Governor's Task Force on Mental Health

CULTURAL LENS: PROBLEMS AND POSSIBLE SOLUTIONS   draft as of 9/23/16

This document lays out problems/opportunities and possible solutions for using a cultural lens to improve services and supports and reduce mental health disparities in five categories. It concludes with questions to pose to the Task Force on September 26, 2016.

A.   Medical Model vs. Culturally-based Healing

Problems and Opportunities:

1. Minnesota's mental health system is currently based in a medical culture that many people find confusing and poorly-aligned with their own values and intuitions about health.
2. There are cultural practices provided by cultural healers outside of Medicaid reimbursable services that are many times more effective than the Medicaid reimbursable service. There is no existing mechanism to reimburse a cultural healer, a crucial mental health provider in many communities.
3. The diagnostic assessments that have been written into Rule 47 (the outpatient mental health rule) have created additional barriers to services and are particularly pronounced in culturally diverse communities where there already exists many other systemic barriers.
4. Real disparities in services and health outcomes exist in our system and the way services are provided currently is not working for all Minnesotans, especially for people of color, American Indians, and people from diverse cultural backgrounds.
5. Communities of color and American Indians in the United States face a social and economic environment of inequality that includes greater exposure to racism, discrimination, violence, and poverty. Living in poverty has the most measurable effect on the rates of mental illness. People in the lowest strata of income, education, and occupation (known as socioeconomic status) are about two to three times more likely than those in the highest strata to have a mental disorder.
6. Cultural background and individual histories influence a person's understanding of what the medical model calls "mental illness" and the willingness or ability to form trusting therapeutic relationships.
7. Negative perceptions surrounding mental illness in many cultures often prevent people from seeking treatment, which can have serious consequences.
8. Untreated mental health conditions like depression are the leading cause of suicide. American Indian youth have the highest suicide rate in Minnesota.
9. Engagement in the treatment process is one of the most crucial predictors of successful treatment and yet there is no reimbursement mechanism for building engagement prior to or as part of assessment and treatment planning.
10. The entire process of accessing mental health services in Minnesota is fractured and difficult to understand; it is even more complicated for someone not familiar with the dominant language and culture. The lack of integration and coordination can result in many people from culturally diverse communities declining to seek care, or failing to find the services they need.

Possible Recommendations:

Treatment should be culturally relevant to the person. One way is to acknowledge and make use of cultural healing practices as a part of the continuum. Another way is combine the best of western medical interventions with a full range of healing modalities that are culturally relevant to the person. To achieve this goal, we could recommend the following:

1. Establish a group of people from multiple cultural backgrounds to explore how culture fits with our understanding of mental wellbeing and mental illness. With this background, the group could develop expanded definitions of wellbeing, mental health, and mental illnesses that would be more responsive to individuals' cultural backgrounds and self-understandings.
2. DHS will include a means of providing a reimbursable part of mental health treatment, particularly if it could be done pre-diagnosis. This will include multiple sessions needed to establish a therapeutic relationship prior to a formal diagnostic assessment.
3. Look at our state rules, statutes, and processes and the Centers for Medicare and Medicaid Services (CMS, the federal agency that enforces Medicaid nationally) rules for where we could be more flexible than we have been in the past. The focus is to reduce barriers and increase access.
4. Create a seamless, integrated system of care that is not based on what can be paid for, but on what the consumer/family needs. Allow mental health agencies to afford to be able provide treatment and ancillary services needed in order to increase the wellbeing of the person. While our state is currently in the planning stages of applying to become a demonstration state for the Certified Community Behavioral Health Clinics, we must examine how to support this type of model with or without federal demonstration dollars. Consider restructuring how the state administers Medicaid dollars.
5. Create or implement assessments that are culturally relevant.
6. Invest in prevention and early intervention. Many of the communities suffering the greatest inequities are not high utilizers of mental health services but are users of other systems (child protection, special education, corrections, etc.). In order to provide true access to mental health services, we must start the continuum much earlier than what our current system allows and not view prevention and early intervention as "soft" services, but as essential parts of our continuum of services, and therefore as part of the benefit set for people with both private and public health insurance.
7. Train and implement one of the various types of feedback-informed treatments that involve creating an intentional process of engagement, feedback, and reparation in therapeutic relationships. Receiving feedback from clients has been shown to boost the effectiveness of therapy, increasing client's wellbeing and decreasing symptoms, dropout rates and no-shows. In order to create a "culture of feedback" and receive such feedback, the therapist has to present an environment that is supportive of honest feedback.[1]

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[1] Research shows clients who provide feedback about their treatment showed about twice as much improvement as clients who didn't provide feedback and in fewer sessions (Reese et. al., 2009).

B.   Supporting and Growing Culturally Specific Providers

Problems and Opportunities:
1. There are existing rules and guidelines about cultural competency and language accessibility, but they are not always followed.[2]
2. Some of the guidelines for cultural competency and language accessibility will be explored further to make sure they actually promote culturally-competent care.
3. Healers and providers from cultural communities often have shared histories with consumers and thus experience "secondary trauma" as they provide services to their clients. This can lead to burnout and loss of crucial expertise. On the other hand, reciprocal healing can also occur.

Possible Recommendations:
1. Increase the availability of culturally-responsive and culturally-specific services across the state (e.g., by supporting training for mental health providers from many cultural backgrounds). This would require special attention to collaboration with American Indian tribes whose unique relationship with county, state, and federal governments creates both challenges and opportunities for increasing access to culturally-specific care for tribal members.
2. Figure out how to expand and support community-based healers. For example, cultural navigators and cultural healers should be paid members of treatment teams when appropriate for the person. This can be crucial for the person's engagement in the healing process.

3. Figure out how we can incorporate cultural healers, cultural brokers, and elders into existing service structures. In addition, examine current provider standards, such as ones for certified peer specialists, peer recovery specialists, family peer specialists and mental health practitioners for barriers that may be preventing the expansion and diversification of the workforce and make the changes needed in order to support this.

4. Develop support mechanisms for providers from cultural communities who share histories with consumers and thus sometimes experience "secondary trauma" as they provide services to their clients. These support mechanisms should be developed in consultation with these healers themselves.

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[2] The HHS Health Resources and Services Administration [HRSA] found that health professionals who lack cultural and linguistic competency can be found liable under tort principles in several areas (2005). For instance, providers may be presumed negligent if an individual is unable to follow guidelines because they conflict with his/her beliefs and the provider neglected to identify and try to accommodate the beliefs (HRSA, 2005). Additionally, if a provider proceeds with treatment or an intervention based on miscommunication due to poor quality language assistance, he/she and his/her organization may face increased civil liability exposure (DeCola, 2010). Thus, culturally and linguistically appropriate communication is essential to minimize the likelihood of liability and malpractice claims.

5. Develop a mechanism to allow providers and consumers to provide DHS and other government systems with feedback on necessary changes in services and policies from providers' and consumers' perspective. The focus should be on ensuring that diverse communities are represented, and that there is a shared system of accountability for providers and government agencies to take action on the reduction of systemic barriers for diverse communities.
6. Cultural consultation should be reimbursable.

C.   Our mental health system needs to be more trauma-informed

Problems and Opportunities:

1. Toxic stress and trauma are barriers to achieving wellbeing and they can lead to self-medication, addiction, and mental illnesses if people are not supported to work through them in ways that are personally and culturally meaningful for them. Toxic stress and trauma are especially prevalent in cultural communities with histories and experiences of poverty, genocide, forced resettlement, being targeted by racism, and being offered one-size-fits-all treatment options that aren't culturally meaningful.
2. Responses to trauma are sometimes interpreted as bad behaviors or symptoms of mental illnesses when it could be more useful to see them as rational responses to untenable life conditions. For example, focusing on an individual child's "resilience" in the face of crushing poverty, danger, or trauma is to mis-identify what needs to change. Children need support, but it's the social conditions—not the children—that are problematic. The mental health system needs to recognize and understand this dynamic in order to address the mental health needs of cultural communities.

Possible Recommendations:

1. Research the prevalence of trauma in Minnesota.
2. Minnesota should invest in treatment modalities that have been particularly effective for culturally diverse communities. For instance, Trauma Systems Therapy for Refugees (TST-R) is one such possible model.[3] This therapy is specifically designed to reduce barriers to mental health services commonly faced by refugee youth and families through the following:
   a) Reduce distrust of authorities by engaging community
   b) Reduce stigma of mental health services by embedding services in existing service systems
   c) Reduce linguistic and cultural barriers by creating a partnership between providers and cultural experts
   d) Reduce primacy of resettlement stressors by integrating services.

   In addition, because of the engagement and prevention nature of TST-R, this model

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[3] TST-R focuses on the experience of trauma that refugees face, from pre-migration, during migration, and during resettlement and beyond. TST-R is not limited to one specific trauma type. Most people who participate in TST-R have experienced multiple traumas as well as enduring other stressful experiences. TST-R also addresses social environmental factors associated with trauma exposure such as poverty. Target population include newly arriving, recently resettled, and established refugee youth and communities. TST-R has been adapted for use with Somali, Somali Bantu, and Bhutanese refugee youth. Other cultural considerations include various religious backgrounds including Muslim, Buddhist, Christian, and Hindu. English is the primary language used, however cultural brokering is utilized. TST-R targets refugee youth who are having difficulty with emotional regulation capacities and the ability of the child's social environment and system of care to help them manage emotions, or keep them safe.

could serve many children and families beyond refugee communities.

3. Promote American Indian culturally adapted Trauma-Focused- Cognitive Behavioral Therapy (TF-CBT), developed by Dr. Bigfoot in Oklahoma.
4. Research and promote other culturally specific trauma informed treatment and other practices. Providers in the community utilize many established treatment practices that have been highly effective for children and adults and should be engaged in adding to the body of knowledge.
5. Working from a trauma-informed perspective involves more than just the services delivered – this also involves working conditions that are also trauma-informed. Trauma-informed organizations emphasize the physical, psychological, and emotional safety of both providers and consumers. Organizations that practice trauma-informed approaches are more likely to be able to support providers and consumers towards wellness, and to decrease the impact of vicarious trauma and burnout for their providers. Establish guidelines, grants, and technical assistance to organizations willing to undergo the process to become trauma-informed.

D.   Evidence Based Practices, Practice Based Evidence and Promising Practices

Evidence-based practices are particular models of health promotion, prevention, early intervention, treatment, community supports, or crisis responses that have been tested and shown to be effective. Basing choices about services and funding on evidence is important for ensuring quality of services and system sustainability, but this practice also raises challenging questions.

Problems and Opportunities:
1. Evidence Based Practices are often developed within the Western medical model and with homogeneous populations. They may not be appropriate or effective, especially if the person being served does not share a cultural background with the population upon which the practice was developed and tested. Evidence gathered within a particular cultural group might not be very instructive when applied to another cultural group.
2. The process for being certified as an "evidence-based practice" is very specific, which means that some practices can be considered "evidence-based" with a fairly small amount of data in limited settings and with limited populations
3. Currently, many evidence-based practices are expensive and providers pay in two ways – for the trainings themselves and follow-up certifications, and in lost revenue due to being in training. In order to continue to uphold the highest standards of treatment, we must create a means for providers and agencies to be able to afford to get and maintain training.

Possible Recommendations:
1. Practices need to be flexible to accommodate the individual and cultural practices of the people being served. "Practice-based evidence"—evidence based on everyday clinical practices—should also be recognized as an important basis for deciding what services and models to follow,

especially with cultural communities.[4] As clinicians work with the many culturally diverse patients they encounter, cultural perspectives are exchanged and negotiated.

2. Public funds should be used to create a demonstration grant to gather evidence that could lead to more sustainable funding options. Perhaps a Return on Investment (ROI) study could also accompany it.
3. Research and implement Medicaid funded cultural activities.
4. Public funds should be used to establish and communicate practice-based evidence about culturally-relevant practices.
5. State agencies should be more transparent about how Evidence Based Practices are viewed and why some EBPs are preferred to others. There should be formal and open conversations with stakeholders to identify and sanction new EBPs, promising practices, and ongoing conversations to change as new developments are made in the field. Create a long-term financially sustainable plan for training providers in appropriate treatment modalities, including EBPs.
6. Clinical expertise of providers must be a part of all of these conversations. We must not forget that providers at different levels already have requirements for training, supervision, or experience (depending on education, work class, etc.) and while we need to continue to refine a system to increase the effectiveness of services, we cannot create a system that becomes so over controlling and bureaucratic that it takes away individual clinical expertise.

E.   Roles and Funding of State, Tribe, County, Providers and Communities

Problems and Opportunities:

1. Right now there is fair agreement that Minnesota should focus more resources on defining and supporting more culturally-responsive mental health activities and services within all seven functions of the mental health continuum of care, but no one agency or organization has responsibility for this. Thus efforts are fragmented and overlapping. More coordination and clarification of accountability are needed.
2. There is a need to define who has what responsibility and how coordination can happen.

Possible Recommendations:

1. Assign responsibility for defining and supporting cultural-responsive mental health services and activities and clarify what agencies, organizations, providers, and consumer groups should be involved. The parties identified should paint a vision for a transformed mental health system that could be culturally-responsive and person-centered and that could reduce disparities. Lay out the range of roles for people in such a transformed system. Suggest concrete steps that could be taken to move toward this visions (e.g., by funding cultural healers through formal mechanisms like Medicaid reimbursement).
2. Fund the work of supporting culturally-responsive mental health services.
3. Identify accountability and funding for ensuring that existing rules about culturally-competent care and language accessibility are enforced.

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[4] Includes 1) recognizing problems in daily practice that produce dissention between recommended and actual care, 2) examining whether treatments with proven efficacy are actually useful and sustainable in the context of real life, and 3) examining how structural and organizational factors may be shaped.

4. We recommend the creation of a feed-back loop where DHS and other government systems can receive feedback on changes in services and policies from providers and consumers, with a focus on ensuring that diverse communities are represented, and that there is a shared system of accountability for providers and government agencies to take action on the reduction of systemic barriers for diverse communities.

F.   Questions for the Task Force

1. Are there particular recommendations that you'd like to add or remove?
2. Is the system ready to embrace these ideas? What do you see as the major barriers to our recommendations?
3. Given all of the barriers that you have identified, which topical areas or particular recommendations would you advise us to focus on first?