

Mapping Progress in Mental Health Disparities in a Transformed California Mental Health System

*Co-sponsored by
UC Davis Health System
Center for Reducing Health Disparities
and
California Department of Mental Health*

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**Thursday May 21, 1:30 pm – 3:30 pm
Afternoon Breakout Sessions**

4. Hard-to-Measure Populations: LGBTQ, Homeless, Geographically Isolated, and Proportionally Small Populations

Facilitator: David Grant, PhD

Introduction

- CHIS (California Health Interview Survey) is a statewide phone survey conducted every other year since 2001 (partnership with DMH since 2005).
- Can compare counties, by gender.
- Have some “rare” populations with “distress” who have 4 interview languages of people that live in households.

PROBLEMS:

- HIPAA requirements: Data must be shared properly. How do you do disease management if you cannot share data?
- Current survey must be funded and new questions require additional funding.
- Comfort and safety in the way questions on the survey are asked. We need to combat stigma (discomfort of people conducting survey). Need training for outreach workers.
- Surveys of clinicians that do intake and do data collection take time, expensive, seems to go to a black hole.

1. Question: If the homeless have high rates of mental illness, isn't assessing/tracking them crucial to tracking mental health and mental health care in CA?

Answers:

- Captive sample when in shelters. It is possible to assess mental illness among shelter population.

- What is the definition of homeless? Use self-identification? Broaden definition, e.g., “couch surfing.”
- Operationalized definitions vary. Federal level vs state level vs local level to serve them.
- Local communities serve them daily—they should be the ones who define who this group are—but need standardization to track them statewide.
- Measurement best done locally as CA is very diverse.
- At state level, it is a quality and infrastructure issue.
- Would be useful to get veterans data. E.g., how many homeless veterans? What are their conditions and needs?
- To get food, persons use different names/aliases. This makes measurement and tracking difficult.
- How do you measure subpopulation that do not accommodate in shelters? Different reasons why they don’t go to shelters: PTSD, couples, children, pets, etc.

2. If we can’t identify a large proportion of those who are LGBTQ, how can we assess need in this population?

- a. Asking about sexual orientation is not always appropriate. When appropriate to do so (e.g., surveys), may not get a true answer. Are there other approaches to assessing need?
- b. E.g., suicide hotlines with special telephone numbers for LGBTQ. E.g., should we offer targeted services to LGBTQ for the purpose of assessing the level of use of these services (as well as perhaps for other reasons)?

Answers:

- LGBTQ are a disaggregated population. How gather group? Connecting and engaging with this “community” is difficult because community is diverse.
- Definition: self-identification? Need to use more than one definition: a range: women-loving-women; lesbian; queer; sex you were born. But what about standardization for tracking?
- Identify at several points sexual orientation and same sex attraction (transition).
- Feasibility: need to go where they are. Determine number and track them.
- Confidentiality, anonymity important. How do you achieve it?
- Cultural diversity among LGBTQ. Language and cultural barriers. Does LGBTQ terminology when directly translated mean the same thing culturally? (E.g., Latino immigrant men who have same-sex sex but don’t identify as “gay” or “bisexual.”)

- Need to combat stigma from people and mental health providers asking the questions.
- Workforce needs to be safe before it can ask population to “come out.”

INSIDE THE BOX:

- At point of contact with mental health providers, need to ask questions about family support, sex attraction, etc.
- Mental health providers need to engage these communities. Need to have integrated programs so they can come to one place for services.
- Need resource listings.
- It is about quality of care and having services.

OUTSIDE THE BOX OR IN ANOTHER BOX

- School boards and county offices of education need to be involved. Service for first 5 years should be involved: Healthy Start, etc.
- Other state systems that have this capacity to measure and assess: Department of Alcohol and Drug Programs, Department of Rehab, Child Welfare.
- Primary health care involvement.
- Again, staff need to be trained and need to be sensitive.
- Organizations that attract community should be involved; e.g., all organizations around Prop 8, social networking sites, and TREVOR PROJECT (warm line services).
- Questions on sexual orientation and gender identity that are culturally sensitive **NEED TO BE IN THERE** (e.g., CHIS, in-take forms for programs). Questions should be first field tested on-line.
- Help all counties revise forms to see if they reflect the diversity of the present population in CA.
- Seattle has done great work in this regard.

3. Question: Don't the geographically isolated and other proportionally small populations (e.g., migrant agricultural workers) have special problems associated with assessing mental health need and care?

Answers:

- Do they use services in Mexico? What is their experience?

- Need bridge services, continuity. Relationships among countries, states, and counties need to be established.
- What are their needs? Do we know?
- Rural counties do not hire Latinas/os. Workforce issue.
- Tracking is difficult because of fear of ICE (Immigration and Customs Enforcement).

Other:

- **Transitional Age Youths (TAYs):** Biggest groups with mental health care needs are LGBTQ youth and foster youth.
- **LGBTQ teens:** How many 12 to 17 years old wanted to access mental health but could not because did not want to tell parents? Or how many 18–24 wanted, when younger, to access mental health, but could not, because needed parental consent? Role of elders, parents with LGBTQ youth? Can create problems if child is afraid of parents or elder.
- **Prison and parole populations:** problems with services being reduced and deinstitutionalization.
- **Disabled people:** problem with access and no good reporting.
- **Alcohol and Drugs:** Self- medication. We have separated drug abuse/treatment from mental issues. How to track in prisons or in treatment? Comorbidity between substance and mental disorders is 40% or higher. Need integration of services and holistic care.
- **Veterans:** New wars, high rates of suicide, pushed into VA. Vet is someone who is retired from the military. Discharged with personality disorder that is a precondition (not related to war or injury). Domestic violence (physical, emotional, other kind of abuse). Funneled to patient education program and cannot seek private care.
- **Hmong**
- **Refugees**