Stepping Higher, INC.

# STEPPING HIGHER

## Faith-Based and Behavioral Health Academy

A Training and Certification Program for Faith-Based Leaders
and Behavioral Health Providers

COUNTY OF SAN DIEGO
HHSA
HEALTH AND HUMAN SERVICES AGENCY

LIVE WELL
SAN DIEGO

SAN DIEGO STATE UNIVERSITY
Social Policy Institute
*School of Social Work*

Leadership, Innovation, and Full Implementation
by Stepping Higher, Inc. with curriculum design
and support by SDSU Social Policy Institute

FUNDED BY THE COUNTY OF SAN DIEGO
HEALTH AND HUMAN SERVICES AGENCY

# STEPPING HIGHER

Faith-based and Behavioral Health Academy

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VERSION 4_4/2023

# Academy Goals

Stepping Higher, Inc's. main goal is to support faith-based leaders and behavioral health providers in aligning and expanding spiritual wellness and mental health in our community. These efforts are meant to strengthen the individuals in the community to thrive and "Live Well."

Specifically, the Stepping Higher Faith-based and Behavioral Health Academy will:

***• engage clergy, faith-based leaders, and behavioral health providers to increase understanding of each other's services, resources, and opportunities,***

***• support the development of collaborations to build capacity and advance wellness in San Diego's Central Region with a focus on the African American and Latinx populations,***

***• identify faith-based and behavioral health champions to provide facilitator training in community venues, and***

***• increase knowledge of behavioral health services for the faith-based community and to increase knowledge of faith-based community services for behavioral health providers.***

# ACKNOWLEDGEMENTS

The Faith-Based Behavioral Health Training & Education Academy (FBBHTEA) would like to thank the following key organizations and people in front and behind the scenes that have been instrumental in bringing this Academy to fruition:

- Funder, County of San Diego, Health and Human Services Agency (HHSA), Behavioral Health Services
- Dr. William A Benson, Phd, D.DIV | Board Chair | President and CEO, Stepping Higher Incorporated (SHI)
- Dr. Rachelle Y. Benson, Project Contract Manager, Vice-President | Executive Director, Behavorial Health Specialist Stepping Higher Incorporated (SHI)

**CORE PROJECT TEAM**

- Behavioral Health Services Contracting Officer's Representatives (COR) Team
- Dr. Carole M. O'Neil | Assistant Project Contract Manager and Core Faith Based Panelist Director of Development, Stepping Higher Incorporation, and Chaplain, Total Deliverance Worship Center
- Steve Hornberger, MSW | Project Curriculum Editor, Director, San Diego State University, (SDSU) Social Policy Institute
- Lori Clarke, | Project Curriculum Editor, Chief Program Officer, San Diego State University (SDSU) Social Policy Institute
- Dr, James Profit, | Project Core Faith Based Panelist And Core Behavorial Health Specialist Pastor, Living Epistles Church and President, CEO The Bridges of San Diego, Substance Abuse & Psychology

**SPECIAL ACKNOWLEDGEMENTS**

- Total Deliverance Worship Center, Inc.
- Pastors on Point of San Diego
- San Diego State University Research Foundation

# IDEA KEEPER

## POINTS TO PONDER



## MY COMMITMENTS GOING FORWARD





## QUESTIONS



## COMMUNITY PARTNERS

# MODULE 1: WELCOME AND OVERVIEW

**PARTICIPANTS WILL HAVE AN OPPORTUNITY TO:**

- *Increase awareness of the County of San Diego's Live Well Vision*
- *Review goals and expectations of Stepping Higher Faith-Based & Behavioral Health Academy*
- *Get to better know their cohort members*
- *Establish an inclusive and respective community with each other*

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# LIVE WELL SAN DIEGO VISION

**BUILDING BETTER HEALTH**

**Improving the health of residents and supporting healthy choices**

**LIVING SAFELY**

**Ensuring residents are protected from crime and abuse, neighborhoods are safe, and communities are resilient to disasters and emergencies**

**THRIVING**

**Cultivating opportunities for all people and communities to grow, connect, and enjoy the highest quality of life**

*For more information see: https://www.livewellsd.org/content/livewell/home/about.html*

# For Reflection:

What do you hope to achieve for your community? (prepare to share with the group)

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**GROUP AGREEMENTS FOR THE STEPPING HIGHER FAITH-BASED & BEHAVIORAL HEALTH ACADEMY**

Review the following list of suggested agreements for the group. Are there any you would add or change? (Write down any that the group agrees to add)

1. Actively listen, only one person speaks at a time
2. Respect each other's opinions and experiences
3. All personal sharing is kept in the group (Maintain confidentiality)
4. Agree to disagree
5. Manage technology
6. Refrain from mentioning political or unrelated religious viewpoints
7. Other:
8. Other:
9. Other:

"Health is the state of complete physical, mental, and social well – being and not merely the absence of disease or infirmity." - World Health Organization, 1949

**FOR REFLECTION:**

Do you agree or disagree with this definition? Why or why not?

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Since the World Health Organization offered this definition, faith-based and professional leaders have included spiritual and environmental elements as essential areas for health, quality of life, and wellness. We will discuss this in further detail, during later modules.

The Stepping Higher Faith-Based & Behavioral Health Academy will provide information and resources to bridge the spiritual and behavioral health communities. This will help those you serve lead healthy and long lives.

**FOR REFLECTION:**

Why are faith leaders and behavioral health professionals both important for helping to improve health and wellness of congregants and the community?

# Notes:

# MODULE 2: MENTAL HEALTH, SPIRITUALITY, & WELLNESS

## PARTICIPANTS WILL HAVE AN OPPORTUNITY TO:

- *Develop a shared understanding of mental health wellness*
- *Develop a shared understanding of spiritual wellness*
- *Increase understanding of the nexus between mental health, spirituality and wellness*

**NOTES:**

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# WHAT IS MENTAL HEALTH?

Mental health includes our emotional, psychological, and social well-being. It affects how we think, feel, and act. It also helps determine how we handle stress, relate to others, and make choices. Mental health is important at every stage of life, from childhood and adolescence through early and older adulthood.

Mental wellness is the successful performance of mental function, resulting in productive daily activities, fulfilling relationships with others, the ability to adapt to change and to cope with adversity.

Over the course of your life, if you experience mental health conditions your thinking, mood, and behavior could be affected. Many factors contribute to mental health conditions, including:

- Biological factors, such as genes or brain chemistry
- Life experiences, such as trauma or abuse
- Family history of mental health issues
- Negative social determinants of health, such as racism, unemployment, lack of housing, etc.

**FOR REFLECTION:**

Take a moment to think about a congregant or client, whom you had concerns for regarding their mental wellness. What did you notice that made you feel concerned?

# EARLY WARNING SIGNS

Experiencing one or more of the following feelings or behaviors can be an early warning sign of a challenge:

- Eating or sleeping too much or too little
- Pulling away from people and/or usual activities
- Having low or no energy
- Feeling numb or like nothing matters
- Having unexplained aches and pains
- Feeling helpless or hopeless
- Smoking, drinking, or using drugs more than usual
- Feeling unusually confused, forgetful, on edge, angry, upset, worried, or scared
- Yelling or fighting with family and friends
- Experiencing severe mood swings that cause challenges in relationships
- Having persistent thoughts and memories you can't get out of your head
- Experiencing nightmares or night terrors
- Hearing voices or believing things that are not true
- Thinking of harming yourself or others
- Inability to perform daily tasks like taking care of your children or getting to work or school

**FOR REFLECTION:**

Were any of the warning signs listed above a factor in causing concern regarding the congregant or client you were reflecting on earlier?

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# MENTAL HEALTH MYTHS AND FACTS

The following are some common mental health myths and facts:

**MYTH: MENTAL HEALTH CONDITIONS DON'T AFFECT ME.**

FACT: Mental health conditions are actually very common.

- One in five American adults experience a mental health issue.
- One in 10 young people experience a period of major depression.
- One in 25 Americans live with a serious mental health condition, such as schizophrenia, bipolar disorder, or major depression.
- Suicide is the 10th leading cause of death in the United States overall and the 2nd leading cause of death for 10 to
- 24 years old. It accounts for the loss of more than 41,000 American lives each year, more than double the number of lives lost to homicide.

**MYTH: CHILDREN DON'T EXPERIENCE MENTAL HEALTH CONDITIONS.**

FACT: Even very young children may show early warning signs of mental health concerns.

- Half of all mental health disorders show first signs before a person turns 14 years old, and 75% of mental health disorders begin before age 24.
- Nationally, less than 20% of children and adolescents with diagnosable mental health challenges receive the treatment they need. In CA less than 5% of children with behavioral health needs are able to access care.
- Early mental health support can help a child before challenges interfere with other developmental needs.

**MYTH: PEOPLE WITH MENTAL HEALTH CONDITIONS ARE VIOLENT AND UNPREDICTABLE.**

FACT: The vast majority of people with mental health conditions are no more likely to be violent than anyone else.

- Only 3%-5% of violent acts can be attributed to individuals living with a serious mental health condition.
- People with severe mental health conditions are over 10 times more likely to be victims of violent crime than the general population.

**MYTH: PEOPLE WITH MENTAL HEALTH CONDITIONS, EVEN THOSE WHO ARE MANAGING, CANNOT TOLERATE THE STRESS OF HOLDING DOWN A JOB.**

FACT: People with mental health conditions are just as productive as other employees. Employers who hire people with mental health conditions report good attendance and punctuality as well as motivation, good work, and job tenure on par with or greater than other employees.

When employees with mental health conditions receive effective treatment, it can result in:

- Lower total medical costs
- Increased productivity
- Lower absenteeism
- Decreased disability costs

**MYTH: THERE IS NO HOPE FOR PEOPLE WITH MENTAL HEALTH CONDITIONS. ONCE A FRIEND OR FAMILY MEMBER DEVELOP MENTAL HEALTH CONDITIONS, HE OR SHE WILL NEVER RECOVER.**

FACT: Numerous studies show that people with mental health conditions can and do get better. Recovery refers to the process in which people are able to live, work, learn, and participate fully in their communities.

- There are many treatment approaches and community support systems than ever before, to assist the person and his/her family.
- Treatment works and people recover.

**MYTH: THERAPY AND SELF-HELP ARE A WASTE OF TIME. WHY BOTHER WHEN YOU CAN JUST TAKE A PILL?**

FACT: Treatment for mental health conditions varies depending on the person, medical condition, and their individual needs.

- Options include medication management, various psychotherapy modalities, group treatment, and online supports.
- Individuals work with a comprehensive support system during the healing and recovery process.
- Faith communities can and do support people with mental health conditions.

**MYTH: PREVENTION DOESN'T WORK. IT IS IMPOSSIBLE TO PREVENT MENTAL CONDITIONS.**

FACT: Prevention of mental, emotional, and behavioral disorders focuses on addressing known risk factors such as exposure to trauma, that can affect the chances that children, youth, and young adults will develop mental health conditions.

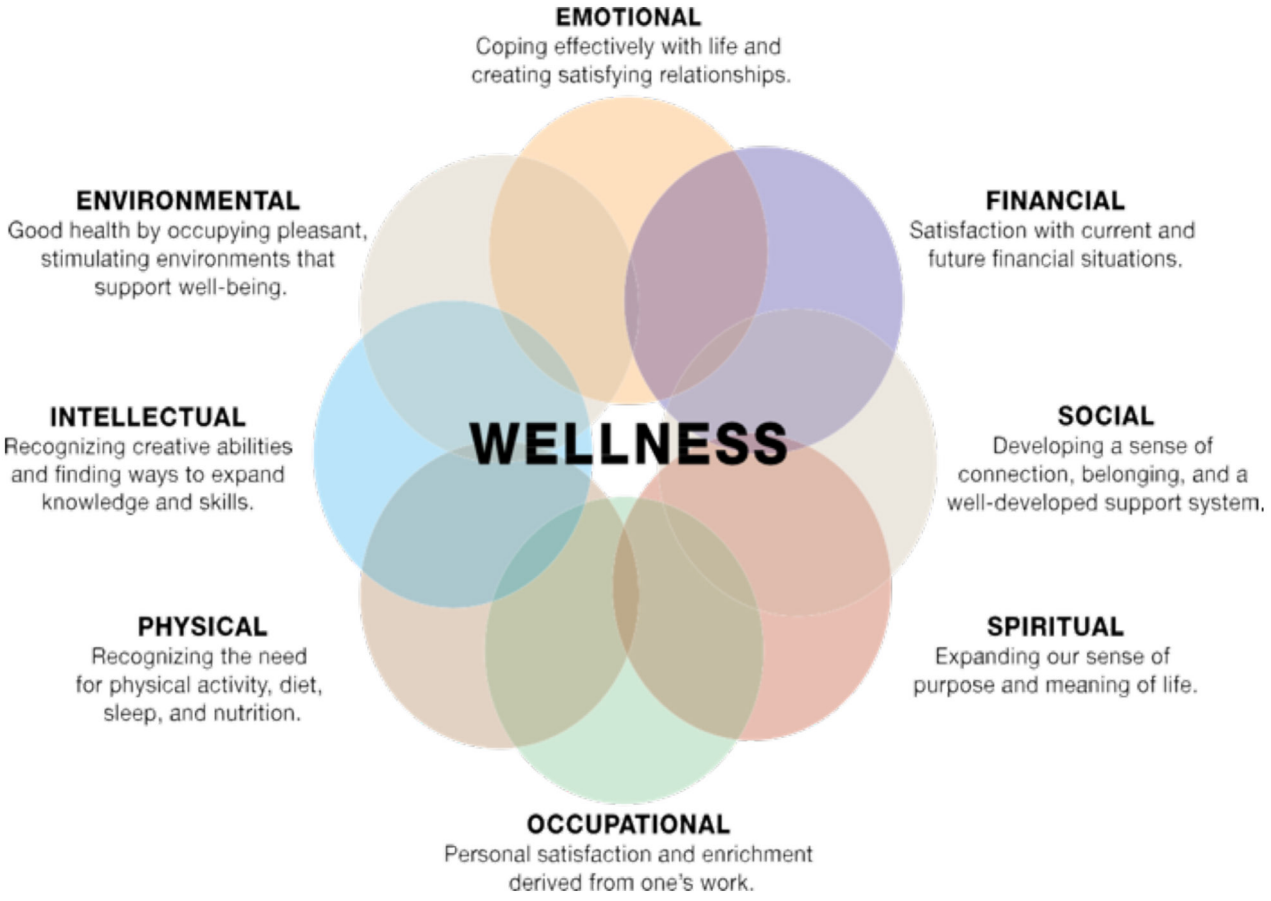
Promoting the social-emotional well-being of children and youth leads to:

- Higher overall productivity
- Better educational outcomes
- Lower crime rates
- Stronger economies
- Improved family wellness

For more information see: *https://www.mentalhealth.gov/basics/what-is-mental-health/*

# RECOVERY, WELLNESS, AND BUILDING RESILIENCE

*Adapted from Swarmbrick, M. (2006). A Wellness Approach. Psychiatric Rehabilitation Journal, 311-314, (4) 29.*




## A COMPREHENSIVE GUIDE TO WHOLE-PERSON WELLNESS

Wellness means overall well-being. For people with mental health and substance use conditions, wellness is not simply the absence of disease, health conditions, or stress, but the presence of purpose in life, active involvement in satisfying work and play, joyful relationships, a healthy body and living environment, and happiness. It incorporates the mental, emotional, physical, occupational, intellectual, and spiritual aspects of a person's life. Each aspect of wellness can affect overall quality of life.

## BUILDING RESILIENCE AND MAINTAINING WELLNESS

Being resilient means a person is able to cope with challenges, trauma, threats, or other forms of stress. Getting help for mental health conditions can improve one's ability to take other steps to build resilience. To strengthen resilience, people need to:

- Build connections with family and friends
- Accept that change is a part of living—some goals may no longer be attainable as a result of changing situations
- Reach out to help others
- Develop realistic goals and take small, regular steps toward them
- Look for growth in loss
- Nurture a positive view of themselves
- Trust instincts
- Take care of themselves; they can't help others if they are unwell themselves
- Boost mental health by remembering that the mind and body are connected—eat well, exercise, get enough sleep, and take care of health challenges promptly
- Avoid alcohol and other drugs

From the SAMHSA Wellness Initiative Abstracted from 2016 Mental Health: A Guide for Faith Leaders, American Psychiatric Association Foundation

### LIVE WELL EVERY DAY

**"To live well is to make healthy choices every day. To feel safe and secure at work, at school, at home and in your neighborhood. To have quality of life."**

Wellness concerns the pursuit of optimal, emotional, mental, and spiritual health!

## SPIRITUALITY

Spirituality is a globally acknowledged concept. It involves belief in powerful force(s), called by many different names in cultures around the world, that controls the seen and unseen universe and the destiny of human beings.

Religion is institutionalized spirituality. There are many different religions having different sets of beliefs, traditions, and doctrines. Each may have different types of community-based worship programs. Spirituality is the common factor in all these religions.

Spirituality involves expressions and experiences of a sense of:

- meaning and purpose in life
- values and ideals such as justice, sustainable environment, peace
- belonging with a people and/or a homeland
- connection with the divine
- wholeness

## SPIRITUAL WELLNESS

Spiritual wellness is a personal matter involving values and beliefs that provide purpose in our lives. While different individuals may have different views of what spirituality is, it is generally considered to be the search for meaning and purpose in human existence, leading one to strive for a state of harmony with oneself and others while working to balance inner needs with the demands of the external, social world.

## MENTAL HEALTH | SPIRITUALITY | RELIGION

Spirituality and religion are important to health and mental health and should be integrated with healthcare services that provide whole person care.

Mental health providers should understand that religion and spirituality are often essential elements in working with individuals and families and there are both mainstream and grassroot congregations that are important within the Latin American, African American, and Multi-ethnic Communities.

**The Process for Reaching Spiritual Wellness**

If you are a person engaged in the process of spiritual wellness, you are willing to transcend your everyday life in order to question the meaning and purpose of life. You seek to find harmony between inner self and the external social and physical forces that impact you.

“Never give up on someone with mental health conditions,
when 'I' is replaced by 'WE' health conditions becomes wellness.”

*- Shannon L. Adler*

## KEY DISCUSSION

What is the relationship between mental health, spirituality, and wellness?

How might your respective faith or behavioral health organization contribute to community wellness?

Where are there opportunities for faith-based and behavioral health organizations to collaborate with each other to improve community wellness?

## NOTES

# MODULE 3: UNDERSTANDING AND PREVENTING TRAUMA

## PARTICIPANTS WILL HAVE AN OPPORTUNITY TO REFLECT ON:

- *What trauma is and its impact on health*
- *The role clergy, faith-based leaders, and behavioral health providers can have in helping to prevent trauma related to neglect, abuse, and family dysfunction*
- *How to promote healthy, stable, and safe relationships*


**NOTES:**

# UNDERSTANDING TRAUMA AND ITS IMPACT

A medical definition relates a physical trauma to bodily injury. The psychological definition views a traumatic stressor as an overwhelming event resulting in a sense of helplessness in the face of intolerable danger, anxiety, and instinctual arousal.

The exposure to multiple stressors, whether they are acute or chronic stressors, greatly decreases a person's ability to cope successfully with their environment.

Psychological trauma can be prompted by natural disasters, violence in families, physical and sexual abuse, community and national violence, neglect, bullying, catastrophic events, mechanical accidents, medical emergencies, war or mass violence, and long-term exposure to extreme poverty or verbal abuse.

Persons exposed to traumatic events have almost twice the rate of psychiatric disorders of individuals without these experiences. Psychological functioning decreases significantly with the number of traumatic events experienced.

Trauma-informed care is a concept that anyone can embrace. It is an approach that recognizes the possibility of trauma and responds to individuals accordingly. The emerging research and shared learning in the field has elevated the importance of focusing on trauma-informed care in an intentional way now more than ever.

Research shows that the most of the brain development occurs before a child turns three years old. Early experiences have a profound effect on brain architecture and traumatic experiences may disrupt this development.

Trauma is widespread and pervasive, impacting many children on a daily basis. Trauma in childhood results from an event or series of events that are, or a child perceives to be, physically or emotionally harmful or life-threatening to the child or someone close to them. These events can have lasting effects on a person's functioning and well-being.

Trauma-informed care (TIC) is the adoption of principles and practices that promote safety, empowerment, and healing. Trauma-informed care recognizes that in order to ensure the best possible outcomes, trauma must be addressed in a safe and sensitive way. Trauma-informed care may be practiced in any setting – health care, law enforcement, education, mental health, and early childhood settings (child's own home, home or place-based childcare setting). Trauma-informed care has been an emerging best practice in recent years and many resources are available statewide, as well as from national partners, to support training and implementation.

**Additional Resources:** Substance Abuse and Mental Health Services Administration. (2014). SAMHSA's concept of trauma and guidance for a trauma-informed approach: HHS Publication No. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration. Retrieved from https://store.samhsa.gov/product/SAMHSA-s-Concept-of-Trauma-and-Guidance-for-a-Trauma-Informed-Approach/SMA14-4884

# ACEs = ADVERSE CHILDHOOD EXPERIENCES

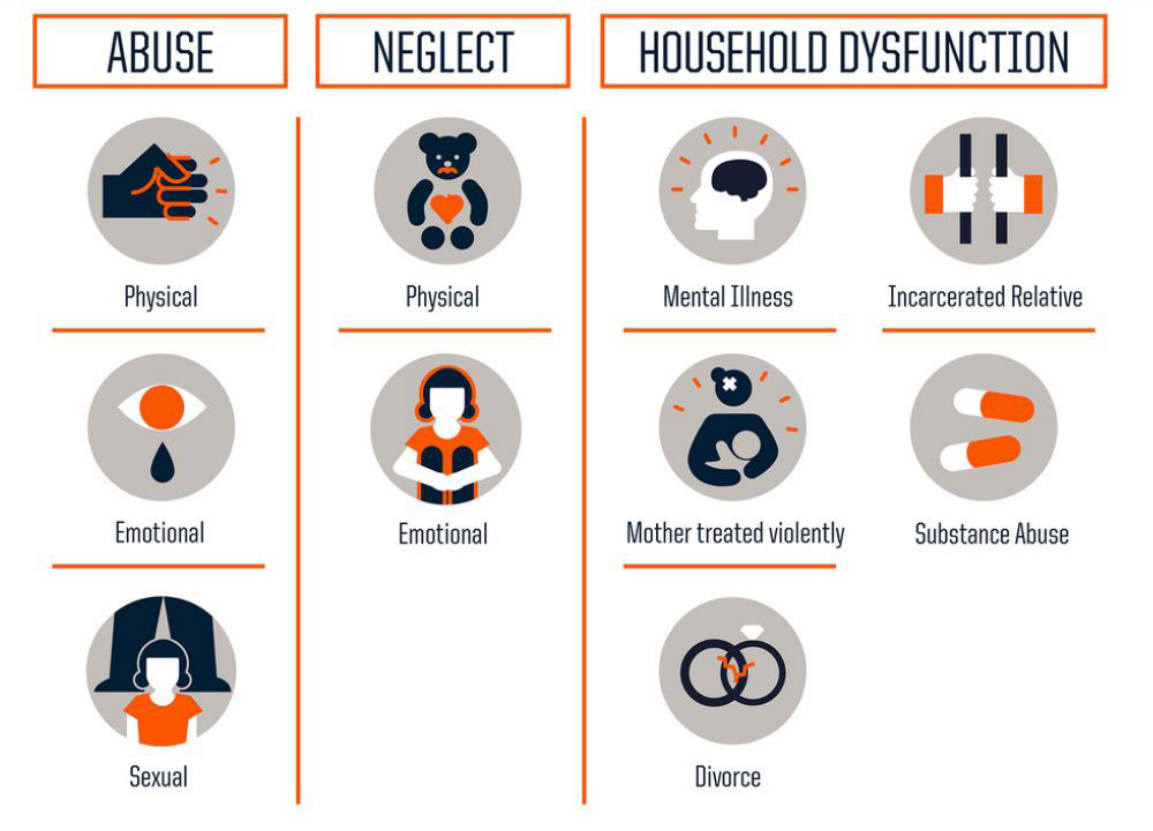



Image: Robert Wood Johnson Foundation; Source: CDC

**FOR REFLECTION:**

1. As you look at the types of adverse experiences above, note how many you experienced as a child. Like most people, the more ACEs you experienced, the greater likelihood you experienced some form of trauma, later life risk or health consequence, however, everyone copes with trauma differently.

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2. What did you do as a child or adult to move forward in life despite any ACEs you may have experienced? Who or what helped you along the way?

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3. How can knowing about ACEs help you help others in your work as a behavioral health or faith-based professional?

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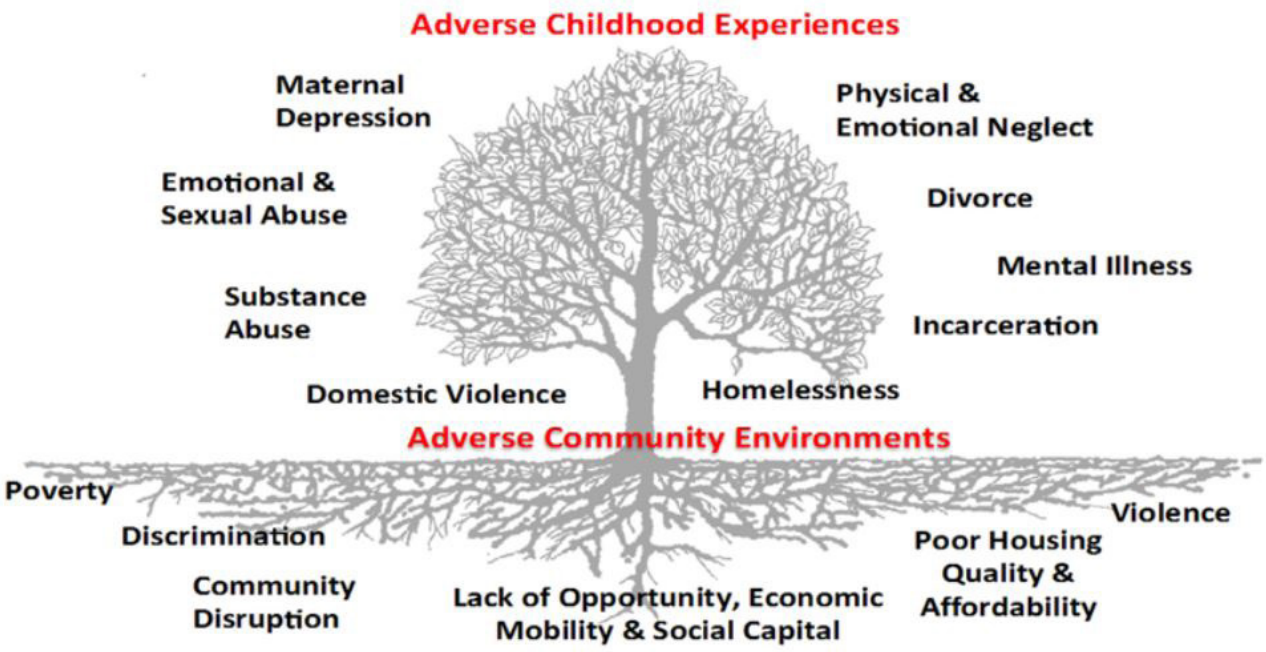
# THE PAIR OF ACEs




The pair of ACEs depicted here shows the interrelatedness of trauma that occurs within a family environment, and also the roots (or associated causes) of trauma that arise from unsupportive or disruptive community environments.

Community trauma is a toxic or negative event or condition that disrupts an entire neighborhood or population. It may be caused by a natural disaster, such as Hurricane Katrina, when people from the whole city and region were displaced and in need of housing, water, food, medical care, and clothing. Often in natural disasters, the wider community responds with good-will. The burden and sorrow are shared.

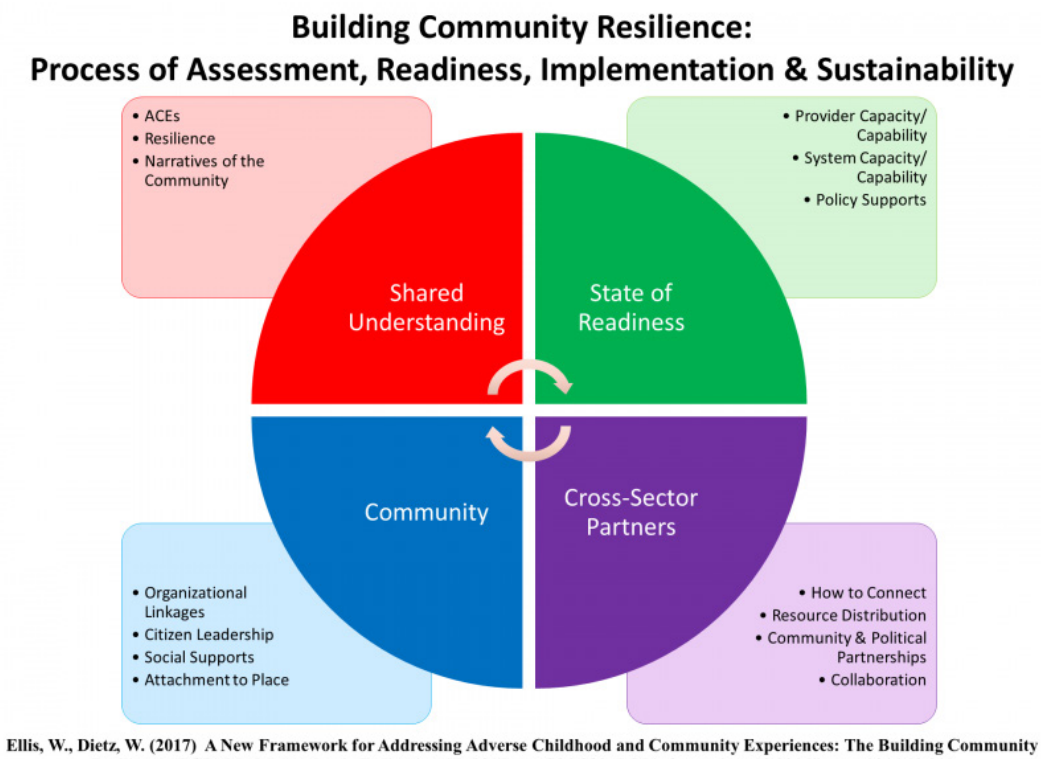
Events such as a school shooting or mass murder are shocking experiences that make everyone feel unsafe. In urban communities, trauma may come in the form of gang violence, struggle to meet daily living needs, the stress of racial discrimination, lack of access to resources, or oppression. Unlike a natural disaster where the wider community is quick to respond with assistance, communities that experience violence and crime are often isolated from the rest of society. The whole community is labeled as dangerous or unstable and those in neighboring communities may even blame the victims, assuming they are involved in gang or criminal activity. Law enforcement, normally providing a sense of safety and order, may not be responsive or trusted by the community.

For more information see: https://stakeholderhealth.org/wp-content/uploads/2016/07/SH-Chapter-7.pdf

## BUILDING COMMUNITY RESILIENCE

Building community resilience is an important factor in preventing childhood adversity and strengthening healthy communities. Focusing on community resilience allows for community partners to understand and address the daily environmental conditions that contribute to toxic stress and threaten individual health and well-being. Such shared knowledge of the wide-ranging health and social consequences of ACEs allows for more effective, and equitable care and interventions while promoting health and well-being. This knowledge is foundational to the prevention of child abuse and neglect by strengthening families and communities. It is also part of building positive mental health and community wellness.

This diagram shows the key elements as collaborative partners work to increase community resilience to address and heal historical, current, and emerging toxic stresses.




Ellis, W., Dietz, W. (2017) A New Framework for Addressing Adverse Childhood and Community Experiences: The Building Community Resilience (BCR) Model. Academic Pediatrics. 17 (2017) pp. S86-S93. DOI information: 10.1016/j.acap.2016.12.011

*For more information see: https://sdsusocialpolicyinstitute.org/tag/building-community-resilience/*

# For Reflection:

1. What actions have you taken as a working professional to help build community resilience? Which of the areas above are you addressing?

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2. What could you do or say to encourage those you partner with and serve to contribute to building community resilience?

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Recently the California Surgeon General Dr. Nadine Burke Harris initiated the ACEs Aware campaign to raise awareness and promote available resources in order to reduce the negative impact of ACEs. The campaign trains physicians and other child and family serving providers, facilitates local networks to screen for ACEs and make referrals for support, thus improving the health and wellness of children, their families, and communities. For more information see: https://www.acesaware.org/

**UNDERSTANDING FAMILY VIOLENCE AND ITS IMPACT**

Violence is a serious public health challenge. From infants to the elderly, it affects people in all stages of life. Many survive violence and suffer physical, mental, and/or emotional health challenges throughout the rest of their lives. CDC is committed to stopping violence before it begins.

For more information see: https://www.cdc.gov/violenceprevention/

**PREVENTING ABUSE, NEGLECT AND HOUSEHOLD DYSFUNCTION**

Child abuse and neglect are serious challenges that can have lasting harmful effects on its victims. The goal in preventing child abuse and neglect is clear—to stop this violence from happening in the first place. Safe, stable,

nurturing relationships and environments for all children and families can prevent abuse and help all children reach their full potential. Child abuse and neglect are complex challenges rooted in unhealthy relationships and environments. Preventing child abuse and neglect requires a comprehensive approach that influences all levels of the social ecology community involvement, relationships among families and neighbors, and individual behaviors.

Effective prevention strategies focus on modifying policies, practices, and societal norms to create safe, stable, nurturing relationships and environments. For more information see: https://www.cdc.gov/violenceprevention/childmaltreatment/prevention.html)

For more information and resources to understand and reduce negative impacts on healthy child development, see: https://share.nned.net/wp-content/uploads/2020/06/Racism-Discrimination-and-Child-Development_SAMHSA-OBHE6520-Final.pdf

**STRENGTHENING FAMILIES™ PROTECTIVE FACTORS FRAMEWORK**

Generally, the best approach to prevention of child abuse and neglect is to use a strengths-based approach that starts with what is strong and working well in the family. Strengths can be leveraged to build protective factors, which are characteristics all families need in order to safely care for and nurture their children. Five protective factors have been identified:

**Social and emotional competence** – a child's ability to communicate clearly, recognize and regulate emotions, and establish and maintain relationships;

**Knowledge of parenting and child development** – understanding the stages of child development and parenting strategies that support physical, cognitive, language, social, and emotional development;


**Parents' resilience** – a parent's or caregiver's ability to navigate the ups and downs of daily life, and manage stress when faced with challenges, adversity, and trauma;

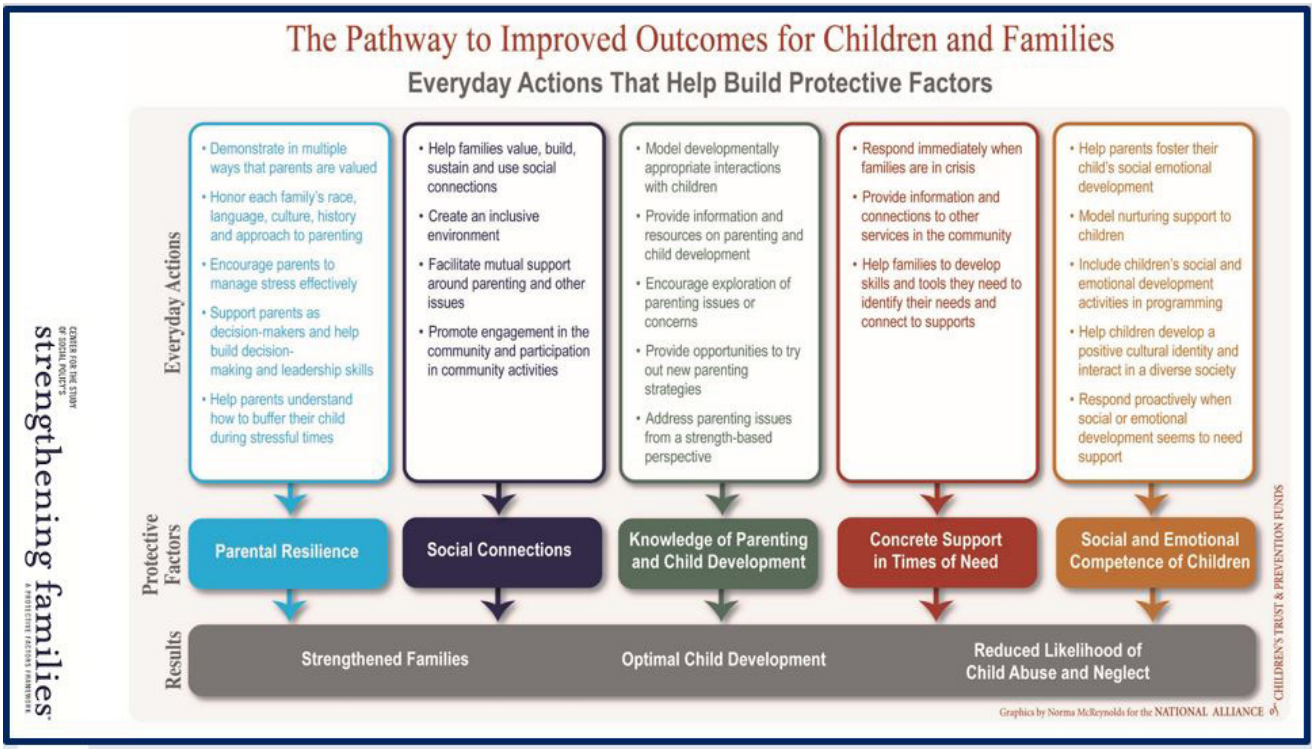
**Social connections** – positive relationships that provide a family emotional, informational, and spiritual support; and

**Concrete supports in times of need** – access to support and services that address a family's basic needs, such as food, healthcare, and housing.

In San Diego County, the YMCA is leading Partners in Prevention, a federally funded community engagement approach that brings cross sector partners together to implement strategies for building protective factors and strengthening communities.

For more information see: https://www.ymcasd.org/about-y/news-center/social-services/child-abuse-prevention-community-issue

The Center for the Study of Social Policy developed the following diagram that shows how certain actions can help build protective factors and result in reduced child abuse and neglect, and improved wellness:




**KEY DISCUSSION**

Which of these everyday actions are within the purview of your professional role?

What role can clergy, faith-based leaders, and mental health providers play in preventing ACEs and promoting health and wellness?

How will Stepping Higher Faith-Based & Behavioral Health Academy members collaborate to support healthy, stable, and safe conditions in our community?

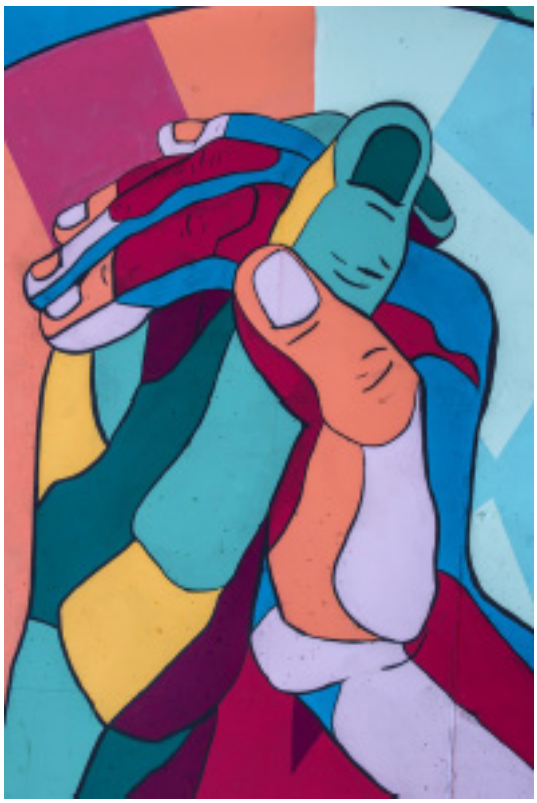
# Notes:

# Notes:

# MODULE 4: STIGMA REDUCTION & CONNECTING WITH CLIENTS

## PARTICIPANTS WILL HAVE AN OPPORTUNITY TO LEARN:

- *Stigma, and how it affects community members in need of and/or seeking mental/behavioral health services*
- *What cohort members can do to reduce and eliminate the impact of stigma*



**NOTES:**

# WHAT IS STIGMA?

**Prejudice + Discrimination = Stigma**

Negative attitudes (prejudice) and negative responses (discrimination) can make a person feel unwanted and shamed (stigmatized).

**Stigma can:**

- Seriously affect the well-being of those who experience it
- Affect people while they are ill, while they are in treatment, while they are healing, and even when a substance use or mental health conditions is a distant memory
- Stop many people from seeking the treatment they need
- Profoundly change how stigmatized people feel about themselves and change the way others see them

Stigma is when someone views you in a negative way because you have a distinguishing characteristic or personal trait that's thought to be, or actually is, a disadvantage (a negative stereotype). Unfortunately, negative attitudes and beliefs toward people who have a mental health condition are common.

Stigma can lead to discrimination. Discrimination may be obvious and direct, such as someone making a negative remark about your mental conditions or your treatment. Or it may be unintentional or subtle, such as someone avoiding you because the person assumes you could be unstable, violent, or dangerous due to your mental condition. You may even judge yourself.

## DISPARITIES IN MENTAL HEALTH SERVICES NATIONALLY

The U.S. Surgeon General's report Mental Health: Culture, Race and Ethnicity, discusses disparities in behavioral health services for members of racial and ethnic minority (co-culture) populations. Latinos and African Americans:

- Are less likely to have access to available mental health services
- Are less likely to receive necessary mental health care
- Often receive a poorer quality of treatment; and
- Are significantly underrepresented in mental health research

**CULTURAL BARRIERS TO MENTAL HEALTH CARE**

People from these populations also experience:

- Stigma that results in mistrust, embarrassment, and/or fear of treatment
- Alternative ideas about what constitutes health conditions and health
- Language barriers and ineffective communication
- Access barriers, such as inadequate insurance coverage, and a lack of diversity in the mental health workforce

*"The single most important barrier to overcome in the community is the stigma and associated discrimination towards a person's suffering from mental and behavioral disorders." - The World Health Organization*

We all have a role in creating a mentally healthy community that supports recovery and social inclusion and reduces discrimination. There are many simple ways everyone can help to reduce prejudice and discrimination towards people who experience a mental condition. These include:

- Learn and share the facts about mental health and health conditions.
- Get to know people with personal experiences of mental health conditions.
- Speak up when friends, family, colleagues, or the media use language and/or misinformation that perpetuates false beliefs and negative stereotypes.
- Offer the same support to people when they are unwell whether they have a physical or mental health condition.
- Don't label or judge people by their condition.
- Treat people with a mental condition with respect and dignity, as you would anyone else.
- Don't discriminate when it comes to participation, housing and employment.
- Talk openly of your own experience of mental health conditions.

The more hidden mental health conditions remain, the more people continue to believe that it is shameful and needs to be concealed.

**For Reflection:**

Review the bullets above.

1. Which of them are you already doing?
2. Which is the hardest for you and why?

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# STIGMA REDUCTION

### IT'S UP TO US CAMPAIGN

The County of San Diego It's Up to Us Campaign was created to encourage people to talk about mental health conditions, recognize symptoms, utilize local resources, and seek help. One in five adult San Diegans suffer from a diagnosable mental health condition and nearly one out of every five children experience some degree of emotional or behavioral difficulty.

Mental health conditions are just as important to address as physical health conditionses. But often, people do not seek professional care, ask for support, nor give support, because of the stigma that is associated with having a mental condition.

It's Up to Us is a multi-media education and awareness campaign for the county of San Diego. With positive, strength-based creative messaging, the campaign aims to encourage San Diegans to speak up and get help or listen up and offer support to those experiencing mental health challenges.

The following are some of the campaign's most recent research studies:

### 7-Year Campaign Study

As of December 2018, seven years after the launch of the It's Up to Us campaign, 71% of San Diego County residents were aware of at least one message or ad pertaining to the campaign. The majority of respondents recalled the message or ad from TV (74%), followed by radio (27%), and social media (23%). See the campaign videos here: https://www.youtube.com/c/up2sd

The campaign provides various community bulletins on a variety of mental health topics. For more information see: https://up2sd.org/community-bulletins

For more information see: https://up2sd.org/resources/resource-guide/

## ENGAGING COMMUNITY MEMBERS

### Establishing Rapport

Trust and credibility are essential elements to establish rapport and are the cornerstones to an effective relationship. In the context of a relationship, trust is the extent to which a person feels we have their best interest at heart.

Credibility in the context of a relationship is the extent to which a person believes we understand them and can and want to help them. Demonstrating compassion is a universal way to foster trust, establish credibility, and build effective relationships.

For example, see Health & Human Services Compassion in Action Guide and the Seven Principles: https://www.hhs.gov/sites/default/files/compassion-in-action.pdf

## SEVEN PRINCIPLES OF COMPASSION IN ACTION

1. THE INHERENT DIGNITY PRINCIPLE
   We affirm the inherent dignity of every person
2. THE Health conditions PRINCIPLE
   We acknowledge Mental Health conditions as an health conditions
3. THE CAREGIVER PRINCIPLE
   We understand mental health conditions impact families and caregivers
4. THE PROFESSIONAL ASSISTANCE PRINCIPLE
   We know mental health conditions require professional assistance
5. THE TREATMENT AND MEDICATION PRINCIPLE
   We encourage participating in recommended psychiatric treatment, including therapy, and as necessary, medication
6. THE COMPLEXITIES PRINCIPLE
   We understand mental health conditions can be a challenging, lifelong journey
7. THE HOPE PRINCIPLE
   We recognize and celebrate that people with mental health conditions can get better

**For Reflection:**

Principle 1: What does it mean to affirm the inherent dignity of another person? What are the words and/or actions that go with this?

Principle 4: How can we help others recognize the need for professional assistance?

**10 WAYS TO PREPARE ONE'S SELF AND DEMONSTRATE COMPASSION TO OTHERS:**

1. Think and feel well of yourself and others.
2. Acknowledge privilege. Be grateful, gracious, and humble.
3. Judge less. Empathize more.
4. Take care of one's self. Set healthy boundaries. Build capacity.
5. Be approachable and fully present. Look pleasant. Show warmth, consideration, patience, and kindness.
6. Listen, observe, and respond empathically and logically. Restate, paraphrase, reflect back, and otherwise respond in a manner that confirms you care and understand.
7. Ensure verbal and nonverbal communication style reflects desired relationship.
8. Build trust. Be trustworthy, trust encouraging, and appropriately trusting.
9. Use authority and influence in a just manner.
10. Foster hope. Be optimistic. Uplift others. Encourage positive possibility thinking.

For more information and resources on establishing a welcoming faith community see: http://tucollaborative.org/wp-content/uploads/2017/04/Developing-Welcoming-Faith-Communities.pdf

Finally, Motivational Interviewing is an approach for building a helping relationship with the person and/or their family. It was originally developed to decrease ambivalence about making a change and to increase willingness and readiness for changing behavior. It is an effective way to help engage, understand the other person's point of view, and develop relationships that are mutual, respectful, and caring.

## STAGES OF CHANGE:

**1. Precontemplation:** Not yet considering change or is unwilling or unable to change
Task: Raising awareness

**2. Contemplation:** Sees the possibility of change but is ambivalent and uncertain
Task: Resolving ambivalence, helping to choose change

**3. Determination:** Committed to changing, still considering what to do
Task: Help identify appropriate change strategies

**4. Action:** Taking steps toward change, but hasn't stabilized in the process
Task: Help support change strategies and reduce possible relapses

**5. Maintenance:** Has achieved the goals and is working to maintain change
Task: Develop new skills and social opportunities

**6. Recurrence:** Experience a recurrence of old behavior
Task: Accept consequences and gain deeper understanding of why it happened

# ACTIVITY

**Where are you with respect to the following?**

| | Precontemplation | Contemplation | Preparation | Action | Maintenance |
|---|---|---|---|---|---|
| PERSONAL WELLNESS | | | | | |
| SAVING FOR RETIREMENT | | | | | |
| BALANCING WORK AND FAMILY LIFE | | | | | |
| TAKING RESPONSIBILITY TO REDUCE STIGMA | | | | | |

**KEY DISCUSSION:**

What steps can clergy, faith-based leaders, and mental health providers take to reduce stigma concerning mental health and substance use conditions?

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# MODULE 5: MENTAL HEALTH CONDITIONS AND WELLNESS

## PARTICIPANTS WILL HAVE AN OPPORTUNITY TO LEARN:

- *What a mental health condition is*
- *Common mental health conditions impacting African American and Latinx communities*
- *Behaviors and symptoms associated with mental health condition diagnoses*
- *Available treatment, services, and resources*


**NOTES:**

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# WHAT ARE MENTAL HEALTH CONDITIONS?

Mental health conditions are health conditions involving changes in emotion, thinking or behavior (or a combination of these). Mental health conditions are associated with distress and/or challenges functioning in social, work, family activities or care of self.

Mental health conditions are treatable. The vast majority of individuals with mental health conditions continue to function in their daily lives. Mental Health involves effective functioning in daily activities resulting in:

- Productive activities (work, school, caregiving)
- Healthy relationships
- Ability to adapt to change and cope with adversity

Mental health is the foundation for emotions, thinking, communication, learning, resilience and self-esteem. Mental health is also key in lasting relationships, personal and emotional wellbeing and contributing to community and society.

Mental health conditions are a medical condition, just like heart disease or diabetes. We are continually expanding our understanding of how the human brain works and effective treatments that are available to help people successfully manage mental health conditions.

Mental health conditions do not discriminate. They can affect anyone regardless of age, gender, geography, income, social status, race/ethnicity, religion/spirituality, sexual orientation, background or other aspects of cultural identity. While mental health conditions can occur at any age, three-fourths of all mental health conditions begin by age 24.

Mental health conditions take many forms. Some are mild and only interfere in limited ways with daily life, such as certain phobias (abnormal fears). Other mental health conditions are so severe that a person may need care in a hospital or inpatient facility.

For more information see: https://www.psychiatry.org/patients-families/what-is-mental-illness

For more information on the current conditions and facts in California, see: https://www.kff.org/interactive/mental-health-and-substance-use-state-fact-sheets/california

## WHY THE ISSUE OF DISPARTIES ARE IMPORTANT

The population of the U.S. is becoming increasingly more diverse. Currently, more than one third of the population are people of color and by 2050[1], they will be more than half of the total population in the U.S.

[1] Census Fast Facts. Retrieved from https://www.census.gov/quickfacts/fact/table/sandiegocountycalifornia/POP0102124

In San Diego, the 2019 median household income is $86,300. However, over 13% of the population lives below the poverty line.[1] When housing costs are considered, referred to as the Supplemental Poverty Measure, SD County's poverty rate rises to 20.4%.[2] 48% of families in SD County with at least one child do not make enough money to be self-sufficient, more than double the rate for households without children, and 69% of single mothers in SD County have incomes too low to cover household expenses.[3] Over 36% of San Diegans speak a language other than English in their home.

COVID-19 has created unprecedented economic and mental health stressors that disproportionately affect vulnerable populations, including parents who are employed in the service or hospitality industries, as well as young children. Research indicates that increased parental stress levels are often a major predictor of physical abuse and neglect of children. The closures of childcare facilities, coupled with job loss or increased work demands, has put many children that were not there before at-risk for potential child abuse.

## HOW DO MENTAL HEALTH CONDITIONS AFFECT THE AFRICAN AMERICAN COMMUNITY?

Although anyone can develop a mental health condition, African Americans sometimes experience more severe forms of mental health conditions due to unmet needs and other systemic barriers. According to the Health and Human Services Office of Minority Health, African Americans are 20% more likely to experience serious mental health challenges than the general population.

Common mental health disorders among African Americans include:

- Major depression
- Attention deficit hyperactivity disorder (ADHD)
- Suicide, among young African American men
- Post-traumatic stress disorder (PTSD), because African Americans are more likely to be victims of violent crime

African Americans are also more likely to experience certain environmental factors that increase the risk for developing a mental health condition:

- Homelessness. People experiencing homelessness in general are at a greater risk of developing a mental health condition. African Americans make up 40% of the homeless population.
- Exposure to violence increases the risk of developing a mental health condition such as depression, anxiety, and post-traumatic stress disorder. African American children are more likely to be exposed to violence than other children. For more information see: (https://www.nami.org/Find-Support/Diverse-Communities/African-Americans)

[2] California Housing Partnership Corporation. (2018). San Diego County's Housing Emergency and Proposed Solutions. (2018). Retrieved from http://chpc.net/wp-content/uploads/2018/05/San-Diego-2018-HNR.pdf.

[3] Center on Policy Initiatives. (2017). Making Ends Meet: A Look at the Self-Sufficiency Standard. Retrieved from https://cpisandiego.org/research/making-ends-meet-2010/ on May 24, 2019.

## MENTAL AND BEHAVIORAL HEALTH - AFRICAN AMERICANS

- Poverty level affects mental health status. African Americans living below the poverty level, as compared to those over twice the poverty level, are twice as likely to report psychological distress.
- Suicide was the second leading cause of death in 2017 for African Americans, ages 15 to 24.[1]
    - The death rate from suicide for African American men was more than four times greater than for African American women in 2017.
    - The overall suicide rate for African Americans is 60% lower than that of the non-Hispanic white population.
    - African American females, grades 9-12, were 70% more likely to attempt suicide in 2017, as compared to non-Hispanic white females of the same age.
    - A report from the U.S. Surgeon General found that from 1980 - 1995, the suicide rate among African Americans ages 10 to 14 increased 233%, as compared to 120% of non-Hispanic whites.[2]

For more information see: https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=24

Furthermore, African Americans are 30% more likely to be diagnosed with serious psychological distress than the general population, more likely to have their first contact of mental health in an emergency room and are underrepresented in outpatient care.

For more information see: https://cpehn.org/what-we-do-2/our-networks/california-reducing-disparities-project/

## HOW DO MENTAL HEALTH CONDITIONS AFFECT THE LATINX COMMUNITY?

Common mental health disorders among Latinx are generalized anxiety disorder, major depression, post-traumatic stress disorder (PTSD), and alcoholism. Additionally, Latina high school girls have high rates of suicide attempts.

While Latinx communities show similar susceptibility to mental health conditions as the general population, unfortunately, Latinx experience disparities in access to treatment and in the quality of treatment they receive. This inequality puts Latinx at a higher risk for more severe and persistent forms of mental health conditions.

As a community, Latinx are less likely to seek mental health treatment. A 2001 Surgeon General's report found that only 20% of Latinos with symptoms of a psychological disorder talk to a doctor about their concerns. Only 10% contact a mental health specialist. Yet, without treatment, certain mental health conditions can worsen and become disabling.

For more information see: https://www.nami.org/Your-Journey/Identity-and-Cultural-Dimensions/Latinx-Hispanic

**Mental and Behavioral Health - Latinx**

- Poverty level affects mental health status. Latinx living below the poverty level, as comparedto Latinx over twice the poverty level, are over twice as likely to report psychological distress.
- The death rate from suicide for Latino men was four times the rate for Latina women in 2017. However, the

suicide rate for Latinx is less than half that of the non-Latinx white population.
- In 2017, suicide was the second leading cause of death for Latinx, ages 15 to 34.[1]
- Suicide attempts for Latina girls, grades 9-12, were 40% higher than for non-Latina white girls in the same age group in 2017.
- Non-Latinx whites received mental health treatment twice as often as Latinx in 2018.

For more information see: https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=69

Furthermore, Latinx have less access to mental health services than whites, are less likely to receive needed care and are more likely to receive poor quality care when treated.

For more information see: https://cpehn.org/what-we-do-2/our-networks/california-reducing-disparities-project/

## WHAT IS DEPRESSION?

Watch Video: https://www.nami.org/About-Mental-Illness/Mental-Health-Conditions/Depression

## SYMPTOMS OF DEPRESSION

Depression can present different symptoms, depending on the person. But for most people, depressive disorder changes how they function day-to-day and typically for more than two weeks. Common symptoms include:

- Changes in sleep
- Changes in appetite
- Lack of focus or concentration
- Loss of energy or increased fatigue
- Lack of interest in activities
- Hopelessness, helplessness, or guilty thoughts
- Changes in movement (less activity or agitation)
- Physical aches and pains
- Suicidal thoughts

## CAUSES OF DEPRESSION

Depression does not have a single cause. It can be triggered by a life crisis, physical illness, or something else—but it can also occur spontaneously. Scientists believe several factors can contribute to depression:

- Trauma: When people experience trauma at an early age, it can cause long-term changes in how their brains respond to fear and stress. These changes may lead to depression.
- Genetics: Mood disorders, such as depression, tend to run in families.
- Life circumstances: Marital status, relationship changes, financial standing, and where a person lives influence whether a person develops depression.
- Brain changes: Imaging studies have shown that the frontal lobe of the brain becomes less active when a person is depressed. Depression is also associated with changes in how the pituitary gland and hypothalamus respond to hormone stimulation.
- Other medical conditions: People who have a history of sleep disturbances, medical health conditions, chronic pain, anxiety, and attention-deficit hyperactivity disorder (ADHD) are more likely to develop depression. Some medical syndromes (like hypothyroidism) can mimic depressive disorder. Some medications can also cause symptoms of depression.
- Drug and alcohol disorder. Approximately 30% of people with substance disorder challenges also have depression. This requires coordinated treatment for both conditions, as alcohol can worsen symptoms.

## RECOGNIZING AND/OR DIAGNOSING DEPRESSION

Depression does not have a single cause. It can be triggered by a life crisis, physical illness, or something else—but it can also occur spontaneously. Scientists believe several factors can contribute to depression:

- Loss of interest or loss of pleasure in all activities
- Change in appetite or weight
- Sleep disturbances
- Feeling agitated or feeling slowed down
- Fatigue
- Feelings of low self-worth, guilt, or shortcomings
- Difficulty concentrating or making decisions
- Suicidal thoughts or intention

## TREATING DEPRESSION OR WHEN TO REFER FOR TREATMENT

Although depressive disorder can be a devastating health conditions, it often responds to treatment. The key is to get a specific evaluation and treatment plan. Safety planning is important for individuals who have suicidal thoughts.

After an assessment rules out medical and other possible causes, a patient-centered treatment plan can include any or a combination of the following:

- Psychotherapy, including cognitive behavioral therapy, family-focused therapy, and interpersonal therapy.
- Medications including antidepressants, mood stabilizers, and antipsychotic medications.
- Exercise can help with prevention and mild-to moderate symptoms.
- Brain stimulation therapies can be tried if psychotherapy and/or medication are not effective. These include electroconvulsive therapy (ECT) for depressive disorder with psychosis or repetitive transcranial magnetic stimulation (rTMS) for severe depression
- Light therapy, which uses a light box to expose a person to full spectrum light in an effort to regulate the hormone melatonin.
- Alternative approaches including acupuncture, meditation, faith, and nutrition can be part of a comprehensive treatment plan. More scientific research is needed to determine the effectiveness of these approaches.

For more information see: https://www.nami.org/About-Mental-Illness/Mental-Health-Conditions/Depression

## WHAT IS POST-TRAUMATIC STRESS DISORDER (PTSD)?

People with PTSD have intense, disturbing thoughts and feelings related to their experience that last long after the traumatic event has ended. They may relive the event through flashbacks or nightmares; they may feel sadness, fear, or anger, and they may feel detached or estranged from other people.

People with PTSD may avoid situations or people that remind them of the traumatic event, and they may have strong negative reactions to something as ordinary as a loud noise or an accidental touch.

Symptoms of PTSD fall into four categories. Specific symptoms can vary in severity.

1. Intrusive thoughts such as repeated, involuntary memories; distressing dreams; or flashbacks of the traumatic event. Flashbacks may be so vivid that people feel they are re-living the traumatic experience or seeing it before their eyes.

2. Avoiding reminders of the traumatic event may include avoiding people, places, activities, objects, and situations that bring on distressing memories. People may try to avoid remembering or thinking about the traumatic event. They may resist talking about what happened or how they feel about it.

3. Negative thoughts and feelings may include ongoing and distorted beliefs about oneself or others (e.g., “I am bad,” “No one can be trusted”); ongoing fear, horror, anger, guilt, or shame; much less interest in activities previously enjoye, or feeling detached or estranged from others.

4. Arousal and reactive symptoms may include being irritable and having angry outbursts; behaving recklessly or in a self-destructive way; being easily startled, or having challenges concentrating or sleeping.

For more information see: https://www.psychiatry.org/patients-families/ptsd/what-is-ptsd

Over the last 5 years, research on young children ages 1–6 years old found that they can develop PTSD, and the symptoms are quite different from those of adults. These findings also saw an increase in PTSD diagnoses in young children by more than 8 times when using the newer criteria.

Symptoms in young children can include:

- Acting out scary events during playtime
- Forgetting how/being unable to talk
- Being excessively clingy with adults
- Extreme temper tantrums, as well as overly aggressive behavior

For more information see: https://www.nami.org/About-Mental-Illness/Mental-Health-Conditions/Posttraumatic-Stress-Disorder

## CAUSES OF PTSD

A person can develop PTSD when they experience, see, or learn about an event involving actual or threatened death, serious injury or sexual violation. Doctors aren't sure why some people get PTSD and others who experience the same trauma may not. As with most mental health challenges, PTSD is caused by a complex mix of:

- Stressful experiences, including the amount and severity of trauma you've gone through in your life
- Inherited mental health risks, such as a family history of anxiety and depression
- Inherited features of your personality — often called your temperament
- The way your brain regulates the chemicals and hormones your body releases in response to stress

## RECOGNIZING AND/OR DIAGNOSING PTSD

Symptoms of PTSD usually begin within 3 months after a traumatic event, but occasionally emerge years afterward. Symptoms must last more than a month to be considered PTSD. PTSD is often accompanied by depression, substance use, or another anxiety disorder.

People can describe symptoms in a variety of ways. How a person describes symptoms often depends on the cultural lens that one is looking through. In Western cultures, people generally talk about their moods or feelings, whereas in many Eastern cultures, people more commonly refer to physical pain.

African Americans and Latinos are more likely to be misdiagnosed, so they should look for a health care professional who understands their background/culture and shares their expectations for treatment.

Because young children have emerging abstract cognitive and limited verbal expression, research indicates that diagnostic criteria needs to be more behaviorally anchored and developmentally sensitive to detect PTSD in preschool children.

## TREATING OF OR REFERRAL FOR PTSD

PTSD is treated and managed in several ways:

- Medications, including mood stabilizers, antipsychotic medications, and antidepressants.
- Psychotherapy, such as cognitive behavioral therapy or group therapy.
- Self-management strategies, such as “self-soothing”. Many therapy techniques, including mindfulness, are helpful to ground a person and bring them back to reality after a dissociative episode or a flashback.
- Service animals, especially dogs, can help soothe some of the symptoms of PTSD.

## PTSD RELATED CONDITIONS

Someone with PTSD may have additional disorders, as well as thoughts of or attempts at suicide:

- Anxiety disorders, including Generalized Anxiety Disorder and Obsessive-Compulsive Disorder
- Borderline Personality Disorder
- Depression
- Substance use

These other health conditionses can make it challenging to treat PTSD. For example, medications used to treat OCD or depression may worsen symptoms of PTSD and may even trigger them. Successfully treating PTSD almost always improves these related health conditionses. And successful treatment of depression, other anxiety or substance use usually improves the symptoms of PTSD.

For more information see: https://www.nami.org/About-Mental-Illness/Mental-Health-Conditions/Posttraumatic-Stress-Disorder

## WHAT IS ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD)?

Attention deficit hyperactivity disorder (ADHD) is a condition which is characterized by inattention, hyperactivity and impulsivity. ADHD is most commonly diagnosed in young people, according to the Center for Disease Control and Prevention (CDC). An estimated 9% of children between ages 3–17 have ADHD. While ADHD is usually diagnosed in childhood, it does not only affect children. An estimated 4% of adults have ADHD.

With treatment, most people with ADHD can be successful in school, work and lead productive lives. Researchers are using new tools such as brain imaging to better understand the condition and to find more effective ways to treat and prevent ADHD.

For more information see: https://www.nami.org/About-Mental-Illness/Mental-Health-Conditions/ADHD

## ADHD SYMPTOMS

While some behaviors associated with ADHD are normal, someone with ADHD will have trouble controlling these behaviors and will show them much more frequently and for longer than 6 months.

Signs of inattention include:

- Becoming easily distracted and jumping from activity to activity
- Becoming bored with a task quickly
- Difficulty focusing attention or completing a single task or activity
- Trouble completing or turning in homework assignments
- Losing things such as school supplies or toys
- Not listening or paying attention when spoken to
- Daydreaming or wandering with lack of motivation
- Difficulty processing information quickly
- Struggling to follow directions

Signs of hyperactivity include:

- Fidgeting and squirming, having trouble sitting still
- Non-stop talking
- Touching or playing with everything
- Difficulty doing quiet tasks or activities

Signs of impulsivity include:

- Impatience
- Acting without regard for consequences, blurting things out
- Difficulty taking turns, waiting or sharing
- Interrupting others

For more information see: https://www.nami.org/About-Mental-Illness/Mental-Health-Conditions/ADHD

## CAUSES OF ADHD

There are several factors believed to contribute to ADHD:

- Genetics: Research shows that genes may be a large contributor to ADHD. ADHD often runs in families and some trends in specific brain areas that contribute to attention.
- Environmental factors: Studies show a link between cigarette smoking and alcohol use during pregnancy and children who have ADHD. Exposure to lead as a child has also been shown to increase the likelihood of ADHD in children.

For more information see: https://www.nami.org/About-Mental-Illness/Mental-Health-Conditions/ADHD

## RECOGNIZING AND DIAGNOSING ADHD

ADHD occurs in both children and adults but is most often diagnosed in childhood. Getting a diagnosis for ADHD can sometimes be difficult because the symptoms of ADHD are similar to typical behavior in most young children. Teachers are often the first to notice ADHD symptoms because they see children in a learning environment with peers every day.

There is no one single test that can diagnose a child with ADHD, so meet with a doctor or mental health professional to gather all the necessary information to make a diagnosis. The goal is to rule out any outside causes for symptoms, such as environmental changes, difficulty in school, medical challenges and ensure that a child is otherwise healthy.

## TREATMENT OR REFERRALS FOR ADHD

ADHD is managed and treated in several ways:

- Medications, including stimulants, nonstimulants, and antidepressants
- Behavioral therapy
- Self-management, education programs and assistance through schools or work or alternative treatment approaches

## ADHD RELATED CONDITIONS

Approximately two-thirds of children with ADHD also have another condition. Many adults are also impacted by the symptoms of another condition. Common conditions associated with ADHD include the following:

- Learning disabilities
- Oppositional defiant disorder: refusal to accept directions or authority from adults or others
- Conduct disorder, persistent destructive or violent behaviors
- Anxiety and depression
- Obsessive-compulsive disorder
- Bipolar disorder
- Tourette's syndrome
- Sleep disorders
- Bed-wetting
- Substance use

Symptoms from other conditions make treating ADHD more difficult. Talking to a skilled professional to help establish an accurate diagnosis can help increase the effectiveness of treatment.

For more information see: https://www.nami.org/About-Mental-Illness/Mental-Health-Conditions/ADHD

## ABOUT SUICIDE

The Federal Communications Commission adopted a new regulation on July 16, 2021 to establish 988 as the new,

nationwide, 3-digit phone number for Americans in crisis to connect with suicide prevention and mental health crisis counselors. The rules require all phone service providers to direct all 988 calls to the existing National Suicide Prevention Lifeline by July 16, 2022.

During the transition to 988, Americans who need help should continue to contact the National Suicide Prevention Lifeline by calling 1-800-273-8255 (1-800-273-TALK).

For more information see: https://www.fcc.gov/document/fcc-designates-988-national-suicide-prevention-lifeline

According to the CDC, each year more than 41,000 individuals die by suicide, leaving behind thousands of friends and family members to navigate the tragedy of their loss. Suicide is the 10th leading cause of death among adults in the U.S. and the 2nd leading cause of death among people aged 10-24; these rates are increasing.

Suicidal thoughts or behaviors are both damaging and dangerous and are therefore considered a psychiatric emergency. Someone experiencing these thoughts should seek immediate assistance from a health or mental health care provider. Having suicidal thoughts does not mean someone is weak or flawed.

## KNOW THE WARNING SIGNS OF SUICIDE

Threats or comments about killing themselves, also known as suicidal ideation, can begin with seemingly harmless thoughts like “I wish I wasn’t here” but can become more overt and dangerous.

- Increased alcohol and drug use
- Aggressive behavior
- Social withdrawal from friends, family, and the community
- Dramatic mood swings
- Talking, writing, or thinking about death
- Impulsive or reckless behavior

For more information see: https://www.nami.org/About-Mental-Illness/Common-with-Mental-Illness/Risk-of-Suicide

## RISK FACTORS FOR SUICIDE

Research has found that about 90% of individuals who die by suicide experience mental health conditions. A number of other things may put a person at risk of suicide, including:

- A family history of suicide
- Substance use. Drugs and alcohol can result in mental highs and lows that exacerbate suicidal thoughts
- Intoxication. More than one in three people who die from suicide are found to be currently under the influence
- Access to firearms
- A serious or chronic medical health conditions
- Gender. Although more women than men attempt suicide, men are four times more likely to die by suicide

- A history of trauma or abuse
- Prolonged stress
- Isolation
- Age. People under age 24 or above age 65 are at a higher risk for suicide
- A recent tragedy or loss
- Agitation and sleep deprivation

For more information see: https://www.nami.org/About-Mental-Illness/Common-with-Mental-Illness/Risk-of-Suicide

## CAN THOUGHTS OF SUICIDE BE PREVENTED

Mental health professionals are trained to help a person understand their feelings and can improve mental wellness and resiliency. Depending on their training they can provide effective ways to help.

Psychotherapy such as cognitive behavioral therapy and dialectical behavior therapy, can help a person with thoughts of suicide recognize unhealthy patterns of thinking and behavior, validate troubling feelings, and learn coping skills.

Medication can be used to treat underlying depression and anxiety and can lower a person's risk of hurting themselves. Depending on the person's mental health diagnosis, other medications can be used to alleviate symptoms.

For more information see: https://www.nami.org/About-Mental-Illness/Common-with-Mental-Illness/Risk-of-Suicide

Faith leaders play a key role in supporting mental health and preventing the tragedy of suicide. Spiritual and religious leaders of all faiths have a long-standing tradition of advising and guiding people through the full arc of life—from birth to death. These leaders are important sources of hope and strength for their congregants, counsel for those in crisis, and comfort and support in the aftermath of a suicide attempt or death.

Following a suicide death, it is the faith leader who, at a memorial service or funeral, has a platform to encourage help-seeking by those at risk and remind all to be alert to the risk of suicide in their community.

## BREAKOUT GROUP ACTIVITY

For the mental health condition your group is assigned, discuss what actions you can take to improve the mental

health and well-being in your community in light of the risk factors noted earlier. Be specific and answer the following four questions:

1. What do you want to do?

2. Who else needs to be involved?

3. For what purpose?

4. How will you know if you are successful?

# Notes:

# MODULE 6: USING FAITH AND SPIRITUAL PRINCIPLES

## PARTICIPANTS WILL HAVE AN OPPORTUNITY TO REFLECT ON:

- *The concept of faith, spiritual principles, and values*
- *How they can be used to support wellness and advance progress in mental health treatment and recovery*


**NOTES:**

Many faith communities and mental health providers are starting to focus on the intersection between spirituality and mental health. Spirituality as a facet of recovery from mental health conditions is being widely discussed – within mental health and religious communities – and many resources are being developed for faith leaders, mental health providers, peers, and others interested in promoting faith and spirituality as recovery tools.

On the mental health side, long-standing mental health wellness tools such as the Wellness Recovery Action Plan (WRAP) and Mental Health First Aid (MHFA) now include information about spirituality, and progress has been made in overcoming the deep-rooted reluctance of clinical personnel to address faith as one aspect of the recovery process.

At the same time, faith communities have turned to mental health providers across the country to build partnerships in order to increase the health and well-being of their congregants.

## SPIRITUAL PRINCIPLES THAT SUPPORT MENTAL WELLNESS:

| | | |
|---|---|---|
| LOVE | HOPE | FAITH |
| PRAYER | VISION | PERSERVERANCE |
| TRUST | GRATITUDE | GRACE |
| MERCY | FORGIVENESS | MEEKNESS |
| JOY | PEACE | PATIENCE |
| KINDNESS | GOODNESS | FAITHFULLNESS |
| GENTLENESS | SELF-CONTROL | TRUTH |

## CORE COMPETENCIES FOR CLERGY AND OTHER PASTORAL MINISTERS IN ADDRESSING ALCOHOL AND DRUG DEPENDENCE AND THE IMPACT ON FAMILY MEMBERS

These competencies are presented as a specific guide to the core knowledge, attitudes, and skills essential to the ability of clergy and pastoral ministers to meet the needs of persons with alcohol and/or drug dependence and their family members.

1. Be aware of the:
- Generally accepted definition of alcohol and drug dependence
- Societal stigma attached to alcohol and drug dependence

2. Be knowledgeable about the:
- Signs of alcohol and drug dependence
- Characteristics of withdrawal
- Effects on the individual and the family
- Characteristics of the stages of recovery

3. Be aware that possible indicators of the disease may include, among others: marital conflict, family violence (physical, emotional, and verbal), suicide, hospitalization, or encounters with the criminal justice system.

4. Understand that addiction erodes and blocks religious and spiritual development; be able to effectively communicate the importance of spirituality and the practice of religion in recovery, using the scripture, traditions, and rituals of the faith community.

5. Be aware of the potential benefits of early intervention to the:
- Addicted person
- Family system
- Affected children

6. Be aware of appropriate pastoral interactions with the:
- Addicted person
- Family system
- • Affected children

7. Be able to communicate and sustain:
- An appropriate level of concern
- Messages of hope and caring

8. Be familiar with and utilize available community resources to ensure a continuum of care for the:
- Addicted person
- Family system
- Affected children

9. Have a general knowledge of, and where possible, exposure to:

- The 12-step programs – AA, NA, Al-Anon, Nar-Anon, Alateen, A.C.O.A., etc.
- Other support groups

10. Be able to acknowledge and address values, issues, and attitudes regarding alcohol and drug use and dependence in:

- Oneself
- One's own family

11. Be able to shape, form, and educate a caring congregation that welcomes and supports persons and families affected by alcohol and drug dependence.

12. Be aware of how prevention strategies can benefit the larger community.

For more information see: https://www.samhsa.gov/sites/default/files/competency.pdf

## FOR REFLECTION:

1. Place a ✓ next to each core competency your congregation or organization is strong in. For the top 2-3 strengths, how did you cultivate that competency in the culture of your congregation or organization?

_____

_____

_____

_____

_____

_____

2. Place a ▲ next to any competencies that are important but need attention in your congregation or organization. What will you do specifically to grow those competencies?

_____

_____

_____

_____

_____

_____

## KEY DISCUSSION

Using the behavioral health concepts discussed so far, each breakout group is to prepare a teach or preach activity using the language and beliefs of your faith tradition.

The goals are to provide education regarding mental health conditions while reducing stigma and increasing motivation to engage in care as needed. The activity should be part of your weekly congregation schedule.

# Notes:

# MODULE 7: COMMUNITY–BASED AND JUSTICE RELATED MENTAL HEALTH SERVICES

## PARTICIPANTS WILL HAVE AN OPPORTUNITY TO:

- *Review mental health services offered during incarceration and in the community*
- *Discuss potential challenges associated with reentry for a justice involved person with mental health needs*
- *Consider how homelessness provides additional challenges for former offenders who are experiencing a mental health conditions*
- *Discover resources in the County of San Diego*

**NOTES:**

San Diego Behavioral Health Services provides a San Diego Access & Crisis Line (ACL) that offers immediate support and resources from an experienced counselor 24 hours a day, 7 days a week. The experienced counselor addresses all behavioral health topics including suicide prevention, crisis intervention, community resources, mental health referrals, alcohol and drug support services and more. Language interpreter services enable the ACL to assist in 150 languages within seconds.

For more information see: https://www.optumsandiego.com/content/sandiego/en/access---crisis-line.html

The San Diego Access & Crisis Line can be reached by calling 1-888-724-7242.

## JUSTICE INVOLVED SERVICES, SUPPORTS, & RESOURCES

The San Diego Central Jail and the Las Colinas Detention & Re-entry Facility both have on-site acute mental health facilities known as Psychiatric Security Units (PSU). These facilities serve the needs of the most critical mental health patients and are staffed with multi-disciplinary teams of Psychiatrists, Licensed Mental Health Clinicians, Nurses, Occupational and Recreational Therapists, and Deputy Sheriffs.

Services provided in these facilities include:

- Assessment of immediate psychological and social needs
- Development of appropriate treatment plans
- Opportunities for a variety of group therapies including: Life Skills Groups, Cognitive Reorganization Groups, and Therapy Groups. Group therapy strives to improve social skills, stress management, effective communications, self-esteem, anger management, and prevention of domestic violence.
- Participation in due process hearings and the tracking of legal processes related to mental health care
- Collateral contacts with family, attorneys, and others involved in disposition planning
- Supportive and crisis counseling
- Development of appropriate discharge plans
- Clinical assessments for referrals to outside service providers

Mental health services are also available to less acute patients. Psychiatric clinic services are available several days per week, and medication may be prescribed. Short term crisis intervention is available and may be requested by any correctional facility staff member or by the inmate. Discharge planning and case management are available to provide continuity of care upon the inmate's release to the community. In addition to the medical services offered during incarceration, the San Diego County Sheriff's Department offers a comprehensive range of mental health services:

- Initial psychiatric assessments are conducted to determine the need for care.
- Professional nursing and social work staff provide these assessments, schedule follow- up services and advise staff regarding inmate placement, or special housing requirements.

Mental health screening services are provided to the following inmate patients:

- Inmates who have been identified as having previously received psychiatric service in the community, and who request continuation of services.
- Inmates who are interested in receiving psychiatric care while in custody without previous psychiatric care in the community.
- Inmates who, after being assessed by medical staff, are believed to require psychiatric services while in custody.
- Patients in crisis are seen immediately and other patients are seen in as timely a fashion as possible, with urgent referrals being made within 24 hours.

## COMMUNITY SUPERVISION EXPLAINED:

The primary mission of Probation Officers is to protect the community by providing services to the courts, clients, and public. The basic concept of this mission is that clients will be appropriately supervised and assisted to become law-abiding individuals.

Supervision may be intensive for clients whose behavior poses a continuous threat to public safety or less intensive for those whose behavior poses less of a risk to the public. In addition to supervision services, Probation Officers complete mandated pre-sentence investigation reports in which they discuss a client's background, provide statements from victims, and make sentencing recommendations to the Court.

In recent years, the Probation Department has regionalized many services to better serve the community, the Court and our collaborative partners, and the clients we supervise. In addition to supervising clients of high, medium, and low risk on formal probation pursuant to PC1203, each region also has officers who supervise clients on various specialized caseloads.

This link below provides a brief summary of those caseloads and programs to which adult clients may be assigned. All clients are assessed and categorized as high, medium, or low risk and are assigned to the corresponding supervision level.

For more information see: https://www.sandiegocounty.gov/content/sdc/probation/adult_information_community_supervision.html

Adult Forensic Services provide psychiatric and psychological evaluations that have been ordered by the court for certain adults facing criminal charges. All services are provided by appointment only. It does not provide evaluations for minors, SSI applicants, or any other service or proceedings requiring psychological evaluations.

Facilities where these services are offered: https://www.sandiegocounty.gov/content/sdc/hhsa/programs/bhs/mental_health_services_adult_older_adult/forensic_services.html

Juvenile Forensic Services provides psychological and psychiatric services to the youth residing within the juvenile detention facilities. These services may include counseling, assessment, crisis intervention, psychiatric medication management, and transition to community-related assistance.

In addition, Juvenile Forensic Services provides assistance to Juvenile Probation, Juvenile Court and Child Welfare Services by way of expert consultation regarding mental health issues, mental competency screenings, and by providing other mental health evaluations for youth.

The Juvenile Forensic Services are provided by the Behavioral Health Services Stabilization, Treatment, Assessment, and Transition Team (STAT) at the following Probation detention facilities:

- Kearny Mesa Juvenile Hall
- East Mesa Juvenile Hall
- Urban Camp

For more information see the San Diego County Probation Department's Juvenile Detention page: https://www.sandiegocounty.gov/content/sdc/hhsa/programs/bhs/mental_health_services_children/juvenile_forensic_services.html

**San Diego Youth Services Bridgeway Program**

BridgeWays program addresses the behavioral health needs of justice involved youth or youth at risk of justice involvement. The new program provides outpatient clinical services, institutional services, and field support services for youth up to age 21.

For more information see: https://sdyouthservices.org/services/juvenile-delinquency-diversion-and-intervention/

## TERMS TO CONSIDER

**Conditional Release:** The release of an inmate from prison to a period of community supervision, typically with a standard set of conditions he or she must abide by in order to remain on parole or post-release supervision. These conditions may include regular reporting, maintenance of a known residence, drug testing, compliance with a curfew and other such conditions. Violation of the conditions of supervision may result in the imposition of sanctions. Such sanctions may be community-based or may result in the revocation of supervision status and a return to prison.

**Halfway House:** A highly supervised residential environment designed to help individuals returning to the community from prison, or to provide housing for individuals awaiting trial. Less than one-half of 1% of all inmates released in 1999 were reportedly served by halfway houses.

**Probation:** Conditional freedom granted to an offender by the court after conviction or a guilty plea with requirements for the offender's behavior, and which any violation of such requirements may result in revocation of the probation. Supervision is usually by a probation officer.

**Recidivism:** The reoccurrence of criminal behavior by prior offenders. The term also refers to a tendency to return to criminal behavior by offenders previously in the criminal justice system. Studies of criminal behavior consistently show that after intervention by the criminal justice system arrests, convictions, punishments, and correctional programs some offenders return to crime.

**Re-entry:** The process of transitioning from prison or jail to the community.

**Supervised Release:** Transferring an individual from the custody of a correctional facility into community supervision.

## RE-ENTRY ROUNDTABLE

The mission of the San Diego Re-entry Roundtable is to promote the safe and successful return of offenders to our community

- Family Fellowship Ministries Support Group, When: Fourth Saturday of every month, Ocean View Church, 2460 Palm Ave San Diego, CA 92154
- Re-Entry Roundtable Meeting, When: 3rd Tuesday of Every Month
- Second Chance, 6145 Imperial Ave, San Diego, CA 92114
- For more information see: https://211sandiego.org/post-incarceration/re-entry-roundtable/

## PROJECT IN-REACH

The Neighborhood House Association (NHA) Project In-Reach program is an outreach and engagement program designed to help incarcerated individuals with substance use and/or mental health disorders as they prepare for re-entry into the community. Program goals include educating clients about addiction and coping mechanisms, decreasing instances of relapse, diminishing the impact of untreated health, mental health and/or substance use issues, and reducing recidivism.

- Project In-Reach can also assist in the successful linkage to community resources and services pre- and post-release, helping guide the transition process and assisting in a positive new beginning.
- Project In-Reach | 286 Euclid Ave., Suite 207 San Diego, CA 92114 | Phone: 619-766-5994, Fax: 619-264-0209 | HOURS: Monday to Friday 8:00 a.m. to 5:00 p.m. | Closed on Holiday

## SAN DIEGO RE-ENTRY TOOLKIT
## PUBLIC HEALTH RE-ENTRY RESOURCE PAGE

For more information see: http://www.sandiegocounty.gov/hhsa/programs/phs/sdreentrytoolkit/index.html

The County of San Diego has created a resource page that provides links to health and living services information for ex-offender's successful transition back into the San Diego Community. Many of the resources provided on this page are for reentrants and their families too.

This page is the result of work of the San Diego Re-Entry Roundtable, San Diego Area Congregations for Change, County of San Diego Probation Department, and County of San Diego Health and Human Services Agency, Public Health Services.

For more information see: http://www.sandiegocounty.gov/hhsa/programs/phs/sdreentrytoolkit/

## TOP 10 THINGS YOU CAN DO FOR A SUCCESSFUL RE-ENTRY INTO THE COMMUNITY

1. Find safe and stable housing.
2. Find stable source of food.
3. Figure out and get transportation.
4. Get important documents: birth certificate, social security card, California ID card (or driver's license).
5. Go to a career center for resume and job resources.
6. Clear up child support and legal issues.
7. Take care of medical needs including prescription refill, dental, vision (eyeglasses), physical examination, HIV STD/
8. Hepatitis testing and treatment.
9. Attend community support meetings (AA, NA and/or local faith-based organizations).
10. Mend family and personal relationships.
11. Build a positive support system of friends, families, and other helpful people.

For more information see: http://www.sandiegocounty.gov/hhsa/programs/phs/sdreentrytoolkit/

**DOWNLOADABLE RESOURCES**

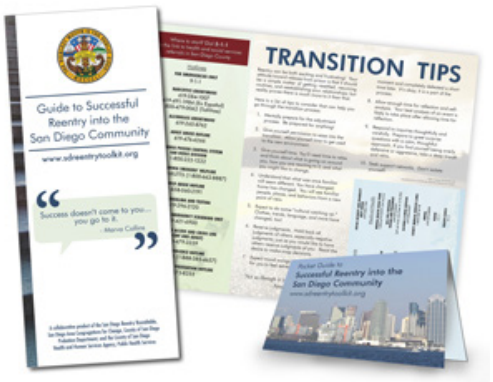
Guide to Successful Reentry into the San Diego Community

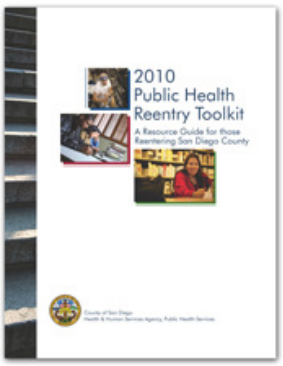
- Brochure with tear-off resource card.

Public Health Reentry Toolkit

- A resource guide for reentrants, their families, and the organizations that serve them.

For more information see: http://www.sandiegocounty.gov/hhsa/programs/phs/sdreentrytoolkit/



## RE-ENTRY MENTORING PROGRAMS

**Re-Entry and Jail Ministry**
Contact Number: 619-482-7258 | Online at www.reentry.org

**Second Chance**
Contact Number: 619-234-8888 | Online at www.secondchanceprogram.org

**United African American Ministerial Action Council (UAAMAC)**
Contact Number: 619-264-1213 | Online at https://uaamac.org/

**United Methodist Urban Ministry (METRO)**
Contact Number: 619-285-5556 | Online at www.metrosandiego.org

**Project In-Reach/Neighborhood House Association**
Contact Number: 868-715-2642 | Online at www.neighborhoodhouse.org

For more information and resources provided by San Diego Behavioral Health Services, please see:

**ADULT SERVICES**

- https://www.sandiegocounty.gov/content/dam/sdc/hhsa/programs/bhs/homepage/BHS_SUD_Brochures/AOA%20SUD%20Brochure%20Programs_8.2.22.pdf
- https://www.sandiegocounty.gov/content/dam/sdc/hhsa/programs/bhs/documents/AOA/2_AOA%20SOC%20Mission%20Guiding%20Principles_rev2018.pdf

**CHILD AND YOUTH SERVICES**

- https://www.sandiegocounty.gov/content/dam/sdc/hhsa/programs/bhs/homepage/BHS_SUD_Brochures/EN%20Adolescents%20-%20SUD%202019%20rev%2005.10.19.pdf
- https://www.sandiegocounty.gov/content/dam/sdc/hhsa/programs/bhs/CYF/CYF%20Framework%203-5-21.pdf

## KEY DISCUSSION

1. What are the overall and behavioral health challenges faced by justice involved populations?

2. What could faith-based and behavioral health agencies provide to the incarcerated person and to his/her family during incarceration?

3. What could faith-based and behavioral health professionals provide to a person who is transitioning from incarceration to the community and his/her family to help support access to ongoing care?To support their wellness and overall needs for support?

# MODULE 8: SUBSTANCE USE & RECOVERY HEALTH SERVICES

## PARTICIPANTS WILL HAVE AN OPPORTUNITY TO LEARN:

- *Definition of substance use*
- *Substance use treatment and prevention options*
- *Recovery concepts*
- *Available services and resources*


**NOTES:**

In 2018, an estimated 164.8 million people aged 12 or older in the United States (60.2 percent) were substance users in the prior month (i.e., tobacco, alcohol, or illicit drugs). While approximately 2 out of 5 people aged 12 or older (108.9 million, or 39.8 percent) did not use any such substances in the past month.

For more information see: https://www.samhsa.gov/data/report/2018-nsduh-annual-national-report

## WHAT IS DRUG ADDICTION?

Many people don't understand why or how other people become addicted to substances, including drugs and alcohol. They may mistakenly think that those who use substances lack moral principles or willpower and that they could stop their drug use simply by choosing to. In reality, drug addiction is a complex disease, and quitting usually takes more than good intentions or a strong will. Over time the use of drugs changes the brain in ways that makes quitting hard, even for those who want to stop using them. Fortunately, researchers know more than ever about how drugs affect the brain and have found treatments that can help people recover from drug addiction and lead productive lives.

Addiction is a chronic disease characterized by drug seeking and use that is compulsive, or difficult to control, despite harmful consequences. The initial decision to take drugs is voluntary for most people, but repeated drug use can lead to brain changes that challenge an addicted person’s self-control and interfere with their ability to resist intense urges to take drugs. These brain changes can be persistent, which is why drug addiction is considered a "relapsing" disease. People in recovery from drug use disorders are at increased risk for returning to drug use even after years of not taking the drug.

For more information see: https://www.drugabuse.gov/publications/drugfacts/understanding-drug-use-addiction

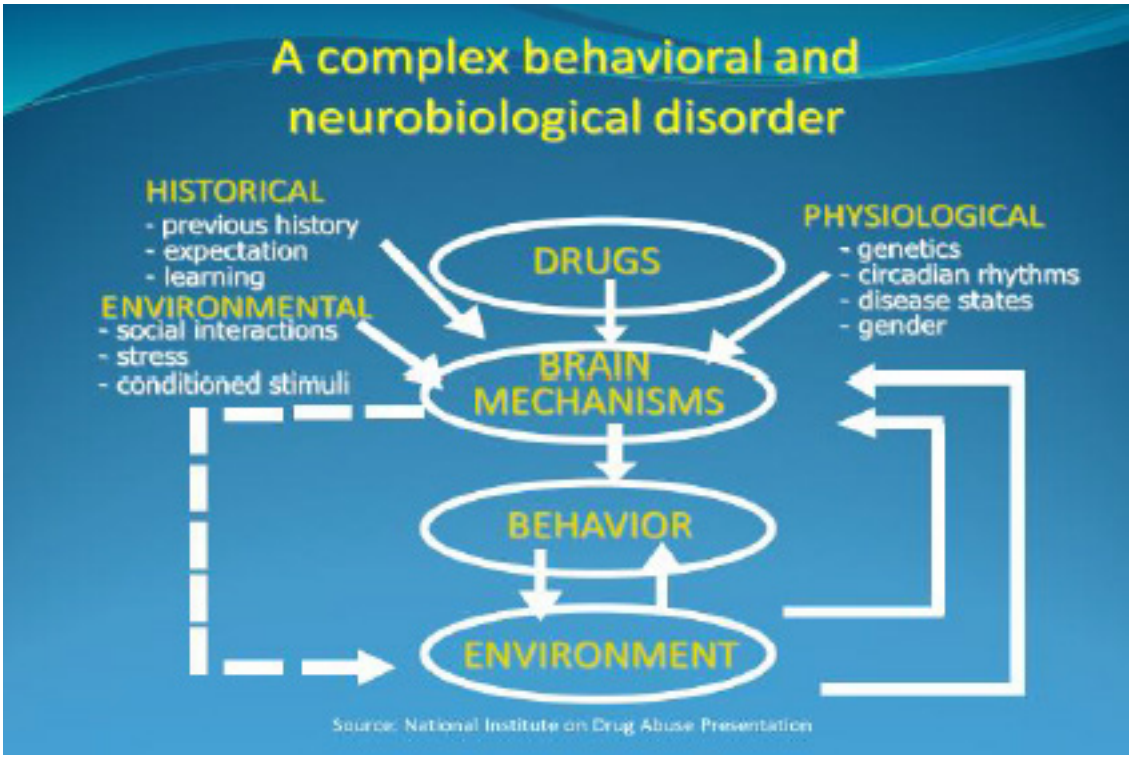
Drug addiction is a complex disease with multiple physical, psychological, social, and spiritual factors. Family history, community conditions and type of drug/method of use are also contributing factors (see chart on next page). However, no single factor determines whether a person will become addicted to drugs.

For more information see NIDA The Science of Addiction: https://www.drugabuse.gov/sites/default/files/soa.pdf

## WHAT ARE SUBSTANCE USE DISORDERS?

Substance use disorders affect people from all walks of life and all age groups; they are common, recurrent, and often serious. However, they are treatable, and many people do recover. Substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically significant impairment, including health challenges, disability, and failure to meet major responsibilities at work, school, or home.

The federal Substance Abuse Mental Health Services Administration’s (SAMHSA) mission is to reduce the impact of mental and substance use disorders on America’s communities. SAMHSA works to prevent and treat mental and substance use disorders and provide supports for people seeking or already in recovery.




Results from the 2019 National Survey on Drug Use and Health (NSDUH) states that during 2018 approximately 21.2 million people age 12 and older met the criteria for substance use disorder and only 2.3 million people received any treatment.

Of the 21.2 million who needed treatment (minus the 2.3 million who received treatment), 18.9 million people age 12 years and over did not receive any treatment. Of these 18.9 million people, only 964,000 felt they needed treatment. That means nearly 95% of all people in need of treatment did not think they needed any treatment for their drug use (denial gap). Of the 964,000 who felt they needed treatment only 385,600 said they made an effort but were unable to access treatment (treatment gap), while 578,400 reported making no effort (motivation gap).

For more information see: https://www.samhsa.gov/data/report/2018-nsduh-annual-national-report

## IMPACTS OF SUBSTANCE USE ISSUES

Substance use and disorders are major public health challenges that impact society on multiple levels.

- Every community is affected by drug use and addiction, as are most families.
- A large number of individuals who are in our jails or prisons are there as a result of illegal drug charges.
- Substance use disorders have significant consequences on family systems.
- Faith leader and congregation members are also impacted by this disease.

## SUBSTANCE USE DISORDERS

Substance use disorders can disrupt a person's ability to work, care for himself/herself, carry on relationships, and lead to major health challenges. People who struggle with substance misuse and disorders need community support and continuity of care to move towards recovery. Also of note, "co-occurring disorders" (identified as the presence of both mental health issues, and a substance use disorder) are common among individuals experiencing behavioral health needs.

## TREATMENT ISSUES AND CONSIDERATIONS

African American clients generally respond better to an egalitarian and authentic relationship with counselors (Sue 2001). Paniagua (1998) suggests that in the initial sessions with African American clients, counselors should develop a collaborative client–counselor relationship. Counselors should request personal information gradually rather than attempting to gain information as quickly as possible. Avoid information gathering methods that clients could perceive as intrusive, or as an interrogation. Pace the session, and do not force a data-gathering agenda (Paniagua 1998; Wright 2001). Counselors must also establish credibility with clients (Boyd-Franklin 2003).

## BELIEFS ABOUT AND TRADITIONS INVOLVING SUBSTANCE USE

In most African American communities, significant alcohol or drug use may be socially unacceptable or seen as a sign of weakness (Wright 2001), even in communities with limited resources, where the sale of such substances may be more acceptable. Overall, African Americans are more likely to believe that drinking and drug use are activities for which one is personally responsible; thus, they may have difficulty accepting alcohol abuse/dependence as a disease (Durant 2005). It may be surprising, but African Americans have one of the highest rates of substance use disorders AND the highest rate of non-use.

Counselors should establish trust. Self-disclosure can be very difficult for some clients because of their histories of experiencing racism and discrimination. These issues can be exacerbated in African American men whose experience of racism has been more severe or who have had fewer positive relationships with White Americans (Reid 2000; Sue 2001). Counselors, therefore, need to be willing to address the issue of race and to validate African American clients' experiences of racism and its reality in their lives, even if it differs from their own experiences (Boyd-Franklin 2003; Kelly and Parsons 2008). Moreover, racism and discrimination can lead to feelings of anger, anxiety, or depression. Often, these feelings are not specific to any given event.

## CORE CULTURALLY RESPONSIVE PRINCIPLES IN COUNSELING AFRICAN AMERICANS

According to Schiele (2000), culturally responsive counseling for African American clients involves adherence to six core principles:

1. Discussion of clients' substance use should be framed in a context that recognizes the totality of life experiences faced by clients as African Americans.

2. Equality is sought in the therapeutic counselor–client relationship, and counselors are less distant and more disclosing.
3. Emphasis is placed on the importance of changing one's environment—not only for the good of clients themselves, but also for the greater good of their communities.
4. Focus is placed on alternatives to substance use that underscore personal rituals, cultural traditions, and spiritual well-being.
5. Recovery is a process that involves gaining power in the forms of knowledge, spiritual insight, and community health.
6. Recovery is framed within a broader context of how recovery contributes to the overall healing and advancement of the African American community.

For more information on addiction treatment and recovery resources see the SAMHSA sponsored Addiction and Technology Transfer Center (ATTC) Network. It is an international, multidisciplinary resource for professionals in the addiction treatment and recovery services field. The ATTC Network mission is to:

- Accelerate the adoption and implementation of evidence-based and promising addiction treatment and recovery-oriented practices and services;
- Heighten the awareness, knowledge, and skills of the workforce that addresses the needs of people with substance use or other behavioral health disorders; and
- Foster regional and national alliances among culturally diverse practitioners, researchers, policy makers, funders, and the recovery community.

The vision of the ATTC Network is to unify science, education and service to transform lives through evidence-based and promising treatment and recovery-oriented practices in a recovery-oriented system of care.

For more information see: https://attcnetwork.org/

## BELIEFS ABOUT THE TRADITIONS INVOLVING SUBSTANCE USE AMONG LATINX CULTURAL GROUPS

Attitudes toward substance use vary among Latinx cultural groups, but Latinx groups are more likely to see use in negative terms than are White Americans. Marin (1998) found that Mexican Americans were significantly more likely to expect negative consequences and less likely to expect positive outcomes as a result of drinking than were White Americans.

Similarly, Hadjicostandi and Cheurprakobkit (2002) note that most Latinx groups believe that prescription drug abuse could have dangerous effects (85.7%), that individuals who abuse substances cause their whole families to suffer (81.4 percent), and that people who use illicit drugs will participate in violent crime (74.9%). Driving under the influence of alcohol is one of the most serious substance use challenges in the Latinx community.

## TREATMENT PATTERNS FOR THE LATINX COMMUNITIES

Barriers to treatment entry for the Latinx community include, but are not limited to, lack of Spanish-speaking service providers, limited English proficiency, financial constraints, lack of culturally responsive services, fears about immigration status and losing custody of children while in treatment, negative attitudes toward providers, and discrimination (Alegria et al. 2012; Mora 2002). Among all ethnic/racial groups included in the 2010 NSDUH, Latinx

groups were the most likely to report that they had a need for treatment but did not receive it because they could not find a program with the appropriate type of treatment or because there were no openings in programs that they wished to attend, which may reflect a lack of linguistically and/or culturally appropriate services (SAMHSA 2011c). They were about twice as likely to state the former and four times as likely to state the latter as members of the group that was the next most likely to make such statements.

## TREATMENT ISSUES AND CONSIDERATIONS

Latinx clients' responsiveness to therapy is influenced not only by counselor and program characteristics, but also by individual characteristics, including worldview, degree of acculturation, gender orientation, religious beliefs, and personality traits. As with other cultural groups, efforts to establish clear communication and a strong therapeutic alliance are essential to positive treatment outcomes among Latinx clients. Foremost, counselors should recognize the importance of—and integrate into their counseling style and approach—expressions of concern, interest in clients' families, and personal warmth personalismo; (Ishikawa et al. 2010).

Counselors and treatment providers need to be educated about culturally specific attributes that can influence participation and clinical interpretation of client behavior in treatment. For instance, some Latinx cultural groups view time as more flexible and less structured; thus, rather than negatively interpreting the client's behavior regarding the keeping of strict schedules or appointment times, counselors should adopt scheduling strategies that provide more flexibility (Alvarez and Ruiz 2001; Sue 2001). However, counselors should also advise Latinx clients of the need to take relevant actions with the aim of arriving on time for each appointment or group session. Counselors should try to avoid framing non-compliance in Latinx clients as resistance or anger. It is often, instead, a pelea nonga (relaxed fight) showing both a sense of being misunderstood and respeto (respect that also encompasses a sense of duty) for the counselor's authority (Barón 2000; Medina 2001).

Unfortunately, many providers who work with Latinx cultural groups continue to have misperceptions and can even see culture as a hindrance to effective treatment rather than as a source of potential strength (Quintero et al. 2007). For instance, in treating the alcohol challenges of the Latinx communities, many counselors believe that they should not incorporate endorsement of traditional and possibly harmful cultural patterns into the services they provide (Mora 2002).

However, other counselors note that the transformative value of the most positive aspects of Latinx cultural groups can be emphasized: strength, perseverance, flexibility, and an ability to survive (Gloria and Peregoy 1996). Respecting women's choices can mean supporting empowerment to pursue new roles and make new choices free of alcohol, guilt, and discrimination (Mora 2002). For others, it can mean reinvigorating the positivity of Latinx culture to promote abstinence while respecting and maintaining traditional family roles for women (Gloria and Peregoy 1996). Because some research has found that Latinx communities have higher rates of treatment dropout than other populations (Amaro et al. 2006), programs working with this population should consider ways to improve retention and outcomes. Treatment retention issues for Latinx communities can be similar to those found for other populations (Amodeo et al. 2008), but culturally specific treatment has been associated with better retention for Latinx cultural groups (Hohman and Galt 2001). Research evaluating ethnic matching with brief motivational interventions also found more favorable substance use treatment outcomes at 12-month follow-up when clients and providers were ethnically

matched (Field and Caetano 2010). Available literature and research highlight four main themes surrounding general counseling issues and programmatic strategies for Latinx communities, including:

**Socializing the client to treatment:** Latinx clients are likely to benefit from orientation sessions that review treatment and counseling processes, treatment goals and expectations, and other components of services (Organista 2006).

**Reassurance of confidentiality:** Regardless of the particular mode of therapy, counselors should explain confidentiality. Many Latinx clients, especially undocumented workers or recent immigrants, are fearful of being discovered by authorities, like the United States Citizenship and Immigration Services, and subsequently deported back to their countries of origin (Ramos- Sanchez 2009).

**Client–counselor matching based on gender:** To date, research does not provide consistent findings on client–counselor matching based on similarity of Latinx cultural groups. However, client–counselor matching based on gender alone appears to have a greater effect on improving engagement and abstinence among Latinx clients than it does for clients of other ethnicities (Fiorentine and Hillhouse 1999).

**Client–program matching:** Matching clients to ethnicity-specific programs appears to improve outcomes for Latinx cultural groups. Takeuchi et al. (1995) found that only 68 percent of Mexican American clients in programs that had a majority of White American clients returned after the first session compared with 97% in those programs where the majority of clients were Mexican American.

The National Hispanic and Latino ATTC, which serves individuals and organizations who provide behavioral health services to Hispanic and Latinx populations throughout the U.S., provides training and technical assistance to a wide range of public, nonprofit and private organizations in culturally and linguistically appropriate practices and programs effective in serving Latinx populations including evidence based, community defined evidence, and other best or emerging practices.

For more information and resources for Latinx Cultural groups see: https://attcnetwork.org/centers/national-hispanic-and-latino-attc/home

## FOR REFLECTION:

When you think of the things you typically say and do (your approach) to working with and/or supporting individuals with substance use disorder:

1. What are you currently doing that is consistent with the approaches outlined in this workbook?

_____

_____

_____

_____

2. What will you do differently to incorporate a more culturally affirming approach?

_____

_____

_____

_____

## WHAT IS RECOVERY?

### SAMHSA's Definition of Recovery

Recovery is a process of change through which people improve their health and wellness, live self-directed lives, and strive to reach their full potential. There are four major dimensions that support recovery:

1. Health—overcoming or managing one's disease(s) or symptoms and making informed, healthy choices that support physical and emotional well-being.
2. Home—having a stable and safe place to live.
3. Purpose—conducting meaningful daily activities and having the independence, income, and resources to participate in society.
4. Community—having relationships and social networks that provide support, friendship, love, and hope.

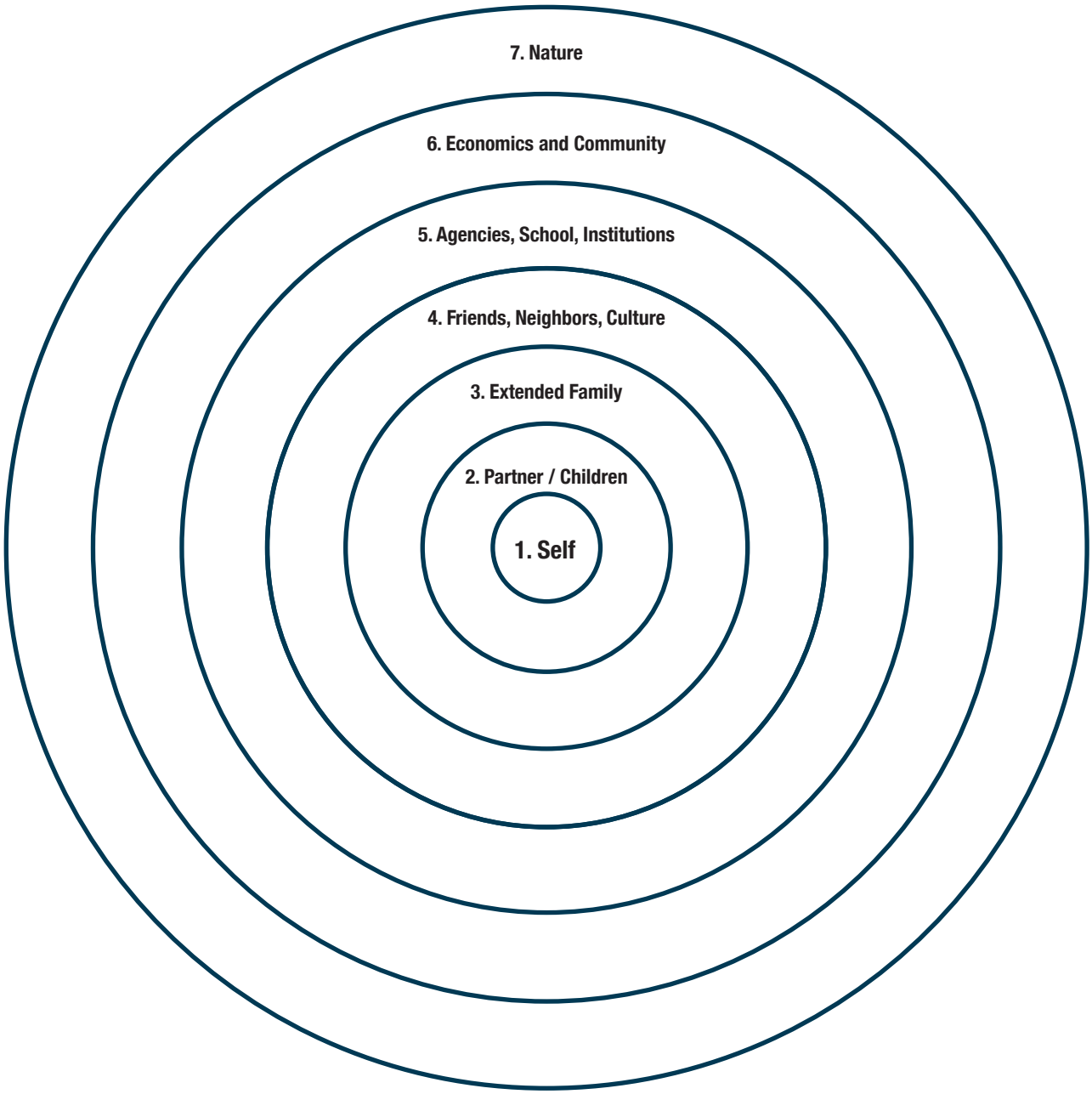
**Hope, the belief that these challenges and conditions can be overcome, is the foundation of recovery.**

The process of recovery is highly personal and occurs via many pathways. Recovery is characterized by continual growth and improvement in one's health and wellness that may involve setbacks. Because setbacks are a natural part of life, resilience becomes a key component of recovery.

The process of recovery is supported through relationships and social networks. This often involves family members who become the champions of their loved one's recovery. Families of people in recovery may experience adversities that lead to increased family stress, guilt, shame, anger, fear, anxiety, loss, grief, and isolation. The concept of resilience in recovery is also vital for family members who need access to intentional supports that promote their health and wellbeing. The support of peers and friends is also crucial in engaging and supporting individuals in recovery.

## ACTIVITY

For each circle of support depicted below, write in what your own personal sources of support are for each area.



Recovery services and supports must be flexible. What may work for adults may be very different for youth or older adults. For example, the nature of social supports, peer mentors, and recovery coaching for adolescents is different than for adults and older adults. Supporting recovery requires that mental health and addiction services:

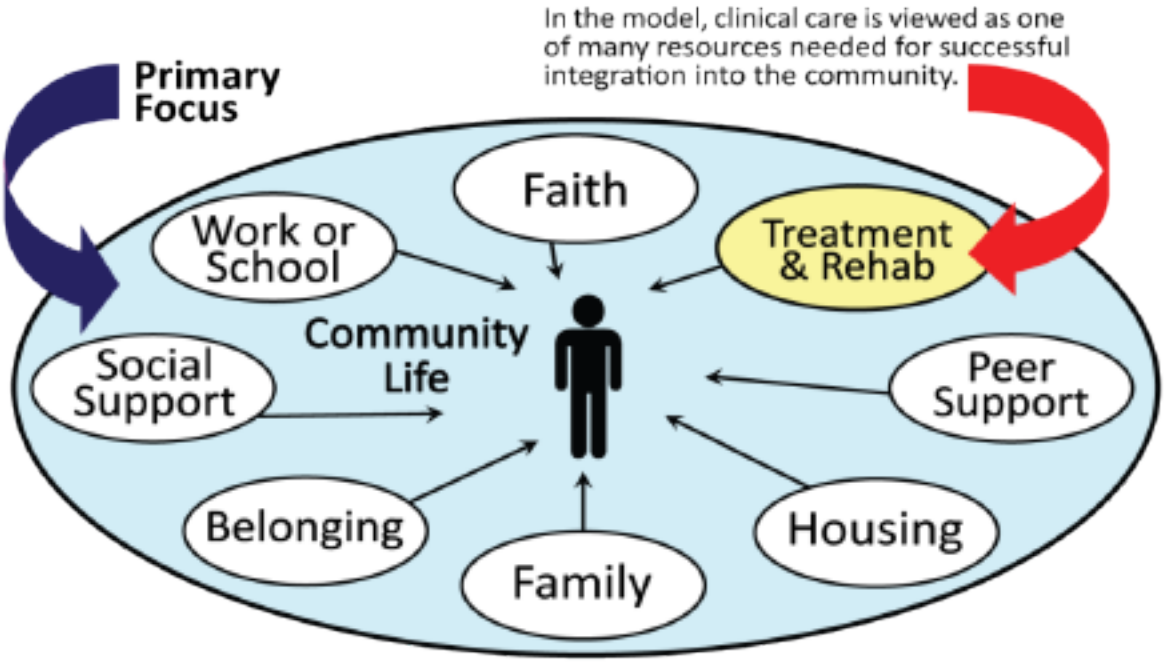
- Be responsive and respectful to the health beliefs, practices, and cultural and linguistic needs of diverse people and groups.
- Actively address diversity in the delivery of services.
- Seek to reduce health disparities in access and outcomes.

For more information see: https://www.samhsa.gov/find-help/recovery

Given the time limited duration of services provided in substance use treatment, the key to promoting and sustaining recovery is to help people develop post-treatment recovery strategies and resources.

Since no one achieves and maintains recovery by themselves, it is important to have a comprehensive approach to provide support, sense of belonging, and purpose. This is known as Recovery Oriented Systems of Care (ROSC) and the faith community is an essential partner for those congregants and those seeking spiritual support.

## RECOVERY ORIENTED SYSTEM OF CARE (ROSC)



## FOR REFLECTION:

Take a look at the Recovery Oriented System of Care Model.

1. Which are the most important resources for successful integration into the community? Why?

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2. What steps could you take to support an individual accessing one of these resources that is not already in place?

_____

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## THE CHILD AND YOUTH SYSTEM – WORKING WITH FAMILIES RESILIENCY AND RECOVERY

Young people who successfully overcome these behavioral health issues have three critical elements in their lives:

- Caring relationships
- High, clear, and fair expectations from their family and primary relationships
- Opportunities for participation and contribution

## STRENGTHS – BASED APPROACH

- At-risk young people need the same holistic attention to supports and opportunities as adults
- No longer just focused on the challenging behavior – a deficit approach
- A new focus for prevention: developing assets and resources

## SHIFT FROM A DEFICIT FOCUS TO A YOUTH DEVELOPMENT APPROACH

**Deficit**

- Challenge fixing
- Single program/single challenge approach
- Youth seen as service recipients
- Rely on public institutions and systems outside young people's communities to treat or prevent challenges
- Different interventions for at risk youth

**Youth Development**

- Healthy development
- Continuity across settings, community-wide strategies
- Youth are active participants
- Strengthen young people's natural support system (families, schools, neighborhoods)
- Equity: the same positive supports and opportunities for all young people

## SUCCESSFUL ORGANIZATIONAL PRACTICES

- Low ratio of youth to staff/volunteers
- Safe, reliable, and accessible activities and spaces
- Flexibility in allocating available resources
- Continuity and consistency of care
- High, clear, and fair standards
- Ongoing, results-based staff and organizational improvement process
- Youth involvement
- Community engagement

## KEY EXPERIENCES FOR HEALTHY DEVELOPMENT

**Young people must experience**

- A sense of physical and emotional safety
- Multiple supportive relationships
- Meaningful participation
- Community involvement
- Challenging and engaging learning experiences that build skills

## FOR REFLECTION:

1. What can you do as clergy or a behavioral health professional to build developmental assets in youth?

_____

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_____

2. What generational differences have you experienced in your practice, and how have you addressed them? (Tie in key points from the material above.)

_____

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## FAMILY RECOVERY

Most adults in or seeking recovery are parents, and many of them identify caring for their children or strengthening their relationships with them as primary recovery goals. Supporting individuals in managing challenges related to their parenting roles supports their overall recovery. A recent systematic review found promising early indications that recovery-oriented parenting supports may improve people's quality of life and progress toward individual recovery goals.

Simply put, these parents do not want their children to go through the same experiences as they did.

A recent issue briefly explores the complex connections between parenting, treatment, and recovery, and examines how peer-run organizations can increase their capacity to assist individuals in recovery with achieving their goals for parenting and recovery.

For more information see: https://c4innovates.com/brsstacs/BRSS-TACS%20Supporting-Families-Brief-Redesign.pdf

## IMPORTANCE OF PEERS

Peer support workers are people who have been successful in the recovery process who help others experiencing similar situations. Through shared understanding, respect, and mutual empowerment, peer support workers help people become and stay engaged in the recovery process and reduce the likelihood of relapse. Peer support services can effectively extend the reach of treatment beyond the clinical setting into the everyday environment of those seeking a successful, sustained recovery process.

The role of the peer support worker has been defined as "offering and receiving help, based on shared understanding, respect and mutual empowerment between people in similar situations." Peer support has been described as "a system of giving and receiving help" based on key principles that include "shared responsibility, and mutual agreement of what is helpful." Peer support workers engage in a wide range of activities, including advocacy, linkage to resources, sharing of experience, community and relationship building, group facilitation, skill building, mentoring, goal setting, and more. They may also plan and develop groups, services or activities, supervise other peer workers, provide training, gather information on resources, administer programs or agencies, educate the public and policymakers, and work to raise awareness.

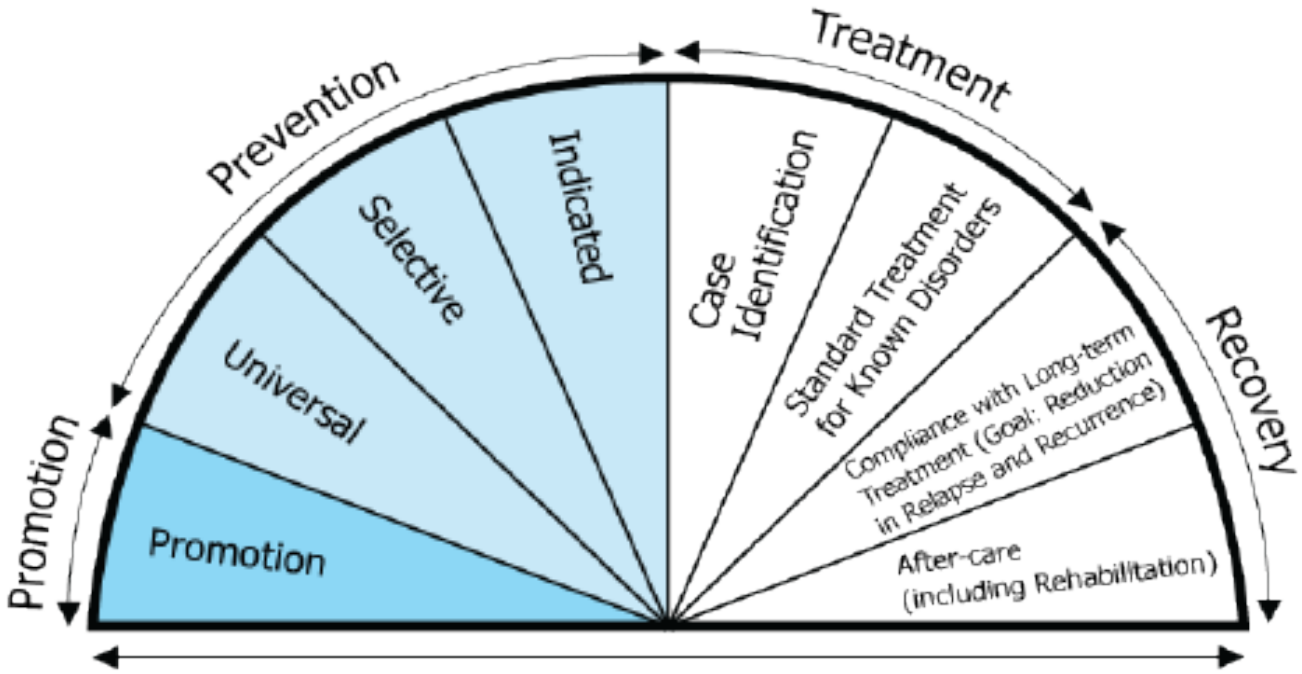
Recently developed Core Competencies are intended to apply to all forms of peer support provided to people living with or in recovery from mental health and/or substance use conditions and delivered by or to adults, young adults, family members and youth.

For more information on core competencies see: https://www.samhsa.gov/brss-tacs/recovery-support-tools/peers/core-competencies-peer-workers.

For information on the evidence base and value of peer supports, see: http://www.psresources.info/the-evidence

## CONTINUUM OF CARE

Behavioral Health services are organized along a continuum of care from raising awareness, to providing education to prevention/early intervention to treatment and recovery.




In San Diego County, Behavioral Health Services has two Systems of Care (SOC):

- Adult and Older Adult System of Care
- Children, Youth and Families System of Care

Both can be accessed at: https://www.sandiegocounty.gov/content/sdc/hhsa/programs/bhs/bhs_services.html.

## FOR REFLECTION:

1. How might the faith-based and behavioral health partners reach, preach and/or teach to community stakeholders in an area of this continuum?

2. What are some key things you can do to help spread awareness about rehabilitation and recovery?

- What do we do in the next 30 days?
- What do we do in the next 90 days?
- How do you create a win-win for internal and external stakeholders?

# Notes:

# MODULE 9: IDENTITY, FAITH AND PASTORAL COUNSELING

## PARTICIPANTS WILL HAVE AN OPPORTUNITY TO:

- *Better understand identity and reference groups*
- *Understand what pastoral counseling is*

**NOTES:**

## FOR REFLECTION:

Over the course of your life development, what are the most important influences that have shaped your identity?

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## IDENTITY

**Identity:** How we see our "self."

**Reputation:** How others see and talk about us.

Both impact our self-esteem and how we feel about our "self."

Groups that we identify ourselves as members of give us a sense of belonging, these are called reference groups.

However, how these reference groups are "judged" by society provides a person with higher or lower esteem. For example, if a group is seen as negative then the person that identifies with that group will also be seen as negative, this is especially true if the identification is clearly visible.

As adults, one of the key factors in these "judgements" is the amount of control or choice the person had in becoming a member of the reference group. For example, attending college is usually seen as a positive (though what major, your GPA, and which college or university is also a consideration), while being homeless is seen as a negative since the reasons for being homeless are usually viewed as "the person's fault."

In sociology, these are judgements that are known as achieved and ascribed statuses (implying choice or no choice). Examples include age, race, height, and sex. Each of us learns judgements about these "facts" as we are socialized in our families, communities, and societies. At best they are guides to understanding the world around us, and how to live in it, but they are also challenging when we negatively prejudge other people.

Developing a positive self-concept can be particularly difficult when a person is not a member of the majority or in-group. If a person happens to be a member of a reference group or culture that is often not welcomed, not understood, and is thought poorly of, developing a positive self-concept can be very challenging.

## FOR REFLECTION:

How might one's interpretation of faith-related teachings support or challenge their self-identity and how they feel about their "self?"

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## LGBTQ (LESBIAN, GAY, BISEXUAL, TRANSGENDER, QUESTIONING/QUEER)

One of San Diego's most vulnerable populations, Lesbian, Gay, Bisexual, Transgender and Questioning/Queer (LGBTQ) youth, often suffer because of non-supportive or even hostile environments in their homes, schools, and communities. LGBTQ youth are more likely than their heterosexual peers to experience difficulties in their lives and school environments.

During the 2013 Southern Region Mental Health Summit hosted by the County of San Diego Behavioral Health Services and Live Well San Diego, the following significant gaps that are unique to adults who identify as LGBTQ include:

- Lack of accurate information regarding LGBTQ individuals and communication among many providers, administrators, policy makers and members of the general public
- Historical classification of homosexuality as pathology, a disorder, or a form of mental health conditions
- Anti-LGTBQ policy initiatives
- Intersecting identities and coming out/staying in process poorly understood by providers

| **Commitment** |
| --- |
| Service providers of all types must be committed to preventing the harm LGBTQ individuals are exposed to by society-at-large. |
| **Diversity** |
| LGBTQ individuals do not only have LGBTQ identities but are influenced by racial, ethnic, and/or cultural identities, traditions, and norms. Therefore, the recommendation from all five reports should be viewed as an intersecting body of work, with the LGBTQ recommendations as an important addition to achieving culturally competent services and equitable treatment for all California populations. |
| **Know What You Don't Know** |
| Harm may be caused through well-meaning, albeit detrimental actions, due to lack of education, lack of adequate supervision, heterosexist ideology, firmly held religious beliefs, or a combination of any of the above. |
| **Detrimental Attitudes** |
| Heterosexist Attitudes:<br>• **Pity**: Practitioners view heterosexuality as preferable to any other sexual orientation. Persons who cannot change their lesbian, gay, bisexual orientation or seem to be born that way should be pitied.<br>• **Tolerance:** Practitioners tolerate same-sex or bisexual orientations as just a phase of adolescent development that eventually will be outgrown. These practitioners treat those who do not outgrow this "phase" or are "immature" in their development with the protectiveness and indulgence one might apply to a young child.<br>• **Acceptance:** Practitioners say they accept LGBTQ persons. Thinking that they have to accept them, however, implies that these clients have a "problem".<br>• **Liberal:** Practitioners are friendly with LGBTQ persons but have not thought beyond this to how they are still biased. They display heterosexist bias, for example, when they take for granted the privilege associated with heterosexual status.<br><br>Negative Attitudes:<br>• Practitioners who are unable or unwilling to change their negative attitudes toward LGBTQ individuals, or who cannot firmly separate their religious beliefs from their mental health practices, should refrain from working with this population. |

***Developed from: First, Do No Harm: Reducing Disparities for Lesbian, Gay, Bisexual, Transgender, Queer and Questioning Populations in California***

Youth Risk Behavior Surveys (YRBS) and other studies have gathered data on lesbian, gay and bisexual youth but did not include questions about transgender and questioning/queer youth.

According to the data from the 2015 national YRBS of surveyed LGB students:

- 10% were threatened or injured with a weapon on school property
- 28% were bullied electronically/virtually
- 34% were bullied on school property
- 23% of LGB students who had dated or went out with someone during the 12 months before the survey had experienced sexual dating violence in the prior year
- 18% of LGB students had experienced physical dating violence

- 18% of LGB students had been forced to have sexual intercourse at some point in their lives

According to the 2015 YRBS, LGB students were 140% more likely not to go to school at least one day during the 30 days prior to the survey because of safety concerns, compared to heterosexual students. LGB students are at greater risk for depression, suicide, substance use, and sexual behaviors that can place them at an increased risk of HIV and sexually transmitted diseases.

One-third (29%) of LGB youth had attempted suicide at least once in the prior year compared to the 6% heterosexual youth. In 2014, young gay and bisexual men accounted for 8 of 10 HIV diagnoses among youth.
Source: https://www.cdc.gov/lgbthealth/youth.htm

Another survey of more than 7,000 seventh and eighth grade students from a large Midwestern county examined the effects of school [social] climate and homophobic bullying on lesbian, gay, bisexual, and questioning (LGBQ) youth and found that:

- LGBQ youth were more likely than heterosexual youth to report high levels of bullying and substance use;
- Students who were questioning their sexual orientation reported more bullying, homophobic victimization, unexcused absences from school, drug use, feelings of depression, and suicidal behaviors than either heterosexual or LGB students;
- LGBQ students who did not experience homophobic teasing reported the lowest levels of depression and suicidal feelings of all student groups (heterosexual, LGBQ, and questioning students); and
- All students, regardless of sexual orientation, reported the lowest levels of depression, suicidal feelings, alcohol and marijuana use, and unexcused absences from school when they were in a positive school climate and not experiencing homophobic teasing.

SAMHSA's Addiction Technology Transfer Program LGBT has developed the first training curriculum specifically designed to help both administrators and clinicians address the various aspects of providing effective substance use treatment to LGBT individuals. The curriculum contains 22 modules to address the specific training needs of a given organization. The training covers such topics as:

- Legal issues
- The "coming out" process as it relates to behavioral health
- How to make a provider organization more LGBT-welcoming
- Specific clinical guidance for addressing the needs of each of the LGBT populations

Family reactions to their LGBT adolescents range from highly rejecting to highly accepting. Thus, a proportion of families respond with acceptance, and more with ambivalence, to learning about their child's LGBT identity – and not with uniform rejection as had been previously assumed.

In fact, rejecting families become less rejecting over time, and access to accurate information is a critical factor in helping parents, families, and caregivers learn to support their LGBT children.

For more information see: https://familyproject.sfsu.edu/sites/default/files/documents/

FamilySupportForLGBTChildrenGuidance.pdf

San Diego resources for LGBTQ youth include:

**The Hillcrest Youth Center** was the first drop-in and recreational center in San Diego County dedicated to the needs of lesbian, gay, bisexual, transgender, questioning/queer and (LGBTQ+) youth. It provides a safe, welcoming, and affirming space to be themselves and access the resources needed.

For more information see: https://thecentersd.org/youth-services/

**Our Safe Place** provides a wide variety of services for youth and their families, including support for alcohol and drug abuse, coming out, mental health treatment, family relationships, gender identity, sexual health, safe dating and transitioning.

Our Safe Place is a collaborative program with San Diego Youth Services, South Bay Community Services and the YMCA of San Diego County. Each partner provides a drop-in center and San Diego Youth Services also provides a community based mental health clinic. The program is funded by the County of San Diego Health and Human Services Agency.

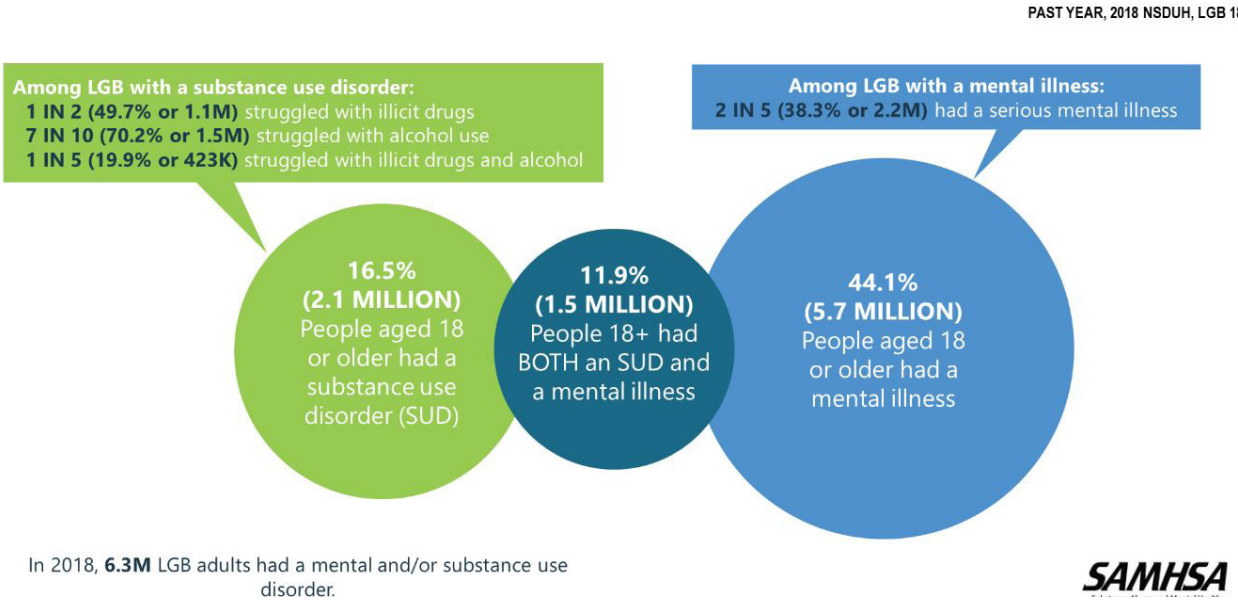
- https://sdyouthservices.org/services/our-safe-place/
- https://sbcssandiego.org/our-safe-place/
- https://www.ymcasd.org/community-support/ymca-youth-and-family-services/youth-and-young-adult-development/our-safe-place

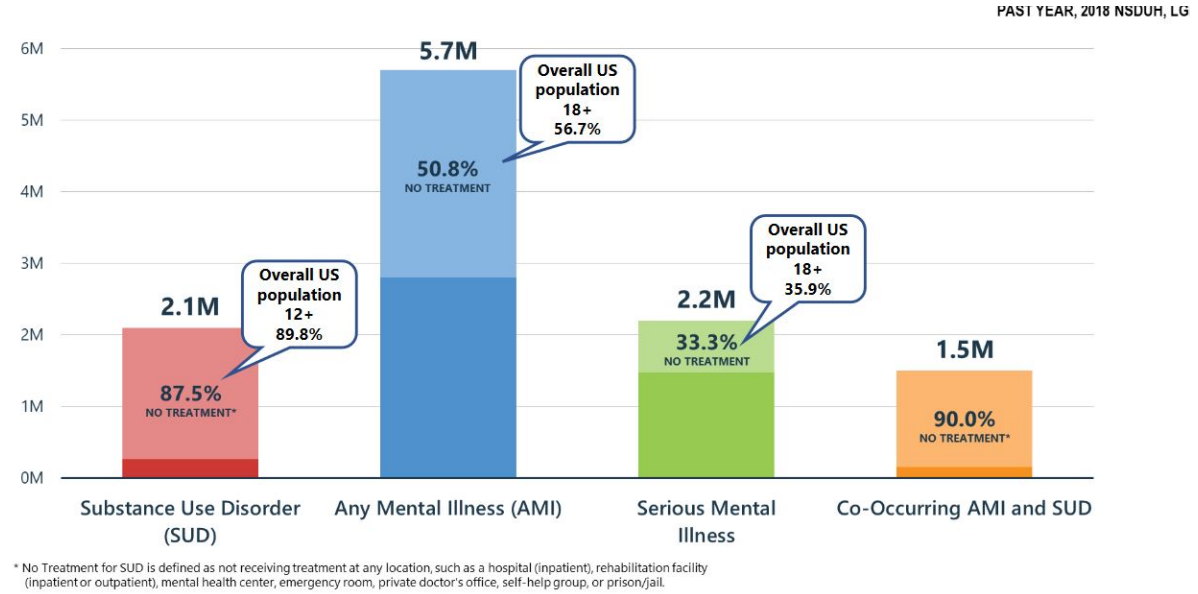
**The Trevor Project** is the leading national organization providing crisis intervention and suicide prevention services to lesbian, gay, bisexual, transgender queer and questioning youth.

For more information see: https://www.thetrevorproject.org/

For more virtual opportunities from LGBTQ+ youth-serving partners, see: https://sdpride.org/virtual-youth-support/

The struggles occurring in adolescence may continue into adulthood with significant disparities in health and well-being. While there is prevalence of unmet need for adults, there is a lack of access to care as well.




As retrieved: https://www.samhsa.gov/data/sites/default/files/reports/rpt23252/7_LGB_2020_01_14_508.pdf

## FOR REFLECTION:

What can the faith-based community and behavioral health providers do to be part of the solution for reducing homelessness and suicide rates amongst the LGBTQ population?

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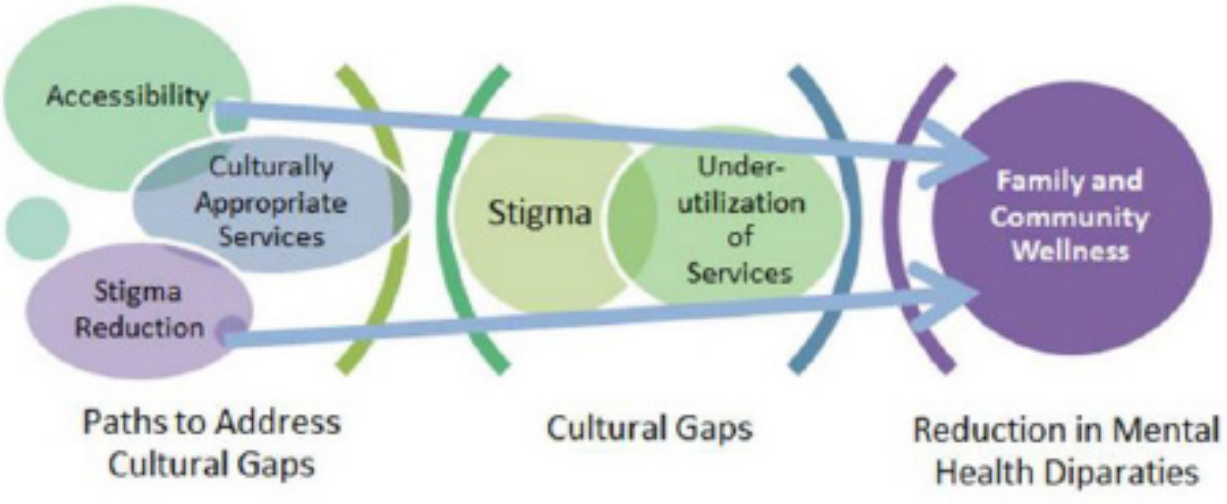
## WHAT FAITH-BASED AND BEHAVIORAL HEALTH CAN DO

This discussion, and that in previous modules, underscores that disparities in quality of life exist for unserved, underserved, and inappropriately served populations. These disparities may be partially explained by racism, prejudice, biased institutional practices, limited community cohesion, and by poor individual choices and behaviors.

The California Reducing Disparities Project identified the following 5 key barriers or gaps to accessing support and quality behavioral health services:

It is clear everyone has a role to play.




## FOR REFLECTION:

Where do you see your role fitting in on this pathway? What specific steps can you take to help reduce mental health disparities and increase family and community wellness?

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## UNDERSTANDING THE ROLE OF PASTORAL COUNSELORS

It is common for a parishioner to seek out assistance from other members of the church or from their pastor when they want to deal with personal issues from a faith-based perspective. In fact, research indicates that when there is a personal or family challenge, more than 25% of all congregants reach out to the faith leaders first. Others may seek out a minister for assistance with spiritual guidance and prayer. However, there are circumstances when the nature of the challenge calls for care from a professional with a more specialized educational background and training.

Pastoral care takes place in settings such as churches, hospitals, prisons, industrial workplaces, homes, law enforcement agencies, and military combat zones. This is one of the primary distinctions between a pastoral

counselor and clinical counselors, such as clinical psychologists, marriage and family therapists and social workers. While most clinical counselors are strongly discouraged from interaction outside the professional counseling relationship, and typically have a single contact setting (an office), pastoral counselors typically find ways to relate to the client on multiple levels and are encouraged to build a relationship and dialogue with a person outside of formal counseling settings.

Pastoral counselors, such as chaplains, pastors, church counselors, and ministerial counselors, are regulated and credentialed by ecclesiastical groups and professional associations. Clinical Counselors are regulated and licensed by state government boards, and often certified or credentialed by professional organizations.

For more information see: https://www.pastoralcounseling.org/how-to-become

The American Association of Pastoral Counselors strives to bring healing, hope and wholeness to individuals and families by integrating spirituality and psychology into their care. Their core values include "excellence in practice, accountability and ethics; respect for the rich diversity of human life...religion, spirituality; ongoing critical analysis and revision of their practice and organization; and lifelong personal, spiritual and professional formation." Collaborative partnerships with religious institutions and mental health-related community organizations provide a comprehensive approach to their work with faith leaders, lay persons and behavioral health partners.

For more information see: https://thecrg.org/resources/american-association-of-pastoral-counselors

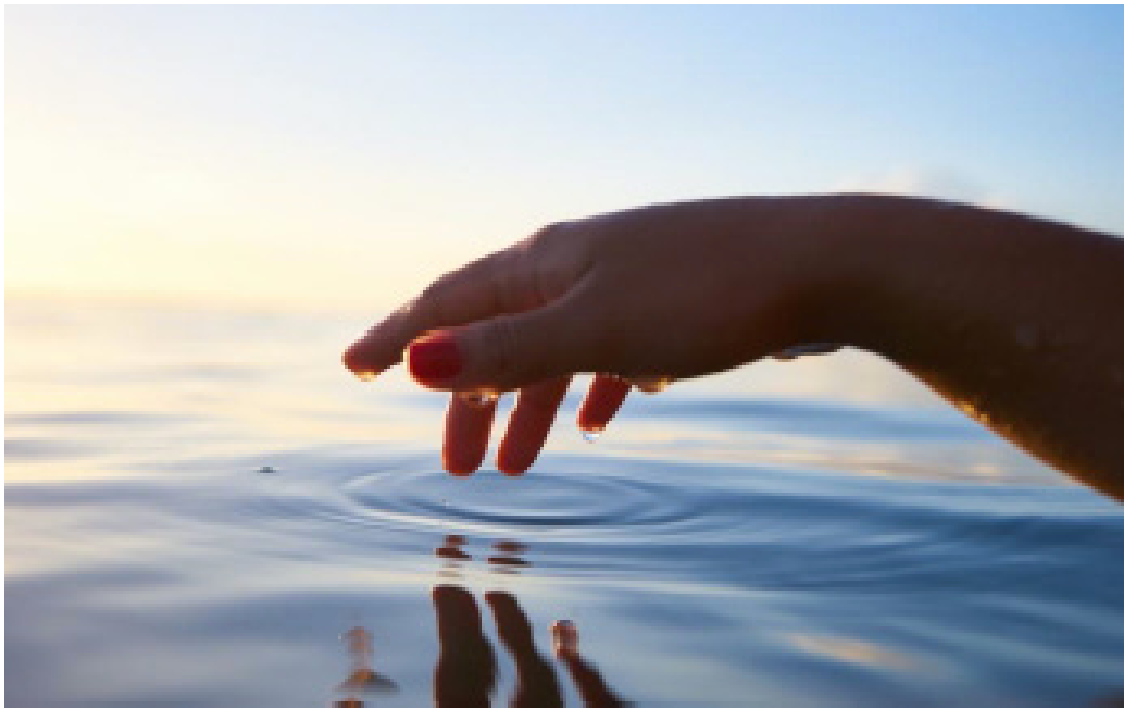
A typical path for a pastoral counselor, which combines professional and spiritual training, is:


For more information see: https://acpe.edu/education/psychotherapy/spiritual-integrated-psychotherapy

# MODULE 10: ROLE OF FAITH-BASED COMMUNITY IN PROMOTING WELLNESS, REFERRALS, & RESOURCES

## PARTICIPANTS WILL HAVE AN OPPORTUNITY TO:

- *Learn how they can become more involved in promoting mental health wellness, referrals, and resource information*
- *Learn more about becoming and serving as a Faith-Based Champion or Behavioral Health Champion*
- *Affirm actions they will take to promote mental health wellness and foster collaboration between the faith-based community and behavioral health providers*



**NOTES:**

## APPROACHES TO HELP DEFINE SHARED UNDERSTANDING

| Model | Underlying Assumptions | Treatment Approaches |
|---|---|---|
| Moral/Legal | Addiction is a set of behaviors that violates religious, moral or legal codes | Abstinence and use of will power<br>External control through hospitalization or incarceration |
| Psychological | Addiction results from deficits in learning, emotional dysfunction, or psychopathology | Cognitive, behavioral, psychoanalytic or psychodynamic psychotherapies |
| Sociocultural | Addiction results from socialization and sociocultural factors. Contributing factors include socioeconomic status, cultural and ethnic beliefs, availability of substances, laws and penalties regulating substance use, norms and rules of families and other social groups, parental and peer expectations, modeling of acceptable behaviors, and the presence or absence of reinforcers | Focus on building new social and family relationships, developing social competency and skills and working within a client's culture. |
| Spiritual | Addiction is a spiritual disease. Recovery is predicated on a recognition of the limitations of the self and a desire to achieve health through a connection with that which transcend the individual | Integrating 12-step recovery principles or other culturally based spiritual practices (e.g.- Native American Wellbriety principles) into addiction treatment<br>Linking clients to 12-step, faith-based recovery and support groups |
| Medical | Addiction is a chronic progressive disease. Genetic predisposition and neurochemical brain changes are primary etiological factors | Medical and behavioral interventions including pharmacotherapy, education, and behavioral change advice and monitoring. |
| Integrated Treatment | Addiction is a chronic disease that is best treated by a collaborative and comprehensive approach that addresses biopsychosocial and spiritual components | Integrated treatment with a recovery focus across treatments settings |
| | | |

## WHAT CLERGY/FAITH LEADERS CAN DO

The faith community is in the unique position to offer a sense of community (aka "fellowship"), prayers, referrals, and support to individuals with substance use and other mental health challenges. It is important to:

- Learn the facts about substance use and mental health conditions;

- Be careful with use of language
- Know resources available in the community
- Keep a current list of resources
- Know your limits; and
- Know the people in your faith community, who are in recovery or have, or are struggling with mental health conditions, and those who can be called upon to serve as peer resources.

## HOW CONGREGATIONS CAN BE MORE INCLUSIVE AND WELCOMING

- Create a Welcoming Environment
- Learn about mental health conditions. Identify myths and stigma through open discussion.
- Mental health conditions can be isolating for individuals and families. Ensure that they feel welcome in all aspects of your community's spiritual life.
- Create a safe environment within the place of worship by promoting an atmosphere of openness and inclusiveness.
- Conduct workshops, give sermons, host lectures to reduce and eliminate the stigma of mental health conditions and create more acceptance in the faith community.
- Invite a mental health professional to address a religious education class or discussion group.
- Apply a bio-psycho-social-spiritual model, understanding mental health conditions and substance use not as spiritual weaknesses but as health conditions for which treatment is available.
- Develop an inventory of community resources.
- Encourage faith leaders and lay leaders to take training through a program like Mental Health First Aid to become familiar with the basics of mental health conditions and ways to respond appropriately.
- Identify congregational leaders who can provide support to individuals and families either in the community or when hospitalized. The importance of individual and family privacy should be emphasized.

Provide direct support to individuals with mental health conditions and their families in one or more of the following ways:

- Visit in the hospital, prison, or at home.
- Offer prayers for him/her at religious services.
- Phone or send cards or letters.
- Listen and give moral support.
- Offer to shop for food or take a meal.
- Offer help with transportation (to appointments, to attend religious services).
- Offer help with childcare.
- Encourage networking with community support/advocacy groups.

Religion and spirituality often play a vital role in healing. People experiencing mental health concerns often turn first to a faith leader. From a public-health perspective, faith community leaders are gatekeepers or "first responders" when individuals and families face mental health or substance use conditions.

The Mental Health Guide for Faith Leaders provides information to help faith leaders work with members of their

congregations and their families who are facing mental health challenges. Its goal is to help faith leaders understand more about mental health, mental conditions, and treatment, and help break down the barriers that prevent people from seeking the care they need.

Behavioral Health professionals should also become familiar with this guide so that they can connect their clients with meaningful spiritual support if they are not already active in a faith community.

The two-page Quick Reference on Mental Health for Faith Leaders offers tips on understanding observable signs, communicating with someone affected by mental health conditions and making a referral to a mental health or medical professional.

For more information see: https://www.psychiatry.org/File%20Library/Psychiatrists/Cultural-Competency/Mental_Health_Guide_Quick_Reference_Guide_2018.pdf

## DEVELOPING A BEHAVIORAL HEALTH MINISTRY

Clergy and faith leaders can also consider developing a behavioral health ministry. Begin by educating the clergy or lay leaders in your congregation of the importance of behavioral health for the members health and well-being. After you have completed this step, an affirmative vote by your major committee/board, as in a Church Council or Consistory, or even by a vote of your whole congregation at an annual meeting, may be necessary. The vote itself, based on the rules of your denomination or order, represents your intention to enact what is needed in your congregation to develop a behavioral health ministry.

## FOLLOW THESE STEPS

Every congregation is unique, so you may want to follow these steps in a different order or add other steps.

**Step 1: Consult with the congregational leader.**

Meet with your Pastor/Head of Staff or other designated leader and enlist his or her support for your vision of developing a behavioral health ministry. Share the reasons why you feel called to make this happen. Discuss the worship leader's role in the process and ask for guidance.

**Step 2: Form a Core Team.**

Gather an ad hoc planning group of three to six people who share your passion for the development of a behavioral health program in your congregation. Invite your worship leader to attend the team's meetings. If your congregation has members who are open about living with a mental health challenge, at least one should be represented on the team. Begin and end meetings with prayer.

**Step 3: Connect with Mental Health Networks and examine available resources.**

Gather an ad hoc planning group of three to six people who share your passion for the development of Mental

Health Networks and examination of available resources. Many denominations have mental health networks that maintain a nationwide network of resources and consultants trained to help congregations through their journey towards building such a ministry. Begin by contacting these networks for denominational materials that can be shared with your congregation, especially sample materials for recommendation and resolutions for congregational leadership members.

In addition, through this initiative, connect with the County of San Diego Behavioral Health Providers, to develop partnerships formally and effectively.

**Step 4: Gather information about your congregation, the neighborhood and create a work-plan.**

You should begin with some reflection on the unique culture of your congregation, your "way of doing things."

Assess the congregation and surrounding local community by answering the following questions:

- What is the mental health challenge most commonly faced?
- What mental health programs already exist locally?
- How does the congregation handle change?
- How can difficult topics be explored in an environment of mutual respect?
- How can the behavioral health ministry process be a "safe space for every member of the congregation?
- What should be the pastor's role?
- What are the potential obstacles?
- Use this information to guide your group's decisions as you create a detailed plan.

**Step 5: Make it Official.**

Until now, your core team has been an unofficial ad hoc body. After developing your plan, you should be ready to form an expanded, official committee of the congregation—sometimes called a "Task Force." Ask the church's leadership teams to approve and bless your task force and your plan. Task force membership will include the original core team and other "internal and external stakeholders" in the congregation.

The transition to an official task force helps the congregation understand that the process is not the project of a special-interest group but is sanctioned by the church's lay and ordained leadership.

**Step 6: Draft a Faith-Based and Behavioral Health Pledge.**

A written pledge puts your congregation and community partners on record that it is truly part of the process or initiative. A pledge will show people who live with mental health challenges that your church strives to be a safe spiritual home for them and their families. Use language that is authentic and reflects your congregation's values. You'll find examples of covenants or pledges within our materials.

**Step 7: Conduct an Exploratory Survey before you Vote.**

While you may be tempted to skip this step, it is a vital one. One of the goals is to help a congregation experience cohesion and inclusion. If you take a vote, and the result shows the congregation is still conflicted, the process will have failed even if the vote passes. To avoid an outcome in which the church is divided, an exploratory survey will help. Have you heard from every constituency? Have you effectively addressed all concerns and fears?

Take a congregational survey or "straw poll" (which should protect the anonymity of respondents). If the result shows that less than 75% would vote in favor of the proposed pledge and ministry, the task force should meet with the pastor and discuss additional steps that may be needed to reach a near consensus. On the other hand, if your survey shows that more than 75% will support the pledge and ministry, you may be ready for a vote.

**Step 8: Vote.**

The vote enables your congregation to "own" your pledge and ministry. The procedure will differ from church to church. Sometimes the entire congregation votes in an annual meeting. Sometimes an elected governing body is empowered to decide. Read your congregation's constitution or bylaws and consult with your church's leadership to decide the right time and place for the vote.

**Step 9: Celebrate.**

Affirm the ministry and pledge at a regular service. Members of the congregation should stand in body or spirit and read the pledge together. Invite members who live with mental health challenges and family members to give public testimony. The choice of hymns, music, readings, and the sermon should be appropriate for the occasion.

**Step 10: Publicize widely and often.**

If you don't publicize your pledge widely, your community won't know that you have an initiative that welcomes and supports those who are living with mental health challenges. Publicity is not a one-time effort. Look for opportunities to reach the wider mental health community and other seekers who are looking for a congregation with welcoming and inclusiveness values.

**Step 11: Turn to the Future.**

As you live your mental health pledge, your congregation will open up to new opportunities for mission, ministry, and evangelism. To keep the momentum going, form a standing Faith-Based Champion committee to explore ways your congregation can have an impact. After one or two years, consider charting the progress you've made, and to engage in informed planning.

## GOING FORWARD

As part of their ministry, clergy may see when a family struggles with substance use disorders and/or dental health conditions. The impact on the family often includes:

**Increased:**

- Family conflicts
- Emotional or physical abuse/violence
- Family isolation
- Family stress from work challenges, marital strain, money troubles, frequent relocations
- Mental health conditions

**Decreased:**

- Family cohesion
- Family organization
- Emotional support
- Happiness

These issues are toxic to family wellness and result in feelings of secrecy, shame, and silence for the family member with "the challenge" as well as the other family members in the house. This negative experience becomes the family's rules for relating to people outside the family:

- Don't Talk
- Don't Feel
- Don't Trust

These families need clergy and faith leaders to offer hope and break the family's don't talk rule.

- Use teachable moments in sermons to inform about the disorders and conditions and invite hurting congregants to heal
- Include information on addiction, mental health, and recovery in your educational programs
- Distribute 12 Steps literature in your racks
- Leave resource materials in your offices and youth centers
- Remember silence is not neutral

**What do family members need?**

**CAREGIVERS**

- Words to share experiences
- Understanding of family disease
- Time with their children for healing
- Making amends and forgiveness

**CHILDREN**

- Words to say what happened
- Understand of family disease
- Time with their caregivers to heal
- Knowledge that it isn't their fault

## THE CHALLENGE

“Perhaps there is no larger gap in health care between two professionals trying to help the same sick person heal than the one that exists between the physician/clinician and the chaplain/member of the clergy. The gap does not usually result from animosity, but simply a neglect of serious communication and integration with one another. This faith–health care gap is even wider outside of the hospital, where most of life and health happens. Even though 80% of patients want to discuss spiritual issues, have prayer and comfort of the mind or soul, explore the meaning of their health conditions, or see a chaplain, most physicians will not ask about these needs.

Later in the day, the hospital chaplain or the community minister, priest, rabbi, or imam may make their rounds, inquiring about any spiritual introspections or reflections the patient might have, exploring the impact of stress from the conditions or its treatment, and offering prayer, comfort, and social connection. Properly performed, the role of the chaplain is to assess and support the spiritual health of the patient and never to proselytize, coerce, or otherwise influence the religious beliefs of the patient or the patient’s family.”

For more information see: https://nam.edu/faith-health-collaboration-to-improve-community-and-population-health/

## THE VISION

A community where everyone is safe, healthy and well, with a sense of belonging, purpose, and opportunity; where all individuals and families impacted by behavioral health needs know there are knowledgeable and caring faith leaders and congregants who:

- Understand what they are experiencin,
- Care about them and are available for them
- Can help them find emotional and physical safety
- Can support their healing and spiritual growth

**For Reflection:**

Do you share this vision? Why or why not?

_____

_____

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## WHAT YOU CAN DO PERSONALLY

- Take good care of yourself, family, friends, and colleagues,
- Learn about behavioral health, recovery, and wellness,
- Advocate for system collaboration and become a change agent,
- Define and monitor outcomes at four levels:
    - Individual and family
    - Program
    - System, and
    - Community
- Be bold, imagine a community where people live better lives, where people achieve their aspirations
- Provide hope

**For Reflection:**

What one thing are you committed to doing personally in the next 10 days?

_____

_____

_____

_____

_____

_____

## WHAT WE CAN DO TOGETHER

- Raise awareness
- Find allies
- Take action to end:
    - Silence
    - Stigma
    - Disparities
- Promote the many roads to recovery
- Promote community health and wellness

## FOR REFLECTION:

Who are your existing allies and champions in this work?

Who will you reach out to as a partner to join in the shared vision and action steps?

## HEEDING THE CALL TO ACTION
## WHAT IS A FAITH-BASED OR BEHAVIORAL HEALTH CHAMPION?

Stepping Higher Faith-Based & Behavioral Health Academy graduates will have an option to be considered to join a team of Faith-Based and Behavioral Health Champions as partners to increase knowledge of behavioral health services in the faith-based community, and to increase knowledge of faith-based community practices and services for behavioral health providers.

To be eligible for certification as a Faith-Based and Behavioral Health Champion, in addition to attending all 15 hours of the Stepping Higher Faith-Based & Behavioral Health Academy, Champion candidates must demonstrate an understanding of material covered and the ability to effectively present and facilitate the information to diverse groups of community members.

Additionally, Behavioral Health Champions shall be paid professionals in good standing with their employer or former employer if retired. Faith-Based Champions shall be experienced faith-based leaders in good standing with a recognized faith-based organization.

## RESPONSE TO CALL TO ACTION

To help promote mental health wellness and collaboration between the faith-based community and behavioral health providers, I will take the following actions:

- Apply to be a Faith-Based Champion
- Apply to be a Behavioral Health Champion
- Ensure congregation/office is inclusive and welcoming
- Develop a Behavioral Health or other specialized Ministry
- Share information on behavioral health and wellness in my congregation
- Make appropriate referrals
- Use and share resources
- Other action(s)

## NOTES:

Stepping Higher, INC.

# WE STRIVE

**To offer assistance to the areas of the community where mainstream support so often neglected.**

**To alleviate the barriers that continue to hamper communities by providing viable alternatives that will move them into new echelons of ethical, social, and cultural development.**

**To foster a deeper resolve for individualized accomplishments and pro-social values (i.e., self-discipline, personal responsibility, community-wide vision).**


Stepping Higher

Faith-Based and Behavioral
Health Academy

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