



# Mental Health Services Act Prevention & Early Intervention

## COMMUNITY REPORT EXECUTIVE SUMMARY COVERSHEET

Instructions:

1. Please use this form as a cover to any report you want to submit for review by the PEI Planning Panels.
2. Email this completed form and an electronic version of your report (Word document or PDF) to [mhsa@acbhcs.org](mailto:mhsa@acbhcs.org) no later than December 14, 2007.

Organization\* (if applicable) Alameda County Public Health Department, Improving Pregnancy Outcomes Program  
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*\*Please attach a list of all groups and organizations that contributed to this report.*

### What age group does your organization serve or represent?

- Children & Youth (0-18)       Transition Age Youth (14-25)       Adults (18-59)       Older Adults (60+)
- (0-2)**

### Under each category, choose the item your report **PRIMARILY** addresses:

#### Key Community Mental Health Needs

- Disparities in Access to Mental Health Services       Stigma and Discrimination  
 Psycho-Social Impact of Trauma       Suicide Risk  
 At-Risk Children, Youth and Young Adult Populations

#### Priority Populations

- Underserved Cultural Populations  
 Individuals Experiencing Onset of Serious Psychiatric Illness  
 Children/Youth in Stressed Families  
 Trauma-Exposed  
 Children/Youth at Risk for School Failure  
 Children and Youth at Risk of Juvenile Justice Involvement

## **Community Report EXECUTIVE SUMMARY**

### **SECTION I – ORGANIZATIONAL BACKGROUND**

The Improving Pregnancy Outcomes Program (IPOP) is a program of the Alameda County Public Health Department's Maternal, Paternal, Child, and Adolescent Health (MPCAH) Section. The goal of IPOP is to reduce infant mortality and improve birth outcomes among low-income, African Americans in targeted zip codes in Oakland, San Leandro, and Emeryville, California. The MPCAH mission is to support activities that promote the health of mothers, children and families. In 2004, MPCAH identified mental health as one of its top five priority issues.

#### *IPOP Services*

IPOP provides one-on-one and in-home case management/care coordination services to pregnant and parenting African American women with high medical and social risk factors whose income is 200% or below the federal poverty level (\$3,333 for a family of four). Case management/care coordination services are provided by public health nurses and community health outreach workers. As part of case management/care coordination services clients are screened for depression and referred for assessment and treatment.

In addition to case management/care coordination services, IPOP provides community education and fatherhood services to reproductive-age African American women and men in the community-at-large. During 2006, some of its community education activities have included psycho-educational workshops to help de-stigmatize mental health services and to provide participants with cognitive therapy techniques to address their depression.

IPOP also promotes system change. It has supported the promotion of linkages between perinatal providers and substance abuse treatment providers to enhance the screening, assessment, referral, and treatment for substance abuse among pregnant women. Its staff is part of the Alameda County Perinatal Substance Abuse Task Force which has promoted the use of a common perinatal substance abuse screening and assessment tool by obstetrical providers in Alameda County. In 2008, it is projected that mental health screening questions will be added to the perinatal substance abuse screen to identify pregnant women who may be depressed.

### **SECTION II – DATA SOURCES**

#### *Focus Groups*

A series of four focus groups were conducted in Oakland, California on July 30, 2002, July 31, 2002 and August 14, 2002, to identify messages that could help decrease infant mortality, promote early entry into prenatal care, and improve pregnancy outcomes. Focus group members were African American pregnant and parenting women between the ages of 15 and 49, living in the IPOP target zip code areas. All participants were either drug users or non-drug users who had given birth to low birth weight, very low birth weight or premature infants within the last two years and were currently parenting those children. Each focus group had 8-10 participants

Most women in every group said they experienced depression at some point before their pregnancy, during their pregnancy, and after their delivery. They noted the lack of family support, lack of stability, not being financially ready, and being overwhelmed as causes of their depression. Although they noticed the symptoms of depression, most did not seek professional help and said instead they just worked their way through it or called on family members.

#### *IPOP Depression Screen Results*

IPOP uses the Edinburgh Postnatal Depression Scale to screen pregnant and parenting women for depression. In the 2006 calendar year, 26.7% of IPOP's pregnant clients screened positive for depression.

#### *Results of Consumer Task Force Input*

Members of the IPOP Consumer Task Force told IPOP staff that among African Americans, the stigma attached to needing mental health support was far greater than the stigma attached to being a drug user/addict. As a race, they self-described as particularly distrusting of non-African American mental health professionals and indicated they did not feel comfortable sharing details of their personal lives. They also recommended that program descriptions be worded in more positive ways, such as *learn how to enjoy life*, rather than, *learn how to reduce stress*; and replace the word 'workshops' with 'gatherings'.

From 2004 to 2006, based on the above, IPOP successfully conducted short-term, afro-centric mental health programs to address each of two concerns: the community-wide stigmatization of mental health services, and the unwillingness of IPOP clients to seek treatment when available and needed.

#### *Results of IPOP's Community Mental Health Promotion/Education Campaign:*

In September 2006, IPOP piloted *Sistah2Sistah*, a psycho-educational workshop series, to address mental health issues among low-income African American pregnant and parenting women. These sessions were facilitated by Dr. Brenda Wade, Ph.D., a San Francisco-based psychologist. An analysis of evaluation responses to the six-week series was very promising. For example, on a scale of 1-10 (with 10 being the highest score possible), the participants gave the workshops an average score of 9.6. Overall, participant responses to questions were very positive. For example, when asked: *After participating in this group workshop, I feel more comfortable seeking help for my mental and emotional well-being* (possible responses were: strongly agree, agree, neither agree or disagree, disagree, and strongly disagree), participants responded: Strongly agree: 80%, Agree: 13%, and Neither agree or disagree: 7%. See Community Report, page 14.

#### *Results of Home-Based Mental Health Assessment & Treatment Mental Services Offered by IPOP*

In an attempt to fill a critical mental health service gap and address the difficulties experienced by clients who were reluctant to seek assessment and treatment services, a mental health clinician was added to the IPOP home-visiting team of nurses and case coordinators for eight months between September 2004 and May 2005. The goal was to improve maternal and child mental health outcomes through assessment and treatment of mental health disorders among perinatal clients. The clinician provided direct mental health services to clients, in the form of home visiting psychotherapy. It included intake, assessment, relationship building, and brief treatment. The brief treatment process included stabilizing crises, coaching, educating clients about the mental health process, empowering clients to have better relationships, mobilizing clients to change, providing referrals for psychiatric evaluation, and facilitating linkages to more intensive longer-term treatment/adjunctive services as needed. In-home

therapy was an effective, efficient way to address mental illness stigma, transportation, and child care problems; the primary barriers to mental health care for IPOP's target population.

### **SECTION III – RECOMMENDATIONS**

To address the mental health needs of low income African American pregnant and parenting women, their children and families by providing in-home psychotherapy services and community-based psycho-educational sessions.

#### *Local Community Health Need To Be Addressed: Stigma and Discrimination*

According to the 1999 Surgeon General's Report, an extensive review of mental health research concluded that one in five Americans has a mental disorder, and that most never seek treatment despite the availability of effective treatments.<sup>1</sup> The report identified the lack of insurance coverage and fear of the stigma attached to mental illness as two major reasons for undiagnosed and/or untreated mental illness. In 2001, results from two research surveys affirmed the need for public education that will lead to more awareness and de-stigmatization of mental illness.<sup>1</sup> Racial/ethnic disparities are indicated in local mental health data, substantiating the need for a targeted mental health community education campaign.

#### *Priority Populations To Be Served: Underserved Cultural Populations*

##### *(Early Interventions for Low Income African American Women, Men and Children)*

The Improving Pregnancy Outcomes Program gives its voice and offers its experience and support for the development of individual and group activities targeting low income African American pregnant and parenting women, their children and families. African Americans are particularly over-represented in high-need populations at-risk for mental illness such as the homeless, incarcerated, foster care/child welfare, and violence-exposed populations.<sup>1</sup> Moreover, a growing body of research argues that racism can adversely affect the mental health of African Americans through multiple pathways, resulting in higher levels of psychological distress, negative socio-emotional development of children, lower levels of life satisfaction, and poorer physical health.<sup>1</sup> While prevalence rates of mental illness among African Americans appear to be similar to non-Hispanic whites, African Americans are more likely to be under-represented in outpatient treatment and over-represented in inpatient treatment.<sup>1</sup> For instance, rates of mental health hospitalization for African American adolescents in Alameda County have doubled while rates in California have remained stable.

#### *Desired Outcomes: Individual & Family*

Research suggests that addressing the mental health needs of women before, during and after pregnancy not only promotes maternal health, but also results in improved birth outcomes, child health and child well being. For example, a prospective cohort study looking at child health outcomes at age 3 years found that women's depressive symptoms were associated with children's delayed language development and behavioral problems.

By creating a targeted public education mental health promotion campaign utilizing psycho-educational sessions as a tool to de-stigmatize mental health services and by offering trained psychotherapists to provide in-home and group support services, more low-income African Americans will drop their resistances and exhibit an increased willingness to address the issues they face, gain greater control, and transform their lives. Over time, they will also transform their children, families and communities, and eventually change the health status inequity data with which we are all so familiar.

A Community Report On

# **African American Parental Mental Health And Its Effect on Birth Outcomes and Child Health & Well Being**



Submitted by

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## Community Report

# **African American Parental Mental Health and Its Effects on Birth Outcomes and Child Health & Well Being**

### **Organizational Background**

The Improving Pregnancy Outcomes Program (IPOP) is a program of the Alameda County Public Health Department's Maternal, Paternal, Child, and Adolescent Health (MPCAH) Section. The goal of IPOP is to reduce infant mortality and improve birth outcomes among low-income, African Americans in targeted zip codes in Oakland, San Leandro, and Emeryville, California. The MPCAH mission is to support activities that promote the health of mothers, children and families. In 2004, MPCAH identified mental health as one of its top five priority issues.

#### **IPOP Services**

IPOP provides one-on-one and in-home case management/care coordination services to pregnant and parenting African American women with high medical and social risk factors whose income is 200% or below the federal poverty level (\$3,333 for a family of four). Case management/care coordination services are provided by public health nurses and community health outreach workers. As part of case management/care coordination services clients are screened for depression and referred for assessment and treatment.

In addition to case management/care coordination services, IPOP provides community education and fatherhood services to reproductive-age African American women and men in the community-at-large. During 2006, some of its community education activities have included psycho-educational workshops to help de-stigmatize mental health services and to provide participants with cognitive therapy techniques to address their depression.

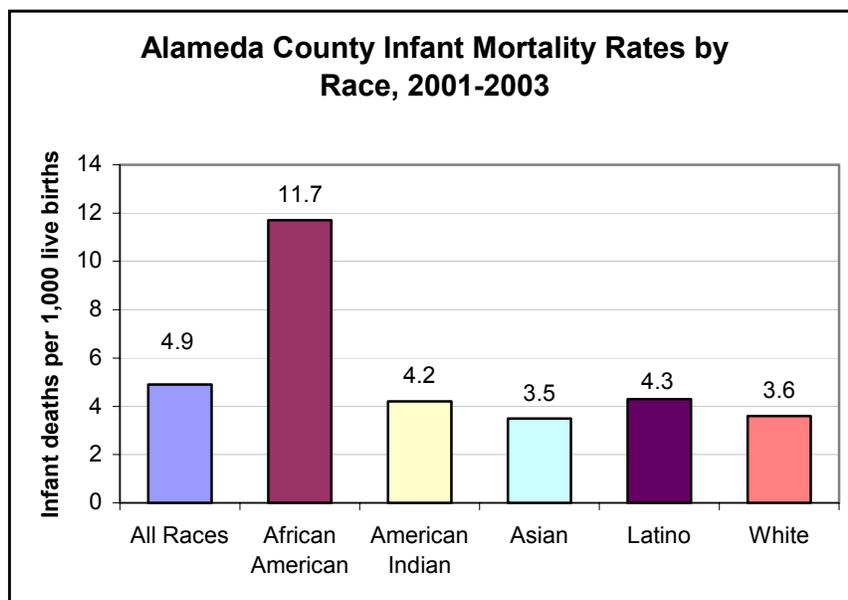
IPOP also promotes system change. It has supported the promotion of linkages between perinatal providers and substance abuse treatment providers to enhance the screening, assessment, referral, and treatment for substance abuse among pregnant women. Its staff is part of the Alameda County Perinatal Substance Abuse Task Force which has promoted the use of a common perinatal substance abuse screening and assessment tool by obstetrical providers in Alameda County. In 2008, it is projected that mental health screening questions will be added to the perinatal substance abuse screen to identify pregnant women who may be depressed.

#### **IPOP Clients**

To be eligible for services, IPOP clients must be below 200% of the federal poverty level (\$3,333 per month for a family of four) and live in one of the ten IPOP target zip codes. These zip codes have the highest African American infant mortality rates in all of Alameda County (located in East Oakland, West Oakland, North Oakland, the Fruitvale and downtown Oakland areas; Emeryville; and San Leandro). During 2005, 82% of IPOP clients were very low income, below 100% of the federal poverty level.

## Infant Mortality in Alameda County

Infant mortality is an important indicator of the health status of a community. Data show that the Alameda County African American infant mortality rate is two to three times higher than all the other groups. During the last ten years, infant mortality rates in Alameda County declined in every race and ethnic group. All groups reached the national *Healthy People 2010* goal of 4.5, except African Americans. The African American infant mortality rate has consistently remained higher than all the others. African Americans in Alameda County also have the highest rates of pre-term births (infants born prior to 37 weeks gestation), low birth weight births (infants born weighing less than 5lbs.8 ozs) and very low birth weight births (infants born weighing less than 3lbs. 4ozs.).



Infant mortality is divided into two categories: neonatal and post neonatal death. A neonatal death is defined as a live born infant who died before 28 days of life. A post neonatal death is defined as a live born infant who died between 29 days and one year of life. The infant mortality rate is defined as the number of deaths of children less than one year old per 1000 live births. In Alameda County,

Studies show factors that put African American mothers at risk for poor birth outcomes occur throughout the mother's lifespan and not just during her pregnancy. They include poverty (income level); unintended pregnancy; parent's unmarried status; low maternal education attainment, low or no employment, maternal stress, poor accessibility to health care, unsatisfactory adult relationships, lack of positive role models, lack of emotional support, relationship abuse; poor access to birth control education; lack of understanding of how to use birth control; late, no or inadequate prenatal care for mom; and internalized and institutionalized racism.

Factors that put babies at risk for infant mortality include preterm birth (born prior to 37 weeks gestation), low birth weight (born weighing less than 5lbs 8ozs), very low birth weight (born weighing less than 3lbs 4ozs), inadequate nutrition for mom and baby, maternal diabetes and hypertension,

alcohol use by mother, tobacco use by mother, drug use by mother, mother's exposure to second hand smoke, STDs and bacterial infections during pregnancy, congenital anomalies (birth defects), Sudden Infant Death Syndrome (SIDS), domestic violence, accidents at home, and car crashes.

## **The Relationship between Mental Health and Birth Outcomes**

The inequity among African American infant mortality rates and those of other races compels development of new strategies for improving birth outcomes. New emphasis is being placed on social and biological mechanisms, including the impact of stress due to racism and poverty, as well as gene-environment interactions.<sup>i</sup> The research suggests that addressing the mental health needs of women before, during and after pregnancy can potentially promote not only maternal health but also child health and well-being.

For instance, the Centers for Disease Control and Prevention (CDC) has supported research targeted toward understanding the etiology and prevention of preterm birth by examining the social context of pregnancy including psychologic influences such as stress, relationships, anger, hostility, hopelessness, anxiety and depression.<sup>ii</sup>

Recent studies that examined the association between maternal psychosocial factors and preterm birth have made significant findings in this area. A prospective cohort study that sampled pregnant women between the 24<sup>th</sup> and 29<sup>th</sup> weeks of pregnancy found that women who engaged in distancing coping styles (i.e., escapism, avoidance, denial, detachment, minimizing) were at increased risk of preterm birth.<sup>iii</sup> Furthermore, a study that looked at child outcomes at age 3 years, found that women's depressive symptoms were associated with children's delayed language development and behavioral problems.<sup>iv</sup>

Focus groups of Alameda County African American women who gave birth to a low birth weight baby and who were drug users and non-drug users during pregnancy indicated that depression was a common condition. They self-identified as depressed before becoming pregnant, during, and after the pregnancy.

## **Focus Group Guidance on Program Development**

A series of four focus groups guided the initial planning for IPOP mental health promotion programs. The groups were conducted in Oakland, California on July 30, July 31, and August 14, 2002, to identify messages that could help decrease infant mortality, promote early entry into prenatal care, and improve pregnancy outcomes. Focus Group members were African American pregnant and parenting women between the ages of 15 and 49, living in the IPOP target zip code areas. All participants were either drug users or non-drug users who had given birth to low birth weight, very low birth weight or premature infants within the last two years and were currently parenting those children.

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<sup>i</sup> Buekens, P and Klebanoff, K. (2001). Preterm birth research: from disillusion to the search for new mechanisms. *Paediatric and Perinatal Epidemiology*, 15 (Suppl. 2), pp. 159-61.

<sup>ii</sup> Defining Strategies for Preterm Delivery Prevention and Reducing Racial Disparities: Report from "The Social Context of Preterm Delivery: Implications for Public Health Conference." Centers for Disease Control and Prevention, February 1999.

<sup>iii</sup> Messer, L.C. et. al. (2005) Pregnancy intendedness, maternal psychosocial factors and preterm birth. *Maternal and Child Health Journal*, v. 9 n. 4, pp. 403-12.

<sup>iv</sup> Kahn, R. et al. (2002). Women's health after pregnancy and child outcomes at age 3 years: a prospective cohort study.

Focus group questions were developed with input from the Alameda County Fetal and Infant Mortality Review Community Action Team (FIMR CAT) IPOP Task Force and Task Force Members were invited to observe. Each focus group lasted 120 minutes, had 8-10 participants, and were audio taped and transcribed. Insight Research, Inc. recruited the participants, conducted the sessions, analyzed the transcripts, and wrote the summary report from which these details are taken. Due to the sample size, the special recruitment methods used, and the study objectives themselves, this research was exploratory in nature.

### **Focus Group Findings: General**

Significant findings included: most women knew the importance of early prenatal care. Fear, stress, lack of support, bewilderment, and depression were key reasons they did not seek it. Many women were unfamiliar with terms such as kick counts and used more primitive methods of determining the viability of the fetus. Most women received their information at the doctor's office from printed materials rather than from the staff. Almost all women were interested in attending community education events but felt incentives were needed to motivate them as well as others.

### **Focus Group Findings on Depression and Abuse**

- Most women in every group said they experienced depression at some point before their pregnancy, during their pregnancy, and after their delivery. They noted the lack of family support, lack of stability, not being financially ready, and being overwhelmed as causes of their depression. Although they noticed the symptoms of depression, most did not seek professional help and instead said they just worked their way through it or called on family members. One non-abuser commented, "I was depressed because basically at the beginning I didn't have any family support, I was moving from house to house and staying in shelters and all kinds of stuff." Another said, "They don't come in and check on the children afterwards, they just let you take your baby home... They don't teach you to do anything different, you are just stuck in a rut with children and that's depressing." One woman commented, "I was depressed because I was trying to figure out what am I going to do. I'm single and I don't have any help, didn't have help with the first one. I'm trying to figure out how am I going to raise another baby...." An abuser remarked, "I was depressed with the father because he was like oh you don't need no more kids. I was just kind of shamed because I have enough kids but another baby?" Another abuser said, "I was drinking. He [the father] said he didn't want to do nothing and he said everything was on me."
  
- Some women indicated they suffered with postpartum depression. One non-user commented, "I'm fussing at my family, fussing at my husband, fussing at my child... Sometimes I'd just sat and I'd be in a daze and I'd just stare because of the overwhelming-ness of taking care of the child, getting up in the middle of the night, and your mind is not all-the-way-there because you are not getting proper sleep."
  
- Some women in all of the groups experienced either physical or emotional abuse. While some left the situation, others stayed. One woman said she got out because, "I don't like getting hit and so it's not good to have a child around and have them being affected by that." However, a non-drug user said she stayed because, "We're still in a relationship together; however we both attend violence resolution so we're working on ourselves." Another stayed because, "I thought I could change and help him to change and stop hitting me." Another stayed because, "He was a good provider, he

provided.”

- They felt the abuse had an impact on their children. One abuser noted, “He [my child] has a lot of anger issues. He’s a smart, intelligent little boy but he has a lot of anger.” Another abuser commented, “He’s like off to himself and he gets angry and has tantrums.” A non-abuser said, “My baby is a nervous wreck. He can’t stand to hear shouting, none of that loud noise, slamming doors, all of that. That makes him nervous.”
- Some women stayed in abusive situations because “some women feel that if the men don’t hit them they don’t love them, they don’t care about them,” or “some women think there is something that they did wrong that made them mad at them to hit them,” or they stay because of the children. An abuser stated, “Well with my three daughters I did it for their sake because I didn’t have a mother or a father and that was something I always wanted for them, so I was 11 years in an abusive relationship.” Another abuser continued, “I stayed in a relationship because I wanted my kids to wake up to see a mommy and a daddy. I stayed in that relationship even when I got beat and raped by my own husband and that’s why my kids got taken away today. I stayed in that relationship because I was taking his money and going and buying me some drugs because every time he beat me I would go use.”

### **Stigmatization of Mental Health Services in the African American Community**

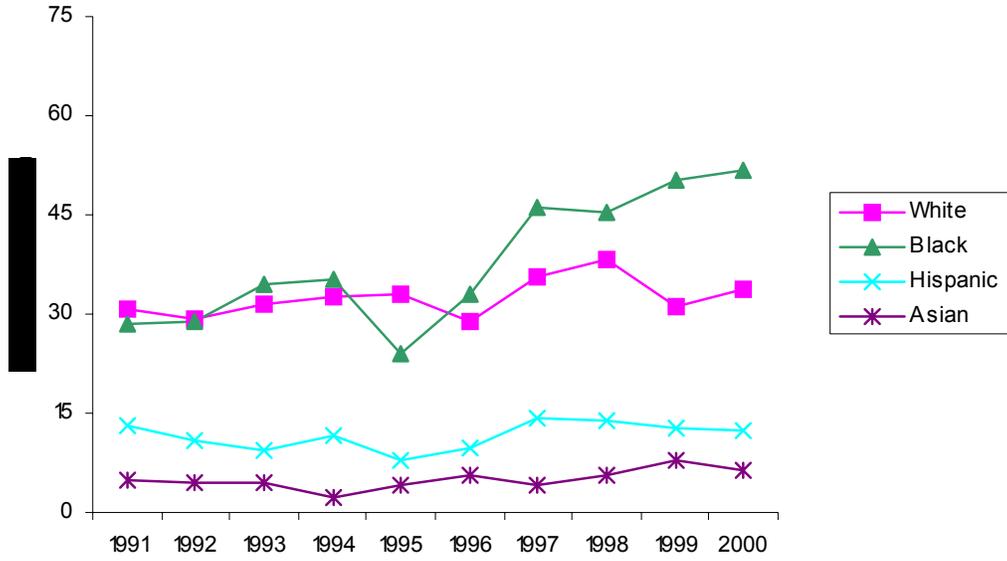
Members of the IPOP Consumer Task Force told us that among African Americans, the stigma attached to needing mental health support was far greater than the stigma attached to being a drug user/addict. As a race, they self-described as particularly distrusting of non-African American mental health professionals to whom they did not feel comfortable giving information about their personal circumstances.

Consumer Task Force members and IPOP case management/care coordination clients corroborated depression as a common condition and requested that we conduct sessions so women may address their issues and receive as much support for behavior change as possible.

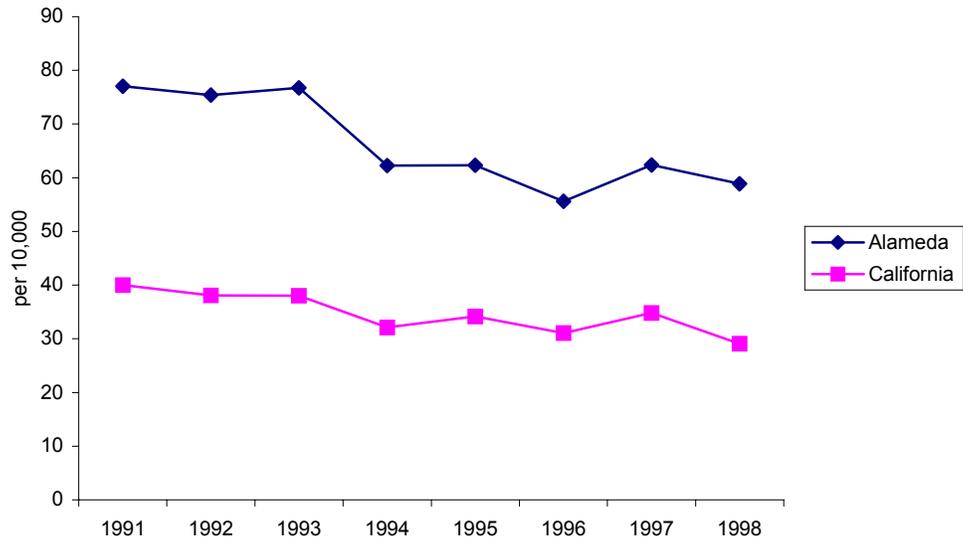
From 2004 to 2006, IPOP staff successfully conducted short-term, afro-centric mental health programs to address each of concerns identified: the community-wide stigmatization of mental health services and the unwillingness of IPOP clients to seek available treatment when need.

African Americans are particularly over-represented in high-need populations at-risk for mental illness such as the homeless, incarcerated, foster care/child welfare, and violence-exposed populations.<sup>1</sup> Moreover, a growing body of research argues that racism can adversely affect the mental health of African Americans through multiple pathways, resulting in higher levels of psychological distress, negative socio-emotional development of children, lower levels of life satisfaction, and poorer physical health.<sup>1</sup> While prevalence rates of mental illness among African Americans appear to be similar to non-Hispanic whites, African Americans are more likely to be under-represented in outpatient treatment and over-represented in inpatient treatment.<sup>1</sup> For instance, rates of mental health hospitalization for African American adolescents in Alameda County have doubled while rates in California have remained stable.

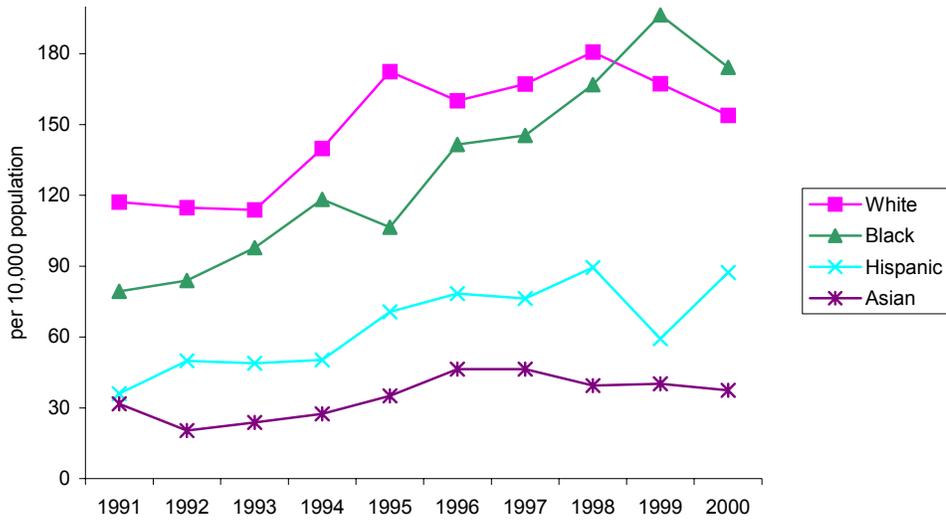
Mental Health Hospitalization Rate  
Alameda County ages 5-14 years



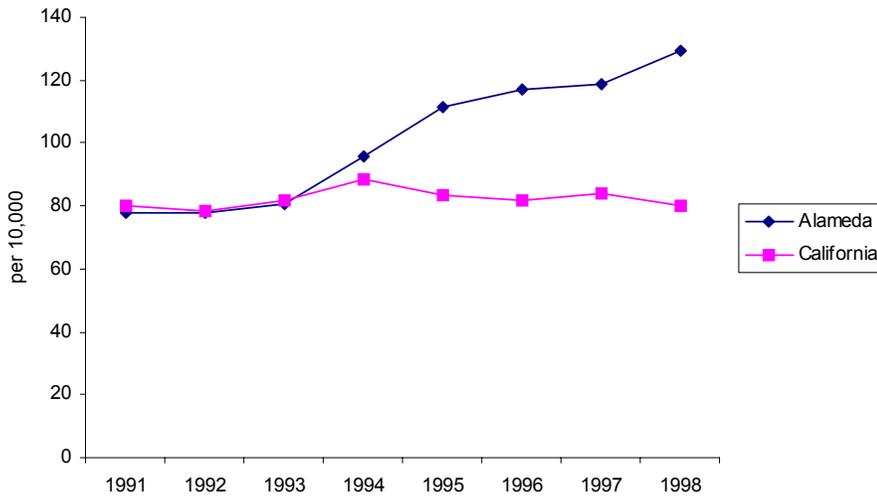
Mental Health Hospitalizations Rate  
Alameda County ages 5-14 yrs



Mental Health Hospitalization Rate  
Alameda County ages 15-19 years



Mental Health Hospitalizations Rate  
Alameda County ages 15-19 yrs



**De-Stigmatization: The IPOP Mental Health Community Education Campaign**

In September 2006, MPCA's Improving Pregnancy Outcomes Program piloted *Sistah2Sistah*, a series of psychoeducational gatherings to address mental health issues among low-income African

American pregnant and parenting women, specifically, the forces that dominated and limited their lives. These sessions were facilitated by Dr. Brenda Wade, Ph.D., a San Francisco-based psychologist, TV host, author, and dynamic international speaker who is best known for her love-centered approach to transformation. Dr. Wade co-authored the newly released *Power Choices: 7 Signposts on Your Journey to Wholeness, Joy, Love and Peace*. Its accompanying PBS Pledge Special continues to air nationwide. Dr. Wade has also co-authored *Love Lessons* and *What Mama Couldn't Tell Us About Love*. Known to television audiences nationwide, she has hosted programs and appeared on shows such as *Good Morning America*, and *Oprah*. Dr. Wade is also a featured writer for *Essence* magazine. We recognize and appreciate the impact of Dr. Wade's work among low-income African American populations.

Evaluation responses to the six-week series were very promising. For example, on a scale of 1-10 (with 10 being the highest score possible), the participants gave the workshops an average score of 9.6. The following is a summary of participant responses for selected questions on the evaluation form:

***After participating in this group workshop, I feel more comfortable seeking help for my mental and emotional well-being.*** (Possible responses were: strongly agree, agree, neither agree or disagree, disagree, and strongly disagree.)

- Strongly agree: 80%
- Agree: 13%
- Neither agree or disagree: 7%

***What is the most practical tool that you learned that you will use in your daily life?***

- "Releasing stress."
- "Clearing my energy from negative to positive."
- "Putting dreams into words."
- "Express yourself."
- "To speak and affirm to myself positive thoughts."
- "Mental control starting in the morning."
- "My rights."
- "The most practical tool I learned is to sit and think about things."
- "To tell myself that I'm pretty and I love myself."
- "I am worthy. I am deserving."
- "Power of sisterhood."
- "Daily healing. Taking time for myself."
- "Meditation."
- "Chanting positive affirmations."
- "To reprogram my way of thinking."

***Would you recommend this workshop to a friend?***

All of those completing the evaluation form said that they would recommend the workshops. Some of the reasons why were:

- "It's needed."
- "Because it's fun and you learn about yourself."

- “Absolutely...wish we had this guidance all the time as different issues come up at different times.”
- “Yes, great information and an opportunity to be exposed to a different thought process.”
- “I feel that it could benefit everybody’s life.”
- “This important because it helps us to learn on different ways on how to deal with stress to better my health.”
- “Warm, inspirational.”
- “I would because my friends need this just as much as I do.”
- “Because it’s healing.”
- “Yes, because it’s encouraging.”
- “Its stress releasing.”
- “Yes because some of my friends need this type of advice.”
- “Yes. It helps you think deep within ourselves and open up to people.”
- “Yes, to bring awareness we all are going through the same things in life. To help.”
- “All women need encouragement and tools to get through life.”
- “Because the workshop offers a lot of self-help techniques.”
- “It will be helpful in every day living.”
- “The material is relevant and necessary in helping women achieve their goals and improve their blessings.”
- “Yes, because there are young ladies who need to have survival tools for themselves to love themselves.”
- “Important for women to come together and share with one another so many commonalities.”
- “I am worthy. I am deserving.”
- “Power of sisterhood.”
- “Daily healing. Taking time for myself.”
- “Meditation.”
- “Chanting positive affirmations.”
- “To reprogram my way of thinking.”
- “Important for women to come together and share with one another so many commonalities.”

From our limited but significant experience, we know there is a huge need for a community mental health education approach similar to the IPOPOP pilot program. A comprehensive model for mental health promotion and intervention has been adopted by the World Health Organization and many other groups.<sup>1</sup> However, within the U.S., almost all mental health resources are directed to the treatment of individuals with established, severe problems while most individuals with an early mental illness go undiagnosed and/or untreated.<sup>1</sup> Previous multifaceted social marketing campaigns to combat stigma offer new options for mental health promotion.<sup>1</sup>

### **The IPOPOP In-Home Mental Health Assessment & Treatment Service**

In an attempt to fill a critical mental health service gap and address the difficulties experienced by clients who are reluctant to seek assessment and treatment services, a mental health clinician was added to the IPOPOP home-visiting team of nurses and case coordinators for eight months between September 2004, and May 2005. The goal was to improve maternal and child mental health outcomes through assessment and treatment of mental health disorders among perinatal clients. The clinician provided direct mental health services to clients and consultations to public health nurse (PHN) and community

health outreach worker (CHOW) staff. The direct client services were in the form of home visiting psychotherapy and included intake, assessment, relationship building, and brief treatment. The brief treatment process included stabilizing crises, coaching, educating clients about mental health process, empowering clients to have better relationships, mobilizing clients to change, providing referrals for psychiatric evaluation, and facilitating linkages to more intensive longer-term treatment/adjunctive services as needed. In-home therapy was an effective, efficient way to address mental illness stigma, transportation, and child care problems; the primary barriers to seeking mental health care.

The results of the short-term therapy with the mothers included stabilizing crises that included child abuse, domestic violence, and suicide. Example: a public health nurse referred a pregnant mother with relationship issues for mental health assessment. The therapist met with her for several sessions and learned about her history of early parent loss, sexual trauma, drug abuse, domestic violence and depression. During the process of therapy she struggled through an emotionally and physically abusive relationship. The client and therapist worked on developing a safety plan regarding domestic violence shelters and other resources. The client's partner was incorporated in the sessions when it was safe and given a referral to the IPOP Fatherhood Program.

As a result of short-term therapy, clients who were paralyzed by depression were mobilized to change their feelings and behavior. For example: A client who was so depressed that she had not left her home in 3 weeks was able to, overtime, address her children's needs as well as her own by enrolling the older children in school, getting respite childcare and enrolling herself in community college courses. With the help of the therapist, the mother obtained medication and followed up with BANANAS (A local bay area parental support organization that offers free information, education, referral and other services). While the mother continues to have set backs, she has also experienced some new ways to behave and solve her problems.

Also as a result of short term therapy, clients were able to deal with feelings in healthier ways such as using psychotherapy, journaling, and taking time for themselves (walks, eating healthy, etc.). In treatment, the therapist coached clients through the feelings of depression by making them more aware of the symptoms and treatments for their disorders. The therapeutic relationship was used to model healthy ways to be in relationship. As the clients became more aware of healthy ways to deal with mental health issues, they were able to develop better relationships with their children and partners.

The clinician also provided consultations to the public health nurses and community health outreach workers. Group consultations took place at bi-weekly meetings and individual consultations occurred as needed. In the group case conference the group defined the subjects to be reviewed. They included depression, the cycle of domestic violence, substance abuse, child abuse, and the provider's counter transferences. One of the main goals of the case conference was to bring the mental health of the family into focus. This was accomplished by assessing risk factors, assessing relationships within the family, assessing children's social and emotional well being, and evaluating DSM diagnoses. As a consultant, the therapist was available for individual phone consultations and joint visits for mental health assessment services. The therapist also provided support for staff dealing with difficult families. This combination of direct services and consultation with the home visitors provided a valuable support for IPOP families.

## RECOMMENDATIONS

A. We recommend development of a community education campaign using social marketing approaches to enhance the existing local Alameda County mental health system. The campaign goal should be to promote mental health and functioning by de-stigmatizing and increasing mental health service utilization among low-income, reproductive-age African American women and men ages 13-35 years. Campaign components are:

1) Dissemination of awareness campaign materials addressing culturally-specific mental health issues, stigma, and resources through face-to-face outreach contacts with low-income, reproductive-age African American women and men ages 13-35 years. Printed campaign materials will increase understanding of mental illness and its effect on African American individuals, families, and communities. Related co-morbidities such as poor physical health and disability, violence, abuse, family cohesion and stability, academic underachievement, and lack of economic self-sufficiency—issues that the community cares deeply about—must be sensitively linked to the mental health and functioning of African Americans. Specific materials needed include a campaign brochure, four bimonthly newsletters, posters, post cards, leaflets, a radio spot, and a targeted web site posting. The brochure should be disseminated to individuals through face-to-face outreach including one-on-one contacts and group presentations. It should specifically address the stigma of mental illness within the African American community. The brochure should increase awareness and reduce stigmatization of mental illness by: 1) emphasizing the need for community healing; 2) reframing the notion of *health* to a more holistic model that includes *mind, body, and soul*; 3) acknowledging the role of oppression on mental health and functioning; 4) dispelling myths about mental illness; and 5) highlighting the benefits of mental health treatment, especially as an effective but underutilized intervention. Lastly, the campaign brochure should list mental health services and resources available to low-income individuals in Alameda County.

2) Dissemination of bimonthly newsletters addressing culturally-specific mental health issues, stigma, and resources to low-income African American households in Alameda County. Four bimonthly newsletters should be mailed to African American households in Alameda County. Selected mental health conditions, which often have environmental antecedents such as depression, stress, anxiety, and post-traumatic stress disorder, will be highlighted. These colorful, attractive, and ethnic-specific newsletters should: 1) briefly explain a mental health condition; 2) describe its affect on health and psychosocial functioning at the individual, family and community levels; 3) address the legacy of oppression and misconceptions; 4) highlight a personal testimonial and/or success story; and 5) provide information and referral for treatment.

3) Contacting African American women and men ages 13-35 years through culturally-specific psychoeducational sessions designed to increase comfort and reduce the stigma of mental health service utilization. The psychoeducational sessions should be facilitated by a mental health consultant who will engage participants through interactive group activities and discussions on mental health. The sessions will provide a non-stigmatizing intermediate step for individuals who would otherwise not seek services when referred to mental health treatment. These sessions should focus on the positive, such as *living with more joy and less pain*; a more culturally acceptable way of addressing mental health issues. Similarly, the sessions should be publicized using language such as *achieving self-love, living life to the fullest, and having a positive outlook on life* (see Attachment B: Sample campaign materials). During these sessions, the facilitator will guide participants through exploring

personal struggles, familial inter-generational patterns, and the impact of oppression on mental health. Furthermore, the facilitator should address mental illness within the context of *body, mind and spirit*\* to increase participants' understanding of the physical and psychosocial aspects of mental health. Mental health service utilization should be reframed as an opportunity for healing and positive personal transformation. These professionally guided activities should increase awareness of mental health, reduce the stigma and sense of shame, and increase comfort with seeking treatment.

4) Training of facilitators to increase the number and availability of community psycho-educational sessions. A part of the campaign, as it was originally conceptualized and discussed with Dr. Wade, included training multiple facilitators to conduct future workshops for IPOP and non-IPOP populations. Dr. Wade's expert ethnocentric presentations would be videotaped and transferred to a DVD format. Facilitators would be trained to intermittently combine portions of Dr. Wade's taped presentations with their in-person group facilitation. Facilitator training manuals and participant materials should be developed. DVDs and portable DVD players should be made available to both facilitators and participants. By training facilitators, these psychoeducational opportunities could be continued into perpetuity and replicated in similar communities across the county, state and nation.

B. We recommend support for in-home psychotherapy services similar to the IPOP services described above. IPOP identified the need to fill a large, critical, mental health service gap between available services and African American women who were paralyzed by the overwhelming circumstances of their lives and/or the stigma attached to needing help. The IPOP clients were reluctant or unable to seek outside services but were willing to allow a clinician to bring both assessment and treatment services into their homes and lives. As a result, evaluations show they benefited and progressed.

## **SUMMARY**

These recommended efforts should help de-stigmatize mental health services and help increase service utilization among low-income African American women, men and their children. Program staff should disseminate a designated list of mental health providers who accept Medicaid insurance as a payment source or a sliding fee scale in Alameda County. Program staff should assist individuals who call for more information in response to the brochure or poster, orient them to the provider list, offer to register them for the psycho-educational sessions, add them to the campaign newsletter mailing list, and make any other appropriate referrals.

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## Attachment A

### References

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**Attachment B**  
**Sample IPOP Community Education Campaign Materials**

# Want to live life to the fullest?

Join other African American women who want to live with more joy and less pain in their lives. This six-part workshop series will be facilitated by Dr. Brenda Wade, an Oakland/San Francisco-based psychologist, who has been featured on Oprah and in Essence magazine. She is best known for her love-centered approach to transformation, and has co-authored books including Love Lessons, What Mama Couldn't Tell Us About Love, and Power Choices.

Workshops will focus on how to achieve self-love, healthy relationships, and a positive outlook on life.

All sessions are free to low-income African American women who live in zip codes 94578, 94579, 94601, 94603, 94605, 94607, 94608, 94609, 94612 and 94621. The series is scheduled for October 14, 21, 28 & December 2, 9 and 16.

For more information and to sign-up in advance, call 510-618-2080.



# Sistah2Sistah

Create the life that you want ...  
you deserve it!

# Want to live life to the fullest?

Join other African American women who want to live with more joy and less pain in their lives. These gatherings will be facilitated by Dr. Brenda Wade, an Oakland/San Francisco-based psychologist, who has been featured on Oprah and in Essence magazine. She is best known for her love-centered approach to transformation, and has co-authored books including Love Lessons, What Mama Couldn't Tell Us About Love, and Power Choices.

Sessions will focus on how to achieve self-love, healthy relationships, and a positive outlook on life.

17 of 17

All sessions are free to low-income African American women who live in zip codes 94578, 94579, 94601, 94603, 94605, 94607, 94608, 94609, 94612 and 94621. The next set of sessions are scheduled for December 2, 9 and 16.

For more information and to sign-up in advance, Call 510-618-2080. See back side for location, map and directions.



# Sistah2Sistah

Create the life that you want ...  
you deserve it!



# Healthy Living, Healthy Families

Published by the Improving Pregnancy Outcomes Program (IPOP) for the Health Promotion & Community Education Campaign

## Getting help for depression *Know the signs and what to do to feel better*

### What is depression?

Depression is an illness that affects the body, mood, and thoughts. People who are depressed may feel hopeless, worthless, very sad, and have no energy or interest in doing anything. Some people describe depression as an "empty, or sad feeling that won't go away." This kind of depression that does not go away is called "clinical depression."

### What causes depression?

Many things cause depression. Depression can run in families. Changes in your brain chemistry and living through painful and difficult events in your life can cause depression.

### What are the signs of depression?

Here is a list of the most common signs of depression. If you have some of these signs that last for more than two weeks, see a health care provider.

- Feeling empty, sad, and anxious
- Feeling tired, having no energy
- Feeling restless and irritable a lot of the time
- Crying more than usual



*Some people describe depression as an "empty, or sad feeling that won't go away."*

- Feeling worthless, helpless, hopeless, and guilty
- Having no interest or joy in life
- Having trouble sleeping or sleeping too much
- Having problems eating too much or too little
- Thinking about suicide and death
- Thinking about hurting your baby or children
- Having trouble concentrating, remembering, and making decisions

### How do you get help for depression?

Depression is not something you can just snap out of and feel better. Depression is a serious illness that needs to be treated. It's not your fault that you are depressed, and you can get better. Most people with depression get better when they get treatment. Talk to your health care provider about how you are feeling.

Source: National Women's Health Information Center, U.S. Department of Health & Human Services

**Did You Know?**



*Take the first step...*

For mental health and treatment referrals in Alameda County,

call ACCESS 24-hour line at 1-800-491-9099.

Mental health services that are available include: support groups, stress reduction and parenting classes, individual counseling, and family counseling.

Low-income and CalWORKs clients can receive referrals to any of these services listed above by calling ACCESS.

### *More information about IPOP*

(serving zip codes 94578, 94579, 94601, 94603, 94605, 94607, 94608, 94609, 94612 and 94621)

If you are pregnant and need help with accessing medical and social services, call.....(510) 618-1967

For free classes on Pregnancy Basics, Healthy Eating and Living for Mom & Baby, and Parent Education including positive discipline and child safety, call.....(510) 618-2080

For IPOP Fatherhood Services and assistance for men, call.....(510) 618-2080



# Healthy Living, Healthy Families

Volume 4 | Issue 3 | 2007

A free community newsletter published by the Improving Pregnancy Outcomes Program Health Promotion & Community Education

## What is depression?

Know the signs and what to do to feel better

Everyone gets the blues now and then, but when there is little joy after doing something pleasant like visiting with good friends or seeing a good movie, there may be a more serious problem. A depressed mood that stays around for a while, without letting up, can change the way a person thinks or feels. Doctors call this “clinical depression.”

Depression is a common, serious illness and not a personal weakness. Depression can happen to anyone, at any age, and to people of any race or ethnic group. It is never a “normal” part of life. Depression, which is treatable, can come from chemical imbalances in the brain, hormonal changes, medications or things going on in your life.

Women suffer from depression twice as often as men. One out of four women may have depression sometime during their lifetime. Many people suffer with depression but do not seek help.

### What are the symptoms of depression?

If you experience five or more of the following symptoms and they last for more than two weeks, or if the symptoms interfere with your daily routine, see a doctor or a qualified mental health professional. A physical examination to rule out other illnesses may be recommended.

- ◆ A persistent sad, anxious or “empty” mood

- ◆ Sleeping too little or too much
- ◆ Reduced appetite and weight loss, or increased appetite and weight gain
- ◆ Loss of interest or lack of pleasure in activities once enjoyed, including sex
- ◆ Restlessness or irritability
- ◆ Persistent physical symptoms that don't respond to treatment (such as headaches, chronic pain, or constipation and other digestive disorders)
- ◆ Difficulty concentrating, remembering or making decisions
- ◆ Fatigue or loss of energy
- ◆ Feeling guilty, hopeless or worthless thoughts of death or suicide.

### What causes depression?

Many things can lead to clinical depression:

**Biological.** People with depression may have too little or too much of certain brain chemicals. Changes in these brain chemicals may cause or play a role in clinical depression.

**Cognitive.** People with negative thinking and low self-esteem are more likely to develop clinical depression.

**Gender.** Women experience clinical depression nearly twice as often as men. The reasons for this are still not understood, but may include hormonal changes women go through during men-



struation, pregnancy, childbirth and menopause. Other reasons may include the stress caused by the many responsibilities that women have.

**Co-occurrence.** Depression is more likely to occur along with certain illnesses, such as heart disease, cancer, Parkinson's disease, diabetes, Alzheimer's disease, and hormonal disorders.

**Medications.** Side effects of some medications can bring about depression.

(Continued on the back side)

## Did You Know?



### Take the first Step

For mental health and treatment referrals in Alameda County, call ACCESS 24-hour line at 1-800-491-9099.

Mental health services that are available include: support groups, stress reduction

and parenting classes, individual counseling, and family counseling.

### More Information about IPOP

If you are pregnant and need help with accessing medical and social services call (510) 618-1967

For IPOP Community Baby Shower and Club Mom, call (510) 618-2080

For IPOP Fatherhood Services and assistance for men, call (510) 618-2080

(Continued from *What is Depression?*)

**Genetic.** A family history of clinical depression increases the risk for developing the illness.

**Situational.** Difficult life events, including divorce, financial problems or the death of a loved one can contribute to clinical depression.✿

## How is Depression Treated?

Depression is the most treatable of all mental illnesses. About 60 percent to 80 percent of depressed people can be treated successfully. Depending on the case, various kinds of therapies seem to work. Treatments such as psychotherapy and support groups help people deal with major changes in life. Several short-term (12-20 weeks) "talk" therapies have proven useful. One method helps patients recognize and change negative thinking patterns that led to the depression. Another approach focuses on improving a patient's relationships with people as a way to reduce depression and feelings of despair.

Antidepressant drugs can also help. These medications can improve mood, sleep, appetite and concentration. There are several types of antidepressant drugs available. Drug therapies often take time before there are real signs of progress. It is important to keep taking medication until it has a chance to work. After feeling better, it is important to continue the medication for at least four to nine months to prevent a recurrence of the depression.



Never stop taking an antidepressant without consulting your doctor. Antidepressant drugs can have side effects but they are usually temporary. If side effects persist and are troublesome, contact your doctor. In some cases, you may need to try different medicines to find the one(s) that help the most. Also, it helps to keep your body in good shape by:

- ◆ Staying active and getting regular exercise
- ◆ Getting plenty of sleep
- ◆ Not smoking
- ◆ Not drinking alcohol; and
- ◆ Limiting drinks with caffeine, like coffee and cola.

## Knowing When to Get Help

Everyone has "been in the dumps," "felt the blues," and been pessimistic at some point in their lives. It's normal to feel these emotions but if they continue for a long period of time, they may be signs of depression.

People are often angry because they are unhappy. If things continue to make a person feel unhappy for an extended period of time, it could lead to mild or major depression. There are three dimensions of depression. First is frequency. How often do you feel down or depressed? Second is severity of the depression. How bad is it? And third is duration. How long does it last? People often ignore or misinterpret the signs of depression. Depression frequently goes undetected and untreated among the general population.

Unfortunately, most people never seek treatment. Left undiagnosed and untreated, depression can worsen, lasting for years and causing untold suffering, and possibly even result in suicide.

### *Beneficial strategies for coping with depression*

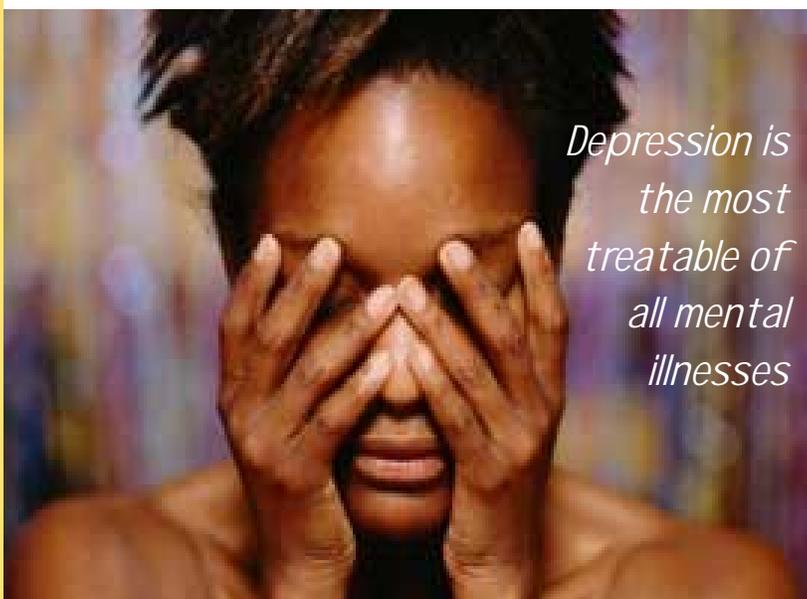
#### **Develop a more healthy, balanced diet.**

We aren't made to run on junk, fat, sugar, caffeine, alcohol, drugs and cigarettes.

#### **Get regular exercise and sufficient sleep.**

For exercise, walking is fine. The times when you least feel like doing it might be the times you need to do it most. Cutting yourself short on sleep can really contribute to a downward spiral in other areas.

Sources: Adapted from materials available by HealthDay; ScoutNews, LLC. All rights reserved; Illinois Department of Public Health; PBSKids.org; University of Texas Counseling and Mental Health Center.



## Attachment C

### Social Marketing Framework

#### for African American Mental Health Community Education Campaign

<b>TARGET AUDIENCE</b>	<ul style="list-style-type: none"> <li>▪ Low-income African Americans residing in Alameda County               <ul style="list-style-type: none"> <li>○ Women</li> <li>○ Men</li> <li>○ 13-35 years</li> </ul> </li> </ul>
<b>STRATEGY</b>	<ul style="list-style-type: none"> <li>▪ Conduct culturally-specific community psychoeducational sessions</li> <li>▪ Conduct community outreach campaign (brochure, posters, newsletters, post cards, newsletters, radio spot, targeted web site postings)</li> <li>▪ Target African American households with culturally-specific mental health awareness information and resources (bimonthly newsletters)</li> </ul>
<b>IMPACT</b>	<ul style="list-style-type: none"> <li>▪ Decreased perceived stigma of mental health service utilization.</li> <li>▪ Increased awareness of the impact of oppression (racism, sexism, poverty) on the mental health and functioning of African Americans.</li> <li>▪ Increased understanding of the trans-generational dynamics of mental health on African American families.</li> <li>▪ Increased awareness of the importance of mental health and its effects on physical health, functioning and relationships at the individual, family and community levels.</li> <li>▪ Increased comfort with mental health service utilization.</li> <li>▪ Increased knowledge of available mental health services and psychoeducational resources in Alameda County.</li> </ul>
<b>BENEFITS</b>	<ul style="list-style-type: none"> <li>▪ Reduced stigma by addressing role of oppression through campaign materials and psychoeducation sessions</li> <li>▪ Validation (effects of oppression on mental health status and functioning)</li> <li>▪ Social support</li> <li>▪ Opportunity for self-care</li> <li>▪ Resources (information and referral; mental health provider list)</li> </ul>

## ATTACHMENT D

### ALAMEDA COUNTY AFRICAN AMERICAN MENTAL HEALTH PUBLIC EDUCATION CAMPAIGN MODEL

*Community education activities increase mental health awareness and understanding*

*Existing mental health providers in Alameda County serving low-income popula-*

