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Mental Illness Awareness in the State of New Hampshire

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COUN 6785: Social Change in Action:
Prevention, Consultation, and Advocacy

Social Change Portfolio

Susan Pomerleau

Contents

Below are the titles for each section of the Social Change Portfolio. To navigate directly to a particular section, hold down <ctrl> and click on the desired section below.

Please do not modify the content section, nor remove the hyperlinks.

[Please note that in brackets throughout this template you will see instructions about information to include in each section. Please delete the instructions that are found in brackets, including this message, and replace the bracketed instructions with the relevant content for each section].

[Overview](#)

[Introduction](#)

[Scope and Consequences](#)

[Social-ecological Model](#)

[Theories of Prevention](#)

[Diversity and Ethical Considerations](#)

[Advocacy](#)

[References](#)

[ScholarWorks Contributor Agreement](#)

OVERVIEW

Keywords: any mental illness (AMI), serious mental illness (SMI), awareness, prevention, State of New Hampshire

Mental Illness Awareness in the State of New Hampshire

Goal Statement: The goal of this prevention program is to bring awareness to serious mental illness (SMI) and any mental illness (AMI) in the state of New Hampshire. The program will take into consideration the minority and ethnic populations in the state and will take into consideration the greater percentages of these minority and ethnic populations who do not seek help due to the stigma of mental illness, cultural misunderstandings of mental illness, and the lack of resources for support of mental illness.

Significant Findings: This Social Change Portfolio has been created to bring awareness to serious mental illness (SMI) and any mental illness (AMI) in the state of New Hampshire. Out of New Hampshire's 1.36 million people, 4% of the population suffer from SMI and only 49.9% of those with AMI will seek help (Resources to Recover, 2020; SAMSHA, 2014). The small percentage of minority and ethnic populations in a state which is 93.1% Caucasian has an even greater need for understanding of mental illness and access to mental health services. The New Hampshire Department of Health and Human Services has implemented a 10-Year Mental Health Plan to address mental health needs in the state of NH while specifically addressing the issue of mental health services for the minority and ethnic populations (NH Department of Health and Human Services, 2019). It will be imperative to promote community educational outreach on mental illness and to follow the efficacy of the 10-Year Mental Health Plan to ensure it is meeting its goals.

Objectives/Strategies/Interventions/Next Steps: Identify the mental health services and/or mental health clinicians within one's community. Identify the need within one's local community for certain mental health services. Identify the population in one's community with attention to the ethnic and minority populations residing within it. Strategically partner with community organizations at the school and local government level to identify any education in place around mental illness; then, implement or add to an educational outreach program within one's community. Finally, incorporate an evidence-based program such as COPE (Creating Opportunities for Personal Empowerment) and modify it as needed for adult mental health.

INTRODUCTION

Mental Illness Awareness in the State of New Hampshire

New Hampshire is a small state with 1.36 million people reported in 2019. In New Hampshire, 4% of adults live with serious mental health conditions, such as schizophrenia, bipolar disorder, and major depression (Resources to Recover, 2020). The National Alliance of Mental Illness (NAMI) has a chapter in New Hampshire to help support, promote, and educate on the topic of mental illness. I would like to partner my effort with NAMI NH and also with the STAMP OUT STIGMA Campaign through the Association for Behavioral Health and Wellness (ABHW) to bring greater awareness of serious mental illness (SMI) and any mental illness (AMI) to New Hampshire.

PART 1: SCOPE AND CONSEQUENCES

Mental Illness Awareness in the State of New Hampshire

I would like to contribute to bring awareness and to address the stigma of Mental Illness (both serious mental illness (SMI) and any mental illness (AMI)) to the state of New Hampshire.

4% of New Hampshire's population suffer from serious mental illness (SMI), such as schizophrenia, bipolar disorder, and major depression (Resources to Recover, 2020). However, of those in New Hampshire who struggle with any mental illness (AMI), only 49.9% of all those adults with AMI will seek treatment or counseling (SAMSHA, 2014). Nationally, 18.9% of the adult population suffer from AMI (NIH, 2019). National trends from 2008 to 2014 show the steadiness of AMI and SMI with 14% of all adults struggling with AMI and with 4.1% of all adults struggling with SMI (SAMHSA, 2014). Thus, I would like to bring awareness to SMI and AMI within the state.

There are many reasons to bring greater awareness to the state. To begin, mental illness affects physical health. People with depression have an increased risk of cardiovascular disease, diabetes, stroke, and Alzheimer's disease (NIH, 2020). Not only is a person's physical health affected, but also a person's mental health is affected by their specific mental illness because it affects their thinking, feeling, behavior or mood (NAMI, 2020). These conditions deeply impact day-to-day living and may also affect the ability to relate to others (NAMI, 2020). In addition to the effects of mental illness on physical and mental health, there are social/educational/family consequences of mental illness. Socially, self-stigma can isolate those struggling with mental illness and educationally, those who are affected by SMI or AMI might have less education because of the struggles with mental illnesses and its symptoms with varying severity levels (Corrigan et al, 2014). Also, looking at caregivers of a family member who struggles with mental

illness, these caregivers can devote up to 32 hours a week of unpaid work to those family members struggling with a mental illness (NAMI, 2019).

Moreover, economically, adults with a mental illness in the US have a higher unemployment rate than those that do not (NAMI, 2019).

PART 2: SOCIAL-ECOLOGICAL MODEL

Mental Illness Awareness in the State of New Hampshire

Risk and protective factors at the individual, peer, family, school, community/cultural levels according to the social-ecological model are multifold. Risk factors at the individual level for developing a mental illness would be through genetics, through life stressors such as a traumatic event, and also, an ongoing chronic illness (Mayo Clinic, 2020). Risk factors at the peer level are brought to light by the Diathesis -stress model. The Diathesis–stress models propose that psychopathology occurs as the result of the combination of individual, cognitive, or biological vulnerabilities (i.e., diatheses) and certain environmental stressors (as cited in Swearer & Hymel, 2015, Cicchetti & Toth, 1998; Lazarus, 1993). Further, these models posit that both negative life events and one’s cognitions about those events contribute to the development of internalizing and externalizing psychopathology (Swearer & Hymel, 2015). In contrast, however, risk factors at the family level would be sharing genetics (i.e. passing the illness through family genetics); risk factors at the school level for developing a mental illness could be through relationship difficulties and/or social isolation; and risk factors at the community/cultural levels could be through missed work or school, legal and financial problems, and poverty and homelessness (Mayo Clinic, 2020). Moving from risk factors, the protective

factors at the individual level are self-esteem, ability to problem solve, communication, nutrition and physical exercise (WHO, 2012). A protective factor at the peer level is a strong support system (i.e. good friends) (WHO, 2012). A protective factor at the family level is strong family support (WHO, 2012). Moreover, protective factors at the school and community levels are non-biased, educated teachers, administration, community businesses and leaders. Culturally, protective factors are social justice, tolerance, and integration (WHO, 2012).

PART 3: THEORIES OF PREVENTION

Mental Illness Awareness in the State of New Hampshire

People with a serious mental illness (SMI) or any mental illness (AMI) would benefit from the Positive Psychology theoretical approach at the individual, community, and state level. Racsynski et al. (2013) states that a positive psychology perspective fits nicely into a prevention framework, as positive psychology studies and promotes individual, group, and institutional assets, and draws attention to what is right with people as opposed to what is wrong. Positive psychiatry encompasses psychological aspects such as optimism, resilience, personal mastery, coping, self-efficacy, social engagement, and spirituality (i.e. meaning in life and wisdom) (Bejerholm & Roe, 2019, p. 420). The scientific movement of positive psychology calls for a deep change in how we think from “preoccupation only with repairing the worst things in life to also building the best” (as cited in Moran & Nemeč, 2013, p. 202; Seligman, 2002, p.3). Instead of asking why certain people fail, positive psychology asks “What makes certain individuals succeed despite adverse conditions?” (Moran & Nemeč, 2013, p. 202). An example of Positive Psychology and some positive research on this theory is the *resiliency training curriculum*

employed in the past with the U.S. Army (Moran & Nemec, 2013). The research and results found were that this intervention fosters protective factors such as optimism, effective problem solving, faith, sense of meaning, self-efficacy, flexibility, impulse control, empathy, close relationships, and spirituality (as cited in Moran & Nemec, 2013, p. 205; Davydov, Stewart, Ritchie, & Chaudieu, 2010; Masten & Reed, 2002). Identifying an evidence-based program for mental illness, such as Creating Opportunities for Personal Empowerment (COPE), can be examined. The Creating Opportunities for Personal Empowerment (COPE) program is an innovative, evidence-based solution to address the high prevalence of child and adolescent depression and anxiety (Melnyk, 2020, p.118). COPE is a manualized intervention program that incorporates the key concepts from CBT into a 7-session cognitive behavioral skills-building program that can be delivered in brief 25–30-minute sessions by both mental health providers and non-psychiatric mental healthcare professionals, including pediatric and family nurse practitioners, pediatricians, family practice physicians, and teachers, in primary care and school-based settings (Melnyk, 2020, p.118). Although the focus of this evidence-based solution addresses child and adolescent depression and anxiety, it possibly could be modified to address depression and anxiety in adults.

PART 4: DIVERSITY AND ETHICAL CONSIDERATIONS

Mental Illness Awareness in the State of New Hampshire

New Hampshire's minority and ethnic populations include a significant number of refugees who are suffering from post-traumatic stress disorder from previous exposure to torture and/or terrorization (US Dept of Health and Human Services, 2020). At the same time, many of

these individuals, as well as their social networks, either stigmatize mental health or believe the services are ineffective (US Department of Health and Human Services, 2020). Even if these individuals have the desire to seek help, they are often too financially insecure to procure health services (US Department of Health and Human Services, 2020). Assistance and outreach programs that might address these issues are hindered by the lack of data on these minority populations (US Department of Health and Human Services, 2020). Additionally, in New Hampshire, I am finding a lack of specific data on these minority populations and on their access to mental health services for serious mental illness (SMI) and any mental illness (AMI). However, the need is there to help minority and ethnic populations with their ability to receive and access mental health services in New Hampshire.

Importantly, two mechanisms that could increase the cultural relevance of a serious mental illness (SMI) or any mental illness (AMI) prevention program in the state of NH could be collaborating with local community leaders within the refugee populations, with other minority and ethnic community leaders, and also, collaborating with refugee resettlement agencies in New Hampshire. Gropalkrishnan (2018) states in circumstances where some cultural groups can be marginalized, as in the context of the issues of historical dispossession, racism, stereotyping, stigmatization, and power differentials, it becomes extremely important to work toward more equitable ways of engaging with communities (61–63). It would certainly add to the nature of these partnerships if the providers also followed a deliberate policy of hiring workers of diverse backgrounds, and especially those from the communities that the service users come from (Gropalkrishnan, 2018). As suggested, these forms of partnerships between refugee groups and health service providers have been shown to be more effective in terms of responding to health and other needs of the refugees than traditional top-down approaches (Gropalkrishnan, 2018).

Thus, collaborating with local community leaders and with refugee resettlement agencies will assist in helping the minority and ethnic populations mentioned to understand the importance of mental health and the resources available to them.

Additionally, core ethical considerations will be to understand and to be educated on the different minority, ethnic, and refugee populations in New Hampshire with the cultural and religious beliefs they hold around mental illness. Partnerships could also be developed between mental health providers and traditional healers and/or community elders where synergies could be built on (54, 67) (Gropalkrishnan, 2018). Moreover, important ethical considerations will be to collaborate with stakeholders, such as the refugee resettlement agencies in NH and other minority and ethnic community organizations. Furthermore, educating the target population on informed consents and confidentiality in mental health prevention and treatment will possibly put the target population more at ease to engage in a SMI and AMI prevention and treatment program.

PART 5: ADVOCACY

Mental Illness Awareness in the State of New Hampshire

At the Institutional level, being schools, churches and community organizations, there would be important barriers to address for residents with serious mental illness (SMI) and any mental illness (AMI) in the state of New Hampshire (Butler et al., 2015). Thus, at the institutional level, a barrier identified in New Hampshire for those residents with SMI and AMI would be the lower rates of access to mental health services for African descendants, Mexican Americans, and other Latinos. These marginalized residents of NH feel discrimination and would be less likely to

access help within the schools, churches, and other community organizations (Gee et al., 2006). At the community level, The Multicultural and Social Justice Counseling Competencies (MSJCC) states that the community as a whole represents the spoken and unspoken norms, value, and regulations that are embedded in society (Butler et al., 2015). The norms, values, and regulations of a community may either be empowering or oppressive to human growth and development (Butler et al., 2015). Thus, the discrimination felt by not only refugees, but also other African descendants, Mexican Americans, and other Latinos in NH would keep them from the institutional organizations needed for mental health services; it would be important for the privileged and marginalized community members as a whole to address and take action to remedy the lower rates of access to and engagement in mental health services for these specific populations.

At the public policy level, the barrier to mental health services of marginalized populations in New Hampshire is being addressed with a 10-Year Mental Health Plan. However, it will be paramount to follow the plan as it is implemented and to ensure that it is doing its job in breaking down the barrier for the marginalized populations in NH and their understanding of mental health and access to mental health services. Nationwide and regionally, racial and ethnic minorities experience a variety of mental healthcare access barriers (Department of Health and Human Services NH, 2019). To fully meet the needs of an increasingly diverse population, the stakeholders believe that NH needs not only equal access, but also culturally and linguistically competent services for all. Access issues can include transportation barriers, challenges with child care and time off work, language barriers, and inadequate healthcare benefits (Department of Health and Human Services NH, 2019). More fundamentally, stigma, racism, and

discrimination can pose significant challenges to equity in mental health access and outcomes (Department of Health and Human Services NH, 2019).

At the institutional level, one advocacy action to take to address the accessing of and engaging in mental health services for the marginalized populations in NH would be educational outreach through the schools, churches and other community organizations. Through education at the institutional level, many people would be informed of and educated in the importance of accessibility and engagement of mental health services for the marginalized populations in NH. Importantly, the dissemination of mental health research and public education about mental disorders remain priorities for NIMH (National Institute of Mental Health) – with new investments that are expanding the reach of the Institute's outreach efforts (NIMH, 2020). In 2019, NIMH launched a new outreach strategy that reflects the significant changes in the way the public accesses health information and how organizations communicate that information to the public (NIMH, 2020). This effort bolsters NIMH's support of the outreach and education activities of community and national organizations with the addition of new education and awareness resources and the Discover NIMH e-newsletter, along with existing mental health information and publications (NIMH, 2020). National Institute of Mental Health's outreach strategy could be an important strategy to align with for an awareness and prevention program in New Hampshire.

At the community level, one advocacy action to take to address the accessing of and engaging in mental health services for the marginalized populations in NH would be continued educational outreach within the specific community organizations within each individual community of NH. Each community in NH doesn't have the same community organizations, so

targeting specific, heavily trafficked organizations with education on this subject would increase community knowledge.

At the Public Policy level, one advocacy action to take to address the accessing of and engaging in mental health services for the marginalized populations in NH would be to follow closely to see if the 10-Year Plan is working. If it is not, then it would be important to re-evaluate the plan and to make adjustments. By following closely to how the plan is working would allow for interventions and if needed, additional advocacy.

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