REPORT OF THE
JOINT COMMISSION ON HEALTH CARE

Minority Access to Mental Health Services

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

REPORT DOCUMENT NO. 149

COMMONWEALTH OF VIRGINIA
RICHMOND
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Code of Virginia § 30-168.

The Joint Commission on Health Care (the Commission) is established in the legislative branch of state government. The purpose of the Commission is to study, report and make recommendations on all areas of health care provision, regulation, insurance, liability, licensing, and delivery of services. In so doing, the Commission shall endeavor to ensure that the Commonwealth as provider, financier, and regulator adopts the most cost-effective and efficacious means of delivery of health care services so that the greatest number of Virginians receive quality health care. Further, the Commission shall encourage the development of uniform policies and services to ensure the availability of quality, affordable and accessible health services and provide a forum for continuing the review and study of programs and services.

The Commission may make recommendations and coordinate the proposals and recommendations of all commissions and agencies as to legislation affecting the provision and delivery of health care.

For the purposes of this chapter, "health care" shall include behavioral health care.

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Preface

Senate Joint Resolution 25 of the 2004 Session of the General Assembly directed the Joint Commission on Health Care (JCHC) to conduct a two-year study of "the mental health needs and treatment of young minority adults in the Commonwealth." A study workgroup, convened by JCHC staff, met during 2004 and 2005. The workgroup developed a work plan and determined that completion of the study would require an additional one to two years in order to address adequately the study issues. The study was completed in 2007. This is the final JCHC report in response to SJR 25 (2004).

The results of the study indicate that while the rates of mental illness are similar for racial/ethnic groups, minorities are more likely to be in high-need sub-populations (like the homeless or incarcerated) whose rates of mental illness are higher and much less likely to be treated. Key disparities for racial and ethnic minorities include a lack of access to quality services, lower levels of help seeking and help utilization, language barriers and lack of cultural competence among practitioners, negative experiences within the mental health system, the pervasiveness of stigma, and a lack of inclusion of minorities in research and clinical trials.

These disparities, at least in part, can be alleviated by increasing the level of cultural competency of all practitioners and addressing workforce issues including practitioner shortages in underserved areas and the lack of racial/ethnic minority health practitioners. The Virginia Department of Health is making improvements in the area of cultural competence through the Culturally and Linguistically Appropriate Health Services (CLAS) Act Initiative; however, cultural competency training needs to be recognized as an important component of all practitioners' training and knowledge. Currently students majoring in the health care professions are not required to demonstrate competency in cross-cultural knowledge or in culturally appropriate care in order to graduate from Virginia's colleges and universities.

To address workforce shortages, various programs provide incentives for health care practitioners to serve in under-served regions of the State but only one program focuses specifically on the mental health field (child psychology/psychiatry internships). Moreover, no program is dedicated solely to increasing the number of racial and ethnic minority mental health care providers.[1] This is a critical shortage that needs to be addressed in order to

[1] With the possible exception of the Virginia College of Osteopathic Medicine where students are trained to treat the individual as a whole and, therefore, have at least basic mental health knowledge. It is likely that some students choose to specialize in the mental health field.

reduce disparities in minority employment opportunities and to provide more culturally appropriate care for minority populations.

Based on the study findings, JCHC voted to request by Chairman's letter that the State Council of Higher Education for Virginia (SCHEV) examine the issue of requiring cultural competence training as part of college curriculum for health profession majors.

On behalf of the Joint Commission and staff, I would like to thank the numerous individuals who assisted in this study, including representatives of community health centers, community services boards, free clinics, indigent defense attorneys, the Psychiatric Society of Virginia, Hampton University, Virginia Commonwealth University, and such State agencies as the Department of Health and the Department of Mental Health, Mental Retardation and Substance Abuse Services.

Kim Snead
Executive Director

June 2008

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Minority Access to Mental Health Services

America is home to a boundless array of cultures, races, and ethnicities. With this diversity comes incalculable energy and optimism. Diversity has enriched our Nation by bringing global ideas, perspectives, and productive contributions to all areas of contemporary life. The enduring contributions of minorities, like those of all Americans, rest on a foundation of mental health.[1]

Authority for Study

Senate Joint Resolution 25 of the 2004 Session of the General Assembly directed the Joint Commission on Health Care (JCHC) to conduct a two-year study of "the mental health needs and treatment of young minority adults in the Commonwealth." The resolution required that JCHC:

- Estimate the "number of mentally disabled young adults by gender, age, and racial and ethnic classification, in the geographic regions of the Commonwealth."
- Identify the "prevailing mental health and emotional disorders and their etiology among minority young adults [and]…the mental health needs of minority citizens, particularly minority young adults in Virginia."
- Determine the "number of racial and ethnic minority persons who receive mental health treatment…and the facilities providing such care."
- Ascertain whether "mental health providers are trained to provide culturally competent mental health treatment" and the level of need for such treatment in Virginia.
- Review "federal and state laws and regulations…and identify the…extent to which medical records information may be disclosed to parents and family members to assist them in obtaining health, social services, and mental health treatment for mentally disabled young adults" and recommend ways to provide information to allow family members to obtain services and treatment without resorting to involuntary commitment.

Background

A study workgroup was convened by JCHC staff and met during 2004 and 2005. The workgroup consisted of representatives of community health centers, community services boards, free clinics, indigent defense attorneys, the Psychiatric Society of Virginia, Hampton University, Virginia Commonwealth

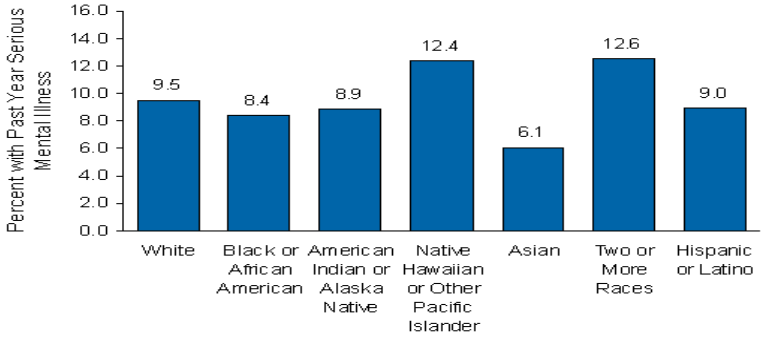
[1] U.S. Department of Health and Human Services. (2001). "Mental Health: Culture, Race, and Ethnicity-- A Supplement to Mental Health: A Report of the Surgeon General." Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Studies

University, and such state agencies as the Department of Health and the Department of Mental Health, Mental Retardation and Substance Abuse Services. The workgroup developed a work plan and determined that completion of the study would require an additional one to two years in order to adequately address the study issues. In 2007, the study was continued and the results of both efforts are reported within this final report.

Rates of Mental Illness by Race and Ethnicity

Mental illness is a health condition that can be found across all races, ethnicities, and cultures. Major mental disorders like depression, bipolar disorder, schizophrenia, and panic disorder exist within all social groups in the U.S. According to the National Co-Morbidity Study (2001) findings, 16.4% of Americans suffer from an anxiety disorder, 7.1% have mood disorders, 1.3% experience schizophrenia, and 2.1% exhibit anti-social personality disorder. The annual prevalence of all mental disorders is approximately 21 percent of adults and children.[2] Overall epidemiological differences in incidence and prevalence by race and ethnicity are minimal.[3] For example, the percentage of the White U.S. population that experienced serious mental illness in 2002 was 9.5%, compared to 8.4% for African Americans and 9% for Hispanics.[4] Although data are currently lacking for the rates of mental illness by race and ethnicity for Virginia, it is reasonable to assume that the Commonwealth's figures mirror those of the United States.

Past Year Serious Mental Illness among Adults Aged 18 or Older, by Race/Ethnicity: 2003



Source: Dept. of Health & Human Services. National Survey on Drug Abuse: Volume I. Summary of National Findings; Prevalence and Treatment of Mental Health Problems (2003).

[2] U.S. Department of Health and Human Services. (1999). "Mental health: A Report of the Surgeon General." Rockville, MD. Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.
[3] Davis, King. (2003). "The Disparity Hypothesis: Populations of Color and Mental Health in the United States." Unpublished manuscript. See also Surgeon General's 1999 report on mental health.
[4] Department of Health and Human Services. National Survey on Drug Abuse: Volume 1. Summary of National Findings; Prevalence and Treatment of Mental Health Problems (2003).

It is important to note that the general finding of similar rates of mental illness for all racial and ethnic groups applies only to minorities living in the community since most studies are based on samples of the general population and do not include persons who are homeless or residing in institutions. Individuals in vulnerable, high-need subgroups such as persons who are homeless, incarcerated, or institutionalized, have higher rates of mental disorders and minorities tend to be over-represented in these categories.[5] Further, rates of mental illness among smaller racial or ethnic groups, such as American Indians and Alaska Natives, are less understood and less reliable due to a lack of research and subsequent data.

Lifetime Prevalence of Psychiatric Disorders by Race/Ethnicity (2001)[6]

	Hispanic	Black	White
Anxiety Disorders	24.9	23.8*	29.4
Mood Disorders	18.3	16.0*	21.9
Impulse Control Disorders	17.9	14.5	15.3
Substance Abuse Disorders	16.1	10.8*	14.8
All Disorders	43.7	38.5*	47.6

*Significant difference from Non-Hispanic Whites evaluated with Chi-Square test at p=.05

Access and Quality of Care

"Because of disparities in mental health services, a disproportionate number of minorities with mental illnesses do not fully benefit from…the opportunities and prosperity of our society. This preventable disability from mental illness exacts a high societal toll and affects all Americans"[7]

[5] Dove, Henry W. et al. (2006). "Mental Health" In Multicultural Medicine and Health Disparities. Edited by David Satcher, Ruben Pamies, and Nancy Woelfl. McGraw Hill: New York, NY.
[6] U.S. Department of Health and Human Services. (2001). "Mental Health: Culture, Race, and Ethnicity-- A Supplement to Mental Health: A Report of the Surgeon General." Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Studies
[7] Ibid. Pg. 3.

Access to Treatment:

The majority of people with diagnosable mental disorders, regardless of race or ethnicity, do not receive treatment. This is often the result of cost, lack of insurance, unavailability or fragmentation of services, a belief that the problem does not require medical attention, a lack of knowledge about mental illness, or the fear of stigma. Stigma prevents many people from seeking treatment in large part because our society still does not recognize mental illness as being a real health condition like diabetes or heart disease. The good news is that for those who do seek help there is an array of effective treatments available for most kinds of mental illness. However, not all individuals have the same likelihood of receiving treatment. In addition to the barriers that exist for all Americans, others like mistrust and fear of treatment, racism and discrimination, and language and cultural differences exist to further deter racial and ethnic minorities from seeking care. Minorities also tend to be over-represented in high-need or at-risk populations that have less access to treatment. The following is information on high-need sub-populations (at increased risk of mental illness), access issues, and use of services for African Americans, Hispanics, Asians/Pacific Islanders, and American Indians/Alaska Natives in the United States.[8]

African Americans:

- High-Need Sub-Populations
  - — Blacks make up 40% of the homeless, 50% of the incarcerated, and 45% of children in foster care
  - — More likely to be exposed to violence and crime
- Access
  - — 25% of African Americans are uninsured (compared to 16% of all Americans).
  - — 21% receive Medicaid
  - — 50% have employer-based health insurance coverage, compared to 70% for Whites
- Use of Services
  - — The percentage of Blacks receiving mental health care is only ½ that of Whites.

Hispanics:

- High-Need Sub-Populations
  - — Under-represented among homeless or children in foster care, but:
  - — Higher rates of incarceration (9%, compared to 3% for non-Hispanic Whites)

[8] U.S. Department of Health and Human Services. (2001). "Mental Health: Culture, Race, and Ethnicity-- A Supplement to Mental Health: A Report of the Surgeon General." Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Studies

— Higher percentage of Vietnam Veterans suffering from post-traumatic stress disorder (PTSD) than Whites and Blacks
— Latino refugees more likely to suffer from civil war related traumas like PTSD
— Latino youth have proportionately more anxiety-related and delinquency problem behaviors, depression, and drug use than do non-Hispanic White youth

- Access
  — 37% of Hispanics are uninsured (compared to 16% of all Americans)
  — 18% receive Medicaid
  — 43% have employer-based health insurance coverage, compared to 70% for Whites

- Use of Services
  — Of American born Hispanics with mental disorders, fewer than 1 in 11 contact a mental health specialist. One in five contact a general practitioner.
  — For immigrants with mental disorders, fewer than 1 in 20 contact a mental health specialist. One in 10 contact a general practitioner.

Asians/Pacific Islanders:

- High-Need Sub-Populations
  — High percentage (ranging from 40%-70%) of refugees suffer from post-traumatic stress disorders (PTSD)

- Access
  — 21% uninsured
  — Very low Medicaid usage rates (possibly due to inaccurate belief that it will jeopardize applications for citizenship)
  — 50% have difficulty accessing treatment due to language issues

- Use of Services
  — Extremely low utilization rates of mental health services, possibly because of shame and stigma associated with mental illness in Asian cultures (One study found only 17% with a mental health disorder sought care.)
  — Often seeking treatment is delayed until symptoms reach crisis proportions

American Indians/Alaska Natives:

- High-Need Sub-Populations
  — American Indians/Alaska Natives make up 8% of the homeless (while representing only 2% of the population)
  — 1 in 25 are incarcerated
  — High levels of alcohol and drug use, possibly as high as 70%
  — 45-57% of American Indian veterans suffer from post-traumatic stress disorders (PTSD)

— Higher overall rates of traumatic exposure results in a 22% rate of PTSD for American Indians/Alaska Natives, compared to 8% in the general U.S. population

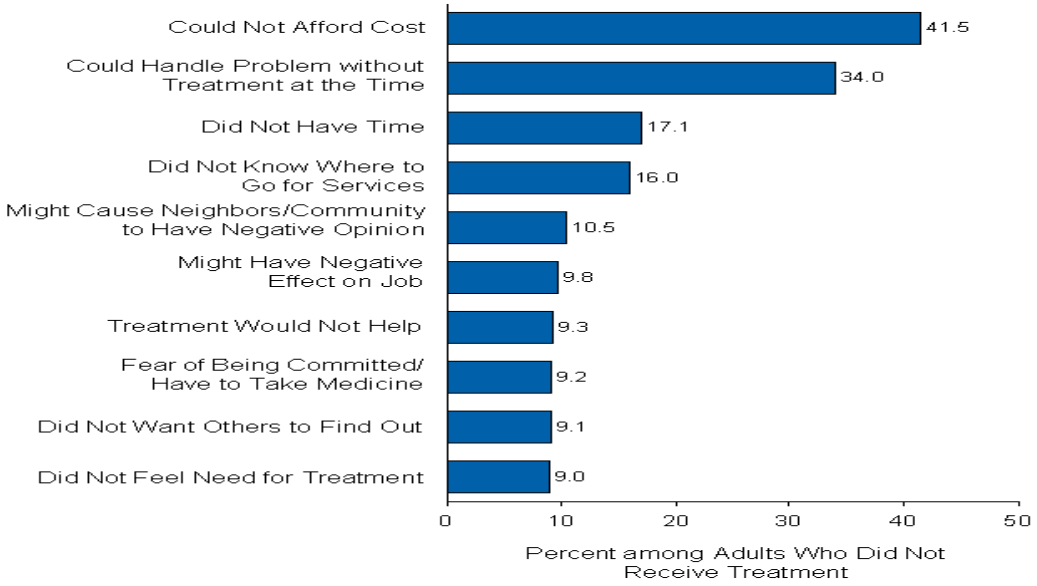
- Access
  - — 24% are uninsured (compared to 16% of all Americans).
  - — 25% receive Medicaid
  - — 50% have employer-based health insurance coverage, compared to 70% for Whites
  - — Only 20% of American Indians report having access to Indian Health Service clinics
- Use of Services
  - — Very limited knowledge regarding use of services
  - — Small studies suggest similar rates of use to Whites.

Percentage of Adults Aged 18 or Older with Past Year Serious Mental Illness and Percentage of those Receiving Mental Health Treatment or Counseling, by Race/Ethnicity, 2001

	% with Mental Illness	% with Mental Illness Receiving Treatment
White	7.5	51.4
Black	7.5	38.4
Hispanic	6.4	27.0

Source: 2001 National Household Survey on Drug Abuse

Reasons for Not Receiving Mental Health Treatment in the Past Year among Adults Aged 18 or Older with an Unmet Need for Treatment Who Did Not Receive Treatment: 2006



Source: 2006 National Household Survey on Drug Abuse

Unduplicated Percentages of Consumers Served by Race and Gender in Virginia's Community Mental Health Services, 2006

	Male	Female	Total	Virginia Population Total
White	30.22	32.49	62.76	72.3**
Black	15.12	13.68	28.85	19.6
Asian / PI*	0.62	0.71	1.32	3.80
AI / AN*	0.22	0.21	0.43	0.30
Other	2.19	2.38	4.60	2.0
Unknown	0.68	0.81	2.06	

*PI = Pacific Islander; AI = American Indian; AN = Alaska Native
**70.2% not including White-Hispanic persons
N=118,732

Source: Community Services Boards' 2007 Overview of Community Services Delivery in Virginia

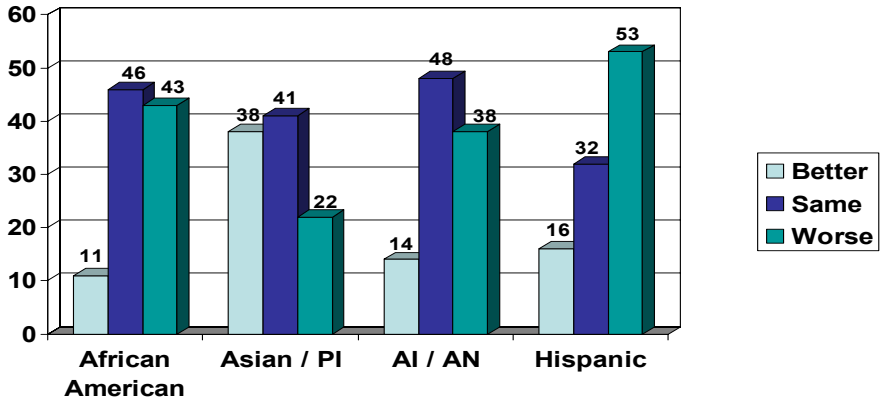
Quality of Care

Research has found that minorities also do not receive the same quality of care as whites in general. As the Surgeon General reported in 1999, the higher level of burden from mental illness experienced by minority groups "stems from minorities receiving less care and poorer quality of care, rather than from their illnesses being inherently more severe or prevalent in the community."[9] Conducted by the U.S. Department of Health and Human Services' Agency for Healthcare Research and Quality, the 2005 National Healthcare Disparities Report (NHDR) is a national survey that tracks the quality of healthcare using 46 core performance measures (http://www.ahrq.gov/qual/nhdr05/nhdr05.htm). As can be seen from the tables on the next page, a significant percentage of minorities receive poorer quality of care, compared to Whites. "For African Americans, quality of care was poorer than that for Whites for 20 out of 46 measures (43%), while care was better quality than Whites for just 5 out of 46 measures (11%). Among the 38 measures that were available for Hispanics, 20 (53%) showed that they received poorer quality than non-Hispanic Whites, and just 6 (16%) showed better quality than non-Hispanic Whites. Of the 21 measures available for American Indians/Alaska Natives, 8 (38%) showed poorer quality than Whites and just 3 (14%) showed better quality than Whites. Asians and Pacific Islanders had better quality than Whites for 12 of the 32 available measures (38%) but still had poorer quality for 7 out of 32 measures (22%)."[10]

[9] U.S. Department of Health and Human Services. (1999). "Mental health: A report of the Surgeon General." Rockville, MD. Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.
[10] James, Cara et al. (2007). "Key Facts: Race, Ethnicity, and Medical Care." Report published by the Kaiser Family Foundation. Pgs. 38-39.

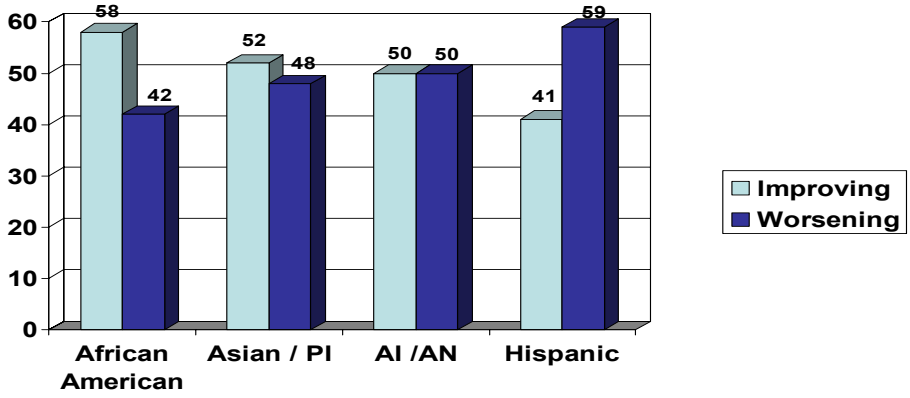
For many minorities the quality of care is getting worse. Almost half of the core quality measures for Asians and Pacific Islanders (48%) and for American Indians/Alaska Natives (50%) were worsening and roughly half were improving

Comparison of Quality of Care Measures for Minority Population Groups vs. Whites (%)



Source: AHRQ, National Healthcare Disparities Report, 2005

Changes in Quality of Care Disparities Over Time: Summary by Race/Ethnicity (%)



Source: AHRQ, National Healthcare Disparities Report, 2005

(48% and 50%, respectively). For African Americans, 42% of the core quality measures were getting worse and 58% were improving. The continuing quality of care for Hispanics is even more problematic. Only 41% of their core indicators showed an improvement in quality of care, while 59% indicating a worsening of conditions. NHDR defined a disparity "as worsening when both the absolute

difference and relative difference between the population and comparison group [Whites] were becoming larger over time.[11]

In addition to receiving poorer quality care, African Americans also tend to be over-represented in admissions to public mental hospitals which tend to be less preferable than community-based sources of treatment (see next table). While consisting of only 19.6% of the commonwealth's total population, 35.5% of admissions to public hospitals in Virginia are for African Americans. These results indicate that more effort needs to be placed on increasing the quality of care received by minorities in both public and private mental health service providers and a coordinated and comprehensive service delivery system is needed – especially for high-need populations.

Summary of Findings of Admissions to the Public Mental Hospitals in Virginia 1990-1999

Group	Group's Percent of Total Virginia Pop.	Hospital Admissions	Percentage of Total Admissions
Selected Findings	Selected Findings	Selected Findings	Selected Findings
European Americans	76.19	68,653	63.54
American Indians	.24	135	.12
Asian Americans	2.53	579	.54
African Americans	18.49	37,872	35.05
Latino Americans	2.55	811	.75

Source: Dr. King Davis. Hogg Foundation for Mental Health. Austin, TX

Cultural Competence of Mental Health Practitioners

The ability for consumers and providers to communicate with one another is essential for all aspects of health care, yet it carries special significance in the area of mental health because mental disorders affect thoughts, moods, and the highest integrative aspects of behavior. The diagnosis and treatment of mental disorders greatly depend on verbal communication and trust between patient and clinician.[12]

[11] James, Cara et al. (2007). "Key Facts: Race, Ethnicity, and Medical Care." Report published by the Kaiser Family Foundation. Pg. 39.

[12] U.S. Department of Health and Human Services. (2001). "Mental Health: Culture, Race, and Ethnicity – A Supplement to Mental Health: A Report of the Surgeon General." Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Studies

The current study focused on two areas of disparity that could be addressed with legislation: language barriers and lack of cultural competence among practitioners and workforce shortage issues. Mental health services, even when accessed, may not meet the individual's needs because "individual circumstances, gender, race, culture, and other characteristics that shape a person's image and identity, and affect response to stress and problems" are not considered in making diagnoses and in treatment.[13] In other words, within the mental health care setting, culture impacts how people label and communicate distress, explain the causes of mental health problems, perceive mental health providers, and utilize/respond to mental health treatment. Cultural competence is "the integration…of knowledge about individuals and groups of people into specific standards, policies, practices and attitudes used in appropriate cultural settings to increase the quality of services; thereby producing better outcomes."[14]

One of the models for cultural competence training is CRAASSH (Culture, Respect, Assess, Affirm, Sensitivity, Self-Awareness, and Humility) and shows the important components of cultural competency. This model was developed by the National Center for Primary Care at Morehouse School of Medicine and emphasizes:

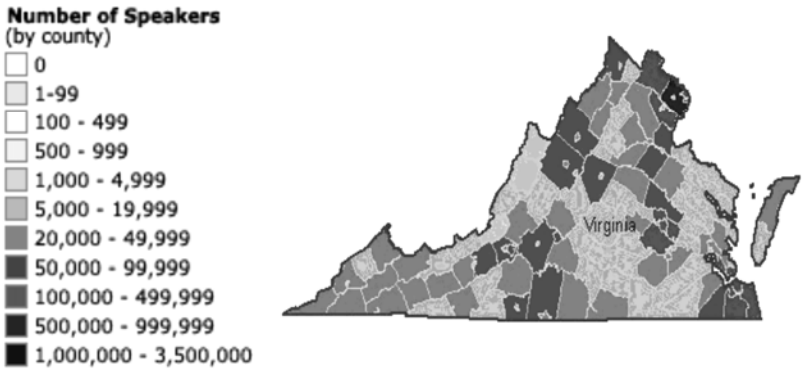
- cultural dynamics and the expression of the many variables that influence culture;
- demonstrating respect by asking questions, addressing patients appropriately, respecting personal boundaries and space, and expressing respect for and seeking to learn about the patient's culture;
- assessing health beliefs, knowledge, literacy, careseeking behaviors, and relevant relationships (who is important to the patient, what role that person plays in the patient's life, and how the patient would like that person to be included);
- affirming the positive values and characteristics of other cultures by recognizing the expertise and experience that the patient offers and reframing cultural differences to address positive characteristics that contribute to practices we may often view as different;
- offering sensitivity through awareness of cultural nuances, historical, political, religious, and social concerns, and differences in models of disease and health;
- examining one's personal attitudes and biases through identifying personal norms and values; and

[13] Davis, King. (1997). Exploring the intersection between cultural competency and managed behavioral health care policy: Implications for state and county mental health agencies.
[14] Ibid.

- exhibiting a measure of humility in recognizing that cultural competence is not a finite skill set that is acquired but rather a life-long journey and commitment.[15]

Research shows that providing culturally and linguistically appropriate services can improve health outcomes, increase patient compliance, be more cost effective, increase patient satisfaction, and increase access to health care.

Non-English Language Speakers in Virginia, By County



Map provided by the Modern Language Association. Source Data: Census 2000

CLAS Act Initiative. Within the Virginia Department of Health, the Office of Minority Health and Public Health Policy is actively working to increase levels of cultural competence among practitioners through the national CLAS Act Initiative (Culturally and Linguistically Appropriate Health Services). It began in 2003 as an informal group of 45 individuals representing 25 agencies/organizations interested in networking and sharing resources regarding the issue of cultural competence in the Commonwealth. In 2007, the initiative became formalized and a coordinator was hired through the Virginia Department of Health. The goal of this program is to "increase access to quality health care for Virginia's increasingly diverse populations by providing and developing resources related to culturally and linguistically appropriate public health services."[16] To accomplish this goal, CLAS Act Initiative currently oversees the following projects:[17]

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[15] Quoted from: Nunez, Ana and Candace Robertson. (2006). "Cultural Competency." In Multicultural Medicine and Health Disparities. Edited by David Satcher, Ruben Pamies, and Nancy Woelfl. McGraw Hill: New York, NY.

[16] www.CLASActVirginia.org

[17] Information from handout provided at the September 26, 2007 meeting of the Minority Health Advisory Committee, Office of Minority Health and Public Policy.

- CLASActVirginia.org
  The website is a resource guide to assist health care providers. Resources include training, reports, and documents on cultural competence, overcoming language barriers, translation, and interpretation. These resources are specific to Virginia with regionally appropriate information on such things as language service programs, Virginia studies and reports, and regional conferences and training.
- Commonly Used Clinical Phrases
  Audio translations of commonly used clinical phrases are available, along with visual flipcharts, on the Initiative's website for Spanish, Korean, Vietnamese, Chinese, French, Arabic, Persian, Russian, and Tagalog languages.
- Culturally Appropriate Public Health Training Series
  This series of training seminars is based on the 2007 Cultural Needs Assessment and provides instruction on working with diverse populations (e.g. General Cultural Competence, Working with the Latino Population, Working with the Muslim Population, etc.)
- Navigating the U.S. Healthcare System for Immigrants, Migrants, and Refugees Project
  A curriculum and supporting materials on how to effectively utilize the health care system.
- Language Needs Assessments of Virginia's Health Districts
  The most common languages in every health district of the Commonwealth are available at www.vdh.virginia.gov/OHPP/clasact/languageprofiles.asp along with recommendations for working with Limited English Proficiency (LEP) populations.
- Medical Interpreter Loan Repayment Program
  This program provides training grants to bilingual individuals for tuition of a medical interpretation course. In exchange, recipients perform 40 hours of community service at a safety net provider site and agree to be on call as interpreters in the event of a public health emergency.
- Statewide Telephonic Interpretation and Translation Contract
  The Initiative's coordinator is the Contract Manager for a contract for statewide telephonic interpretation and translation services between the Virginia Department of Health and Language Services Associates. This service provides practitioners with access to over 200 languages 24 hours a day, seven days a week.

Other current efforts to increase cultural competency among practitioners in Virginia include the Department of Mental Health, Mental Retardation and Substance Abuse Services' "Cultural and Linguistic Competency Conference" held in October 2007 and scheduled again in September, 2008; and the Virginia Commonwealth University's 2007 conference on Latino health disparities.

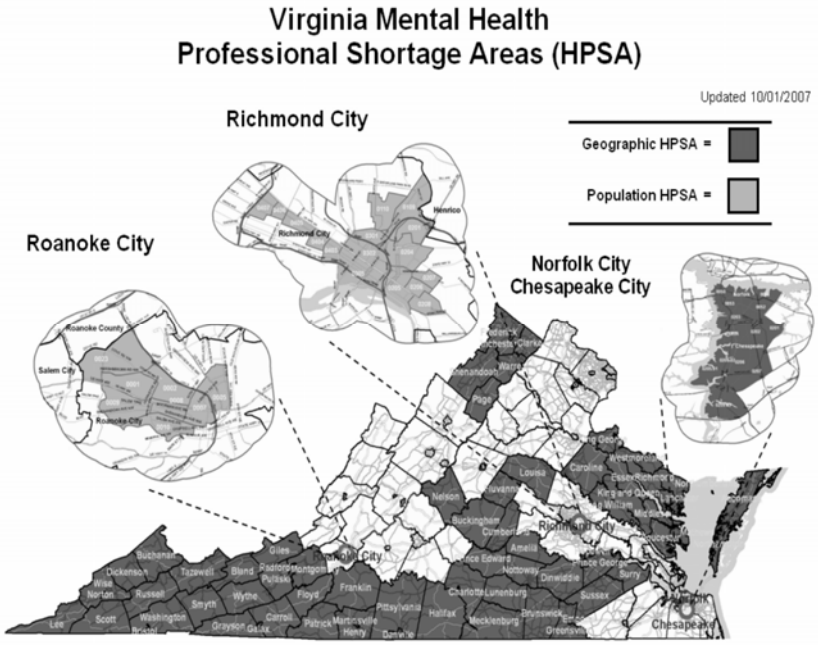
Workforce Shortages in Mental Health Fields

Another area of disparity addressed by this study is workforce shortages in underserved areas of the Commonwealth and the under-representation of minority practitioners in the mental health field. SJR 25 allowed for additional issues to be considered in order to address the objectives of the resolution. Encouraging more minority individuals to go into mental health careers was added to the study's plan in 2005. In its 2004 study, "Missing Persons: Minorities in the Health Professions" the Sullivan Commission on Diversity in the Healthcare Workplace reported that "today's physicians, nurses and dentists have too little resemblance to the diverse populations they serve, leaving many Americans feeling excluded by a system that seems distant and uncaring. In future years, our health professionals will have even less resemblance to the general population if minority enrollments in schools of medicine, dentistry, and nursing continue to decline and if health professions education remains mired in the past and – despite some improvements – inherently unequal and increasingly isolated from the demographic realities of mainstream America." Currently African Americans make up only 2 percent of psychiatrists and psychologists. The percentage of Spanish-speaking mental health professionals is not known, but only one percent of licensed psychologists who are also members of the American Psychological Association identify themselves as Hispanic. The Office of the Surgeon General estimates that there are 29 Hispanic mental health providers for every 100,000 Hispanics in the U.S., 101 American Indian/Alaska Native mental health providers for every 100,000 American Indians/Alaska Natives, and 70 Asian/Pacific Islander mental health providers per 100,000 Asians/Pacific Islanders (compared to 173/100,000 ratio for whites). [18]

Regarding Virginia specifically, regions of the State with higher percentages of racial and ethnic minorities tend to have fewer mental health care providers such as psychiatrists, psychologists, clinical social workers. Research has shown that increasing the proportion of racial and ethnic minority practitioners in the mental health field helps alleviate the problems associated with cultural and linguistic competency. Current efforts to increase health professionals in underserved areas include the Virginia Department of Health Loan Repayment Programs, Virginia's Nurse Practitioner/Nurse Midwife Scholarship Program, the J1 Visa Waiver, Virginia's child psychology/psychiatry internships, and efforts by the Virginia College of Osteopathic Medicine to train practitioners to work in underserved areas.

[18] U.S. Department of Health and Human Services. (2001). "Mental Health: Culture, Race, and Ethnicity-- A Supplement to Mental Health: A Report of the Surgeon General." Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Studies

In 2000, the Virginia Department of Health offered a scholarship program specifically for increasing the number of mental health professionals in underserved areas. This was the Psychiatrists in Underserved Communities



Scholarship. However, the program experienced high default rates partly due to CSBs not having adequate funding for full time positions, so many of the program participants had problems finding a suitable employment placement in an underserved area. As a result, this scholarship program was folded into the Virginia Department of Health's Loan Repayment Programs, VLRP and SLRP. VLRP is a State-funded program and SLRP is a State-funded program that also receives federal matched funds. The purpose of these programs is to recruit and retain primary care professionals in health professional shortage areas (HPSAs) and medically underserved areas (MUAs). The loans are intended for post-residency positions and provide $50,000 for a two-year commitment with an additional $35,000 if the individual agrees to work for another 1-2 years. These programs experience minimal loan defaults, primarily due to the flexibility of the program. If a participant is unhappy with their placement or needs to move for personal reasons (e.g. marriage) then VDH can approve a recipient changing their practice site without going into default.

The Virginia Nurse Practitioner/Nurse Midwife Scholarship Program provides $5000 per year for a maximum of two years in exchange for one year of service in a medically-underserved area for each year that the scholarship is received. The funds for this program are appropriated by the Virginia General Assembly. The J1 Visa Waiver is a national program designed to encourage foreign medical students to complete their residency in the United States. The program increases

the number of physicians in high-need regions of the Commonwealth by requiring the participants to work in a medically-underserved area for 3 years. Finally, $493,000 in general funds was appropriated beginning in FY 2008 for 8 internship positions in medically underserved areas for individuals specializing in child psychology or child psychiatry at a Virginia Institution of higher education. Each recipient is required to be employed in a qualified region designated by DMHMRSAS for a period equal to the number of years that he/she was a beneficiary of the internship program.

Finally, the Edward Via Virginia College of Osteopathic Medicine (VCOM) is addressing both the shortage of practitioners in underserved areas and the shortage of minority practitioners through its recruitment efforts. VCOM was founded in 2001 and graduated its first class in 2007. It has received full accreditation from the A.O.A. Commission on Osteopathic College Accreditation and there are currently over 600 students enrolled in the college. As part of the college's mission, students from rural and medically-underserved regions are actively recruited and provided incentives to return to underserved areas upon graduation. The college's efforts appear to be successful. Of the 600 students enrolled in the first four years, 350 were from the Appalachian region, 139 were from medically-underserved counties of Virginia, and 103 were minorities (African American, Latino, and American Indian).[19]

While only one of these current programs focuses specifically on the mental health field of medicine (the child psychology/psychiatry internships), they all provide increased incentives for practitioners to serve in high-need regions of the State where employees are needed in all health-related fields. None of the current programs are dedicated solely to increasing the number of racial and ethnic minority mental health care providers.[20] This is a critical shortage that needs to be addressed in order to reduce disparities in minority employment opportunities and provide more culturally-appropriate care for minority populations.

Conclusion

The results of this study indicate that while the rates of mental illness are similar for racial/ethnic groups in the general population, minorities are more likely to be in high-need sub-populations (like the homeless or incarcerated) whose rates of mental illness are higher and much less likely to be treated. Minorities with a mental illness also are less likely to access the mental health system due to fear of

[19] Information received from October 17, 2007 presentation to the JCHC, "A Report to the Joint Commission on Health Care by the Edward Via Virginia College of Medicine."

[20] With the possible exception of the Virginia College of Osteopathic Medicine where students are trained to treat the individual as a whole and, therefore, have at least basic mental health knowledge. It is likely that some students choose to specialize in the mental health field.

stigma, discrimination, and cultural/linguistic issues. When racial/ethnic minorities do seek treatment, they are more likely to receive poorer quality care.

These disparities, at least in part, can be alleviated by increasing the level of cultural competency of all practitioners and addressing workforce shortages in underserved areas and the lack of racial/ethnic minority health practitioners. The Virginia Department of Health already is making positive improvements in the area of cultural competence through the CLAS Act Initiative; however, real improvement will not be seen until cultural competency training is recognized as an important component of all practitioners' training and knowledge. Currently students majoring in the health care professions are not required to demonstrate competency in cross-cultural knowledge and culturally appropriate care in order to graduate from Virginia's colleges and universities. Legislative action in other states does provide precedent for this type of requirement. In 2006, Washington State legislators passed Senate Bill 6194 requiring "by July 1, 2008 each education program with a curriculum to train health professionals for employment in a profession credentialed by a disciplining authority under chapter 18.130 RCW shall integrate into the curriculum instruction in multicultural health as part of its basic education preparation curriculum." New Jersey's Bryant Law (enacted in 2005) requires all medical school students within New Jersey to complete cultural competency training as a licensure requirement. And a California Assembly Bill (2005) required the accreditation associations to develop standards by July, 2006 for continuing medical education (CME) providers to include curriculum in cultural and linguistic competency in all coursework that includes direct patient care. Other states considering legislation on cultural competency training include Arizona, Illinois, New York, and Ohio. Much of this legislation was introduced as part of a larger effort to address the continuing problem of minority-health disparities in the U.S. and reflects a growing awareness, and acceptance, of the importance of cultural competency training for providing quality health care to all individuals.

While all of the aforementioned programs in Virginia provide incentives for practitioners to serve in under-served regions of the State, only one focuses specifically on mental health (child psychology/psychiatry internship). Moreover, no program is dedicated solely to increasing the number of racial and ethnic minority mental health care providers.[21] This is a critical shortage that needs to be addressed in order to reduce disparities in minority employment opportunities and to provide more culturally appropriate care for minority populations. More effort is needed to encourage racial/ethnic minorities to enter the mental health professions and, to be most effective, needs to begin at the elementary or high school level and include incentives at the college level such as

[21] With the possible exception of the Virginia College of Osteopathic Medicine where students are trained to treat the individual as a whole and, therefore, have at least basic mental health knowledge. It is likely that some students choose to specialize in the mental health field.

grants, scholarships, and loans. Research shows that this is an important issue critical not only for the health of minorities, but for the Commonwealth as well.

Policy Options

Option 1: Take no action

Option 2: Request by letter from JCHC Chairman for the Virginia Department of Health Professions (or the Board of Medicine and the Board of Psychology) to examine and report on the issue of requiring cultural competence training for licensure of health practitioners or as a mandatory continuing education unit.

☑ **Option 3:** Request by letter from JCHC Chairman for the State Council of Higher Education for Virginia (SCHEV) to examine the issue of requiring cultural competence training as part of college curriculum for health profession majors.

Public Comments

No public comments were received on any of the policy options.

JCHC Staff for this Report
Michele L. Chesser, Ph.D.
Senior Health Policy Analyst

Virginia Joint Commission on Health Care

Staff Report: Minority Access to Mental Health Services

SJR 25, 2004 (Patron: Senator Henry Marsh)

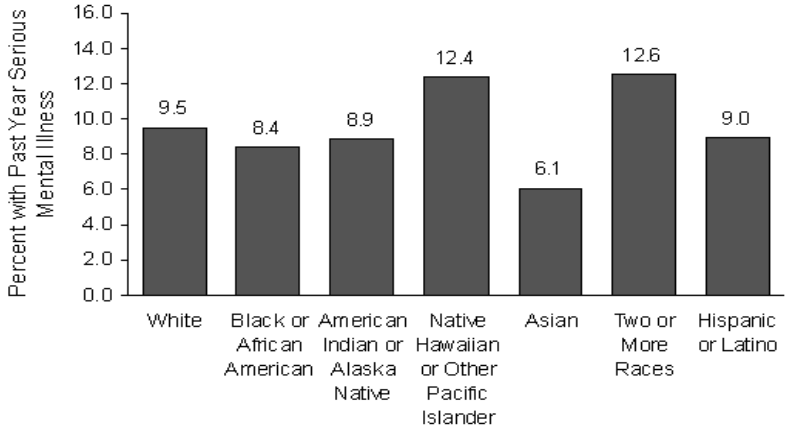
Michele Chesser, PhD
Senior Health Policy Analyst
October 27, 2007

Introduction

National Co-Morbidity Study Findings (2001)

Disorder	Rate	Disorder	Rate
All Anxiety	**16.4%**	**Schizophrenia**	**1.3%**
Simple Phobia	8.3%	Non-affective Psychosis	0.2%
Social Phobia	2.0%	Somatization	0.2%
Agoraphobia	4.9%	**Anti-social Personality**	**2.1%**
Panic Disorder	1.6%	**Anorexia**	**0.1%**
Mood Disorders	**7.1%**	**Lifetime Incidence [all]**	**25%**
Major Depress.	6.5%		
Unipolar	5.3%		
Dysthymia	1.6%		
Bipolar	1.1%		

Past Year Serious Mental Illness among Adults Aged 18 or Older, by Race/Ethnicity: 2003



Source: Dept. of Health & Human Services. National Survey on Drug Abuse: Volume I. Summary of National Findings; Prevalence and Treatment of Mental Health Problems (2003).

Summary of Findings of Admissions to the Public Mental Hospitals in Virginia 1990-1999

Group	Group's Percent of Total Virginia Pop.	Hospital Admissions	Percentage of Total Admissions
Selected Findings	Selected Findings	Selected Findings	Selected Findings
European Americans	76.19	68,653	63.54
American Indians	.24	135	.12
Asian Americans	2.53	579	.54
African Americans	18.49	37,872	35.05
Latino Americans	2.55	811	.75

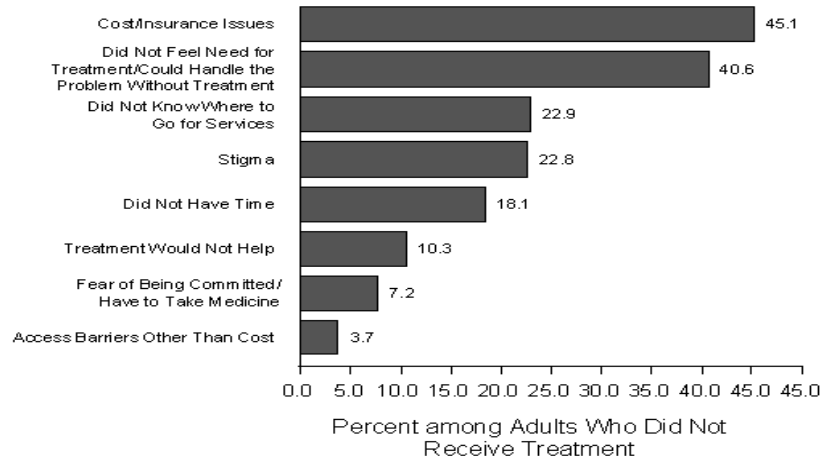
Source: Dr. King Davis. Hogg Foundation for Mental Health. Austin, TX

Black-White Comparison of Cumulative Proportions of Cases making Treatment Contact by Selected Years After Disorder Onset

	Cumulative Percentages						
# years after disorder onset	1	2	5	10	15	20	30
Major Depression							
African American	27.2	31.7	39.0	46.4	57.4	64.3	77.6
White American	39.5	44.4	51.1	58.2	64.7	70.3	78.0
Bipolar Disorder							
African American	17.3	19.5	24.5	33.0	38.1	38.1	43.9
White American	40.5	44.3	49.8	58.2	70.5	71.3	79.4

Source: Neighbors, Baser & Martin (2007). Unpublished data from the National Survey of American Life

Reasons for Not Receiving Treatment in the Past Year among Persons Aged 18 or Older with an Unmet Need for Treatment Who Did Not Receive Treatment: 2003



Source: Dept. of Health & Human Services. National Survey on Drug Abuse: Volume I. Summary of National Findings; Prevalence and Treatment of Mental Health Problems (2003).

Race/Ethnic Mental Health Disparities

- Minimal "true" epidemiological differences in incidence & prevalence by race and ethnicity
- National Institute of Mental Health (NIMH) 5 year strategic plan focuses on disparities in *services*
- Key Disparities:
  - Access to quality services
  - Help seeking and help utilization
  - Negative experiences within the system
  - Pervasiveness of stigma
  - Language and cultural competence
  - Lack of inclusion in research and clinical trials

Cultural Competence

Cultural Competence

Defined as a set of congruent practice skills, behaviors, attitudes and policies that come together in a system, agency or among providers and professionals that enables that system, agency, or professionals to work effectively in cross-cultural situations.

Source: Cross TL, Bazron BJ, et al. Towards a Culturally Competent System of Care. CASSP Technical Assistance Center, Georgetown University Child Development Center, March 1989

In the mental health care setting, culture impacts how people:

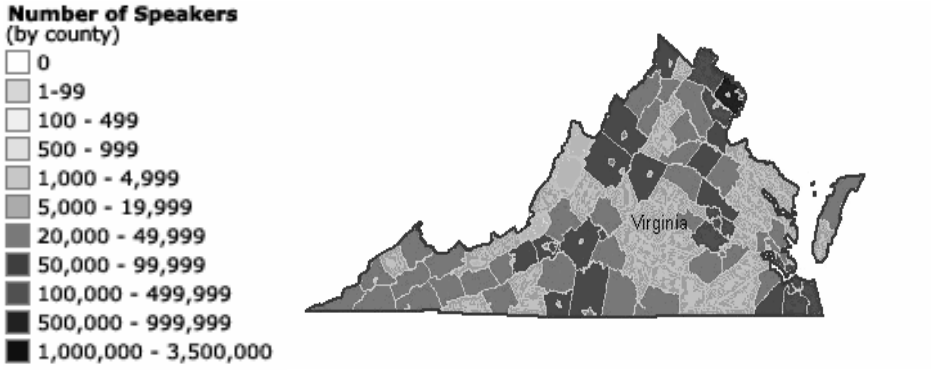
- Label and communicate distress
- Explain the causes of mental health problems
- Perceive mental health providers
- Utilize and respond to mental health treatment

Importance of Language Interpretation Services

"A call from the mother and sister of a Spanish-speaking man reported that he was "intoxicado." Paramedics and the hospital personnel incorrectly interpreted this as intoxicated or drunk and, therefore left him alone, offering no treatment. It turned out the man was actually having a stroke and this mistake resulted in him being paralyzed. After settling out of court, the health care institution was required to pay $71 million."

Source: Virginia CLAS Act Initiative

Non-English Language Speakers in Virginia, By County



Map provided by the Modern Language Association. Source Data: Census 2000

Goal of Cultural Competence Involves:

- Recognizing that culturally appropriate, community-driven programs are critical
- Promoting cultural awareness
- Encouraging cultural competence inclusion in medical school and health careers curriculum
- Advocating for the needs of the patients by providing translators, culturally competent information and instructions in simple language

Goal of Cultural Competence Involves:

- Encouraging recruitment, admission and retention of persons of color into the health professions
- Fostering mentorships for young people to help them remain in school and work towards a goal
- Supporting other physicians and health workers of color in attaining their goals

Goal of Cultural Competence

Why is this goal important?

Research shows that providing competent cultural & language services can and does:

Improve ***health outcomes***

Increase patient ***compliance***

Be more ***cost effective***

Increase patient ***satisfaction***

Increase access to health care

Source: VDH Office of Minority Health & Public Health Policy (OMHPHP)

Current Efforts to Increase Cultural Competence

- DMHMRSAS: Workforce & Cultural Competency Conference. October 24 & 25, 2007. Newport News, VA
- Office of Minority Health & Public Health Policy: CLAS Act Initiative
  - CLAS Act Coordinator: Fatima Sharif (Fatima.Sharif@vdh.virginia.gov)
  - Goal: Increase access to quality health care for Virginia's increasingly diverse populations by providing and developing resources related to culturally and linguistically appropriate public health services

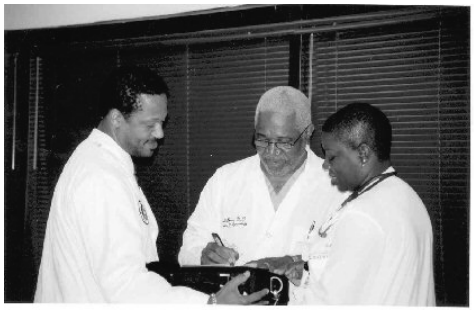
Current Efforts to Increase Cultural Competence

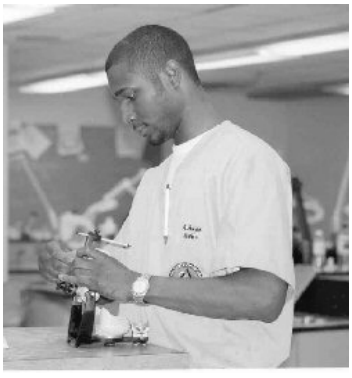
- CLAS Act Initiative (continued)
  - www.CLASActVirginia.org is a resource guide to assist health care providers. Resources include training, reports, and other documents on:
    - Cultural competence
    - Overcoming language barriers
    - Translation
    - Interpretation

Current Efforts to Increase Cultural Competence

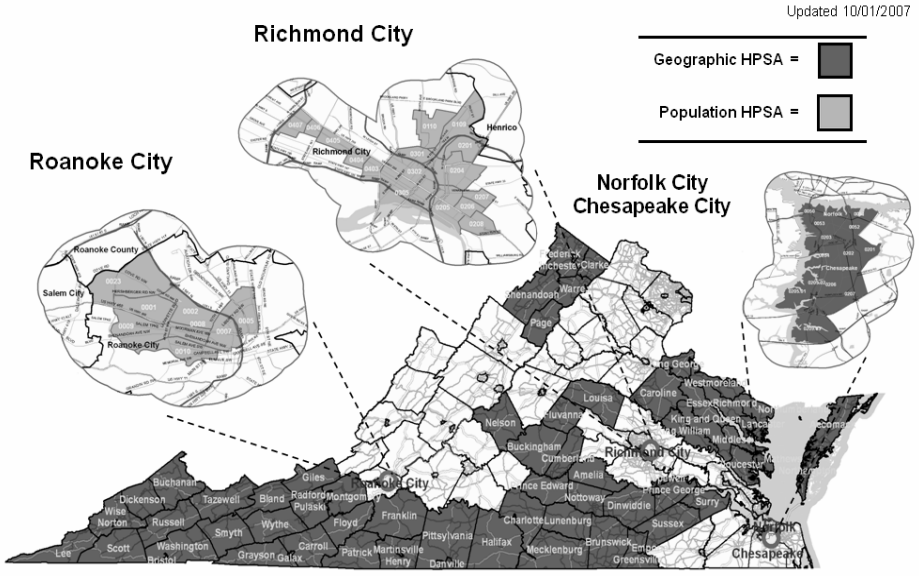
- CLAS Act Initiative (continued)
  - Resources are specific to Virginia with regionally appropriate information on:
    - Language service programs
    - Multicultural health and human service programs
    - Virginia studies and reports
    - Regional conferences and training
  - Translated resources through the site include
    - Links to thousands of translated documents
    - Commonly used clinical phrases in Spanish and Korean with accompanying audio and visual flip charts

Workforce Shortages

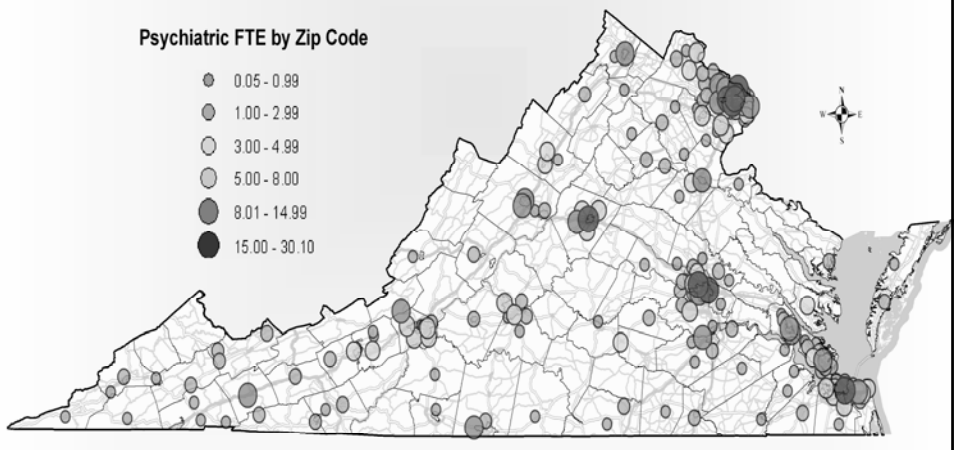




Virginia Mental Health Professional Shortage Areas (HPSA)

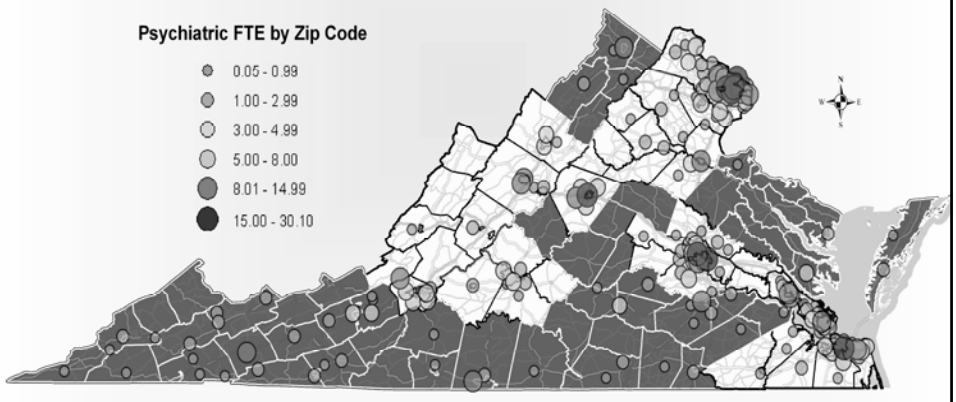


All Virginia Psychiatric Practice Sites Aggregated to Zip Codes*



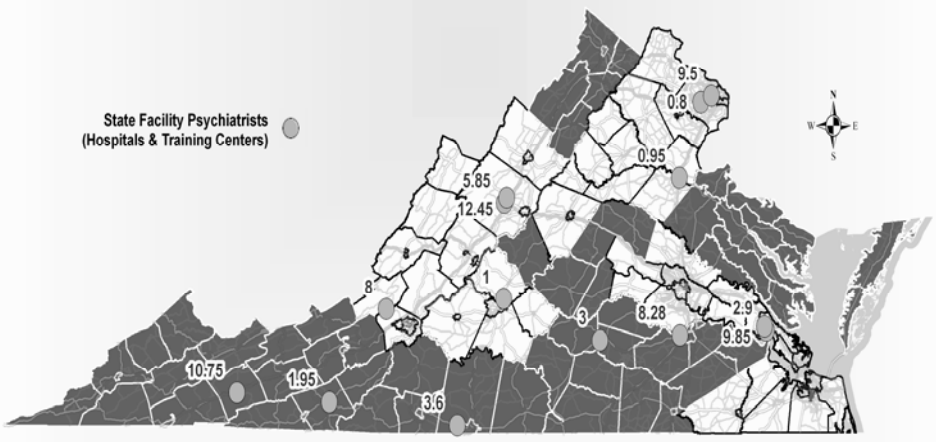
* Source: Virginia Board of Medicine: http://www.vahealthprovider.com/

All Virginia Psychiatric Practice Sites Aggregated to Zip Codes with HPSAs Identified*



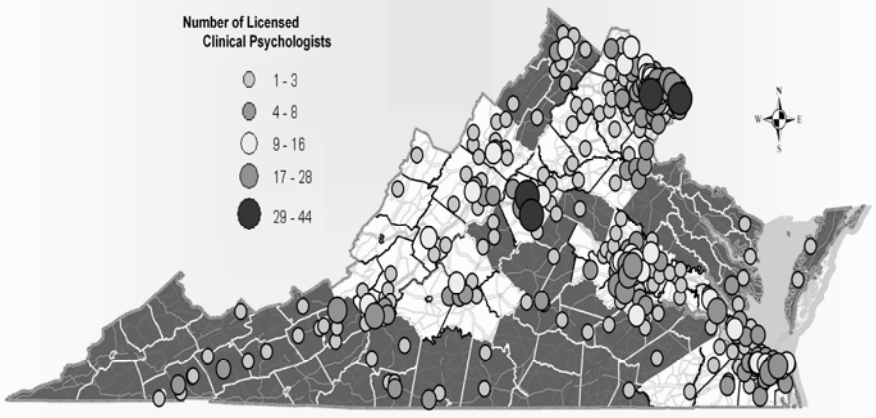
* Source: Virginia Board of Medicine: http://www.vahealthprovider.com/

Psychiatrists Practicing at State Mental Health Facilities with FTE estimates *



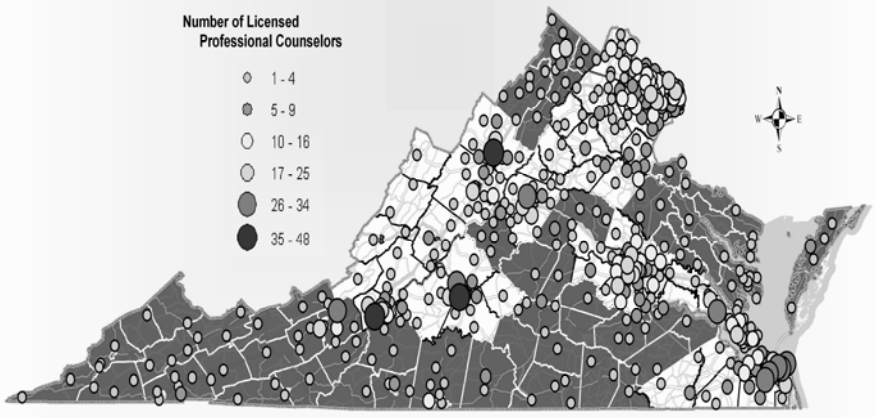
* Source: Virginia Board of Medicine: http://www.vahealthprovider.com/. The Zip Code FTE summaries are estimates computed from self-identification with a state practice site or with a state facility address within the Board of Medicine database.

Licensed Clinical Psychologists in Virginia
Zip Code Count Summary *



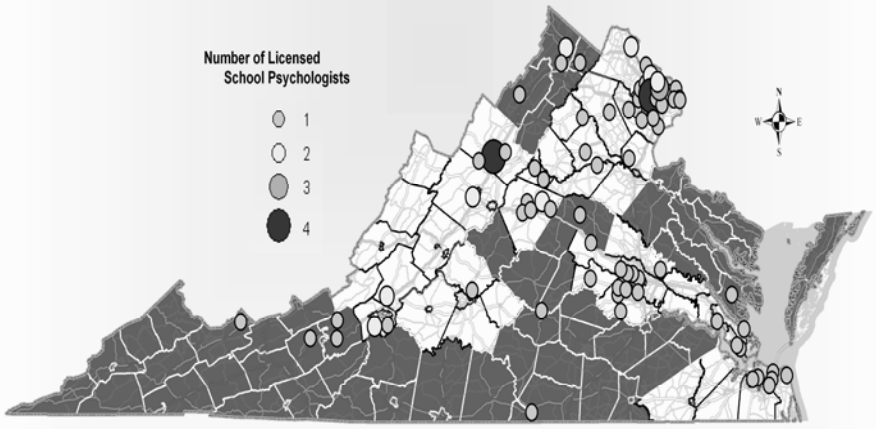
* Source: Virginia Department of Health Professions: http://www2.vipnet.org/dhp/cgi-bin/search_publicdb.cgihttp://www.vahealthprovider.com/. The Zip Code summaries are counts of Licensed Clinical Psychologists and represent only the licensure location of record and not practice activity or FTE estimates.

Licensed Professional Counselors in Virginia
Zip Code Count Summary *



* Source: Virginia Department of Health Professions: http://www2.vipnet.org/dhp/cgi-bin/search_publicdb.cgihttp://www.vahealthprovider.com/. The Zip Code summaries are counts of Licensed Professional Counselors and represent only the licensure location of record and not practice activity or FTE estimates.

Licensed School Psychologists in Virginia
Zip Code Count Summary *



* Source: Virginia Department of Health Professions: http://www2.vipnet.org/dhp/cgi-bin/search_publicdb.cgihttp://www.vahealthprovider.com/. The Zip Code summaries are counts of Licensed School Psychologists and represent only the licensure location of record and not practice activity or FTE estimates.

Current Efforts to Increase Health Professionals in Underserved Areas

- Virginia Department of Health Loan Repayment Programs
  - VLRP (State funded program) & SLRP (State/federal matched funds)
  - Purpose is to recruit and retain primary care professionals in health professional shortage areas (HPSAs) and medically underserved areas (MUAs)
  - Intended for post-residency
  - $50,000 for 2 year commitment
  - $35,000 for 1-2 additional year(s)
  - Minimum loan defaults due to flexibility of program
    - I.e. VDH can approve a recipient to change their practice site without going into default.

Current Efforts to Increase Health Professionals in Underserved Areas

- Virginia's Nurse Practitioner/Nurse Midwife Scholarship Program
  - $5000 per year for maximum of 2 years
  - Funds appropriated by the VA General Assembly ($25,000)
  - One year of service in medically underserved area required for each year that scholarship was received
- J1 Visa Waiver
  - For foreign medical students to do residency in the U.S.
  - Required to work in medically underserved area for 3 years
  - Virginia fills approximately 14 of 30 available slots
- Key Issues: Increase retention efforts and OMH&PHP staff

Current Efforts to Increase Health Professionals in Underserved Areas

- $493,000 General Funds was appropriated for FY2008 for 8 internship positions in medically underserved areas for individuals specializing in child psychology or child psychiatry at a Virginia institution of higher education.
- Virginia College of Osteopathic Medicine

Challenges

- Increasing the number of culturally competent providers
- Increasing awareness & availability of linguistic/translation services
- Mentoring young people into health careers: recruitment and promotion
- Inclusion of minorities in research & clinical trials
- Improving the health of our communities
- Fostering healthcare partnerships and collaboration

Source: Nereida Correa M.D. February 26, 2004. Women's Healthcare Network-Iona College

Policy Options

Option 1: Take no action

Option 2: Request by letter from JCHC Chairman for the Virginia Department of Health Professions (or Board of Medicine/Psychology) to examine the issue of requiring cultural competence training for licensure of health practitioners.

New Jersey (Senate Bill 144): Passed 2005

Requires doctors to receive cultural competence training before they can obtain a state medical license or be re-licensed. The State Board of Medical Examiners determines required hours of training

California (Assembly Bill 1195): Passed 2006

Requires all continuing medical education courses, unless exempted, to contain curriculum pertaining to cultural and linguistic competence in the practice of medicine

Policy Options

Option 3: Request by letter from JCHC Chairman for the State Council of Higher Education for Virginia (SCHEV) to examine the issue of requiring cultural competence training as part of college curriculum for health profession majors.

Washington (Senate Bill 6194): Passed 2006

1. Each education program with a curriculum to train health professionals for employment in a profession credentialed by a disciplining authority shall require a course in multicultural health as part of its basic education preparation curriculum
2. Each health professional regulatory authority authorized to establish continuing education requirements according to this title shall adopt rules that provide continuing education training in multicultural health. Each such authority shall consult with a knowledgeable entity within a state institution of higher education specializing in health disparities & multicultural care or with the department of health in the development of these rules

Acknowledgements

- Office of Minority Health & Public Health Policy
  - Dr. Michael Royster, Director
  - Kenneth Studer, Rural Health Manager
  - Aileen Harris, Incentives Coordinator
- Dr. King Davis, Director of Hogg Foundation for Mental Health. Austin, Texas
- Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS)
  - India Sue Ridout, Human Resources & Workforce Development Manager
- Fatima Sharif, Virginia Department of Health, CLAS Act Coordinator
- Allen Lewis and Mary K. Blair, Virginia Commonwealth University, Department of Rehabilitation Counseling

Public Comments

- Written public comments on the proposed options may be submitted to JCHC by close of business on November 5, 2007. However, to ensure comments are included in the preliminary matrix draft that will be distributed to JCHC members prior to the meeting, the comments must be received by close of business November 1st.
- Comments may be submitted via:
  - Email sareid@leg.state.va.us
  - Fax: 804-786-5538 or
  - Mail: Joint Commission on Health Care
    P.O. Box 1322
    Richmond, VA 23218
  - Comments will be summarized and presented to JCHC during its November 8th meeting.

JCHC Members

Delegate Phillip A. Hamilton, Chairman
Senator Stephen H. Martin, Vice-Chairman

Senator J. Brandon Bell, II
Senator Harry B. Blevins
Senator R. Edward Houck
Senator Benjamin J. Lambert, III
Senator Linda T. Puller
Senator Nick Rerras
Senator William C. Wampler, Jr.

Delegate Clifford L. Athey, Jr.
Delegate Robert H. Brink
Delegate Benjamin L. Cline
Delegate Franklin P. Hall
Delegate Kenneth R. Melvin
Delegate Harvey B. Morgan
Delegate David A. Nutter
Delegate John M. O'Bannon, III
Delegate John J. Welch, III

The Honorable Marilyn B. Tavenner
Secretary of Health and Human Resources

Appendix A

2004 SESSION

ENROLLED

SENATE JOINT RESOLUTION NO. 25

Directing the Joint Commission on Health Care to study the mental health needs and treatment of young minority adults in the Commonwealth. Report.

Agreed to by the Senate, February 17, 2004
Agreed to by the House of Delegates, March 9, 2004

WHEREAS, today, Americans assign high priority to disease prevention, the benefits of healthy lifestyles, and personal well-being, and most people agree that sound mental health is essential to a fulfilling and healthy life; and

WHEREAS, mental health care is often an afterthought and illnesses of the mind remain shrouded in fear and misunderstanding; and

WHEREAS, mental disorders are real health conditions that have an immense impact on individuals and families throughout the Commonwealth, and persons suffering from mental disorders present with a variety of symptoms that may include inappropriate anxiety, disturbances of thought and perception, deregulation of mood, and cognitive dysfunction which may be specific to a particular diagnosis or cultural influence; and

WHEREAS, the transition from youth to adulthood is stressful and undiagnosed mental health problems during this phase of life may intensify and be exacerbated by unemployment, homelessness, poverty, lack of preventive health care and support systems, and other social pressures during this stage of life; and

WHEREAS, many mentally disabled young adults have complex needs and the least financial resources, and the nature of their mental illness obscures their ability to acknowledge the need for or to seek appropriate health care and mental health treatment; and

WHEREAS, due to their mental disabilities, these persons often wander away from the safety and protection of home, and without cognitive and social skills to care for or defend themselves, fall prey to predators, become entangled in criminal activities, experience deteriorating physical and mental health, and encounter many dangers; and

WHEREAS, due to federal and state laws designed to protect patient medical records and health care, parents and family caregivers of mentally disabled young adults have little recourse short of involuntary commitment to obtain health care, social services, and mental health treatment for them; and

WHEREAS, a constellation of barriers deters persons of racial and ethnic populations from seeking treatment, including discrimination and the stigma of mental illness, which impede help-seeking behavior; and

WHEREAS, if racial and ethnic minority persons succeed in accessing mental health care services, the treatment may be inappropriate to meet their needs because diagnosis and treatment services frequently do not consider individual circumstances, gender, race, culture, and other characteristics that shape a person's image and identity, and affect response to stress and problems; and

WHEREAS, parents of mentally disabled young adults face legal, privacy, and financial obstacles, and are frustrated when navigating the mental health system to secure specialized care for their adult children; and

WHEREAS, this difficult situation may grow increasingly more difficult for mentally disabled young adults and their families when these persons become homeless, encounter the criminal justice system, or experience other unfortunate circumstances; and

WHEREAS, the development of alternatives within the legal parameters established by federal and state laws governing the confidentiality of health care, mental health treatment, and medical records that allow the parents and family members of mentally disabled young adults to appropriate culturally competent mental health treatment that they need may lessen the need for long-term, intensive care or involuntary commitment; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Joint Commission on Health Care be directed to study the mental health needs and treatment of young minority adults in the Commonwealth.

In conducting the study, the Joint Commission on Health Care shall, to the extent possible, (i) estimate the number of mentally disabled young adults by gender, age, and racial and ethnic classification, in the geographical regions of the Commonwealth; (ii) identify the prevailing mental health and emotional disorders and their etiology among minority young adults; (iii) identify the mental health needs of minority citizens, particularly minority young adults in Virginia; (iv) determine the number of racial and ethnic minority persons who receive mental health treatment each year and the facilities providing such care; (v) determine whether mental health care providers are trained to provide

culturally competent mental health treatment; (vi) assess the need for culturally competent mental health treatment in Virginia; (vii) review federal and state laws and regulations governing the confidentiality of health care, mental health treatment, and medical records and identify the conditions and the extent to which medical records information may be disclosed to parents and family members to assist them in obtaining health, social services, and mental health treatment for mentally disabled young adults; (viii) recommend ways and alternatives, within the law, to provide parents and family members of mentally disabled young adults the ability to obtain needed health, social services, and mental health treatment for such persons without involuntary commitment; and (ix) consider such other related matters as the Commission may determine necessary to address the objectives of this resolution.

Technical assistance shall be provided to the Commission by the Department of Mental Health, Mental Retardation and Substance Abuse Services. All agencies of the Commonwealth shall provide assistance to the Commission for this study, upon request.

The Joint Commission on Health Care shall complete its meetings for the first year by November 30, 2004, and for the second year by November 30, 2005, and the Chairman of the Commission shall submit to the Division of Legislative Automated Systems an executive summary of its findings and recommendations no later than the first day of the next Regular Session of the General Assembly for each year. Each executive summary shall state whether the Commission intends to submit a document of its findings and recommendations to the Governor and the General Assembly. The executive summaries and the documents shall be submitted as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents and reports and shall be posted on the General Assembly's website.

Joint Commission on Health Care

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