

DEPARTMENT OF BEHAVIORAL HEALTH

JULY - SEPTEMBER 2018

CULTURAL COMPETENCE NEWSLETTER



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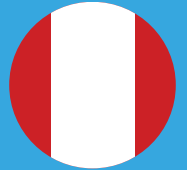
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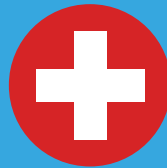
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Behavioral Health
Department
Health Agency



Cultural Competence Committee



Members:

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Desiree Troxell, Patients Rights Advocate

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Ellen Sturtz, GALA Volunteer

Bonita Thomas, PAAT Member, Peer Advisory and Advocate Team

Laura Gabriella Zarate, Health Agency Secretary



INTRODUCTION:

Dear Reader,

Thank you for reading the first newsletter for the new fiscal year 2018-2019. Our Cultural Competence Committee (CCC) intends to make the newsletter a quarterly publication and keep our mental health partners informed about events, trainings, and relevant information pertinent to our community. In this and future editions, we will be reporting information regarding mental health and the efforts made to ensure culturally and linguistically competent services and programs in our community. We shall also include details of the current committee members, and specific topics related to mental health as it applies to cultural competence. The Cultural Competence Committee consists of staff members from various programs of the Behavioral Health Department as well as community partners, consumers, family members, and community advocates.

The CCC continues to assess, advise, implement, and monitor policies and programs which assure effective services are provided in cross-cultural situations. The committee members, representing diverse cultural backgrounds and other special interests, will continue to provide input and insight to the community in order to create a safe and welcoming environment for all.

This new fiscal year will be marked by our continued effort to put forth trainings highlighting the needs of our community. The following topics will inform our upcoming trainings: challenges and values of different cultures, LGBTQ and trans-affirming, youth and mental health training, older adults and mental health, and engaging minorities and language barriers. As we move forward, we can't wait to share more information and the work we do to better serve our community.

Sinceramente,

Nestor Veloz-Passalacqua, M.P.P.
Cultural Competence and Ethnic Services Manager

Telemedicine Takes Transgender Care Beyond The City

BY KEREN LANDMAN



At an outpatient lab in Tifton, Ga., where Karen Williams gets her blood drawn, a clerk looked from her computer screen to Williams' printed lab order, then back again.

"This is not right," the clerk said, squinting at the lab order. There, the birthdate and address matched the ones on the screen, but the name displayed was a male one.

A transgender woman, Williams lived as a man for nearly 50 years before beginning

to make physical changes several years ago. She's grown out her hair and has gotten most of an old goatee lasered off. One of the things that hasn't changed, however, is her legal name – so in most health care situations, she usually uses her old name and driver's license.

The clerk looked at the computer again. Williams took a deep breath.

"Does it say 'Karen Williams?' " she asked the clerk.

The clerk nodded.

“That’s me,” Williams said.

For many transgender people, moments like this, when a health care worker first becomes aware of their gender identity, are often fraught with fear and anxiety.

Ten percent of transgender people said they had been personally discriminated against when going to a doctor or health clinic, according to a 2017 poll conducted by NPR, the Robert Wood Johnson Foundation and the Harvard T.H. Chan School of Public Health. And 22 percent of transgender people say they have avoided a doctor or seeking health care out of concern that they would be discriminated against.

Many fear discrimination will increase with strengthened protections for doctors and nurses refusing to provide certain care on religious grounds. The more care refusals transgender people experience, the less care they seek, and the higher their rates of preventable and treatable conditions, including cancers, mental health problems, and substance-use disorders.

In rural areas, doctors and nurses competent in transgender care are few and far between. It can also be a challenge to find providers who offer respectful care for medical issues unrelated to gender identity.

Remote medical consultation by video-conference is one possible solution.

Williams has a primary care doctor at a family practice in town, where framed Bible verses hang on the wall and Christian music plays in the waiting area. When she felt ready to begin taking hormones for

gender transition, she didn’t bother asking her local doctor. Instead, she made an appointment with Dr. Izzy Lowell, a family practitioner who specializes in caring for transgender and gender non-conforming people. But Lowell is based in Atlanta, a three-hour drive away.

Getting to the appointment took some doing. Williams teaches fifth grade and is the primary caregiver for her disabled 32-year-old son. She scheduled the appointment over her school’s spring break and arranged for care for her son during her trip.

After all the effort to get to her first visit, she was initially taken aback when Lowell informed her she would soon be scaling back her brick-and-mortar practice to focus on telemedicine. Williams came around to the advantages fairly quickly. “I know lots of people in rural areas, like me, where they don’t have any doctor who remotely knows anything about transgender care,” she said.

It’s those patients Lowell had in mind when she opened QMed in the late summer of 2017. The practice offers care exclusively to transgender and gender nonconforming patients in the southeastern United States. Lowell’s intent was to lower the barrier to access for adults and adolescents living in rural parts of the region. In less than a year, she’s been able to do that, with only occasional hiccups.

Williams, for instance, no longer has to plan weeks in advance for her visits with Lowell. They are now as close as her nearest webcam – at least, in theory. During Williams’ last appointment, Lowell’s video-conferencing software was uncooperative,

and they had to make do with a phone call. But that was the exception.

Typically, patients are able to use the software to choose their preferred name and pronouns before each visit. These often change during gender transition, Lowell says. Patients encounter no one other than Lowell as she assesses sensitive issues like changes in body hair and sexual function from her location in a hip Atlanta neighborhood. Although she could conduct most of her patient care online, about half of her patients still prefer to come to her office.

Because Lowell uses headphones during video visits, patients' voices aren't audible in the room. But for an extra layer of privacy, and for the patients who still choose to come in person, Lowell keeps white noise machines in the waiting room she shares with another small business.

Before first visiting Lowell in her old office, Williams mentally prepared herself to endure being called "mister" by clinic staff and being stared at by others in the waiting room. The one-on-one contact of the virtual office eliminates that familiar dread.

"That is one of the beauties of telehealth," says Mei Kwong, executive director of the California-based Center for Connected Health Policy. In communities where everybody knows each other's business, she says, telemedicine adds a level of confidentiality that is particularly beneficial to people with potentially stigmatizing conditions.

Telemedicine also reduces travel costs related to health care for people in rural areas.

In a study of rural sexual and gender minorities, 14 percent of transgender people

reported traveling more than an hour to see their primary care provider – not necessarily the doctor who provided gender-related care. And in a 2017 survey by the Center for American Progress, 30 percent of transgender people living outside metro areas said it would be very difficult or impossible to find an alternative to their existing provider.

Rural transgender people aren't alone in struggling to get health care. In the U.S., many rural households suffer from lower rates of health insurance coverage, shortages of doctors and nurses and low access to the private or public transportation necessary to get to a health care facility. But for transgender people, those challenges are exacerbated due to increased vulnerability to unemployment and poverty, says Laura Durso, who helped lead the Center for American Progress survey.

While telemedicine could give rural Americans a bridge to better health care, there's a catch. Nearly 30 percent of rural dwellers in America don't have access to broadband Internet service, a necessity for telemedicine to work well.

Underpowered Internet service can discourage health care providers from offering telemedicine services, says Kwong. Many state laws and insurance policies don't regard audio-only interactions as telehealth, so if a video connection fails, as Williams' did, the provider can't bill for the visit.

As it is, insurance reimbursement for telemedicine services is often so low that many telemedicine providers struggle to break even, says Kwong. Analyses of 2013 data collected by the Health Care Cost Institute

suggest that, on average, private insurers pay for telemedicine services at rates about 30 to 40 percent lower than for the same services provided face-to-face. Kwong says many providers are motivated more by altruism than profit: "They do it because this is the only way they can get those services to their community."

Lowell is lucky to live in one of 32 states with a telemedicine parity law, which mandates that private insurance companies pay her as much for a telemedicine visit as they would for a face-to-face visit.

Less than a year into her practice, she is almost breaking even, and is near the point of covering her startup expenses from 2017.

While she bears the significant administrative burdens of an independent practice by herself, the occasional headache is worthwhile because providing access is so important. "The current system is not at all fair to transgender people," she wrote in an email, "and I don't like unfairness."

Williams has been fortunate. Much of her care with Lowell is covered by insurance. And she has been pleasantly surprised by the reactions of health care workers to whom she's disclosed her status. Back at the outpatient lab, when she explained to the confused clerk that she was in the process of transitioning, she got an unexpected response. "That's awesome," said the clerk. "This is awesome. So, which name do you want to use?" ♦

U.S. Suicide Rates Are Rising Faster Among Women Than Men

BY RHITU CHATTERJEE



The number of people dying by suicide in the United States has risen by about 30 percent in the past two decades. And while the majority of suicide-related deaths today are among boys and men, a study published Thursday by the National Center for Health Statistics finds that the number of girls and women taking their own lives is rising.

“Typically there’s between three and four times as many suicides among males as among females,” says Dr. Holly Hedegaard, a medical epidemiologist at the NCHS and the main author of the new study. In 2016, about 21 boys or men out of 100,000 took their own lives. On the other hand, just six

girls or women out of 100,000 died by suicide that year.

But when Hedegaard and her colleagues compared the rise in the rates of death by suicide from 2000 to 2016, the increase was significantly larger for females — increasing by 21 percent for boys and men, compared with 50 percent for girls and women.

There's "sort of a narrowing of the [gender] gap in rates," Hedegaard notes.

The biggest change was seen among women in late middle age. "For females between the ages of 45 and 64, the suicide rate increased by 60 percent," she says. "That's a pretty large increase in a relatively short period of time."

That the increase for women was more than double the increase for men "did indeed surprise me," says Nadine Kaslow, a psychologist at Emory University and the past president of the American Psychological Association, who was not involved in the study. She says she finds the overall trends for both men and women "disturbing."

Scientists don't yet know the reasons behind the steeper rise in the number of girls and women taking their own lives, says Kaslow. "We're really just beginning to see these differences, and so people are just now beginning to look at this."

Though there are different factors at play in each case, excessive stress is a known risk factor for suicide overall, she says.

"People often die by suicide when they just feel totally overwhelmed," Kaslow says.

According to the American Psychological Association, women say their stress levels have risen in recent years. And middle-aged women belonging to the sandwich generation are especially feeling the pressure of their many responsibilities at home and at work.

"So they may be taking care of children, of parents, have work demands and then

more responsibilities," Kaslow says.

There's also been a rise in the last few decades in the number of single-parent households headed by women. That means more women trying to do everything alone, she says.

"And so there's, sort of, stress everywhere," she says. "They may not have time to take care of themselves, to be kind to themselves, to get the social support they need."

The new report also shows that more adolescent girls are choosing to end their lives, notes Kaslow. So the problem is not specific to middle-aged women, but across all age groups.



Helping those who are suffering know they are not alone is one step toward suicide prevention, researchers say.



"Suicide is a public health concern," says Jill Harkavy-Friedman, the vice president of research at the American Foundation for Suicide Prevention. The statistics published Thursday underscore the need for a national prevention effort, she adds.

The report also looked at the means of suicide, as recorded in death certificates,

and found that firearms remain an important method, particularly for boys and men.

“For males, pretty much from age 15 and older, the majority of the suicides [involved] firearms,” says Hedegaard.

“We know that limiting access to lethal-means of any kind can reduce suicide,” Harkavy-Friedman says, “especially if you limit access during a crisis moment.”

To help prevent suicide, society needs to offer better access to mental health care, she says. And each one of us can do our bit, too, by watching out for the warnings signs among friends and family.

Be aware, she says, if you notice something’s changing in a loved one, friend or colleague. For example, if their mood is changing, she says, “maybe they’re more irritable, or withdrawn. Maybe they’re talking about being a burden.”

At times like these, it is important to let people know they’re not alone. “It sounds simple,” she says. “But it does make a difference.”◆

DATES TO REMEMBER:

JULY

- National Minority Mental Health Month

AUGUST

- National Health Care Week (Aug. 12-18)
- International Overdose Awareness Day (Aug. 31)

SEPTEMBER

- World Suicide Prevention Day (Sept. 10)
- National Suicide Prevention Week (Sept. 9-15)
- National Wellness Week (Sept. 16-22)
- National Recovery Month
- National Alcohol & Drug Addiction Recovery Month
- National Suicide Prevention Month

DATES TO REMEMBER:

OCTOBER

- National Depression and Mental Health Screening Month
- Health Literacy Month
- ADHD Awareness Month
- Bullying Prevention Month
- Mental Illness Awareness Week (TBD)
- OCD Awareness Week (TBD)
- National Health Education Week (Oct. 15–19)
- World Mental Health Day (Oct 10)
- National Depression Screening Day (Oct. 11)

NOVEMBER

- Anti-Bullying Awareness Week (Nov. 11–16)
- International Stress Awareness Day (Nov. 1)
- International Survivors of Suicide Day (Nov. 17)
- National Family Health History Day (Nov. 24)

DECEMBER

- World AIDS Day (Dec. 1)
- National Stress-Free Family Holiday's Month
- International Day of Person's with Disabilities (Dec. 3)

RESOURCES

Drug & Alcohol Services

SAN LUIS OBISPO ADULT
2180 JOHNSON AVE,
SAN LUIS OBISPO, CA 93401
(805)781-4275

SAN LUIS OBISPO YOUTH
277 SOUTH ST. SUITE T,
SAN LUIS OBISPO, CA 93401
(805)781-4754

PASO ROBLES YOUTH & ADULT
1763 RAMADA DRIVE,
PASO ROBLES, CA 93446
(805)226-3200

ATASCADERO YOUTH & ADULT
5575 HOSPITAL DRIVE
ATASCADERO, CA 93422
(805)461-6080

PREVENTION & OUTREACH
277 SOUTH ST. SUITE T,
SAN LUIS OBISPO, CA 93401
(805)781-4754

Mental Health Services

**SAN LUIS OBISPO YOUTH 0-5
MARTHA'S PLACE CHILDREN'S
ASSESSMENT CENTER**
2925 MCMILLAN AVE,
SAN LUIS OBISPO, CA 93401
(805)781-4948

SAN LUIS OBISPO YOUTH
1989 VICENTE,
SAN LUIS OBISPO, CA 93401
(805)781-4179

SAN LUIS OBISPO ADULT
2178 JOHNSON AVE,
SAN LUIS OBISPO, CA 93401
(805)781-4700

**SAN LUIS OBISPO PSYCHIATRIC
HEALTH FACILITY**
2178 JOHNSON AVE,
SAN LUIS OBISPO, CA 93401
(805)781-4711

ARROYO GRANDE YOUTH
345 S. HALCYON,
ARROYO GRANDE, CA 93420
(805)473-7060

ARROYO GRANDE ADULT
1650 GRAND AVE,
ARROYO GRANDE, CA 93420
(805)474-2154

ATASCADERO YOUTH & ADULT
5575 HOSPITAL DRIVE,
ATASCADERO, CA 93422
(805)461-6060

**SERVICES AFFIRMING FAMILY
EMPOWERMENT (SAFE)**
1086 GRAND AVE,
ARROYO GRANDE, CA 93420
(805)4742105

Resources in the Community

**TRANSITIONS-MENTAL HEALTH
ASSOCIATION (TMHA)**
784 HIGH ST,
SAN LUIS OBISPO, CA 93401
805-540-6500

**COMMUNITY ACTION
PARTNERSHIP OF SLO (CAPSLO)**
1030 SOUTHWOOD DR,
SAN LUIS OBISPO, CA 93401
(805) 544-4355

**THE LINK FAMILY RESOURCE
CENTER**
6500 MORRO RD # A,
ATASCADERO, CA 93422
(805) 466-5404

**CENTER FOR FAMILY
STRENGTHENING (CFS)**
3480 HIGUERA ST SUITE 100,
SAN LUIS OBISPO, CA 93401
805-543-6216

WILSHIRE COMMUNITY SERVICES
285 SOUTH STREET SUITE J
SAN LUIS OBISPO, CA, 93401
PHONE: (805)547-7025

**COMMUNITY COUNSELING
CENTER (CCC)**
1129 MARSH ST,
SAN LUIS OBISPO, CA 9340
805-543-7969

FAMILY CARE NETWORK (FCN)
1255 KENDALL RD,
SAN LUIS OBISPO, CA 93401
805-781-3535

**RISE | RESPECT. INSPIRE.
SUPPORT. EMPOWER.**
LGBTQ HEALTHY
RELATIONSHIPS SUPPORT
GROUP
(805)226-6791

ACCESS SUPPORT NETWORK
1320 NIPOMO ST.
SAN LUIS OBISPO, CA 93401
(805)781-3660

**GAY AND LESBIAN ALLIANCE
(GALA) OF THE CENTRAL COAST**
(805)541-4252

TRANZ CENTRAL COAST
SLO AND NORTH COUNTY
SUPPORT GROUPS
(805)242-3821

Cultural Competence Committee



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