Having Healthy Conversations:

CHW behavioral health & advocacy training

February, 2023

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Welcome!

- Introductions
- History of the Project
- Review Training Series Learning Goals
- Review Module 1 Learning Goals & Objectives
- Icebreaker
- Create Group Agreements

Let’s Get Introduced…

- **Name and Personal Pronouns**
- **Agency and CHW Role**

*It’s helpful for you to change your Zoom name to reflect the name you’d like to be referred to and your pronouns!
*Complete pre-test evaluation now if you have not yet

Schedule/breaks

- **5 min break appx 10am**
- **Lunch appx 12:30-1pm**
- **5 min break appx 2:30**

Training Series Learning Goals

- Center work with BH clients through a racial equity lens & continually develop culturally-informed practices
- Deepen working knowledge of client-centered mental health & substance use care
- Understand and apply a harm reduction & holistic health framework to care of high-risk clients
- Practice assessment & tailoring skills to meet individual client needs
- Develop skills for working through client fear & resistance to addressing their behavioral health issues
- Build familiarity & confidence using *Healthy Conversations* curriculum materials
- Evaluation overview

CHW Training Overview: 4 Modules

Module 1:
- Welcome & Objectives
- Framing & Core Approaches
- Introducing *Healthy Conversations* Curriculum
- Racial Equity

TODAY

Module 2:
- Mental Health Topics: Teaching & Practice

Module 3:
- Substance Use (SU) Topics: Teaching & Practice

NEXT THURSDAY

Module 4:
- Advocacy Topics: Teaching & Practice
- Integrative Group Practice

CHW Integration into BH Systems

4 Central Components that are Interconnected

1. **Building CHW Baseline Behavioral Health Knowledge:** Understanding diagnoses, care models, treatment, provider roles for effective care coordinating & relationship-building with clients & their teams
2. **Understanding Systemic and Structural Barriers:** Naming and skillfully navigating bias, roadblocks, root causes of BH issues, and power dynamics between providers from an equity lens
3. **Developing a Sustainable Approach to CHW Work:** Boundaries, wellness resources, self-reflection, navigating shared experiences and triggers, peer support and collaborative supervision
4. **Honing Communication and Advocacy Skills:** For developing strong collaborations and effective strategies to get client needs met and proactively addressing barriers and bias

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Module 1: Overview, Framing, and Racial Equity

Module 1: Learning Goals

- Orient CHWs to the goals, approach, and structure of this training series, including the Healthy Conversations curriculum through review and practice: its purpose, structure, and uses for ongoing learning.
- Ensure CHWs can use the tools and perspectives central to client-centered behavioral health navigation.
- Support CHWs in conceptualizing behavioral health issues in a holistic, non-stigmatizing, systemic way in the context of structural racism/inequality and intergenerational trauma, drawing on the Liberation Health model.
- Empower CHWs to recognize and name racial equity issues in BH access and engagement in care and specific ways to mitigate them.

Module 1: Objectives

- Participants will be confident and able to use at least 2 *Healthy Conversations* curriculum chapters as a resource in their daily work.
- Participants will articulate 2 key principles of Motivational Interviewing, Stages of Change, and Harm Reduction and 2 ways to use each with clients.
- Participants will apply the Liberation Health framework to conceptualizing and care planning with specific clients.
- Participants will name 3 ways structural racism impacts BH outcomes and 3 practical strategies to address them as CHWs.

Group Agreements

- Confidentiality
- Tech Etiquette
- Take Space/Make Space
- 1 Diva 1 Mic
- Respectful Listening/Agree to Disagree
- Assume all experience is in the room
- Positive Risk
- Raise Cultural Concerns/Equity Questions
- Get Your Needs Met
- Have Fun!

Assessment Conversation

- What challenges have you seen/do you anticipate in working with your clients with BH issues?
- What knowledge & skills are you confident about?
- What would you like to learn that would help you feel more capable & successful with your new clients?

BH Intersectional Framework

- **Holistic view** of person, person is NOT their diagnosis or history
- Looks at family, community, cultural, **systemic & structural factors** that shape a person's health, quality of life, & behaviors
- **Recognizes oppression** & inequality are root causes of addiction, chronic disease, and many mental health symptoms
- Emphasizes the common challenges & **less than perfect coping skills** we share with clients as human beings

Intersectional Framework (cont.)

- **Avoids trying to fix people,** blame people for their problems, or take responsibility for "saving people" from themselves
- Increases empathy, flexibility, & our ability to **see complexity & sit with discomfort**
- **Believes change is possible** with individualized support and effort over time, with respect & collaboration as core practices

Healthy Conversations Origins

- Blue Cross Foundation 2013 grant to PACT to reduce health disparities
- Developed by a **multicultural team** of CHWs, social workers, MPHs, primary care doctors, psychiatrists, & holistic health practitioners in Boston
- Currently used by community health teams working with HIV+ people in Boston & NYC, folks with chronic diseases in Los Angeles, rural Arkansas, & Vermont

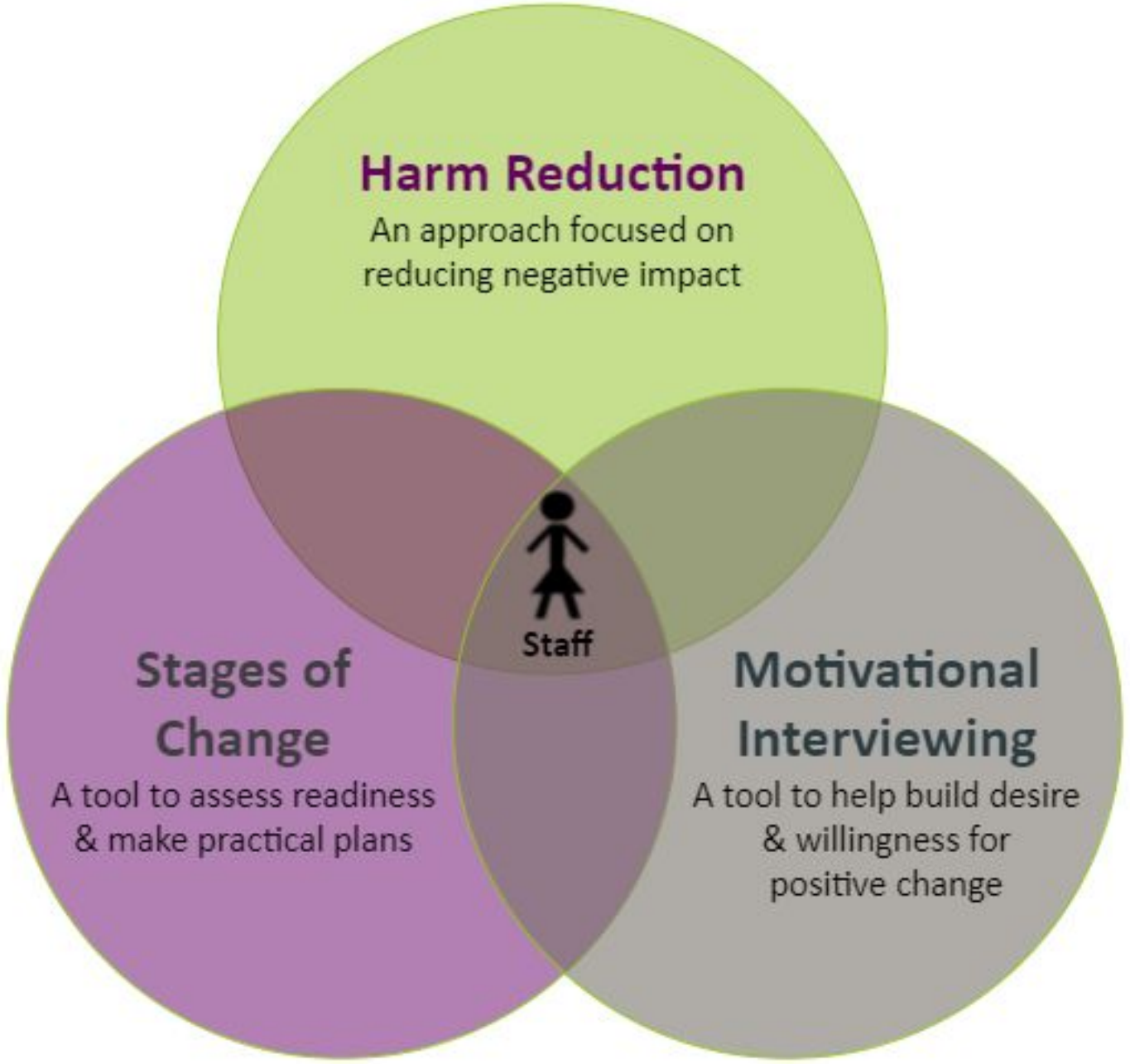
Nuts & Bolts

- 3 tracks:
  - 1) Mental Health
  - 2) Substance Use
  - 3) Dual Diagnosis
- 25 Topics broken into short conversations, each with teaching content & activities (about 15 min), cheat sheet at start, & wrap-up questions

- Resources for your learning & to share with clients: images/metaphors on key concepts, digestible psychoeducation, wellness activities, expressive arts, planning worksheets

Icebreaker

- Discuss in small group:
  - One reason you decided to become a CHW
  - One thing you like about being a CHW so far


Harm Reduction
An approach focused on reducing negative impact
Staff
Stages of Change
A tool to assess readiness & make practical plans
Motivational Interviewing
A tool to help build desire & willingness for positive change

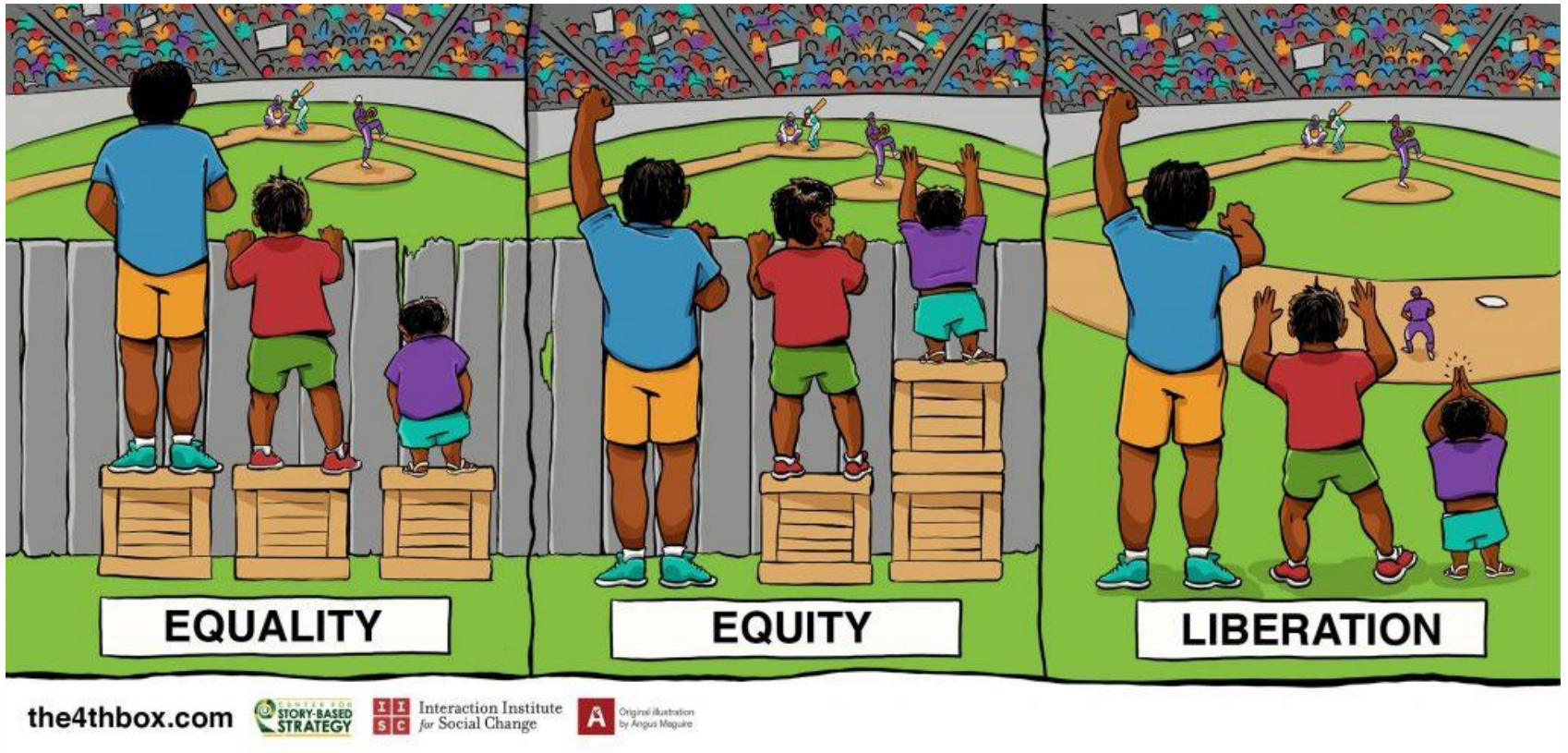
Motivational Interviewing (MI) Teach Back

- What are the OARSS & why do we like them?
- How does MI help us work with clients around behavior change?
- What are the Stages of Change, and how can we use them?
- Name 3 key aspects of Harm Reduction.

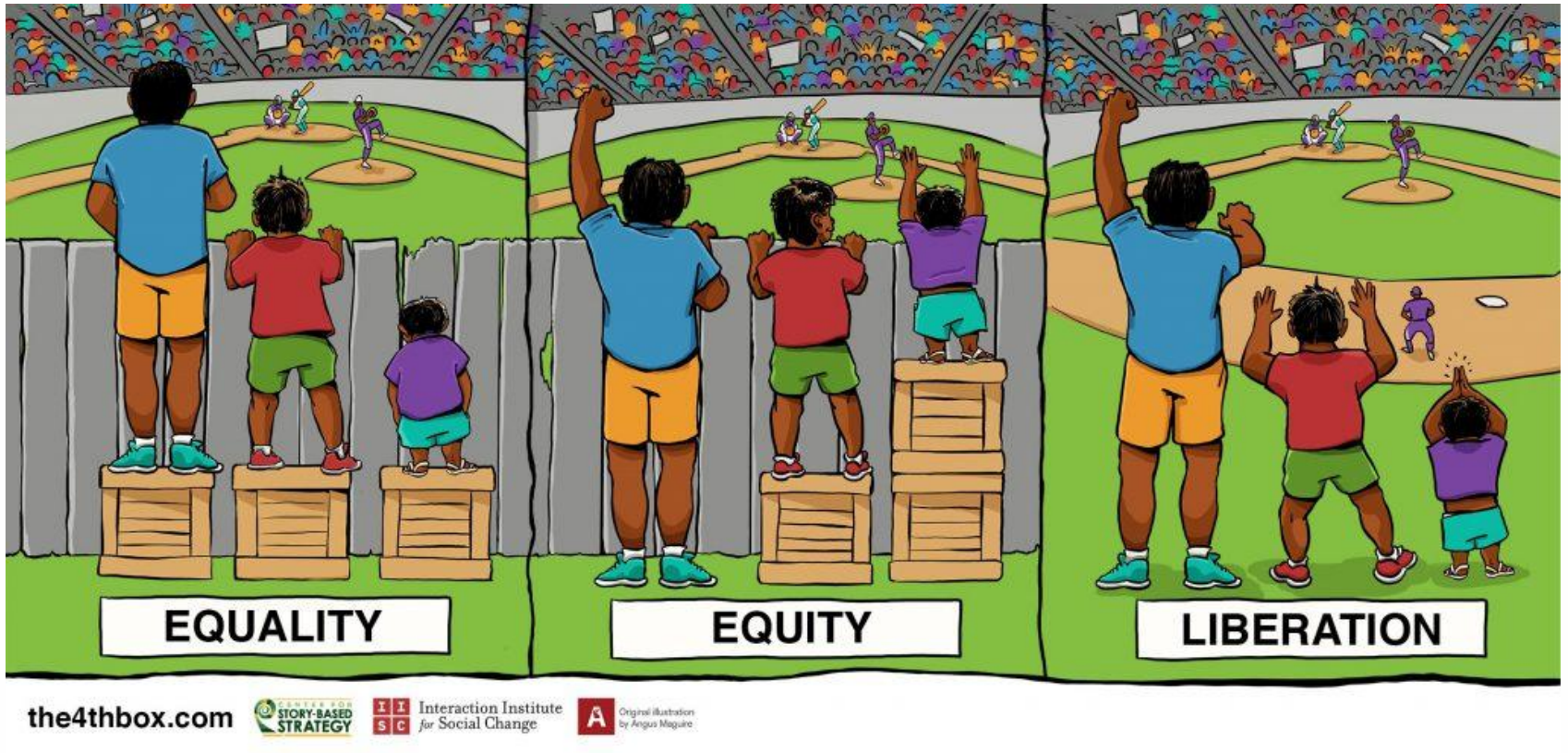
Motivational Interviewing(MI) Brief Overview

- **Motivational Interviewing**: Conversational tool to build readiness for small changes based on client's values, priorities, and wishes.
- **OARSS**: MI tools to build rapport, learn about the client, and set realistic & collaborative goals:
  - **O**pen questions
  - **A**ffirmations
  - **R**eflections
  - **S**ummaries
  - **S**ilence
- **Stages of Change**: Framework to assess client readiness to make any change in a specific area of life. Helps the worker match their approach to where the client is at:
  - Precontemplation
  - Contemplation
  - Preparation
  - Action
  - Maintenance
  - Relapse
- **Harm Reduction**: Set of values and practices that focus on reducing the harm of current behaviors, preventing more serious consequences, recognizing barriers, and valuing small, positive changes.

Defining Our Terms



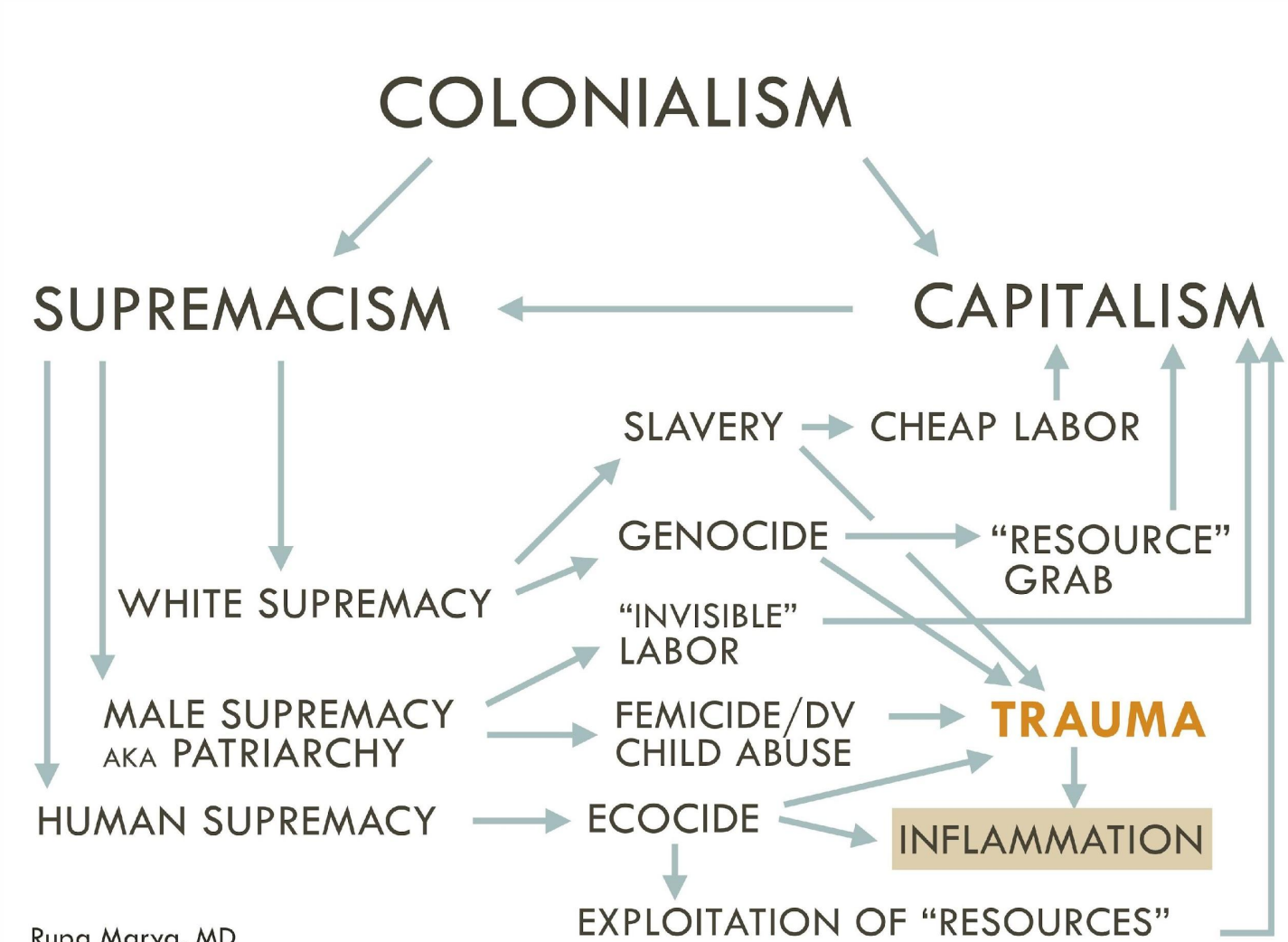
Defining Our Terms



Bringing a Racial Equity Lens to CHW Work:

- How do you see CHWs as mitigating the impact of structural racism & health disparities?
- What racial and cultural issues & barriers come up often in trying to access behavioral health?
- How do you see a CHW's role in ensuring equitable access to care & addressing the aspects of oppression that are root causes?
- What questions do you have about centering racial equity in your client, provider, or community-facing work?

Really Big Picture



Rupa Marya, MD

The Hydra of Racism in BH Care (Many Heads)

https://jamboard.google.com/d/1n1quh6WQf3BkTUL_BPkiQeJM4BclvJc_Sp1nxBiT2OM/edit?usp=sharing

The Hydra of Racism in BH Care (Many Heads)

- **Access Issues:**
  - Income inequality
  - Racial wealth gap
  - Insurance issues
  - Digital divide
  - Limited providers
- **Retention Issues:**
  - Implicit bias
  - Lack of provider training
  - Lack of representation in BH leadership/knowledge creation
  - Cultural barriers
- **Roots Causes:**
  - Intergenerational trauma
  - Lived impact of racism (micro & macroaggressions)
  - Stigma
  - Intersectional marginalization

Language & Racial Categories

- We recognize **race as a social construct** with **systems of power** enforcing economic, social, and structural barriers and inequality around these categories
- We recognize that even within a community, people have **different preferences of how they identify** based on generation, cultural background/national origin, and political perspective (eg. Black vs. African-American; Hispanic vs. Latino vs. Latinx vs. Chicano/Boricua/Dominicano)
- We strive to **name the specific barriers to care** that different communities face rather than lumping divergent experiences together under a general “Black Indigineous People of Color/BIPOC” label
- We share research data using the **language from the study,** knowing that those labels will feel fine to some people and not to others
- We encourage you to use the words for your own identity that feel most **respectful & resonant** and do the same with your clients and colleagues, even if their preferred terms may be different.

COVID-19 as a Mental Health Crisis!

- For essential workers (disproportionately BIPOC & immigrant people)
- For people with economic/housing/job insecurity
- For BIPOC people (twinned with national racial reckoning)
- For parents & youth (related to isolation, virtual school, work, childcare, etc.)
- For substance users (soaring OD deaths & reduced access to prevention & treatment)
- For folks with existing MH conditions
- **Likely to continue 3+ years post pandemic crisis (at least)**

Source: https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/

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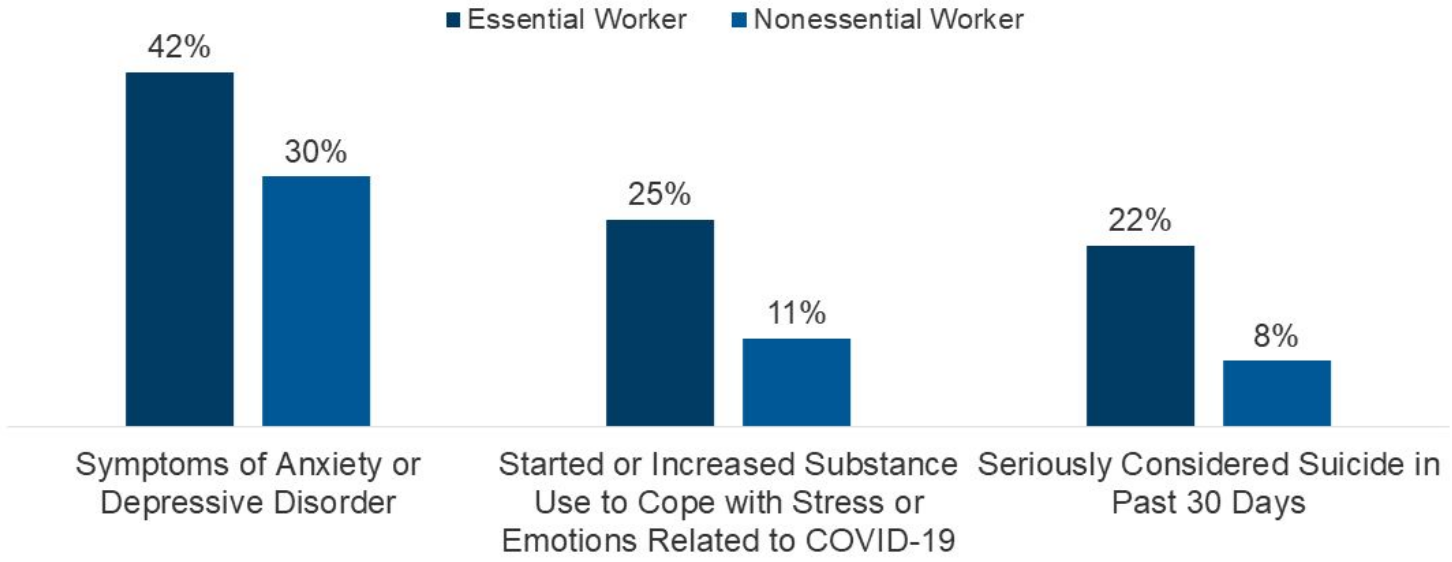
Rising Distress & Rough Coping:

Figure 8

Among Essential and Nonessential Workers, Share of Adults Reporting Mental Distress and Substance Use, June 2020



NOTES: Data is among adults ages 18 and above. Essential worker status was self-reported.

SOURCE: Czeisler MÉ , Lane RI, Petrosky E, et al. Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic — United States, June 24–30, 2020. MMWR Morb Mortal Wkly Rep 2020;69:1049–1057. DOI: http://dx.doi.org/10.15585/mmwr.mm6932a1

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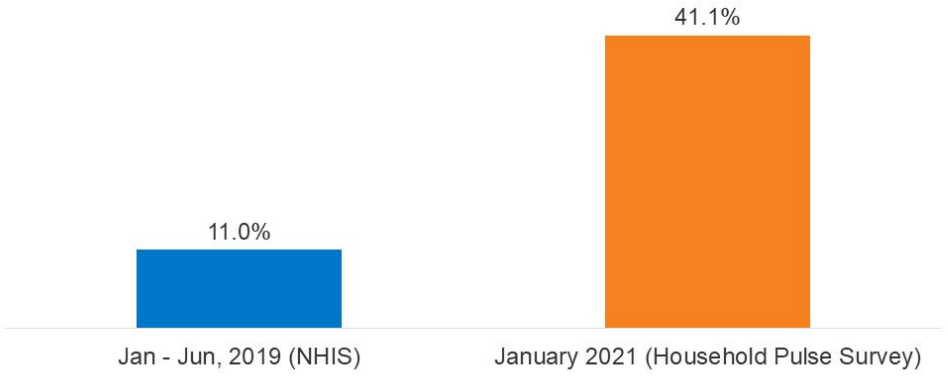
Surge of Symptoms, Racial Impact

Figure 1

Average Share of Adults Reporting Symptoms of Anxiety Disorder and/or Depressive Disorder, January-June 2019 vs. January 2021



NOTES: Percentages are based on responses to the GAD-2 and PHQ-2 scales. Pulse findings (shown here for January 6 – 18, 2021) have been stable overall since data collection began in April 2020.
SOURCE: NHIS Early Release Program and U.S. Census Bureau Household Pulse Survey. For more detail on methods, see: https://www.cdc.gov/nchs/data/nhis/earlyrelease/ERmentalhealth-508.pdf

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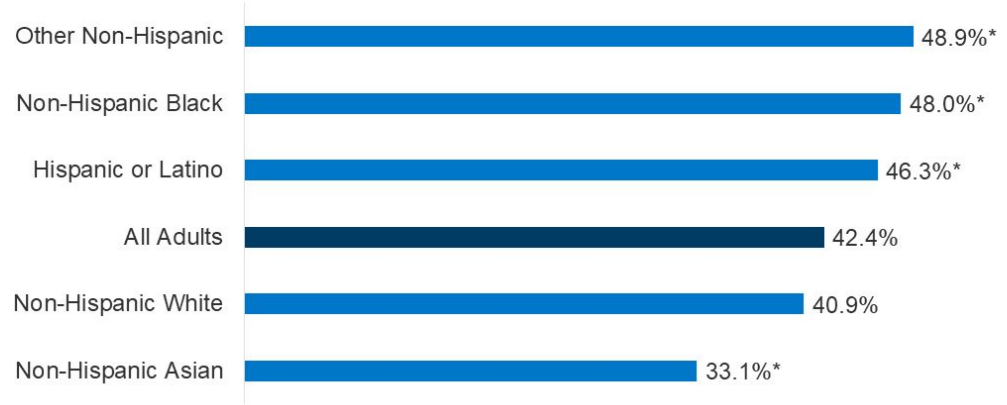
Figure 7

Share of Adults Reporting Symptoms of Anxiety and/or Depressive Disorder During the COVID-19 Pandemic, by Race/Ethnicity



NOTES: *Indicates a statistically significant difference relative to Non-Hispanic White adults at the p<0.05 level. These adults (ages 18+) report symptoms of anxiety and/or depressive disorder generally occurring more than half the days or nearly every day. "Other Non-Hispanic" includes people of other races and multiple races. Data shown are for December 9 – 21, 2020.
SOURCE: KFF analysis of the U.S. Census Bureau Household Pulse Survey, 2020.

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Source: https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/

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COVID Disparities in BH Care

- NIH Study 2020: **Decrease in behavioral health visits** by Black (down 25%) and Latinx populations (down 33%) in MA during COVID in spite of increases access by non-Latinx white populations via telemedicine. Medicare & Medicaid patient appointments down 20%. Overall BH appointments increased by 11% during this period, with 83% of those being virtual visits.

- MA AG Office 2021 Report: BH During the pandemic has worsened across the country for most demographics. For the second half of 2020, the CDC reported that 11% of adults in the US have seriously considered suicide. That number goes up to **15%** for "non-Hispanic Black" respondents and **19%** for Hispanic respondents. Compounded by the fact that BIPOC folks living in the US are **half as likely to receive mental health care** as white folks.

- **The "Digital Divide" in MA:** With telehealth as the new norm in MA, 30% of households in high-poverty urban zip codes either do not have an internet subscription or do not have access to a computer, smartphone, or other similar electronic device.

Sources:
1. https://pubmed.ncbi.nlm.nih.gov/33091782/
2. https://www.mass.gov/doc/building-toward-racial-justice-and-equity-in-health-a-call-to-action/download
3. https://www.purdue.edu/hhs/hdfs/fii/wp-content/uploads/2018/04/Unhealthy-Unwealthy-Family_Impact_Seminar_2017-briefing-report.pdf

Massachusetts Data

- 2017 Clark University study found that stress decreased and mental health improved when MA residents moved from a high poverty area to a less impoverished neighborhood (correlating with greater stability). With racial/ethnic minorities, however, socioeconomic status does not guarantee improved health outcomes due to "minority stressors" aka continued microaggressions and racial stigma.

- MA AG Report: Half of MA mental health care providers do not accept MassHealth and **13% of people with MassHealth insurance are Hispanic and 17% are non-Hispanic Black** (while they make up **11% and 7.63% of the MA population, respectively).** This forces marginalized populations to pay out of pocket, which is rarely a realistic option. **Racialized poverty remains a root cause of disparities!**

Sources:

1. Clark University Study
2. https://www.mass.gov/doc/building-toward-racial-justice-and-equity-in-health-a-call-to-action/download

Access & Retention Issues

- Data suggests equal prevalence of mental illness among Black people as in the general American population, but:
  - Poorer access, with only 1 in 3 Black people who need support getting it
  - Lack of access to culturally responsive care
  - Worse care when they do get care at all
  - Lower rates of outpatient and medication services, higher rates of inpatient services
  - More likely to use the ER than mental health specialists

- **Access:** In 2018, 58% of Black youth (18-25) and 50% of adults (26-49) in the US did not receive treatment for serious mental health conditions. From 2008-2018, serious mental illness rose for Black people in the US. **Black people with SMI are still statistically more likely to be incarcerated than receive care!**

Source:

1. https://onlinelibrary.wiley.com/doi/10.1002/wps.20695

Root Causes

- **Childhood trauma** (Alegria): National surveys that show **61% of Black children have experienced at least one adverse childhood event** compared with 40% of White non-Hispanic children.
  - We too often focus on individuals and family responsibility versus systems and institutions taking responsibility by changing policy to reduce disparities in mental health care and root causes of minority stress and poverty.

- **Systems problem:** Less than 2% of the American Psychological Association (APA) members are Black. These folks create frameworks for understanding symptoms, diagnosis, & treatment of MH issues.
  Representation and perspective matter: "Nothing about us without us!"

Source:

1. https://nimhd.blogs.govdelivery.com/2020/07/15/national-minority-mental-health-awareness-month/

Implicit Bias & Discrimination

- Black individuals are more likely to be **diagnosed with schizophrenia** (rather than a mood disorder) than their White counterparts experiencing the same symptoms, and are **less likely to be offered medical treatment.**
  - Lower diagnosis rates impacts treatment access, adding more barriers to a population that already distrusts medical institutions for historical abuses and disproportionate rates of institutionalization.

- **Barriers to engagement in BH care** (Worcester study):
  - Stigma
  - Lack of skill with non-Western views of mental health
  - Long waiting lists
  - Lack of provider language proficiency

Sources:

1. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6856783/

Asian Americans and Behavioral Health

- NLAAS found: Asian Americans have 17% lifetime rate of any psychiatric disorder (and a 9% annual rate), yet are **three times less likely to seek mental health services** than whites. Only 9% of Asian Americans sought any type of mental health services or resources compared to nearly 18% of the general population nationwide.

Culturally-Specific Stressors May Include:

- Parental pressure to succeed in academics
- Discussing mental health concerns is considered taboo in many Asian cultures, and as a result, Asian Americans tend to dismiss, deny, or neglect their symptoms
- Pressure to live up to the "model minority" stereotype (a view that inaccurately portrays Asian Americans as successfully integrating into mainstream culture and having overcome the challenges of racial bias)
- Family obligations based on strong traditional and cultural values
- Discrimination due to racial or cultural background
- Difficulty in balancing two different cultures and developing a bicultural sense of self

Source:

1. https://www.apa.org/pi/oema/resources/ethnicity-health/asian-american/article-mental-health

Native Americans and Behavioral Health

- Native people in the United States report experiencing **serious psychological distress 2.5 times more** than the general population over a month's time.
- The **suicide death rate** for US Indigenous people **ages 15-19 is more than double** that of non-Hispanic whites.
- Native/Indigenous people in America start to **use and misuse alcohol and other drugs at younger ages,** and at **higher rates,** than all other ethnic groups.
- Many Native/Indigenous tribes embrace a worldview that encompasses the notions of connectedness (with the past and with others), strong family bonds, adaptability, oneness with nature, wisdom of elders, meaningful traditions, and strong spirit that may serve as **protective factors** when it comes to mental illness.
- Root causes: **Intergenerational trauma** related to **colonization and genocide.**

Source:

1. https://www.mhanational.org/issues/native-and-indigenous-communities-and-mental-health

Latinx Clients & Dual-Diagnosis Care

Dually-diagnosed clients (co-occurring mental health and substance use disorders) access behavioral health treatment at much lower rates than individuals without comorbidities. For example, only **9% of these individuals receive treatment for both disorders, while 53% receive no treatment at all.**

- Research has shown that **Latinos have lower rates of treatment adherence,** attending fewer sessions and prematurely dropping out of cognitive behavioral therapy (CBT) compared to non-Latino whites.

- These differences are connected to the **double stigma associated with mental illness and being an ethnic minority,** logistical, motivational, and attitudinal factors. Approximately **50% of Latino immigrants reported self-reliant attitudes regarding behavioral health care** (e.g. wanting to handle problems on their own) **and structural barriers** (e.g difficulties with transportation and scheduling flexibility).

Source:

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6856783/

Racial Equity & BH Key Points

- BH models are **culturally bound** (in white European, capitalist, patriarchal western medical models of pathology) & MH research has historically been done on cishet white men (meds and tx efficacy)
- Extreme **whiteness of BH providers** (low pay & high schooling cost in the face of racial wealth gap are factors) & historic lack of culturally-informed, affordable, language-accessible care
- Providers as **agents of social control** in racially-biased systems (DCF, SW, school counselors, ER) with **power** to harm
- Many BH providers take **only private insurance** which has a disparate impact on access. Reimbursement rates for Medicaid/Managed Care are low & billing is tedious & time-consuming so the pool of providers is small & often early career people.

Interlude: Breath & Partner Chat

- Take a moment to stretch & breathe as we digest this info
- Notice how your body is feeling and any sensations
- Check in with a partner about what stands out to you from the data
- How does this disparity material make you feel?
- How does it confirm/challenge your lived experience as a CHW and/or client?

What Helps Address Disparities?

- Harvard Policy Review 2019: **CHWs are essential**
  - in reducing stigma/exclusion by empowering clients & amplifying their voices
  - In reaching disengaged populations
  - As more accessible than clinical providers for those living with mental illness
  - CHW integration into mental health services promotes adherence to treatment, increasing the likelihood of positive clinical outcomes.
- Increasing supply and diversity of BH providers: improves access for clients of color in particular!
- Evidence-based and culturally-tailored interventions provided by ethnically matched providers (Alegria)

Sources:

1. http://www.hhpronline.org/articles/2019/11/26/the-opportunity-for-systems-transformation-community-health-workers-and-peer-coaches-for-reducing-mental-health-inequities
2. https://pubmed.ncbi.nlm.nih.gov/23466259
3. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6856783/

What Community Members Want:

- 2017 Worcester community needs assessment (participants = ⅔ immigrants and 88% racial/ethnic minorities) identified need for:
  - Integrated care/wraparound services/coordinated care
  - Use of CHWs to engage immigrants and people of color
  - Increased cultural responsiveness and cultural humility by providers
  - Increased language capacity
  - **Increased health literacy and psychoeducational work with patients**

Source
https://www.purdue.edu/hhs/hdfs/fii/wp-content/uploads/2018/04/Unhealthy-Unwealthy-Family_Impact_Seminar_2017-briefing-report.pdf

How can CHWs center racial equity?

- Remember that BH issues are partially chronic stress responses/coping to intergenerational trauma, structural inequality, macro & microaggressions. Naming that and responding accordingly can help reduce stigma & keep clients connected to care.
- Remember that clients of color face culturally-specific BH stigmas that persist barriers to care. How can CHWs respond to them **(resources: *Healthy Conversations* stigma chapter, naming, Kleinman questions)**?
- Remember the CHW role is **vital** in cultural interpretation, advocacy, validation as fundamental to client readiness, access, retention, & outcomes
- **Our goal** in this training series: bring equity lens to dialogue/framing on all areas we're teaching

Kleinman's Questions

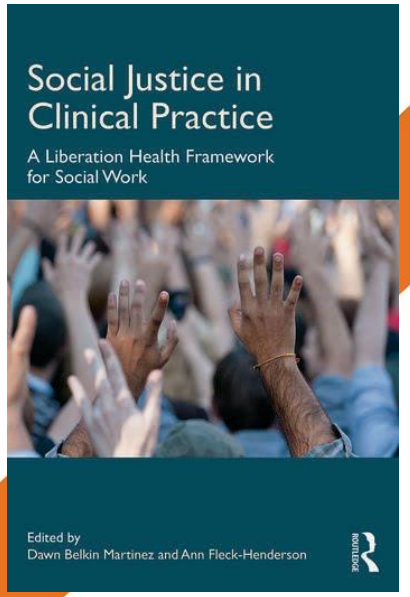
For culturally-informed care

1. "What do you call the problem?"
2. "What do think has caused the problem?"
3. "Why do you think it started when it did?"
4. "What do you think the sickness does? How does it work?"
5. "How severe is the sickness? Will it have a long or a short course?"
6. "What kind of treatment do you think the patient should receive?"
7. "What are the chief problems the sickness has caused?"
8. "What do you fear most about the sickness?"

Learn more: https://www.med.upenn.edu/gec/user_docs/PDF/Health%20Equity%20and%20Literacy/Kleinman_s_8_Questions.pdf

Liberation Health Model

- "The Liberation Health Group is open to all advocates of social justice and human liberation involved in the **struggle for a healthy society.** We understand "health" as more than the absence of disease and are committed to **addressing the personal, cultural, and institutional barriers** that prevent us from being healthy!"
- "Members of our group…strive to link immediate issues and struggles relating to our current healthcare system to the **larger societal structures** that regulate it and the dominant worldview messages that rationalize the existing **unjust allocation and distribution of resources** and services."



Learn more: https://www.bostonliberationhealth.org/

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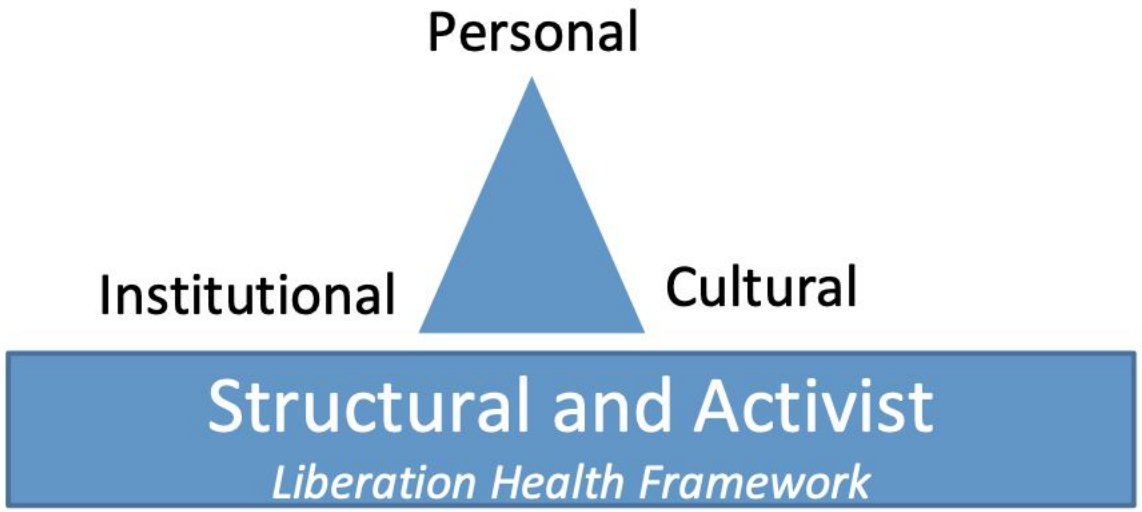
More Liberation Health:

- “As healthcare workers and clients, we recognize the **need to ally** with our brothers and sisters who are experiencing oppression, here in Boston, and around the world. Our solidarity with the individual clients, families, and communities with whom we work mean recognizing their right to **meaningful participation in the health decisions** that affect their lives.”
- “We propose and fight for alternative forms of social organization that promote a more just distribution of natural and human resources and a **healthy society that prioritizes human needs over accumulation of wealth and profit.** We identify with the oppressed, dominated, and marginalized of the world and their struggles to **achieve economic, political, and cultural freedom and self-determination.”**

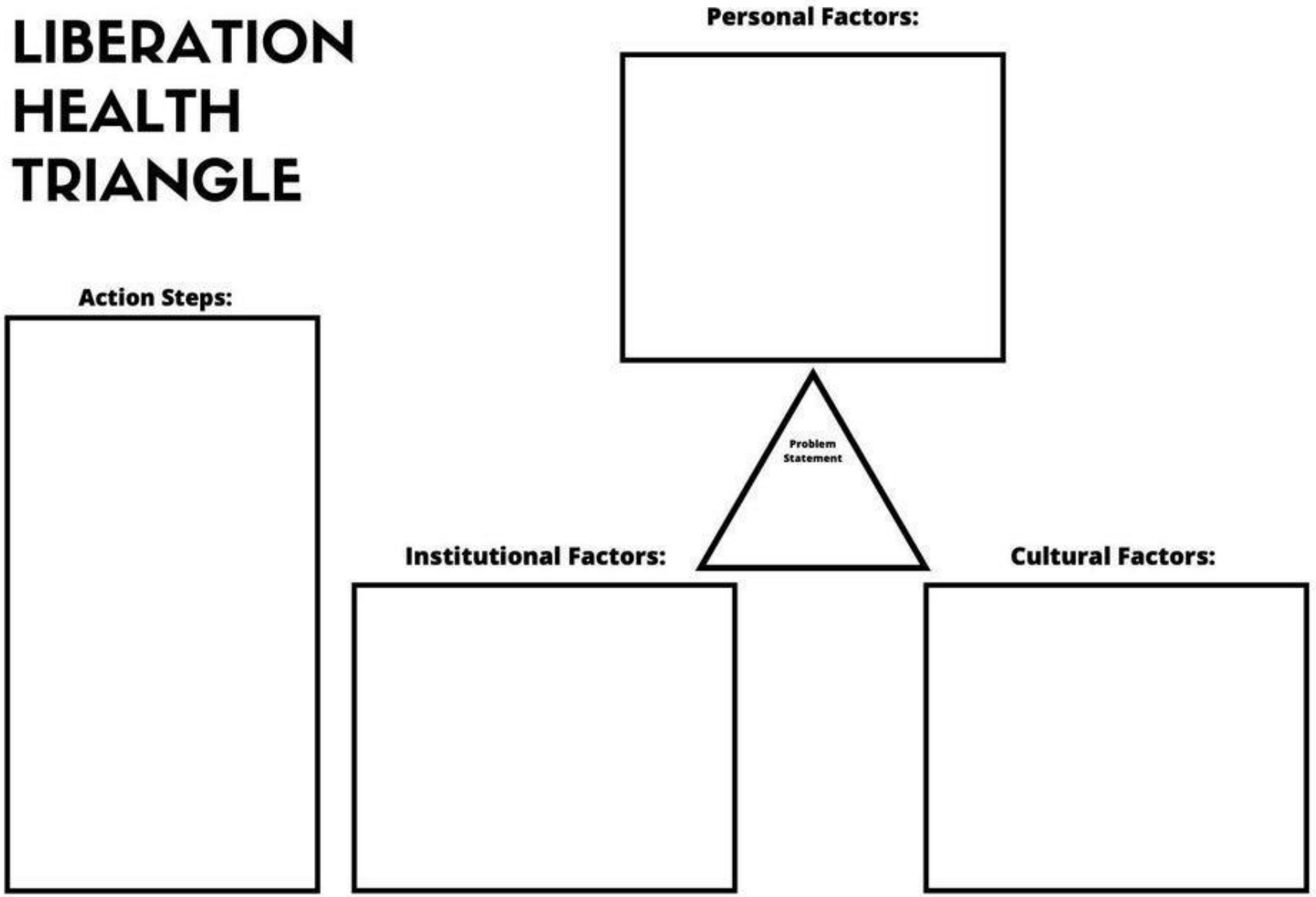


Personal
what is going on with the person/couple/family

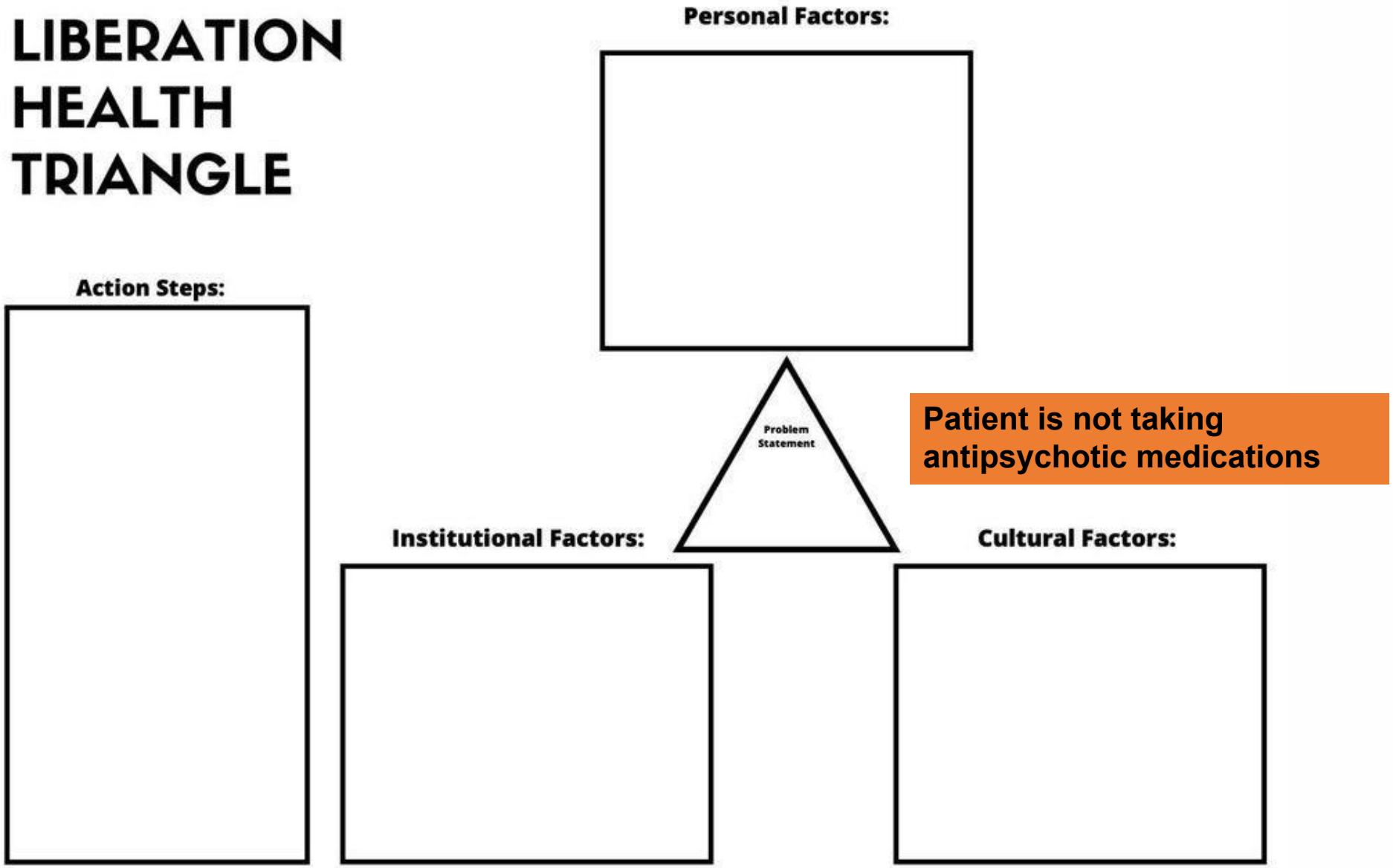
Institutional
governmental policies, laws, capitalism, access to power

Cultural
all forms of oppression based on social identities
cultural norms and values

LIBERATION HEALTH TRIANGLE

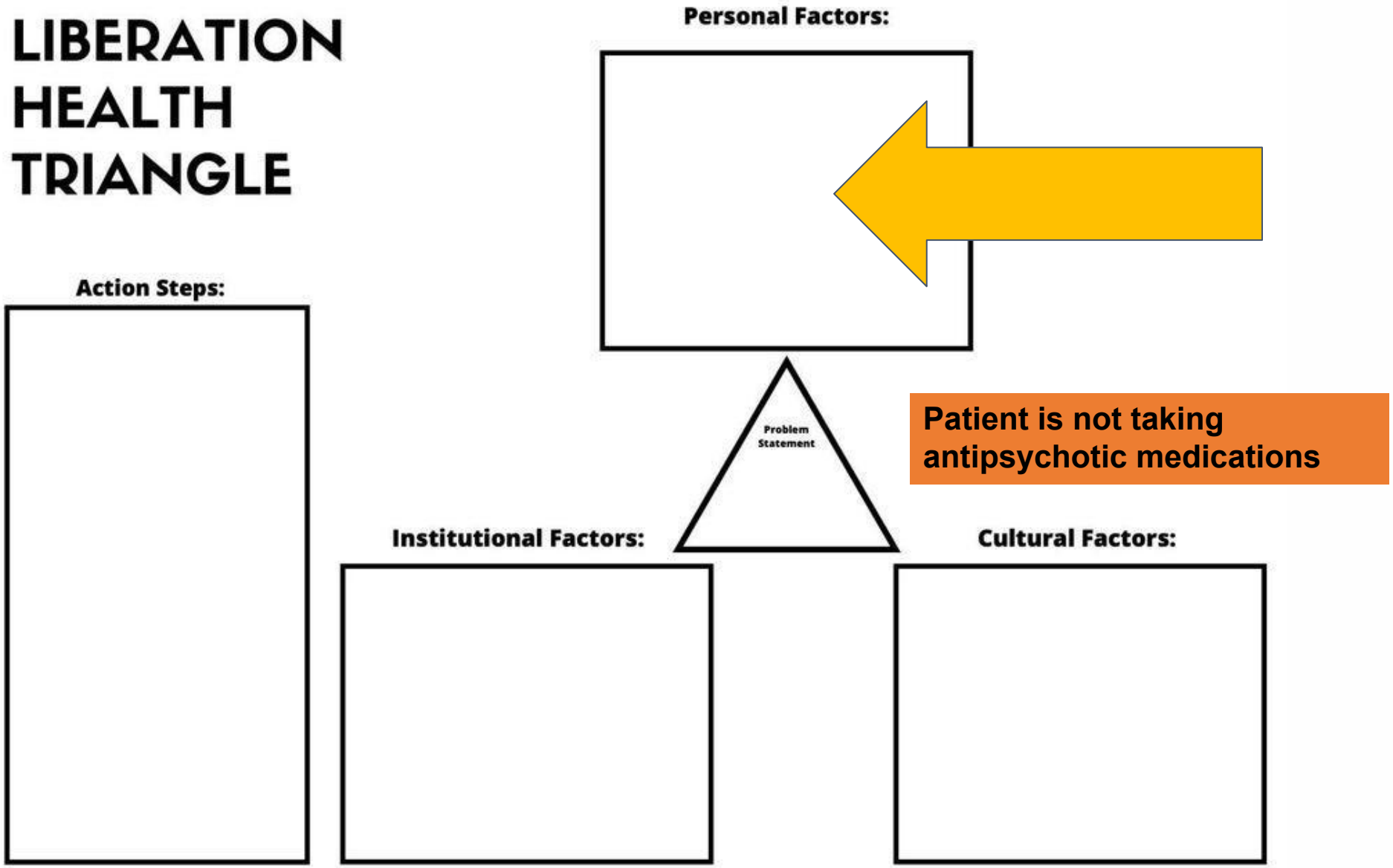


LIBERATION HEALTH TRIANGLE



Patient is not taking antipsychotic medications

LIBERATION HEALTH TRIANGLE



LIBERATION HEALTH TRIANGLE

Personal Factors:

Not a safe place to store meds in the home

Family feels uncomfortable in having visiting nurse come to home

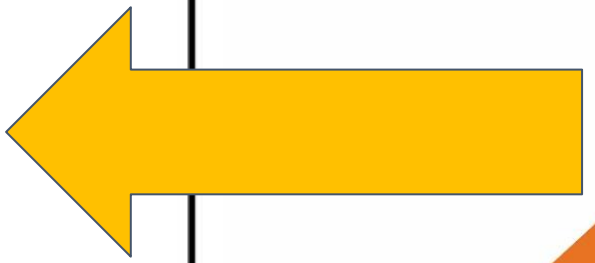
Action Steps:

Problem Statement

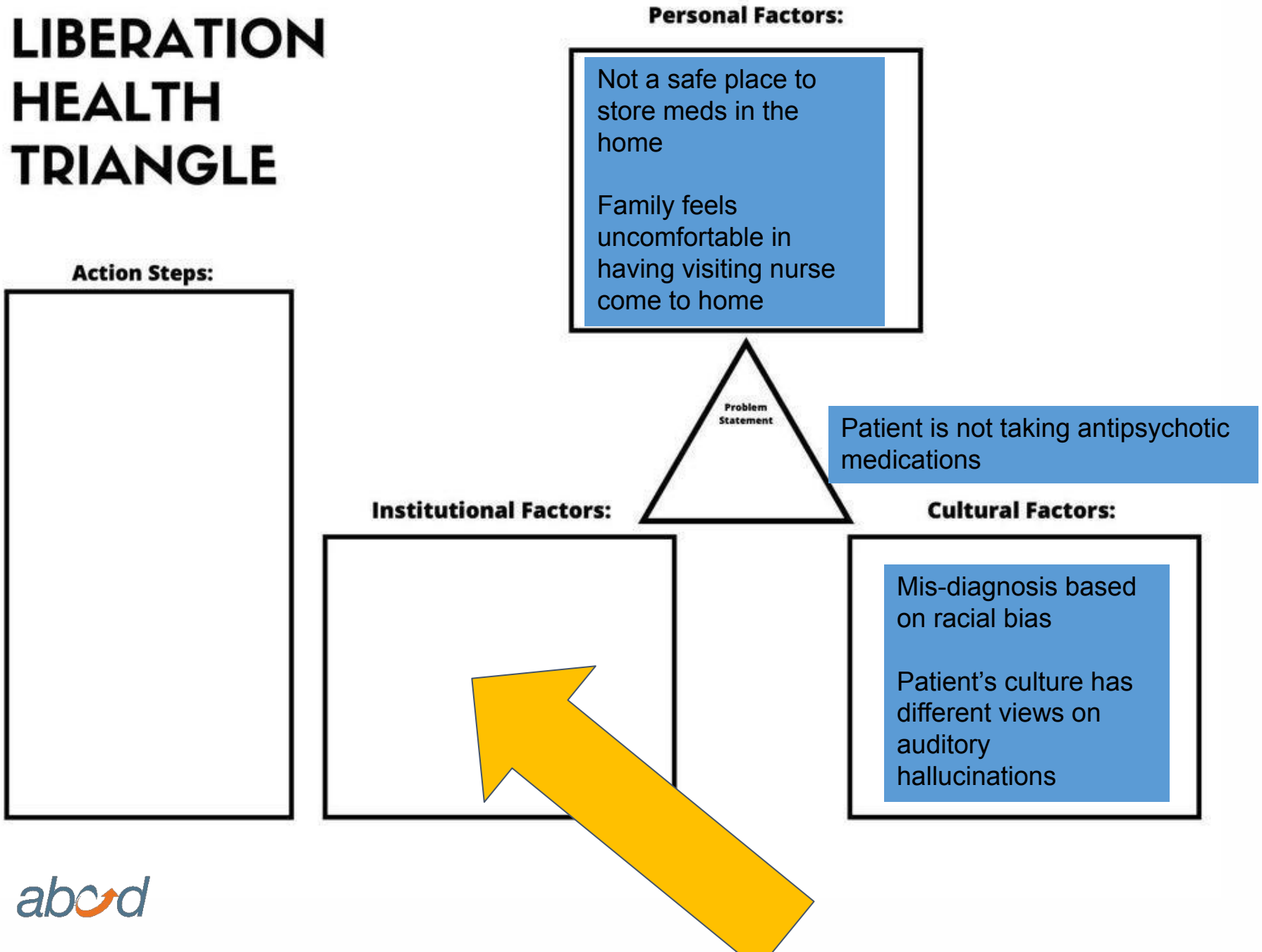
Patient is not taking antipsychotic medications

Institutional Factors:

Cultural Factors:



LIBERATION HEALTH TRIANGLE



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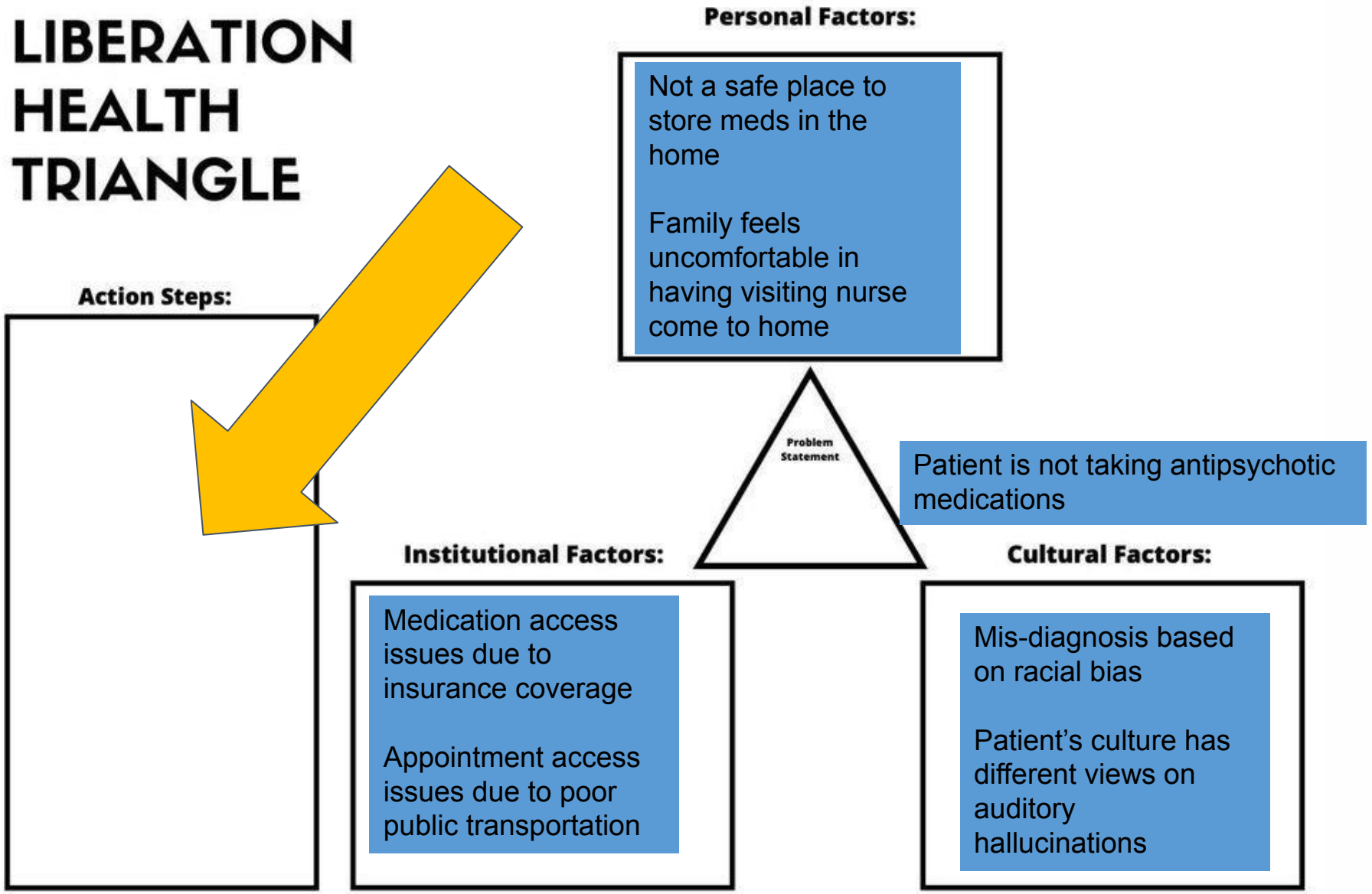

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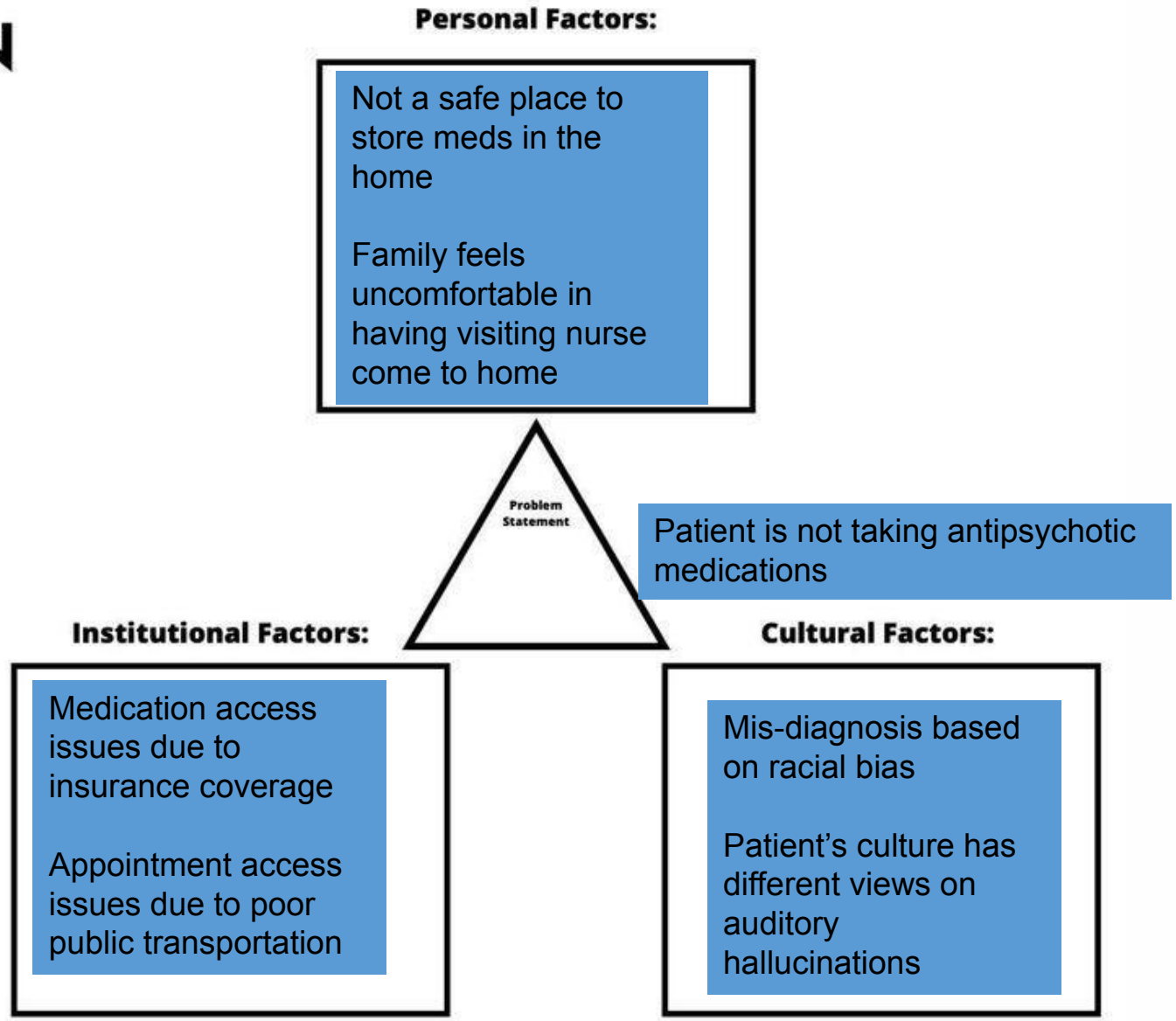


Action Steps:

Complete home visit to help understand medication storage issue

Consider referral to provider who has more cultural awareness, shares culture/identity with family

Help address insurance/ transportation barriers

Consider more holistic approaches to address hallucinations (acupuncture, yoga, etc)

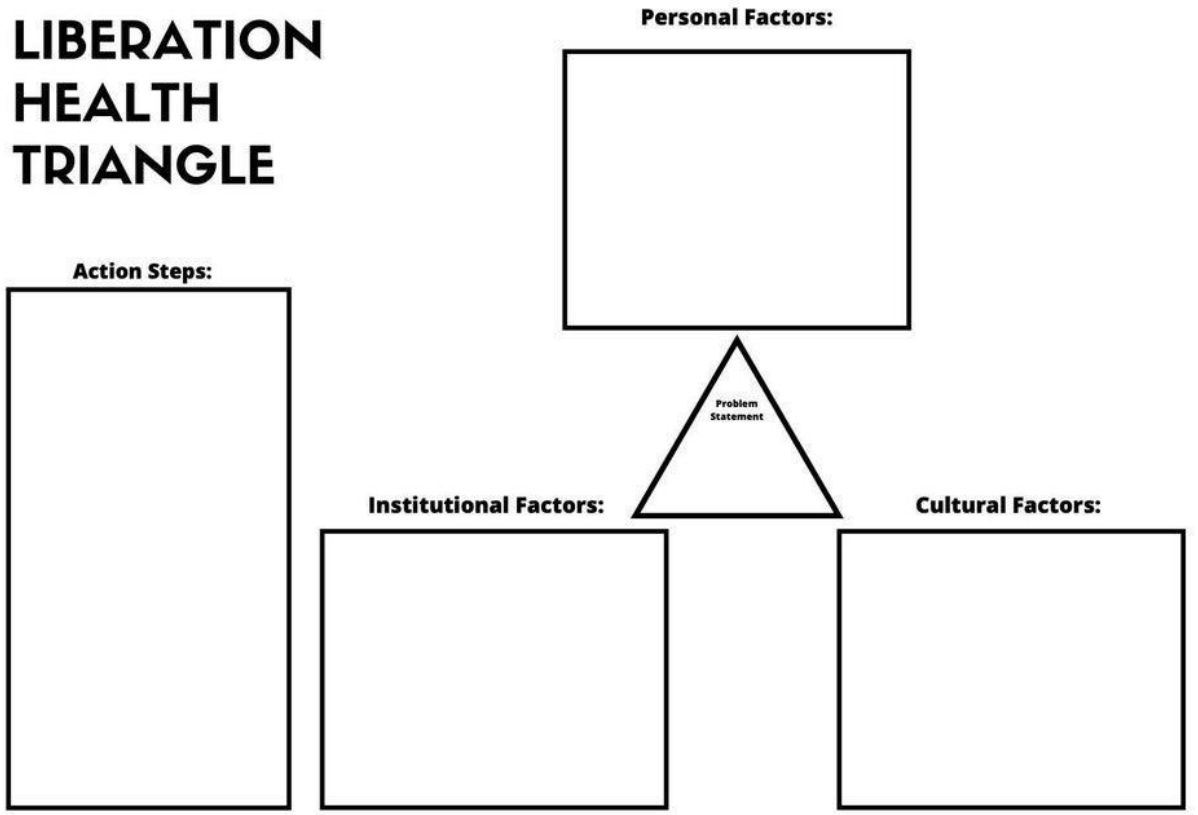
Challenge the thinking that AH/VH are a deficit

Groupwork: Racial Equity Case Studies

- Small groups in breakout rooms
- Each team is assigned one scenario where racial equity issues/power dynamics come up with care team or within client's care plan. Please name the issues at play and practical ways to mitigate them using the Liberation Health Triangle Framework.
- One scribe for each team will briefly report back highlights to the full group

A young adult gay male who is undocumented and first generation American of Dominican parents (Afro-Latinx), and came to the US when he was 11. While in public high school student he faced bullying at school for his gender expression & sexuality. His family is supportive of him. He has a diagnosis of bipolar disorder (including past hospitalization & suicide attempts). He's been arrested several times for possession of weed/dealing and his family is at risk of losing their subsidized apartment if he's convicted. His family is also worried about him smoking because it exacerbates severe asthma he's had since childhood (triggered also by stress, dogs, & air pollutants).

He's referred to you as a CHW for support with navigating safer sex, stabilizing mental health, and reducing ER visits for not being able to breathe.



What are you seeing?

- What kinds of mental health issues are most common with your population?
- How has this changed since COVID, if at all?
- Which strategies of working with these clients have you found most helpful?
- What are the biggest unmet needs you see for this population?
- What makes you proud of your work with this population?
- What are the biggest challenges for you in successfully accompanying folks with MH issues?

CHW Approach with BH Clients:

- Relational
- Tailored
- Holistic
- Non-judgmental (combat stigma)
- Reliable
- Curious
- Culturally-informed
- Collaborative
- Bettencourt's big 3: empathy, curiosity, & respect

These are helpful approaches for all CHWs but more essential when working with BH clients who likely have trauma, tricky behaviors, & negative past experiences in care.

Challenging the stigma of mental illness

- Most people will have some symptoms in their lives of depression, anxiety, or PTSD.
- Many are normal responses to stress in life that get exaggerated and become a problem (i.e. stress response).
- It becomes a diagnosable issue when it won't go away, causes serious distress, or impacts ADLs.

Causes? Some theories:

- We don’t really know!
- Family history/upbringing
- Genes/biology
- Environment
- Life stressors
- Spiritual crisis
- Suffering turned vs. the self
- Response to oppression/structural inequality

MH Challenges

- Stigma (pathology framework)
- Healing is a long-term process!
- Broken or inaccessible systems of care
- Multiple issues: dual diagnosis, chronic diseases, poverty
- Agencies under stress: staff turnover, unreliable funding, heavy documentation, unclear roles, limited support
- Clients with MH issues may trigger us into defensive behaviors that lead to burnout (overwork, rescuing, what else?)
- Larger context: income inequality, sexism, structural racism, war on drugs
- Systems of care are often culturally-mismatched and/or retraumatizing for clients

Protective Factors

- Social support: non-judgmental family (biological or chosen), community, friends, and pets
- Sense of “belonging”: can be social, spiritual, with nature, etc.
- One trusted adult = central to resilience for kids going through trauma/stress
- Positive meaning-making:
  - Being able to name external factors in the problems rather than blaming oneself or being overtaken by guilt/shame
  - Seeing an issue as **situational** rather than about one’s character
  - Finding learning or growth in challenges
- Resonant coping skills: may be learned from others or developed through trial and error
- Normalizing the problems: when people know others who talk openly and respectfully about a challenge, it’s often easier to cope/feel less alone or overwhelmed.

Lunch time!

While having lunch look through your assigned Healthy Conversations chapter!

Depression (pg. 83-90)
OR
Anxiety (pg. 91-105)

Module 2:
Mental Health Concepts & Practice

Module 2 Learning Goals

- CHWs will be able to recognize and name symptoms of the 3 most common mental health diagnosis (depression, anxiety, PTSD) and specific strategies to work with them.
- CHWs will learn about & practice culturally-informed, non-stigmatizing ways to assess clients' symptoms, needs, and readiness for care.
- CHWs will understand and work with mental health issues contextually & structurally, rather than as purely biopsychosocial, and respond strategically & skillfully to both aspects. With specific clients, CHWs will be able to name 3 structural/contextual factors underlying their behavioral health symptoms.

Module 2 Objectives

- Participants will be able to name 2 causes, 2 symptoms and 2 coping tools for Depression, Anxiety, and PTSD.
- Participants will be able to name & practice 2 non-stigmatizing approaches to BH assessment & engagement with clients.
- Participants will be able to name 3 common barriers to accessing behavioral health care & 3 specific ways to tackle them as CHWs. CHWs will be able to recognize barriers to engagement in MH care (systemic, agency, cultural, & individual) & have practical tools to tackle them collaboratively.

Small Group MH Topic Review

- “Depression” (pg. 83-90), “Anxiety” (pg. 91-105) “PTSD” (107-122)
- Each group will review assigned chapter with goal of teaching back to the large group

  Include:

  - Definitions
  - symptoms
  - treatments

MH Topic Highlights to Focus on:

Group 1: Depression (pg. 83-90):

- Cheat Sheet pg. 83
- Open questions about client's experience pg. 84
- Symptom list pg. 85
- Real life examples pg. 86
- Causes pg. 87
- Treatment Options pg. 89

Group 2: Anxiety (pg. 91-105):

- Cheat sheet pg. 91
- Open questions about client's experience pg. 92-93
- Symptom list pg. 94
- Types of anxiety pg. 95
- Causes pg. 97
- Smoke alarm analogy pg. 98
- Real life examples pg. 99
- Treatment options pg. 101-102

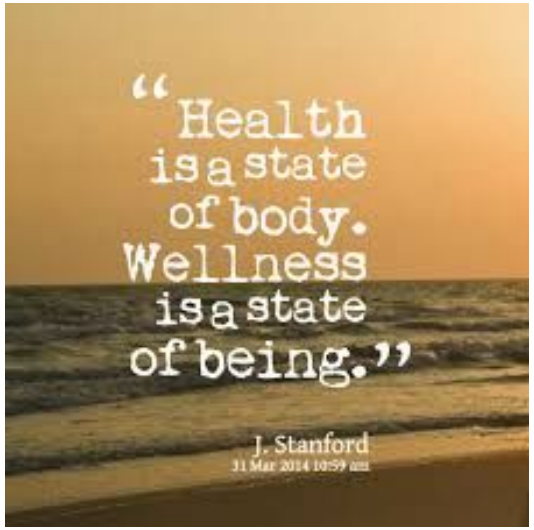

TIME
FOR A
BREAK

Understanding PTSD (pg. 107-122)

- Sharing Experiences
- Key Concepts & Essential Questions
- Pairs Role Play, Activity #1: "Making Treatment Decisions" pg. 120 & Appointment Preparation Worksheet pg. 121-122
- Wrap-Up/Debrief

What is Wellness?

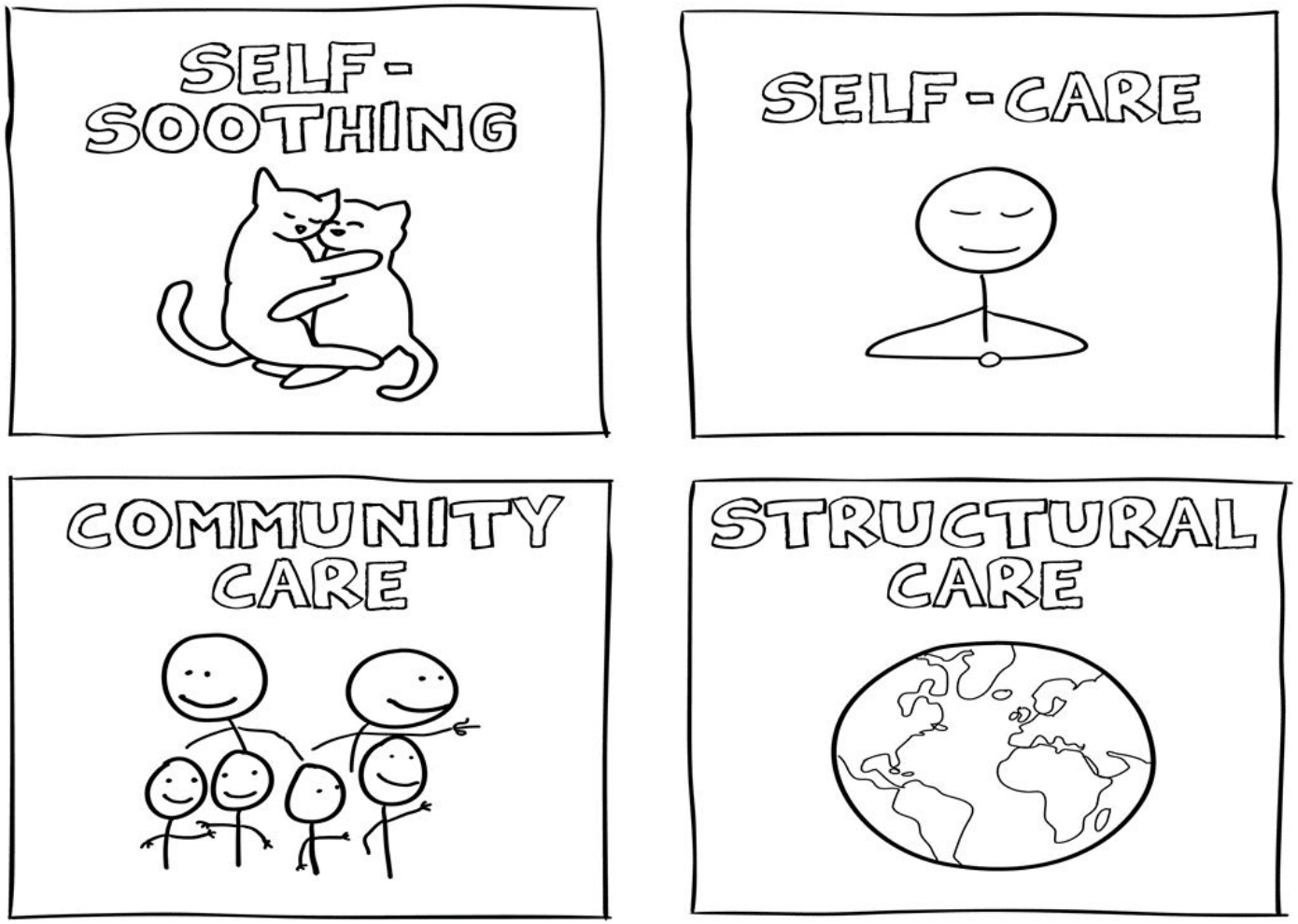
- Health is: not being sick!, variable, may feel out of one's control (meds, genes, etc.), relies on "experts"
- Wellness is:
  - Proactive attitude and set of behaviors to cultivate personal health & happiness
  - Preventative & holistic (mind, body, emotions, and spirit)
  - Striving for balance (not just being "pure")



Our Experiences with Wellness

- How do you do your own self-care?
- How do you talk about self-care with clients?

No single person can do all the kinds of care that are needed all the time; we each can play a role in supporting each other in different ways, though. Now, go forth and care for each other—and yourself.



@deannazandt

Holistic Options (pg. 71)

- Massage/Body Work
- Energy Work/Reiki
- Yoga
- Martial Arts
- Spiritual Practice
- Meditation
- Prayer
- Expressive Arts
- Community Sports

Wellness Content Tour

- Stress Response pg. 41
- Wellness 101 pg. 55
- Attitude is Powerful pg. 189
- Spiritual Coping pg. 199
- Wellness 102 pg. 207

Holistic Trios Practice

In your breakout room group:

- Teach 1 assigned wellness activity
- Practice briefly together
- Debrief the experience

Wellness options (assigned)

- Metta pg. 205-206 Guided Relaxation
- Body Scan pg. 46-47
- Belly Breathing pg. 52-53

Module 2 Wrap-Up

- Round Robin: 1 take-away from today
- Lingering questions
- Assign HC Substance Use Chapter for Next Session:
  - Harm Reduction Approaches (pg. 241-254)
  - I Got Sober (pg. 271-276)
- Evaluations

Module 3: Exploring Substance use & Harm Reduction

Welcome Back!

- Icebreaker & Stretch
- Lingering questions
- Brief review of ground rules & objectives
- Schedule for today
  - Morning SUD/Harm Reduction
  - Lunch 12:30
  - Afternoon: Patient Advocacy and Dual Diagnosis

Group Agreements

- Confidentiality
- Tech Etiquette
- Take Space/Make Space
- 1 Diva 1 Mic
- Respectful Listening/Agree to Disagree
- Assume all experience is in the room
- Positive Risk
- Raise Cultural Concerns/Equity Questions
- Get Your Needs Met
- Own impact first before deciding if you need to explain your intent
- Recognize and own growth and learning
- Have Fun!

Substance Use Module Goals

- To understand substance use as a continuum & a coping strategy worthy of respect & curiosity, rooted in recognizing the individuality & human rights of individuals who have used
- To practice harm reduction as both a practical philosophy centering client autonomy, competence, & strengths and a set of tools to mitigate drug-related harm
- To enable CHWs to help clients navigate a range of substance use treatment options in an informed & effective way
- To **empower CHWs** to take an active role in naming & **dismantling stigma** as a primary barrier to care and trigger for cycles of use
- To capacitate CHWs with tools for assessing clients' use and generating options to increase safety in a collaborative way.

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What are you seeing?

- What drugs do you see used/abused most commonly?
- Which strategies for collaboration have you found most helpful? Has this changed since COVID?
- What are the biggest challenges for you in successfully accompanying folks who use drugs?

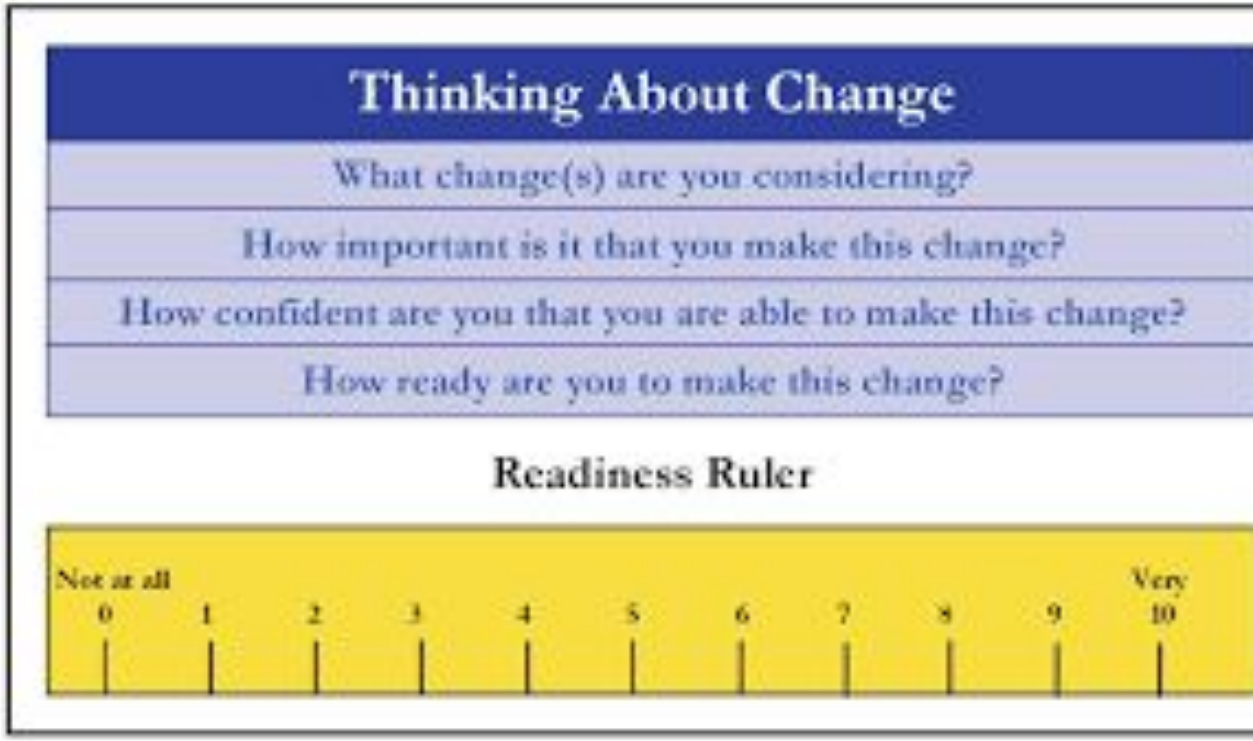
How do you bring up use? How do you ask about substances?

How do you bring up use?

- Once there's rapport, it's important to ask about client's use in a neutral way.
- Explain that your role is to listen and support, not judge or push treatment.
- If client denies or minimizes use, don't challenge them. Let them know you're open to talking about it in the future if they want to.

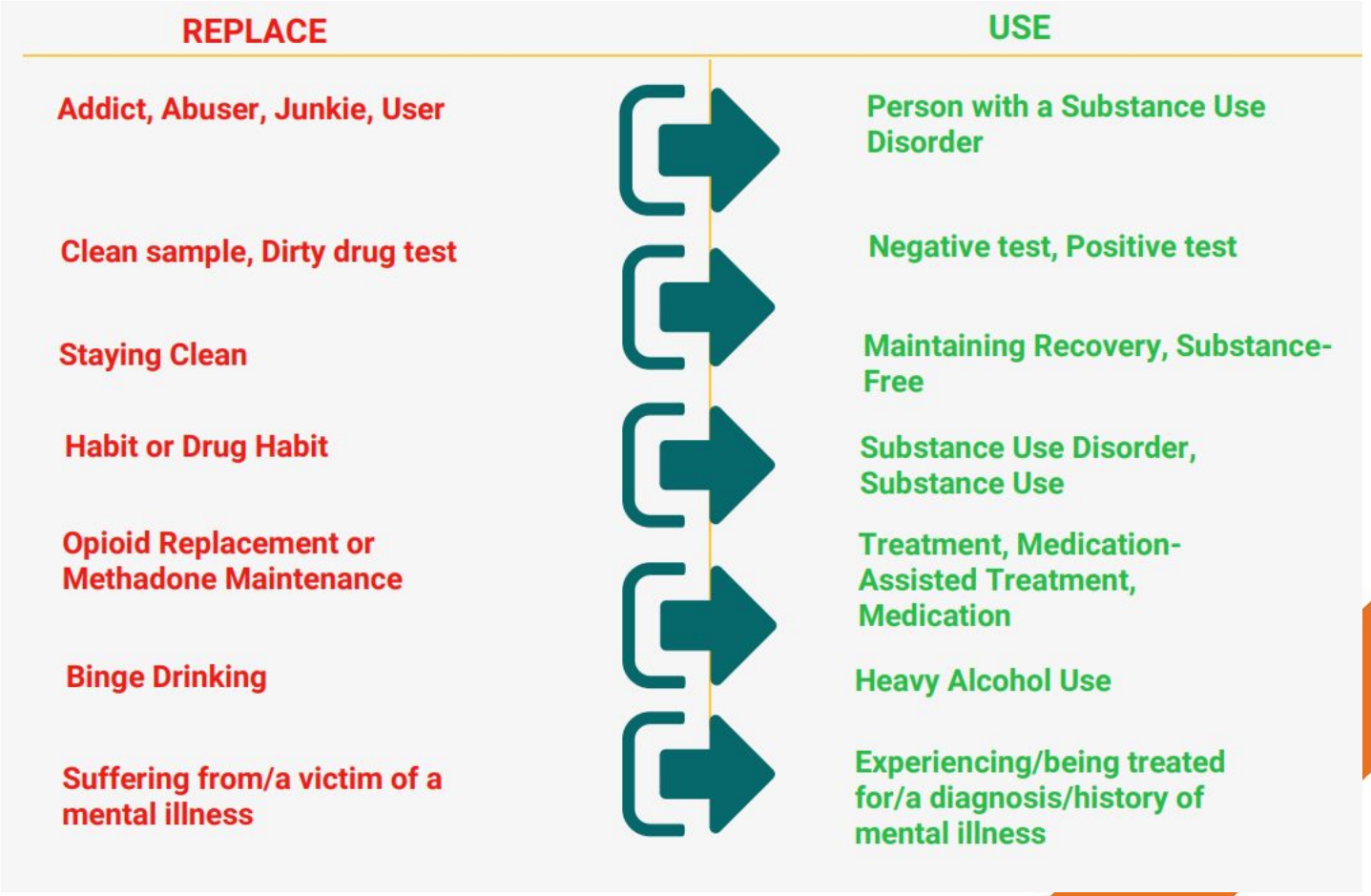
Readiness Ruler

- One tool to engage patients in a conversation about their substance use
- Utilizes motivational interviewing techniques
- *Sample on Page 251 in Healthy Conversations Manual*



Words Matter!

Many people who are unfamiliar with Substance Use Disorder (SUD), may find themselves unintentionally using words that perpetuate negative stigmas. These words shape the opinions of others, reinforce longstanding stereotypes, and have been found to adversely affect quality of care and treatment outcomes. They may also deter help-seeking among those with substance use disorders and their families.



https://www.bchumanservices.net/2016/11/the-language-of-addiction-updated-guide/

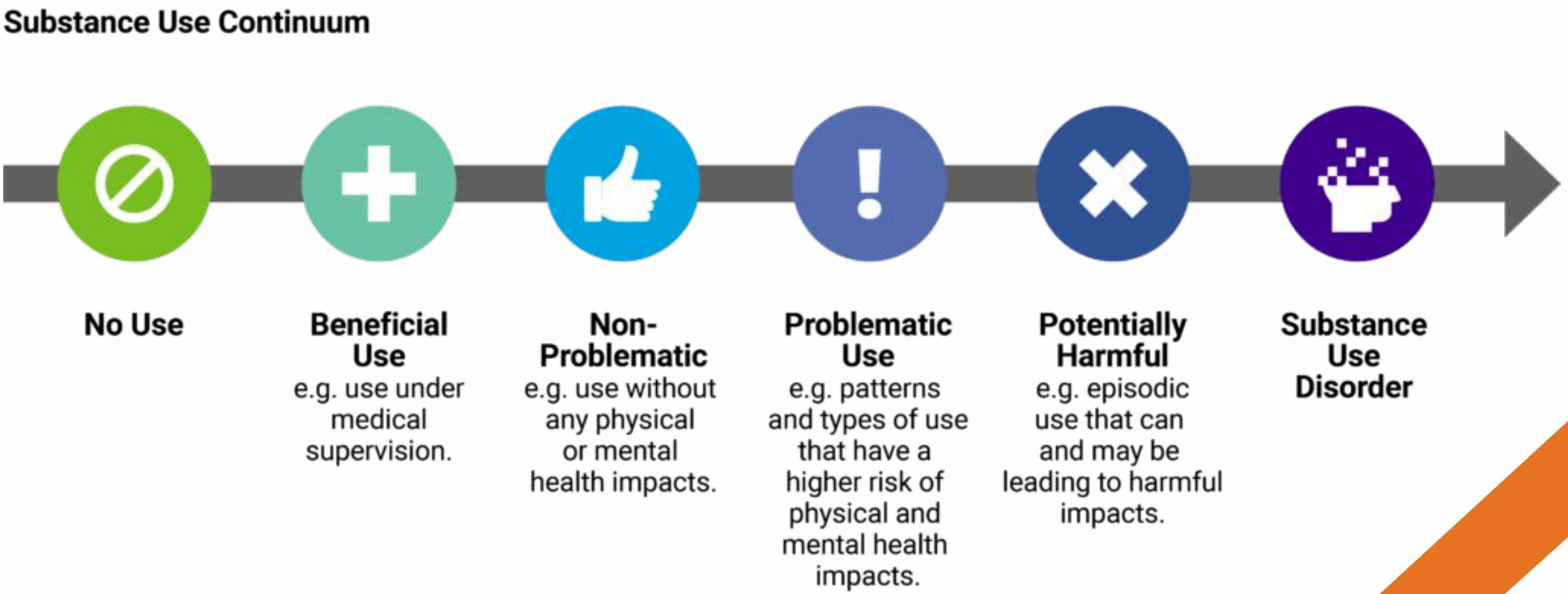
A Note on Terms

- Use vs. Misuse vs. Abuse vs. Substance Use Disorder
- Drug vs. Substance vs. Illicit/Illegal Drug
- Drug User vs. Person Who Uses Drugs
- **Goal:** Non-stigmatizing, person first, humanizing, respectful language
- Different people use/have used substances may prefer different terms
- All humans are substance users (caffeine, sugar, etc) in that we use substances intentionally or habitually for their physical/emotional/psychological effects.

Harm Reduction is…

- Reducing the harm caused by a behavior without stopping completely
- Realizing that clients face many personal, social, & economic barriers to change
- Believing that changes can be made despite these barriers
- Recognizing that even small changes are valuable

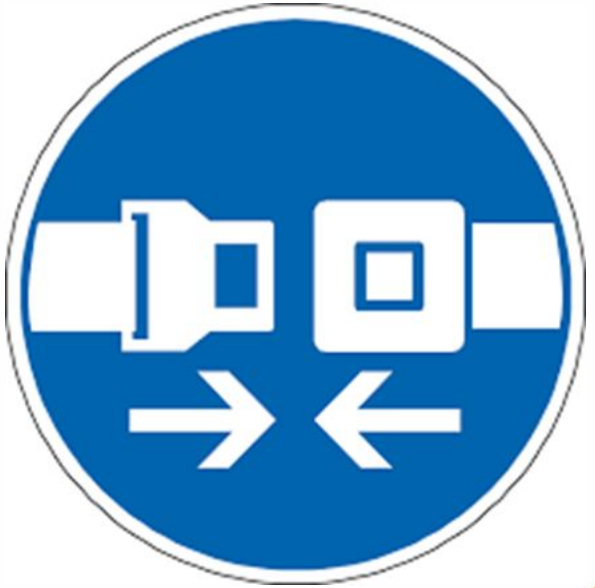
Continuum of Use



Take-Away Points

Harm Reduction includes:

- Understanding the client's unique barriers
- Setting goals that fit for the client now
- Appreciating small changes
- Practicing non-judgement
- Remembering we **all** do things that aren't good for us
- Working with any "unhealthy" behavior



Activity: Harm Reduction Options Brainstorm

- Each team has 8 minutes to come up with as many creative HRM strategies as they can given the below scenarios
- Choose a spokesperson who will present your group's HRM strategies

- A client who you often see on outreach is actively injecting opiates and has history of depression. Today, you don't see him, and he isn't answering his phone.
- A long time active substance user (crack and weed) is freaking out because she got an eviction notice for non-payment of rent.
- A newly diagnosed HIV+ sex worker is concerned both about preventing transmitting HIV and disclosing his status to his partners.
- A young women who was recently diagnosed with depression is drinking in order to cope with her grief and fear.
- A trans peer worker relapsed last week and is afraid she'll lose her job, which she loves.
- A former injection drug users who wants to stay sober, but his partners recently relapsed on crystal

Challenges Managing Substance Use?

- **Stigma/shame** (barrier to honest conversation and seeking help)
- Criminalization of drug use: yields legal complications and intergenerational harm from racial war on drugs
- Substance use may impact health behaviors: adherence to meds, appointments, & self care
- Substances may speed up chronic disease progression (crack & HIV, drinking & liver disease)
- Substance use may create instability (financial, housing, employment) that undermines overall health and intensifies stress.

More Substance Use Challenges

- Substance use is often connected to trauma which unhealed can be a barrier to trust, feeling deserving, & accessing support
- Current & former users may not get needed medication (i.e. meds for pain or anxiety) due to being seen as “med seeking”
- Some needed medical treatment can be a trigger for folks in recovery (i.e. injecting insulin)
- Protecting confidentiality may impede effective care coordination

OARSS Refresher

- **Motivational Interviewing**: Conversational tool to build readiness for small changes based on client's values, priorities, and wishes.
- **OARSS**: MI tools to build rapport, learn about the client, and set realistic & collaborative goals:
  - **O**pen questions
  - **A**ffirmations
  - **R**eflections
  - **S**ummaries
  - **S**ilence

Partner Reflection with OARSS

- In breakout rooms, share an example of practicing harm reduction with yourself or someone in your life *(i.e. going for a walk with diabetic partner instead of nagging them, switching to decaf)*
- **Explore:**
  - How did it work to make a small change?
  - How did you get ready to do it?
  - What were your barriers?
  - How did it feel to change?
  - What supported you in maintaining the change?


15-Minute Break

Discussion- Challenges

Sometimes it is hard working with clients who are putting their health at risk.

- Can you tell us about a time when you felt frustrated or angry when a client who was engaged in unhealthy behavior and didn't make the change?

Working With Our “Stuff”

aka Counter-Transference

- What if we support clients in making the small changes they are ready for, but that’s not enough to avoid serious consequences?
- How might we feel & how can we sit with it?
- How do we work with the stress of our work during this pandemic?

Watch out for...

- Our personal beliefs re: drug use
- Our history of use/recovery
- Family issues with addiction
- Internalized social stigma re: use
- **Check yourself & respect your client to earn trust.**

Substance Use Treatment

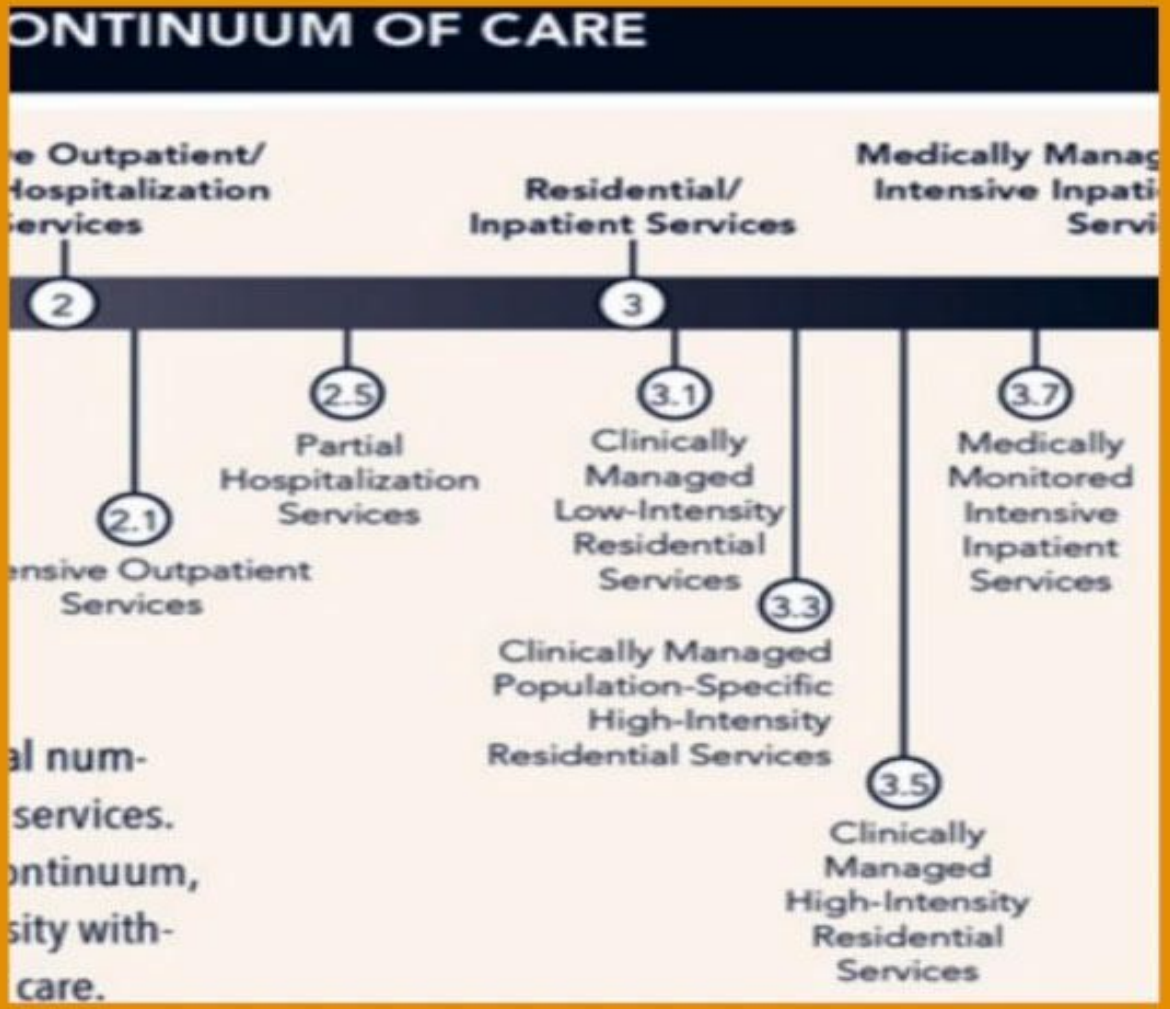
Name one kind of support for
risk reduction, substance use treatment, or sustaining
recovery that people choose and tell us how it can be helpful.

(example: a smoking cessation group)

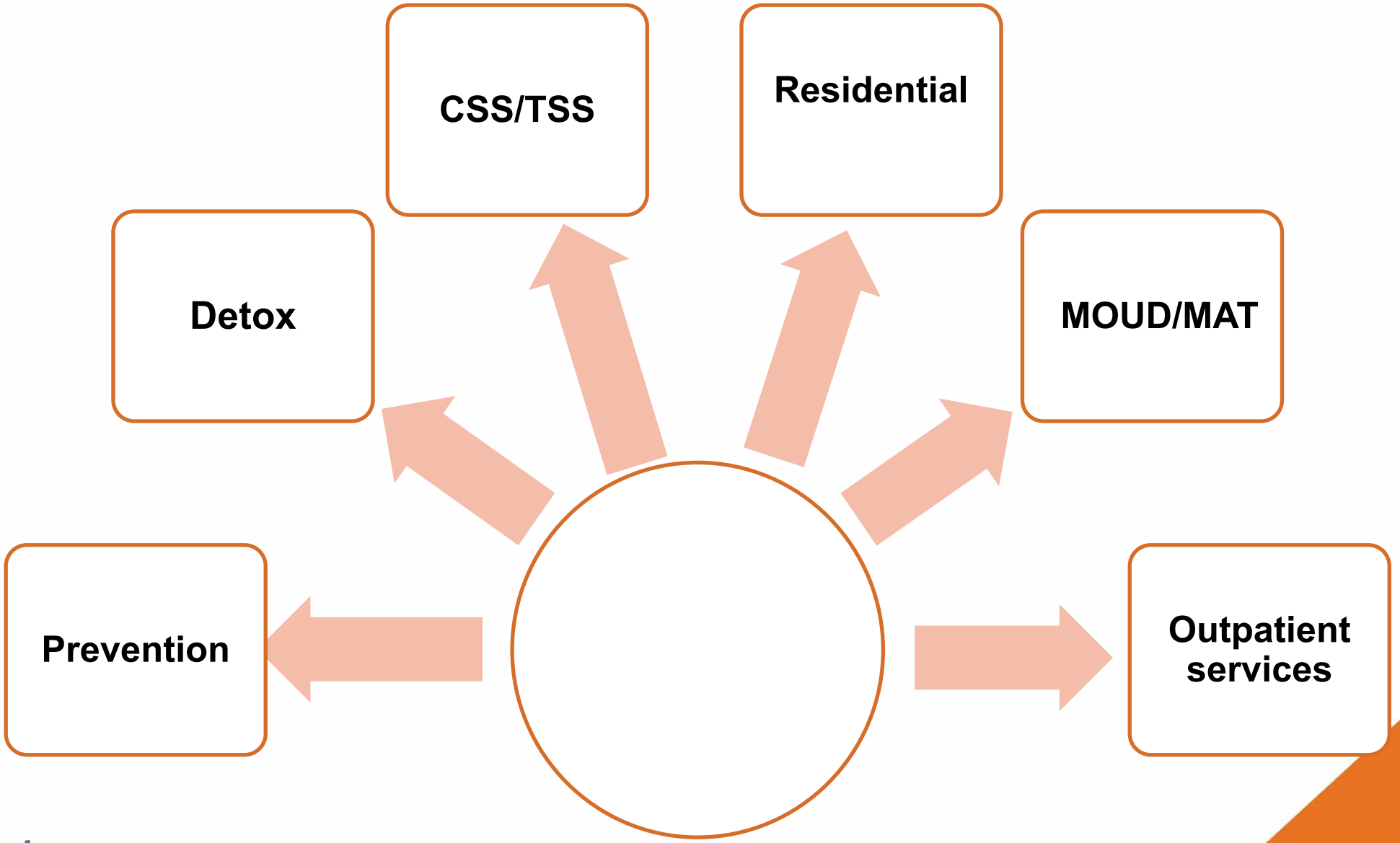
Substance Use Treatment (pg. 255-263)

- Curriculum Context
- Key Concepts & Essential Questions
- Trios Role Play: Activity #2 “Treatment Map” pg. 262
- Wrap-Up/Debrief

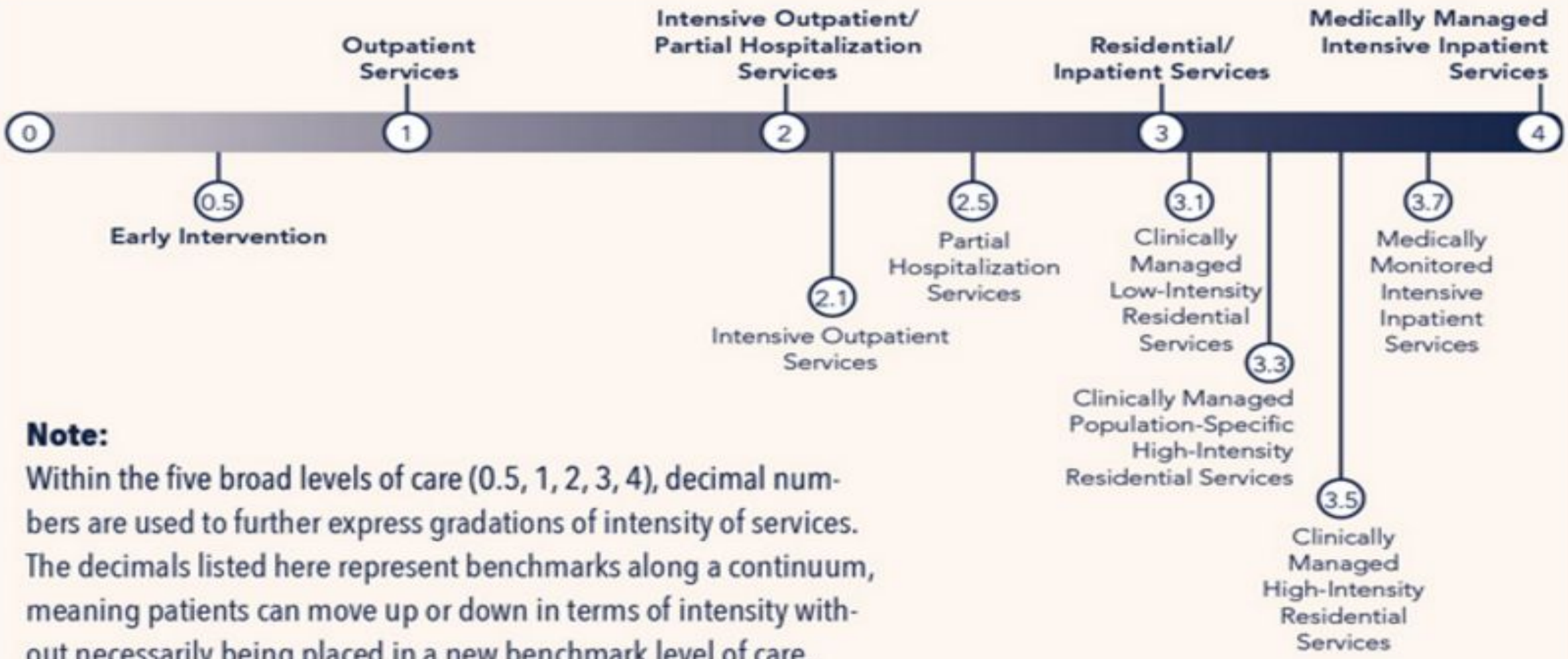
Treatment map role-play video



Substance Use Treatment



REFLECTING A CONTINUUM OF CARE



Note:

Within the five broad levels of care (0.5, 1, 2, 3, 4), decimal numbers are used to further express gradations of intensity of services. The decimals listed here represent benchmarks along a continuum, meaning patients can move up or down in terms of intensity without necessarily being placed in a new benchmark level of care.

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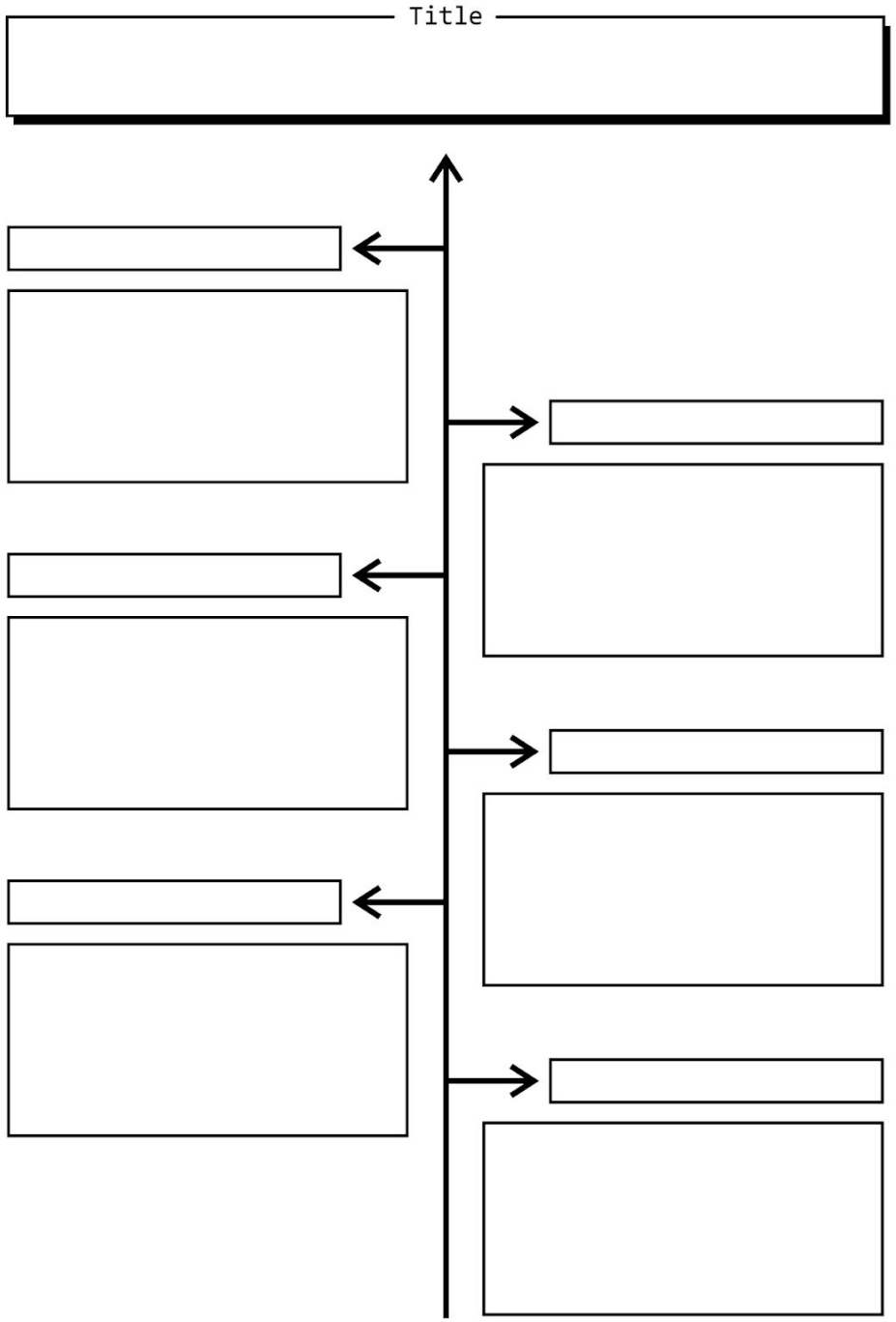
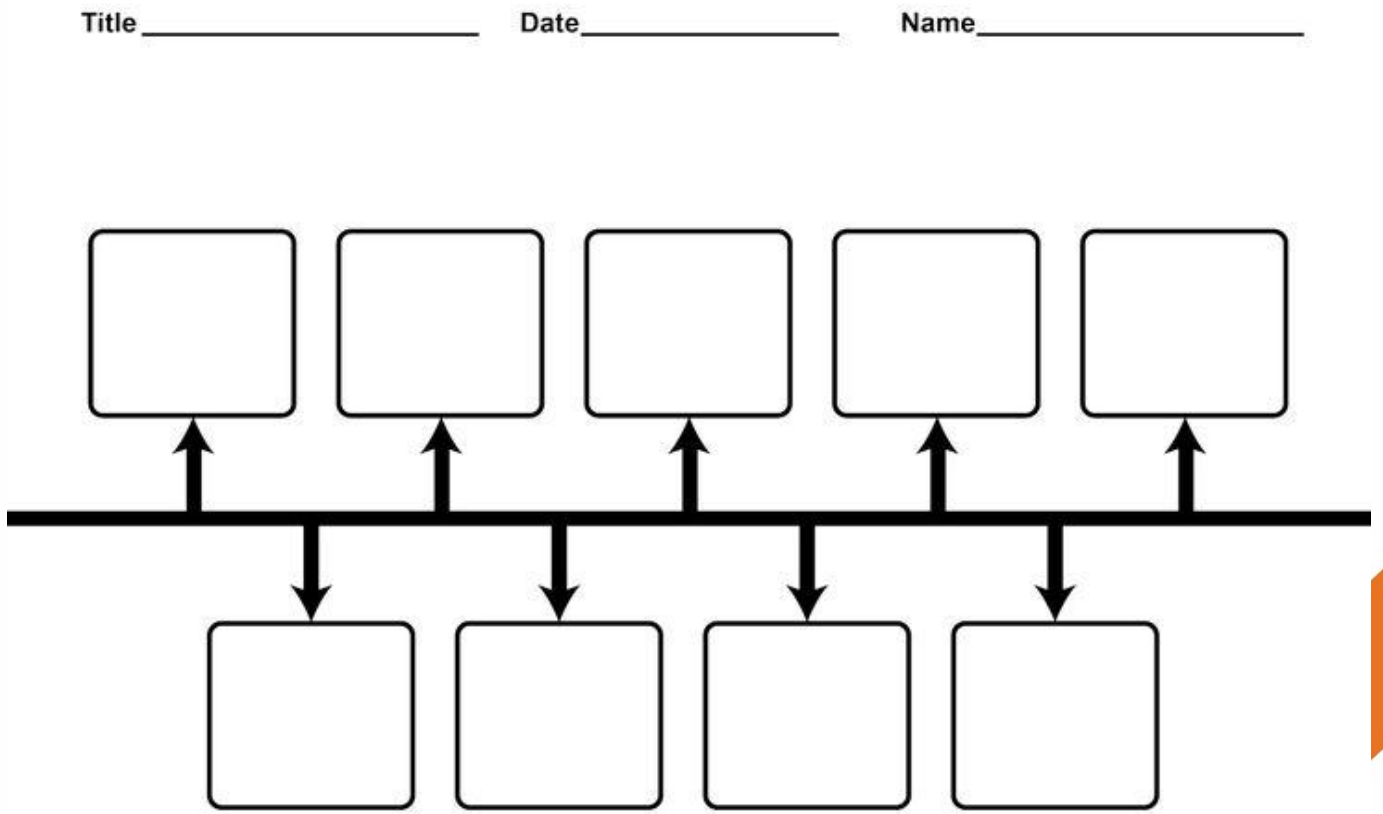
Treatment Roadmap Samples





Treatment Roadmap Sample

ATS
Acute Treatment Services (detox)

Appx Date/Time Period	Treatment/Event	Experience
Fall 2018	Detox Worcester, MA	Rude staff, physically uncomfortable, left after 2 days
Fall 2018	Detox Tewksbury MA	Nice place/staff, completed detox
Xmas 2019	Relapsed at family holiday party	Shame, guilt, drama w/ family
January 2020	Bradston St Methadone Clinic	Started on methadone, news year resolution
Spring 2020	NA meetings	Identified home meeting, started attending, got sponsor, feeling hopeful
Summer 2020	Detox Boston, MA	Relapsed, kicked out of methadone clinic, difficult after several months of sobriety, felt horrible, let my daughter down
Summer 2020	Weymouth CSS/TSS	Went right from detox into program, felt good to stick with it
August 2020	Hello House Residential Tx	Entered residential treatment, feeling really good, got part time job, allowed visitations with daughter, worried about losing everything again

MOUD
Medication for Opioid Use Disorder

12 Step/Peer led groups
(NA, AA, etc)

CSS/TSS post-detoxification residential treatment intervention

Long term residential treatment

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Substance Use Curriculum Content to Focus on:

Group 1: Harm Reduction Approaches (pg. 241-254):

- HRM key points pg. 242
- Current Use Assessment Tool pg. 243 and Debrief Questions pg. 244
- OD Prevention key points pg. 245-246
- Safer injection/smoking key points pg. 247-250
- Safer use tips sheet pg. 252

Group 2: I Got Sober (pg. 271-276):

- Cheat sheet pg. 271
- Open questions about client's recovery pg. 272
- Key points pg. 273
- Activities: Role model pg. 274 and Resources/Triggers pg. 275

Small Group Substance Use Topic Review

Healthy Conversations Curriculum Chapter Group Review questions:

- What are 3-5 key points from the chapter?
- What questions do you have on the material?
- How might you use this material with clients?
- (Optional) Lead group in 1 activity from the chapter as if we were your clients

Harm Reduction as a Tool vs. Oppression

- Marginalized people cope with microaggressions & **cumulative trauma** that pile up & create suffering.
- Most "risky" behaviors are a strategy to cope with the harm associated with inequality (poverty, violence, stigma)
- **Root cause = interpersonal, internalized, institutional, & structural inequality**
- *Related to: race, gender, sexual orientation, gender expression, national origin, physical ability, or class*

If we understand drug use, risky sex, or smoking as logical coping tools in this larger context, how does that change our work?

Context Matters Because it Helps us…

- Avoid blaming clients for their problems (focus on context not just individual behavior)
- Avoid blaming ourselves for being unable to make bigger changes in broken, racially-biased systems
- Expand empathy for all involved
- Help clients process and let go of internalized stigma holding them back & recognize systemic barriers to their thriving
- Empowers us as advocates to be honest, powerful voices for addressing institutional inequality
- Be part of a larger movement to change attitudes & the social systems that perpetuate disparities

Lunch Time

- Lingering questions
- Assign Healthy Conversation Chapters to review over lunch:
  - SU Provider Teams pg. 263-270
  - Ready for Treatment pg. 133-146

Module 4:

Advocacy & Integrating what you have learned into your practice

Welcome to Module 4!

- Icebreaker *(Advocate you admire & why)*
- Thoughts/Questions from Prior Modules

Group Agreements

- Confidentiality
- Tech Etiquette
- Take Space/Make Space
- 1 Diva 1 Mic
- Respectful Listening/Agree to Disagree
- Assume all experience is in the room
- Positive Risk
- Raise Cultural Concerns/Equity Questions
- Get Your Needs Met
- Own impact first before deciding if you need to explain your intent
- Recognize and own growth and learning
- Have Fun!

Module 4: Learning Goals

- CHWs will identify common barriers to accessing care (personal, cultural, and systemic) and effective strategies for tackling them.
- CHWs will understand the basics of how Behavioral Health care teams/systems work to facilitate effective navigation.
- CHWs will be able to acknowledge power dynamics and turf issues among care teams and reflect on ways to approach them with equanimity (inner confidence) and client-centered advocacy skills
- CHWs will increase confidence and skill in advocating clearly, professionally, tenaciously, and with client consent and participation
- CHWs will acknowledge and reflect on ways that client experiences of marginalization may echo and trigger the CHW's own experiences and how to cope with that proactively as a resource for empathy and action

Module 4: Learning Objectives

- Participants will be able to identify 5 common barriers to accessing care (barriers could be personal, systemic, or community-based).
- Participants will be able to define 5 key players and their roles in Behavioral Health teams.
- Participants will be able to identify two ways power dynamics show up on care teams and two strategies to address them in service to the clients.
- Participants will demonstrate skill and report confidence in their client advocacy skills.
- Participants will be able to name two meaningful ways their lived experience impacts their client care and two concrete ways to safeguard both the CHW and the client from related harm.

Assessment Conversation: Advocacy Skills & Barriers

- What skills & qualities make a CHW a strong advocate?
- What are some of your strengths and growth areas as an advocate?
- What kind of barriers to care do you feel most comfortable addressing with care teams? Which kind are harder to tackle and why?
- How do you address racial disparity issues in your role? Pros/cons to direct vs. indirect approach
- How do you handle “turf”/power issues that come up with medical providers?
- What would help you feel more confident in your advocacy role?

Advocacy in BH Systems Tips

- Proactively build relationships with all players involved & identify allies
- Frame concerns in terms of client needs and treatment goals; emphasize shared vision & values with the team
- Understand your role/limits and be able to explain them well to other stakeholders
- Strategic persistence
- Go up the food chain as needed
- Draw on peer and supervisor support, also clinical supervision
- Know your worth & the value of your work
- “Take no shit & don’t take shit personally!”
- Practice asking questions and giving feedback in a clear, non-blaming way


BREAK

Feedback & You

- How do you like to hear feedback?
- What bugs you in getting feedback?
- What's important about giving feedback?
- Any examples to share?

Effective Feedback

- Be specific!
- Start with the positive & give generously
- Limit critical feedback to a few things
- Always be respectful & empathetic
- Present it as your perspective, not the “truth”
- If you’re emotional/heated, wait until later to share
- Give feedback privately & in a moment staff will be more able to hear it non-defensively

What does “patient advocacy” mean to you?

Advocacy Skills Practice: Feedback Circle

- Scenarios where CHWs need to give feedback to teammates, supervisors, or other providers regarding client care around cultural competence, harm reduction, racial equity, or being client-centered
- Debrief:
  - For you, what is easy or hard about giving feedback to your colleagues?
  - How can you continue to practice these skills?

Small Group Advocacy Topic Review

Assign SU Provider Teams (pg. 263-270) & Ready for TX (pg. 133-146) to two teams to read, summarize, & present back. (One trainer will sit with each group as support during reading, discussion, & prep).

HC Curriculum Chapter Group Review questions:

- What are 3-5 key points from the chapter?
- What questions do you have on the material?
- How might you use this material with clients?
- Lead the group in 1 activity from the chapter as if we were your clients

HC Chapter Highlights to Focus on

Group 1: SU Provider Teams (pg. 263-270):

- Provider Team Goals pg. 264
- Team members pg. 265-266
- "Who should I call" activity pg. 267-268
- Options for working together pg. 269

Group 2: Ready for TX (pg. 133-146):

- Open questions and teaching points re: client's tx experiences pg. 134
- Treatment myths and facts pg. 137-138
- Assessing impact of MH symptoms pg. 139-140
- Case examples pg. 141-142
- "Who's really talking?" activity and chart pg. 143-144
- Treatment decision worksheet pg. 146

Dual Diagnosis

- Sharing Experiences
- Reading Curriculum Context
  - Case study pg. 278
  - Key points pg. 279
  - Swimming analogy pg. 280
- Key Concepts & Essential Questions
- Wrap-Up/Debrief

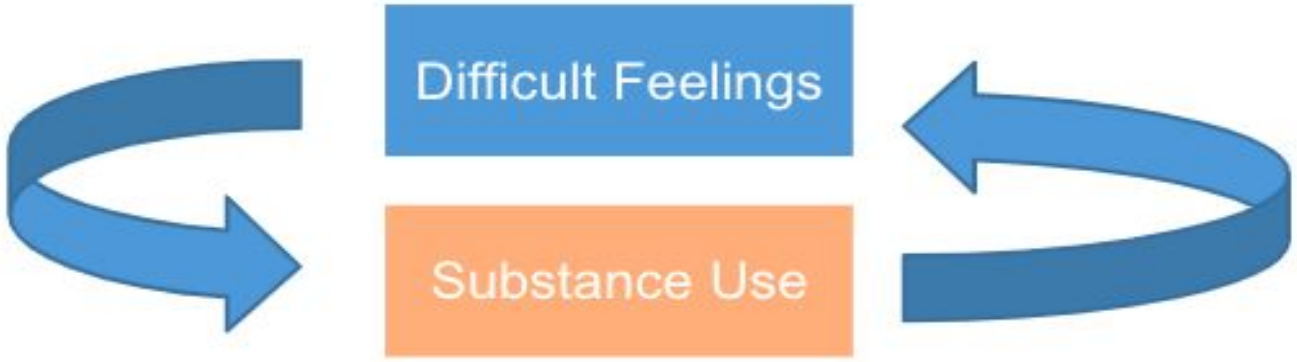
Scenario Page 278

Sandra has been smoking crack for many years. She also survived physical abuse as a child and adult, and often feels very depressed and down. She says the crack helps distract her from the pain of her memories and from her shame about losing custody of her children. When she decided to try to stop using, she went to a drug treatment program near her apartment where they focused on triggers and avoiding her drug friends, and encouraged her to go to AA meetings.

However, whenever she tried to stop using, she would feel flooded with sad feelings and panic about all the bad choices she felt she had made, and she would eventually start using again because all those symptoms of mental illness were still there and not being addressed at the drug treatment program. Sandra needed a program that could help her manage multiple sides of her challenge: the abuse history, the depression, and the addiction.

ANALOGY: Having mental health issues is like trying to swim in rough seas. It's hard to be steady and keep your head above water with such big waves. Dealing with addiction is like trying to swim with all your clothes on and heavy shoes. Either one of those things alone make it harder to swim and more likely you might drown. The swimmer gets more tired and overwhelmed than someone swimming on a calm sunny day (someone without mental health issues) or in just a swimsuit (someone without addiction issues). If you have a dual diagnosis, it's like trying to swim in a storm with all your clothes on. Some programs say you have to deal with the substance abuse first— basically take off the heavy clothes so they can see how well you can actually swim.

What the swimmer needs is a life preserver—something to help you float until you can get out of the heavy clothes (addiction) and find a stable boat (treatment) or improve your swimming skills to deal with the choppy seas (mental health issues). Ideally dual-diagnosis treatment is a life raft—to help you get safe and stable enough to address both issues together.



Series Wrap-Up & Group Reflection

- How does this training inform or support your work around the 4 areas of BH integration?
  - Baseline BH knowledge
  - Advocacy and communication skills
  - Sustainable approaches to CHW work and wellness
  - Naming and working against systemic barriers and bias
- What felt most and least useful/meaningful?
- What did you learn here that will be most helpful to your clients?

Wrap-Up

- Lingering questions
- Evaluations
- Be in touch with Deb at Deborah.Goldfarb@bmc.org and Devorath at devorathruiz@gmail.com
- ABCD Training questions/concerns:

  email Erin at erin.mcsweeney@bostonabcd.org
- Erin will send certificates of completion to your email

Mental Health Treatment Options

- Brainstorm Activity
- Reading Curriculum Context
- Key Concepts & Essential Questions
- Relay Role Play: “Who Can Help” pg. 156
- Wrap-Up/Debrief

Group Work: Trios role play to tie all these pieces together

- Tailored case studies in trios: analyze client barriers, resources, interventions, and goals; then role play with 1 CHW, 1 client, and an observer giving feedback sharing 1) what did they do well 2) what could be improved
- Use case scenario in chat
- Teams choose one of the interactivities from the “Managing My Health” chapter to use in their role play:
  - Impact of My Behaviors pg. 126-127
  - Health Change Plan pg. 129-130
  - Social Support Mapping pg. 131-132