



Children's Behavioral Health System of Care

Ensuring Equity Working Group

May 20, 2021, 3-4 pm

See referenced deck here: <https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2021-05/CBHSOC%20-%20Ensuring%20Equity%20Presentation%2005.20.21.pdf>

**Meeting attendees:** Marti Rosenberg, EOHHS, Samantha Brinz, RIDE, Jesse Hunter, CPNRI, Tina Spears, CPNRI, Danielle Loughlin, Perspectives Corporation, Melissa Santoro, St. Mary's Home for the Children, Ruth Tureckova, Frank Olean Center, Veronica Bourget, PSNRI, Maria Terrero-Kamara, DCYF, Charlotte Kreger, EOHHS, Jordan Maddox, BHDDH, James Rajotte, EOHHS, Jenny Bautista, BCBSRI, James Simon, Perspectives Corporation, Susan Duffy, Hasbro Children's Hospital, Susan Hayward, BHDDH, Kayla David, FSRI, Trisha Suggs, BHDDH, Danielle Cyprien, PSN, Alyssia Ramos, Groden Center

**Minutes:**

Charlotte Kreger introduced the agenda:

1. Welcome and introductions
  - a. Zoom rules: please mute, introduce yourself in the chat, use the raise hand function
  - b. Intros from speakers:
    - i. Charlotte Kreger from Policy, Planning, and Research Unit at EOHHS
    - ii. James Rajotte, Chief Strategy Officer for EOHHS
    - iii. Jordan Maddox, statewide youth coordinator on Healthy Transitions grant from BHDDH
  - c. Charlotte reviewed some general ground rules (see slide 5)
2. Workgroup purpose
  - a. Statewide planning process for Children's Behavioral Health System of Care
  - b. 6 other workgroups are working over the next four months to be able to achieve implementable goals
  - c. Make sure this planning process is aligned with current and future statewide initiatives, as well as the other workgroups
    - i. Want to create formal liaisons between workgroups
  - d. Meeting goal: listen to the community about inequities in the system and think about how to address these inequities in the short and long term
    - i. We want to think about these things intentionally, and think about who else we need at the table
3. Setting the state – An Equity Primer: James Rajotte
  - a. Start at the highest levels within the Secretariat, we are focusing on the following priorities, which all are relevant to this workgroup: improving access, shifting systems to



equity, addressing the opioid epidemic, and promoting efficient and effective delivery of services

- i. This group ties into all 4 of EOHHS's key strategic priorities
  - b. Focusing on 3 guiding principles:
    - i. Choice
    - ii. Race Equity
    - iii. Engagement
  - c. We need to understand how our policies and programs impact communities of color, and think about how we can pivot based on what we hear from the community to improve our services
  - d. What is Equity?
    - i. Fair opportunity to achieve their full potential
    - ii. Reality: resources distributed unequally; Equality: resource distributed equally but don't take into consideration the differing starting positions; Equity: everyone gets the support they need to succeed; Justice: the barriers to success and inequities in the system are removed
  - e. Behavioral Health Equity:
    - i. Access to services should be available regardless of race, ethnicity, gender, SES, sexual orientation, geographical location, etc.
    - ii. Need to consider SDOH
  - f. Race Equity and other "-isms"
    - i. Socioeconomic status does not explain away the differences between populations. There are ingrained biases and historical inequities that are perpetuated and have an outsized impact on those populations.
4. Community Feedback and Discussion
  - a. Danielle C: 80% of our BH support comes from outside of providers. A lot of support people get from their mental health come from outside of healthcare system. Speaks to the responsibility and importance of the communities to support those who have BH disorders. Some of the injustices that need to be focused on are the criminalization of BH on communities of color, as well as destigmatizing BH needs within communities of color, which also includes changing the narrative of what getting MH help looks like. It's not one route to therapy but looking at holistic approaches and normalizing that. Most people of color don't have access to quality healthcare. Even when they do gain access to it, it doesn't mean that doctors will abide by that and treat them the same. Sometimes people are denied services based on judgments. This is all backed up by studies and reports—there is quantitative data to back this up.
  - b. James R: I challenge all of us in the workgroup to think about our words. We same "to be treated the same" – that's still equality, not equity. We need to make sure individuals have access to the services they need and deserve, not just the exact same type of services others get. I.e. Maybe they need a 3-hour appointment, not a half hour, or



maybe they need transportation and other supports in addition to their treatment. Let's hold ourselves accountable to changing the narrative.

- c. Charlotte: let's make sure we're thinking about the Children's BH system of care. We need to hone in on where the inequities are for children, families, and youth in the system.
- d. Veronica: I'm returning to RI from FL, so I'm getting back into the swing of it. How are we doing as a state with children who need residential treatment and went out of state? Do the children have voices, or is just their parents? Can the youth speak on their own behalf?
- e. Charlotte: That's one of the answers to who's missing: kids, the youth voice. How can we invite them to this group? If anyone has experience or thoughts of how to listen to the kids who we're trying to improve the system for, please share.
- f. Susan L: DCYF facilitates the care for children who need out-of-state care for BH or IDD needs. Our numbers are down to the lowest they've been—61 children are out of state. The majority are in a 35-mile radius. We're responsible for these children who are out of state and DCYF understands and is trying to move towards the idea of family voice and choice. They need to be partners with us to help plan care for their children. We are improving but there is always more to do.
- g. Alyssia R: I oversee residential services at Groden Center. We need more education in terms of the public understanding the population we service—intellectual and developmental disabilities, ASD, also the members that are impacted by racial inequities. Additional component of access to resources is a barrier. Providing our residents the services they actual need: more staff support, more clinical support, more oversight. We need to be able to fund the services that they need. The community needs to understand that there are limitations that need to be better supported. It might take longer or need to be taught in a different way.
- h. Susan D: pediatrician who works at Hasbro ED. Cares for patients with acute mental health needs—to support what everyone is getting at: the treatments for MH care for children don't align with cultural values of families and communities. There's not enough of an individualized approach to what children need—whether they're more concrete services, or home-based services. There are few options of choice. There is a shortage of services, but we haven't placed enough value on the cultural alignment of services.
- i. Charlotte: any quick ideas about how we could approach that and improve the alignment?
- j. Susan D: My lens is through an ED physician. It's a lack of a diverse provider population that come from diverse cultures. When assessing someone for a treatment plan, need to consider needs of the whole family, and align with culture. Change in attitude based on what patient/family needs – a global approach.



- k. Danielle C: an example—sometimes MH disorders are seen as spiritual or demons. There are differences in cultures surrounding how to treat certain illnesses at home, discipline, different standards of what’s abuse, how to parent, etc. We could get people from different offices who work with diverse populations to come in and speak to explain cultural preferences and ideas.
- l. Veronica: We could also get people from those placements from out of state and learn from other states who might have other creative ideas.
- m. Maria T: When we’re looking at clinical assessments, we need to look at it with a cultural lens. We might look at a child and think they need individual therapy. However, that might not work for some families. We’re missing the immigrant population—which is a serious determinant of health. These groups have individual needs – let’s add another part of it, to consider cultural lens. When do we do that? The ED? The CMHCs? The health insurance plans? Can they require this piece so we can do individualized treatments for families? We have a shortage of culturally diverse providers. How do we facilitate an improved workforce? How do we train these folks and do a search for these providers?
- n. Jesse: Perspective of children with disabilities, looking at race equity question specifically with Hispanic families. Some of the strategies: looking at it systemically while working with providers, looking into what other states are doing to enhance the cultural competence of their workforce. We’re doing focus groups with families—we’re struggling with engagement. We have treatments, but if you can’t even get people into the treatment, then that’s the first barrier. I would suggest doing some focus groups with families that the system is working for them—what treatment approaches work for them? Look into the treatment assessment tools—one example is that a child is assessed based on if they can pick up a cheerio, but that might not be important in their culture. Let’s look into the cultural biases baked into our assessment tools. Who can we find to help develop more culturally competent assessment tools? It’s important to ask the families what their barriers are.
- o. James: How do we do listening sessions with groups of families? How do we understand from their perspective what MH means, maybe partner with clinicians in training. What would be the ideal type of treatment? With whom? Where? We could consider redesigning treatment approaches according to what we hear. Ask families what keeps them up at night to learn what we should prioritize.
- p. Veronica: the word engagement is big and we’re struggling to engage people because of the pandemic. We could go through a parenting group, which could give us information on what we should look into. The parents have been in the system of care and are receiving services.
- q. James: **Next steps: brainstorm where we need to go to engagement and who? Parenting groups? Community Groups? Youth groups?**



- r. Jordan: the underlying issue is the stigma behind mental health. That is the first and most important thing: understanding where these families are, and what MH means to them, and how they see the stigma. How is it a stigma to them? Is it cultural? Or is it just that they don't want their kid to be bullied?
- s. Veronica: even the language itself can be stigmatizing
- t. Kayla D: The stigma is a huge impact, and by the time people come into services, if they're not treated appropriately and discriminated against—because we don't have training for providers to be competent—even by their own parents (i.e. in the LGBTQ+ community). There are places that are accessing providers who are not informed—beyond the LGBTQ community. We need providers to be culturally aware and informed. What are kids getting when they're walking in the door? Is the paper culturally appropriate? There is a unified response and assessment, regardless of where they get services.
- u. James: The initial engagement for a psychiatric appointment is so much more high stakes than a medical appointment. If someone has a bad experience, it can be a blocker and the patient won't seek treatment ever again. How do we reframe, and think about, that initial engagement? Starting with the paperwork, providers need to be extra aware to support certain populations.
- v. Kayla: for everyone, no matter how people are presenting coming in, considering the differences between gender expression and gender identity. People in the mental health field are uncomfortable talking about these things.
- w. Samantha: So much happens outside of treatment—in the community, in schools. Consider: community before content; community before treatment: who are our families, our patients, consider an asset-based shift in thinking. What does wellness look to them? Reduce stigma—where can we have a common vision for a continuum of wellness and a common language across agencies.
- x. Danielle L: my perspective comes from a disability lens. That first introduction to that person, before I go in to talk to deaf and hard of hearing families. It's hard to get that help in RI—a lot of places don't follow the ADA, it's hard to get access to treatment in the state. That's one thing: you have to consider the time and how that access is going to happen.
- y. Charlotte: The deaf and hard of hearing perspective is often one that's missing. This is another community and population that's not thought about for access—not just care, but to meetings like this and to be able to advocate for themselves.
- z. Danielle C: There are a lot of meetings that I'm in, if the providers on those meetings aren't open to hearing from other populations, then it shuts down the entire project. There are so many other meetings that affect entire communities and it's hard to get into the meetings and there's no guarantee that you'll be listened to. In some meetings, promises aren't kept, things kids say aren't respected. We need to create an



environment that actually does the work. We can't make commitments we won't follow through with. Youth will walk away if they don't feel like they're not listened to.

- aa. Trisha S: The same with data. We're missing entire populations of color. They're not approached for surveys, so we're not getting their perspectives. My family (who is biracial) barely go to primary care physicians. That is not a relevant entry point to engage communities of color. If you're not going to certain places, you're not going to get services or referrals.
- bb. Danielle C: The outreach team needs to go to houses, not just providers.
- cc. Trisha: We have to think outside the box: houses, neighborhood corner stores
- dd. Marti: **Will bring that back to the Outreach team.** I want to underline what others have said: its can't only be here in this workgroup that we're talking about equity. I'm gleaning that we have to bring this over into the other workgroups. There is where we need to be making real, the points we're all raising about equity. We need expand from here out to all the other work. Let's look at the deck and edit it, and it's reflecting the perspectives we're bringing to the table.
- ee. James: please continue to add comments in the chat to capture for notes.

#### 5. Next Steps and Logistics

- a. We want to bring this group and its goals to the other workgroups, so we're all on the same page, and the other groups can apply it to their work
  - i. **Email Jordan if you want to be the liaison for any of the other workgroups**
- b. If you're already on a workgroup, we want to formalize these liaisons to have this feedback and connections
- c. We want to make sure this group has a community co-chair to help during the off weeks and talk about formulating agendas, thinking about strategy, and the development of this work and how the meetings go. To engage deeper beyond the monthly meetings.
- d. Meeting the third Thursday of the month from 3-4 pm
  - i. Community co-chair would meet another time
- e. **Focus for next meeting:**
  - i. Getting providers and community on same page, hearing back from youth and parents, addressing stigma
  - ii. Do we need to meet outside of the normal business day to expand access? Or meet twice monthly and add another meeting time?
  - iii. Challenge: for the next meeting, bring a buddy. Bring someone to engage in the conversation to expand our impact.

#### 6. Adjourn

#### Zoom Chat:

15:02:03 From Marti Rosenberg to Everyone : Marti Rosenberg (she/her/hers) - EOHHS

15:02:19 From RIDE\_Samantha Brinz to Everyone : Hello, Samantha Brinz, RI Department of Education, she/hers



15:02:21 From Jess Hunter to Everyone : Hi! Jesse Hunter, Pronouns: They/Them/Theirs, CPNRI

15:02:27 From Tina Spears to Everyone : Tina Spears, Community Provider Network of Rhode Island (CPNRI). She/Her

15:02:28 From Danielle Loughlin to Everyone : Danielle Loughlin (she/her), Perspectives Corporation, dloughlin@perspectivescorporation.com

15:02:32 From Melissa Santoro to Everyone : Melissa Santoro, she/her/hers, Director of the Outpatient Department, St Marys Home for Children msantoro@smhfc.org

15:02:40 From Ruth Tureckova, Olean Center to Everyone : Ruth Tureckova, she/her/hers, Frank Olean Center

15:02:40 From VERONICA BOURGET to Everyone : Veronica Bourget, PSNRI, Child & Family Statewide, Manager

15:02:52 From Maria Terrero-Kamara DCYF to Everyone : Maria Terrero-kamara, She/Her/Hers. Community Services Behavioral Health, DCYF.

15:02:53 From Jenny Bautista, Diversity Equity and Inclusion Mgr. (she/hers) to Everyone : Jenny Bautista, she/hers, DE&I Manager, Blue Cross & Blue Shield of RI, jenny.bautista@bcbsri.org

15:03:08 From VERONICA BOURGET to Everyone : Veronica Bourget V.bourget@psnri.org

15:03:35 From James Simon to Everyone : Jim Simon, LICSW, Perspectives Corporation (he/him)

15:03:35 From Jordan Maddox to Everyone : Jordan Maddox, BHDDH, Statewide Youth Coordinator, Jordan.maddox@bhddh.ri.gov

15:03:37 From Susan Duffy to Everyone : Susan Duffy, MD Hasbro Children's Hospital ED, AAP

15:03:37 From Susan Hayward to Everyone : Susan Hayward, she/her/hers, BHDDH/DDD Administrator, Transition Services

15:04:15 From Danielle Loughlin to Charlotte Kreger (she/her) - EOHHS(Direct Message) : I need people to be video off so the interpreter shows up, or the interpreter and yourself pinned. Sorry!

15:04:17 From James Rajotte, EOHHS (he/him/his/el) to Everyone : James Rajotte, EOHHS

Chief Strategy Officer

him/him/his/el

15:04:38 From James Rajotte, EOHHS (he/him/his/el) to Everyone : James.C.Rajotte@ohhs.ri.gov

15:04:51 From Kayla David (she/her) to Everyone : Kayla David (she/her), Clinical Director FSRI



15:05:27 From Trisha Suggs to Everyone : Trisha Suggs, BHDDH, Project Director State Youth Treatment Trisha.suggs@bhddh.ri.gov

15:07:00 From Charlotte Kreger (she/her) - EOHHS to Danielle Loughlin(Direct Message) : Hi! Do I need to pin the interpreter or can you?

15:07:27 From Danielle Loughlin to Charlotte Kreger (she/her) - EOHHS(Direct Message) : Let me try. It will make everyone else disappear.

15:07:54 From Danielle Loughlin to Charlotte Kreger (she/her) - EOHHS(Direct Message) : Okay, this is ok.

15:25:02 From James Rajotte, EOHHS (he/him/his/el) to Everyone : Danielle -- thank you for sharing -- which agency are you from or whom are you representing since I am new :)

15:25:43 From Danielle Cyprien to Everyone : I am the Statewide Youth Coordinator for the Parent Support Network

15:25:58 From James Rajotte, EOHHS (he/him/his/el) to Everyone : Excellent -- thank you for being with us today!

15:26:22 From Danielle Cyprien to Everyone : Thank you James

15:27:13 From James Rajotte, EOHHS (he/him/his/el) to Everyone : Veronica -- welcome back from FL. We will certainly keep that on the radar

15:29:07 From James Rajotte, EOHHS (he/him/his/el) to Everyone : Thank you for bringing our IDD population to the table, Alyssia

15:32:40 From Charlotte Kreger (she/her) - EOHHS to Everyone : Jess please feel free to chime in next!

15:34:20 From Charlotte Kreger (she/her) - EOHHS to Everyone : That's a great point, Maria!

15:34:25 From James Rajotte, EOHHS (he/him/his/el) to Everyone : Thank you, Susan and Maria.

15:37:48 From Danielle Cyprien to Everyone : Well said Jess

15:37:55 From James Rajotte, EOHHS (he/him/his/el) to Everyone : Listening sessions sounds like a great idea

15:38:01 From James Rajotte, EOHHS (he/him/his/el) to Everyone : Thank you, Jess

15:38:02 From Tina Spears to Everyone : Great point Jess!

15:41:04 From Danielle Cyprien to Everyone : Youth groups

15:44:22 From James Rajotte, EOHHS (he/him/his/el) to Everyone : Thank you, Kayla. Good point.





15:46:04 From Danielle Cyprien to Everyone : Training is a great step, however we need a system to ensure the quality and implementation of the training elements because one bad provider can put a youth off to services indefinitely. A lot of providers look at trainings as a check list and don't fully internalize it..

15:47:09 From James Rajotte, EOHHS (he/him/his/el) to Everyone : Danielle -- good point. Training versus guided training/facilitation/experiences to understand and unpack these concerns is critical.

15:47:46 From Kayla David (she/her) to Everyone : Yes, Danielle!

15:48:17 From James Rajotte, EOHHS (he/him/his/el) to Everyone : Thank you, Samantha--community first. I like that.

15:49:09 From Danielle Cyprien to Everyone : Yass Danielle Thank you!

15:49:19 From Tina Spears to Everyone : Great point Danielle

15:53:04 From James Rajotte, EOHHS (he/him/his/el) to Everyone : Trish -- that is a very good point. MOdel design needs to be thinking about meeting people where they do go

15:56:05 From Jordan Maddox to Everyone : jordan.maddox@bhddh.ri.gov

15:56:50 From Jess Hunter to Charlotte Kreger (she/her) - EOHHS(Direct Message) : Im still interested!

15:57:51 From Charlotte Kreger (she/her) - EOHHS to Jess Hunter(Direct Message) : Great!! :)

16:01:35 From Tina Spears to Everyone : Thank you James. Good idea.

16:01:48 From Susan Duffy to Everyone : Good Luck Charlotte!