let me say this, yes I think that you could do the hospital discharge and have someone that is before the person leaves gets connected to make sure that that person really can transition the person from one service to the next.
[14:21:21] I do think However, I'm a very big advocate of this, of having at least some in presence connection.
[14:21:34] Just because I think it really creates more of a bonding experience, or sometimes the person feels like this not a person I would want to work.
[14:21:44] And it's important to figure that out early on, so that there can be a change some other person, seeing them or second, you know, in trying to repair that that bad connection that happened because if not, you're going to lose the patient.
[14:22:04] Yeah. And this is a good segue into the next question which you've kind of started to answer but do you see the future of healthcare being telehealth.
[14:22:15] As we gradually kind of open up after the pandemic. Will we be seeing people go back to the office, or will telehealth continue to dominate.
[14:22:25] I think we're going to go into the hybrid of some people wanting to have in person we are are already seeing it, you know we're, we do, we have done telehealth for a long, long time.
[14:22:41] But now, some people are saying they want to get back to in person. I think telehealth says proven, the, the issue of transportation the issue of being more available for more people.
[14:22:53] I think it's obviously super important.

[14:22:58] But I think it's going to stay with us, just because it's so convenient for many people to do it.

[14:23:05] And I know I see up a question here I haven't been able to see all the questions but I really liked this question about some of her proposals are beyond our control especially for minority agencies.

[14:23:20] Better salaries Actually, no, I think, dead. You know we have to keep on advocating that we give people better salaries in this area. And I think it's going to be an issue of competition.

[14:23:36] For example, we, we are actually the block grants are supposed to improve, you know, some of this. But I also think we need more add what I bought se and I've been saying it over and over again, a better salaries for behavioral health.

[14:23:48] Because imagine that you were going to cancer, and you told people in cancer that you could only treat 45% of people that have cancer, there would be complete, you know turmoil people would be screaming out to policymakers, but we don't do the same for mental health and substance abuse, we don't say you know we don't have enough. We have an incredible shortage. We need to increase the pay line and we need to make sure that the federal and state governments put more investment in behavioral health.

[14:24:26] And I think we're going to have to start demanding that or if not, we're going to be going to be paying a big, big price.

[14:24:47] Well thank you for answering that and I think there were a couple other questions that I saw trickling in in the last couple minutes were very similar themes of how, how do we address kind of the financial barriers and, Yeah, other kind of elements that are not necessarily in our control.

[14:24:56] Yeah, I think they the, and this happens, I mean, I want to emphasize that I'm not oblivious to it, because many, many people that we see.

[14:25:08] Talk about and people, you can imagine people called saying we need some services.

[14:25:15] One of the things that we think we need to do is really sign petitions for more services I really think anything you can do, I mean I try to write articles as you have seen, I try to go everywhere, because I see the need and I see trying to get more payment for that, but that's why one of the reasons as use. If you've seen that Health Affairs paper that I went to write to policymakers and the same I'm doing and another paper I'm writing for policymakers in trying to see how we influence our policymakers to see the need for more investment in behavioral health, I think. Biden Harris administration at least in the end what they put forth in their plan.

[14:26:09] There are several things that are very much in line with what we're talking about.

[14:26:15] That's really encouraging to hear, and thank you for all, all the work you're doing. and advocating and I know everything I've read from your work and I do encourage others to go.

[14:26:25] Go read that themselves to has been extremely beneficial from kind of a managed care organization perspective where I am, but hopefully our policymakers are taking that into.
[14:26:37] I highly encouraged, if any policy makers are on the call and, but I want to take. And we actually I didn't have any other questions here. If anyone has a last minute question, I think we had, we're going to try if there's any, any lingering to see if we can answer them in a different way directly to you. So thank you again for all your questions. And so in the last few minutes I just wanted to take an opportunity to really thank you so much for your time, Dr. Alegria.
[14:27:06] It's been really an honor to hear from you. And also, you know, an honor to get to know you offline as well and I want to thank the two ASL interpreters that we've had.
[14:27:18] Julia and Veronica, and to thank you guys so much, and I also want to give you a chance Dr. Alegria if you have anything that you wanted to anywhere you could send folks who want to learn more about you or your work, or if you wanted to see more about your research.
[14:27:35] Yeah, absolutely, people can go to our website at the disparities Research Unit at the Mongan Institute and the Mass General Hospital in I you know I write a newsletter every month, Conversando con Margarita, you know conversations with Margarita.
[14:27:56] It's a very light, you know, newsletter because I really wanted to communicate to communities, and also show people with communities, the assets that community have to organize themselves and do amazing work, and they're doing it, you know, so I also want to bring forward how much communities are doing themselves, as something that doesn't get you know brought over. So yeah please feel free to contact me also, there's my email in the website and I'm happy to send literature or send information for people. And thanks so much Nancy and Kelsie. Thank you so much it's been a great experience.
Yes, totally agree, and thank you to all MBHP folks that helped behind the scenes, Nancy and others. With that, we'll wrap up the webinar. Just as a reminder, this will be sent out as a recording and transcript, and we will publish everything on the MBHP website and if you are comfortable with it Dr. Alegria, we can send the link to your website as part of that follow up.
Thank you all!