FaithHealthNC
Community Health Assets Mapping Partnership
CHAMP

EXECUTIVE SUMMARY

Behavioral Health

Davidson, Davie & Forsyth Counties

April 1-2, 2016

CHAMP Access to Care Workshop

FaithHealthNC
A Shared Mission of Healing

Wake Forest School of Medicine

IRHAP
International Religious Health Assets Programme
ARHAP African Religious Health Assets Programme

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This report is available online at: www.faithhealthnc.org

CHAMP BACKGROUND

Community Health Mapping Partnership (CHAMP) is an adaptation of the Participatory Inquiry into Religious Health Assets, Networks, and Agency (PIRHANA), a research model developed by Dr. Gary Gunderson, Dr. James Cochrane and Dr. Deborah McFarland. Begun in sub-Sahara Africa, the research method focused on identifying positive health assets present within communities in the midst of the HIV/AIDS epidemic within sub-Sahara Africa. PIRHANA was initially developed for work undertaken in 2005-2006 by the African Religious Health Assets Programme (ARHAP), which is now the International Religious Health Assets Programme (IRHAP). CHAMP was further developed and refined by Dr. Teresa Cutts and team in Memphis, from 2007-2013.

The objective of CHAMP is to translate the PIRHANA research method for North Carolina communities to discover positive health and faith based assets within their respective counties and regions. Rather than focusing on the problems and deficiencies in communities, the PIRHANA research method works to identify the things that are good and positive in communities. The PIRHANA workshop process is different from a traditional focus group or town hall meeting since the participants actually become 'researchers' during the workshop and the results are given back to the participants and community to use for planning and future activities.

STUDY AREA BACKGROUND

Two half-day workshops, facilitated by Wake Forest University Medical Center's FaithHealthNC, was offered in Winston-Salem at the behavioral health provider and seeker levels. As a part of the Community Health Asset Mapping Partnership in Winston-Salem, the workshops focused on institutional, organizational and individual behavioral health providers offering services and those receiving services in Davidson, Davie, and Forsyth Counties [**Figure 1**].

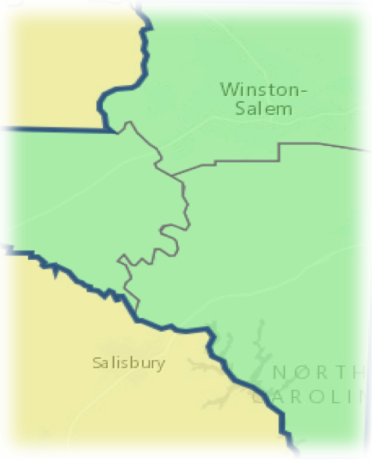

Figure 1

The Behavioral Health Asset Mapping workshop for providers took place on April 1, 2016 at Green Tree Peer Center on South Broad Street in Winston-Salem, NC. The workshop began at 9:00 am and was completed by 1:30 pm. The Behavioral Health Asset Mapping workshop for seekers took place on April 2, 2016 at Green Tree Peer Center. The workshop began at 9:00 am and concluded by 3:00 pm. Green Tree offered a central location for both providers of behavioral health services and seekers of such services. The workshop was held in the multipurpose room, positioned accessibly in the center of the building. The multipurpose room was handicap accessible and snacks were available for participants as they entered the space.

PROCESS AND METHODS

Upon registration, each participant was asked to document their address and contact information, gender, race and/or ethnicity, marital status, age, level of completed education, occupation and/or school, church affiliation and the length of time they have lived in Davidson, Davie, or Forsyth Counties. In addition, each participant signed an informed consent form.

Eighteen participants registered and represent a variety of behavioral health care providers within Davidson, Davie, and Forsyth Counties. Fifteen of the eighteen participants identified as White/Caucasian and two identified as Black/African-American. Fourteen participants identified as female, and four identified as male. Five participants hold Bachelors' degrees as well as eleven other participants hold

Master's degrees. Two participants have some college experience. The average age of participants was forty-six years old.

The average age of the seeker participants was forty-five (45) years old. The oldest participant was fifty-nine (59) years old, while the youngest was twenty-one (21) years old. Eleven participants identified as female and five identified as male. Seven participants identified themselves as African-American, six participants as white, one participant identified as "mixed," one participant identified as Hispanic, and one participant did not identify his/her race/ethnicity. Twelve participants were single, two were married, one had separated and one was divorced. The highest level of education for nine participants was high school. Three other participants completed at least Bachelor degrees and one participant completed a Master's degree.

The provider and seeker workshops differ both in focus and in the types of exercises used to elicit information. The provider workshop consisted of several structured and participatory activities (drawing maps, ranking in groups, writing a factor onto an index card) while the seeker workshops varied in structure and were more discussion based. The resulting data from these workshops was collected and analyzed by the workshop facilitation staff and packaged into a report that describes each workshop in detail. **Figure 2** is a comparison of activities at the two workshops. These reports are available online at http://www.faithhealthnc.org.

Behavioral Health Provider Workshop	**Behavioral Health Seeker Workshops**
1. Community Mapping: Exercise provides a greater awareness of which organizations are present in Davidson, Davie, and Forsyth Counties and helps to note gaps in the community. 2. Health Services Matrix: Participants identify the ways that local entities contribute to behavioral health 3. Health and Well-Being Index: Part I consisted of the participants brainstorming the two factors they personally believe are most important to the health and well-being of those who seek behavioral healthcare. Part II consisted of two factors their organizations believe are most important to the health and well being of those seeking behavioral health services. 4. Social Network Mapping: Spider gram of relationships 5. Local Action: Participants discuss where we go from here	*Primarily discussion based* 1. Community Mapping: Participants draw maps of the assets in their community 2. Health and Well-Being Index: Participants identify the most important factors contributing and working against behavioral health in the community 3. Ranking of facilities: Participants rank community organization on how well they support factors contributing to health 4. Good Practice: Participants list outstanding community organizations and describe their characteristics 5. Religion and Health Index: Participants identify ways religion and religious organizations contribute to mental health 6. Local Action: Participants discuss where we go from here

Figure 2: Comparison of Workshop Activities

HEALTH AND WELL-BEING INDEX

The health and well-being index exercise consisted of a two-part brainstorming. Part I consisted of the participants brainstorming the two factors they personally believe are most important to the health and well-being of those who seek behavioral health services. Part II consisted of two factors their organizations believe are most important to the health and well-being of those seeking behavioral health services. The charts below depict the **providers responses.**

Question	Results
*"What do **you personally** believe to be the most important factors regarding the health and well-being of those seeking behavioral health services?"*	1. Person-Centeredness 2. Accessibility

Question	Results
*"What does **your organization** believe to be the most important factors regarding the health and well-being of those seeking behavioral health services?"*	1. Person-Centeredness 2. Accessibility

Participants in the **seeker workshop** informally discussed the factors that work against health and well being in regards to access to care in the Piedmont area. The most frequently mentioned challenges among participants were:

- Lack of respect
- Lack of coordination of services
- Self-direction of resources
- Access support
- Lack of motivation

When asked to discuss factors that work for health and well being in the community, participants raised the following assets:

- Peer and community support
- Self-management
- Financial resources
- Provider competence
- Care coordination

Though there are many similarities on both seeker and provider lists, it appears that seeker participants were most concerned with being able to self-manage their needs through clear care coordination and peer support. Although both groups seemed to agree on person-centeredness and accessibility, it seemed as though there were conflicting understandings of care coordination as it pertained to accessibility. Seekers desired partnership as they manage their own resources, whereas providers voiced a need for continued organizational partnership and greater accessibility among organizations.

FACILITY/HEALTH RANKING

The final exercise consisted of seekers ranking various community assets on their levels of efficiency in various contexts. The objective of this activity was to picture the ways in which different entities

contribute to mental health and well being as it relates to access to care. Each group was asked to rate various community entities on a scale of one to five (one being poor and five being great).

GROUP AVERAGES						
	Transportation	Financial Resources	Provider Competence	Care Coordination	Self-Management	Peer and Community Support
Retail	2.5	2	N/A	N/A	2.5	3.5
Church (Faith Community)	4	3.5	4	3	3	3.5
Parks	5	3.5	N/A	N/A	3.5	3
Hospitals and Clinics	3.5	2	3	2	2.5	2.5
Community Centers	4	3	3.5	3.5	3.75	3.5
Shelters	2.5	2.5	2.5	3.5	3	3

LOCAL ACTION

Participants in both workshops were asked to identify what they want to see happen next within the community. Participants came up with a list of both tangible and intangible ideals for improving the behavioral health care system.

Seeker responses:

- Increase transportation
- Provider training and competence
- More activities
- Current and easy-to-use resource list to network
- Improve communication with providers
- More women's shelters after overflow
- Avenues for conversation between psychiatry and primary care physicians around monitoring psychotropic medications
- Coordination between housing and other agencies
- Increased involvement with peers
- Increase number of bus passes

Provider responses:

- Create a virtual website to act as a resource directory
- Ongoing collaboration and engagement, including the resurrection of "Every Mind Matters"
- Social media access
- Invite the medical and spiritual community to the table of discussion
- Have a real plan following these meetings
- Conduct a mental health fair to promote networking and resourcing

- Insure reports go to local government
- Mental Health Association

NOTES FROM FOLLOW-UP MEETING

A follow-up meeting for both the seekers and providers was held on Monday, May 9, 2016 in Davis Chapel Basement at Wake Forest Baptist Medical Center. In attendance were 7 providers and 0 seekers.

Question: Do you see any differences between the things that the behavioral health seekers mentioned and the things that the behavioral health providers mentioned?

Discussion:

The seekers were an empowered group that focused on self-management of their condition. Those working with peer specialists have become more empowered through risk taking and feel that it is safer to engage the "service world" through the peer-to-peer approach. In regards to medication, behavioral health seekers are more concerned about the side effects of medication and feel that no one is managing their overall picture of health. While clients feel empowered to ask questions of their psychiatrists, it doesn't seem to the behavioral health seekers that there is an expectation on the part of the physician.

There seems to be a difference in action words between the providers and seekers of behavioral health services. Seekers seem to use proactive suggestions concerning the related problem, such as "increase" or "fix." Providers seem to offer reactive suggestions, such as "planning to create a plan." It seems like the providers think they have everything they need but people just need to access it better, whereas the seekers are saying that there is something missing.

Question: Do you see any other steps that we can take together?

Discussion:

The group suggests further engaging the Mental Health Collaborative. According to the group, there is no ongoing representation of the biggest mental health care providers in the community. There are more networking/informational events rather than collaborative and strategic conversations. There are a lot of things that can be better tied together, but we need a framework, and we really don't have one. The group suggests creating a mixed-media approach for seekers to have various entry points into behavioral health resources. In addition, the group suggests finding specific ways to advocate for more peers in the community, especially in terms of local government funding.

Question: What did you get out of the workshop?

Discussion:

Members of the group mentioned the remaining gap between what providers believe that we offer, and what the seekers are asking for. Participants stated that given Maslow's hierarchy, we are not meeting the basic needs of our seekers. In addition, participants said they learned about different organizations within the Winston-Salem area. However, if providers are

not aware of the resources in the community, then it is assumed that seekers will not know the providers in the area either.

Participants expressed surprise in how much the seekers spread information through "word-of-mouth." Many of the seekers present for the mapping event were deeply invested in their own wellness. Most of the providers' practices are "recovery-informed", trained in psychosocial rehabilitation skills and have a strong emphasis on relationship/engagement. What I sensed is that not only do we have a problem with engagement between seekers and providers, but also there's a problem with engagement amongst providers. Could we have a solution-focused forum? If we really want solutions in the community, we are all going to have to sacrifice. According to one provider, we have to "get out of being provider-centric."

Question: How can we use our community assets to move forward on these next steps?

Discussion: The report needs to be distributed to the "collaborative" and to others with decision-making power.