



ALAMEDA COUNTY BHCS
ROUND THREE
INNOVATION GRANT PROGRAM

O-Well!



TheOverallWellnessMovement

California Institute For Behavioral Health Solutions

Alameda County Peer Support
in Congregations Collaborative:
Education and Peer Support Project
AKA Overall Wellness Movement



California Institute For Behavioral Health Solutions

Alameda County Peer Support in Congregations Collaborative: Education and Peer Support Project AKA Overall Wellness Movement

OUR STORY

The Overall Wellness Movement is a collaborative of faith-based organizations. These congregations are led by LGBTQI2S people who have extensive experience providing spiritual support to LGBTQI2S people of color with serious emotional disturbances and mental illness. The church is often the first place members of the community go for support to address family crises. LGBTQI2S people of color living with mental illness are no different. The church plays a critical role in managing mental illness in this community. This project builds the church's capacity to provide emotional, spiritual and practical support to people living with mental illness. Churches, as first responders, have the potential to expand the resources available to respond to the mental health needs of LGBTQI2S individuals and families.

For more information, please contact:

Affirming Hope Ministries

Pastor Kenneth Melton
1608 Webster Street—Oakland, CA 95612

New Revelation Community Church

Rev. Dr. Donna E. Allen
1448 14th Street—Oakland, CA 94607
Church 510.473.7783 | Cell 510.593.5602
info@newrevelationcommunitychurch.org
www.newrevelationcommunitychurch.org

City of Refuge UCC

Rev. Dr. Toni Dunbar, Associate Pastor & Dean
8400 Enterprise Way—Oakland, CA 94621
510.633.6316

info@cityofrefugeucc.org | www.cityofrefugeucc.org

California Institute for Behavioral Health Solutions (CIBHS)

Kristee L. Haggins, Ph.D., Senior Associate
2125 19th Street—Sacramento, CA 95818
916.224.0875

khaggins@cibhs.org | www.cibhs.org

This work is placed in the public domain and may be freely reproduced, distributed, transmitted, used, modified, built upon, or otherwise used by anyone for any purpose.

The views and opinions of authors expressed herein do not necessarily state or reflect those of the County of Alameda or the County Behavioral Health Care Services Agency.

This project was funded by the Innovation Grants Program through the Prop 63 Mental Health Services Act.

O-Well!



TheOverallWellnessMovement

O-Well Program Design

*Submitted by
The Overall Wellness Collaborative*

Alameda County Peer Support and Congregations Collaborative
Education and Peer Support Project
(Grant#: 3INN295LGBT-LD-CIMH)

Program Design Content Guidelines

Date: February 29, 2016

Project Name: Alameda County Peer Support and Congregations Collaborative – Education and Peer Support Project. The Overall Wellness Collaborative (O-Well)

Grantee Organization: California Institute for Behavioral Health Solutions (CIBHS) [formerly the California Institute for Mental Health (CiMH)]

Contact Information: 2125 19th St. Sacramento, CA 95818

Project Contact: Kristee Haggins

LEARNING QUESTION

#3) How would BHCS work more effectively with families who have a LGBTQI2S member with a serious emotional disturbance or serious mental illness?

BHCS is responsible for the provision of mental health services to eligible residents of Alameda County. LGBTQI2S individuals are a subset of the residents of Alameda County but are unserved and underserved within the system of care. There are not enough providers trained to address the needs of this complex population. The Overall Wellness Collaborative (O-Well) proposes that BHCS begin by expanding its definition of family to include the rich diversity of family constellations demonstrated within the LGBTQI2S community. For some LGBTQI2S individuals “family” includes or is their “church community,” as the relationship with their family of origin may be strained or non-existent. The church becomes a place for healing and refuge.

BHCS should also expand its capacity to provide culturally appropriate services to LGBTQI2S consumers and their families by training natural sources of supports established within the LGBTQI2S community. There are numerous effective strategies which can be provided through connections with the faith community, and LGBTQI2S affirming congregations in particular. By using evidence based practices such as, or similar to Wellness Recovery Action Planning (WRAP) and Mental Health First Aid (MHFA) in conjunction with peer support, LGBTQI2S people with lived experience can raise their awareness of mental illness, reduce stigma related to mental illness, and be trained to provide prevention and early intervention support. Interventions are provided in a safe environment by people with proven experience providing services to the LGBTQI2S community.

Research indicates most people turn first to their spiritual leader for support when in a crisis rather than a therapist. Given this and the unique stressors of the LGBTQI2S population, it is critical to build the capacity of churches to respond to the behavioral health needs of its own community. Affirming ministries play a unique and important role in improving mental health, establishing hope, focusing

on recovery, providing support, offering prevention strategies, and reducing stigma. Establishing collaborative relationships between faith based organizations (FBOs) and BHCS so that both the FBO and the system can learn and grow, increases the likelihood of effective service provision for this population.

Desired Outcome: Final Program Design shall include a process for arriving at recommendations supported by evidence-based or best practice findings; collaboration with LGBTQI2S stakeholders and a process for stakeholder involvement with BHCS clients/consumers, family members and providers; and be specific regarding program design, components, resource requirements, and pro forma budget.

PROGRAM DESIGN

1. What are the program goals?

- To expand the capacity of BHCS to meet the needs of LGBTQI2S through the training of open and affirming / LGBTQI2S Faith Based Organizations (FBOs) to respond to behavioral health needs of LGBTQI2S people
- To increase the capacity of open and affirming FBOs to respond to behavioral health needs LGBTQI2S people through stigma reduction, training and peer support strategies
- Identification of strategies for engaging the LGBTQI2S community with sensitivity to and awareness of the role of spirituality and religion.

2. Describe the Program Design, including the essential program components (e.g., outreach & engagement, service, evaluation, etc.)

The Overall Wellness Collaborative (O-Well) aka the Alameda County Peer Support & Congregations Collaborative Education & Peer Support Program – is a collaborative of five Alameda County churches that are same gender loving affirming congregations. They reach out to LGBTQI2S youth and adults, their peers, families, allies and providers with certified, evidence-based mental health family and community support training; ongoing peer support; and resources for culturally-competent, LGBTQI2S-peer or allied spiritual care, especially for people of color.

O-Well worked closely with BHCS, trained dozens of people in Wellness Recovery Action Planning® (WRAP) and Mental Health First Aid® (MHFA), and developed a number of initiatives aimed at eliminating stigma and increasing the number of people in our communities who can provide wellness support for themselves and others with lived experience. O-Well does not proselytize, but brings the resources of faith communities forward in the public debate and support for systems of care for people with mental health. This project provides a unique strategy for supporting this community and encouraging the utilization of BHCS care where appropriate.

Specifically, OWELL included:

- Training of faith leaders and congregants as Mental Health First Aid (MHFA) and Wellness Recovery Action Planning (WRAP) Facilitators
- Mental Health Education and Stigma Reduction Sessions – Inclusive of MHFA and various other presentations
- Development of Specialized unique support groups for LGBTQI2S populations

3. How did the program impact the population served by this project?

The first signs that the program was effective came in the feedback from the churches that the number of requests for support around a mental health crisis had significantly increased. In response, the churches began training increased numbers of lay leaders and people with lived experience in MHFA. One church trained over 40 people in the church, which included all of their staff and lay leaders as well as congregants and their families. The uptake of WRAP within the churches resulted in leaders developing self care programs for the peers who were providing support because they, too, were overwhelmed by the positive response resulting in increased requests for WRAP and support in general.

Participants found the MHFA and WRAP trainings very effective in helping them communicate, identify, and respond to mental health challenges in their community and themselves. Many felt it gave them a new way to support each other. The training offered insight on why and how mental health was affecting their lives. It also gave them ideas about how and when to support others who were going through crisis. The support groups developed as a result provided a structured means of responding to the needs of LGBTQI2S people around them. The peers developed the groups and its content. They often reported being satisfied that people were finally listening and asking them what they needed. They were empowered by the opportunities to develop strategies that spoke to their specific challenge.

There were several occasions where participants described their relief in having a safe place where they could discuss their mental health challenges. Many described themselves as “being in the closet” regarding their mental health diagnosis, the medications prescribed for them, and their need for support. After being trained in MHFA and WRAP, they no longer felt alone; there were other people around them who were also trained and living with similar challenges. Now, they also have a place to go for support. In this case, the project reduced internalized stigma.

Training the clergy and lay leaders in the church in MHFA and WRAP also reduced the stigma in the church, making it possible for individuals living with mental illness to get the type of support they needed. As a result of the project, two of the churches are developing counseling spaces within their facilities.

Finally, it was brought to our attention that oftentimes mental illness is discussed outside the context of sexual orientation and the church. This project brought all three together, one respondent said... “You’re finally talking about me!” The project provided a safe space to navigate the complexity of their every day lives.

PROGRAM STRATEGIES

Describe the strategy(s), methods of implementation and timeframe.

Phase 1 (First quarter)

- Building capacity for communication between churches and participants;
- Developing materials (e.g., marketing flyers; O-Well website)
- Recruitment of potential participants (i.e., email lists)
- Outreach activities at events (e.g., City of Refuge Health Fair; Lambda Youth Gay Prom; Uniting for Justice Conference)
- Presentations provided (e.g., “No Stigma-No Shame”; “Stigma and Mental Illness in the Black community”)

Phase 2 (Second quarter)

- MHFA Training provided for recruitment of facilitators
- Training of MHFA Facilitators from Churches
- Continued outreach at events for recruitment (e.g., Oakland Art & Soul; Oakland Pride)

Phase 3 (Third quarter)

- MHFA Trainings offered by Facilitators
- Presentations Provided (e.g., “Mind, Body, and Soul”; Spirituality Factor Conference)
- Ongoing recruitment efforts – via email, phone, face-to-face (i.e., Mental Health and Spirituality Initiative Conference)
- Beginning Development of Support Group Curriculum – using a field testing type process (e.g., Well-abled Ministry Support Group [WAM]; Brutha’s Rising)
- Collaborative project established with The TransExcellence Clinic to begin providing transgender-focused medical and mental health services onsite at COR

Phase 4 (Fourth quarter)

- Group Curriculum Development Continued (e.g., WAM and Brutha’s Rising)
- MHFA Trainings – Begin exploring how to support those trained in MHFA; responding to crises

Phase 5 (Fifth quarter)

- WRAP Trainings for facilitators (2 and 5 days)
- MHFA Trainings offered by facilitators
- Group Curriculum Development Continued (e.g., WAM and Brutha’s Rising)
- Group Curriculum Development (e.g., MHFA Support and WRAP Anti-Burnout)
- Presentations provided

Phase 6 (Completion)

- Completion of Curriculum Development and Implementation (e.g., WAM, Brutha’s Rising, MHFA Support, WRAP Anti-Burnout)
- MHFA Trainings offered by facilitators
- Presentations Provided

PROJECT SUBPOPULATION

Identify the subpopulation of LGBTQI2S clients / consumers for whom this program was most effective. Please include age, culture/ ethnicity, language, and other factors. How was this determined?

In this project the LGBTQI2S consumers were predominantly African American people who have a strong sense of attachment to and faith in Christian churches that support LGBTQI2S community. The leaders of those churches were predominantly members of the LGBTQI2S community. The peers who were trained in MHFA and WRAP were members who identified as LGBTQI2S as well. The churches that participated in the project are “radically inclusive”, embracing same gender loving and gender non-conforming people from all walks of life.

The people who received services through the project ranged in age from 18-77; they were primarily low income; most were on some form of disability from either physical ailments and/or behavioral health conditions. Many were tenuously housed and/or unemployed; but unlike the general population of the unemployed, most had completed high school and had some exposure to a college education.

This population of LGBTQI2S individuals resides in a very transient community. People move often looking for work, relationships and housing. Many were biological parents of children. Many created families made up of a variety of adult peers after having been rejected by their own families as a result of their homosexuality and / or gender non-conformity. This network of “family” is fluid, allowing people to move in or out based on need and serves as a safety net during difficult times. This notion of family also runs through the churches as well. It is not uncommon to hear members of the churches referred to as “momma” between people who have no blood ties between them. This family reinforces the wellness of the community.

This marginalized community often reported experiences of social isolation, hopelessness, fear of violence, suicidal impulses and behaviors, chronic depression, anxiety, bipolar conditions, psychotic disorders all of which may be influenced by some form of substance use.

How are the strategies culturally responsive to the target population?

The project utilized peers as the foundation of the approach to train trainers, develop curricula, in the delivery of the content, and as providers of support. The support groups were all developed by LGBTQI2S individuals with lived experience with mental illness and or their families. The field test participants recognized these strategies as culturally competent for the LGBTQI2S community when delivered by LGBTQI2S individuals or family members. All of the curricula were developed and delivered by the target population. The content of the groups organized through Well-Abled Ministry (WAM) and Brutha’s Rising was selected by the individuals who participated in the groups.

PROGRAM COLLABORATORS **

1. Describe collaborations with LGBTQI2S stakeholders, the process for LGBTQI2S stakeholders

This question appears to be relevant to learning question 4. However, this project capitalized on the collaborations for the Welcoming Toolkit, for which O-Well also received a grant. Collaborative partners who

assisted with recruitment were Volunteers of America, West Oakland Senior Center, Berkeley Women's Health Center, Marijke Fakasiieiki, a Certified Enrollment Counselor for Covered CA, Uniting for Justice Conference, Dr. Mary Jane Simms, Bishop Bonnie Allen, Elaine Shelley, Lambda Youth Gay Prom, and LGBT Social Security Administration employees.

- 2. Describe process for stakeholder involvement with BHCS clients/ consumers, family members, and BHCS contracted providers. * For LQ 4:** (i.e., Parents, Families & Friends of Lesbians and Gays (www.pflag.org); the Gay-Straight Alliance Network (www.gsanetwork.org);

This question appears to be relevant to learning question 4. See response above.

EFFECTIVENESS OF STRATEGIES

- 3. How do you know these strategies are effective in achieving goal of reducing isolation for the target population?**

Using video taped testimonials, we were able to collect vignettes of people who participated in the project describing their participation in the project and its impact on their mental health and lives. The two churches that implemented the entire program experienced an upsurge in the number of requests for support related to mental illness or and emotional crisis. At the initial phases of the program, churches dramatically increased the number of people trained in MHFA as a result of the feedback given by participants in its early training. Church leaders have reported an increase in the number of people engaged in care, people who have voluntarily committed themselves into inpatient psychiatric settings; there have also been reports of interventions that resulted in a disruption of suicidal ideation and behaviors. The churches have started planning the creation of formal spaces within the church for ongoing counseling and mental health support.

- 4. Describe the process for arriving at the Program Design supported by evidence-based or community defined best practice findings.**

This program design began as a statewide initiative aimed at introducing clergy to MHFA, WRAP and peer support as a means of managing mental illness within the church. There were five churches from Alameda County that participated in the initial statewide project. At the completion of that project, the churches decided that they wanted to extend the concept across their community and incorporate specific strategies using a support group format to engage specific populations within their congregations. The opportunity to do so through the Alameda Innovations BHCS grant became available and thus the creation of the Overall-Wellness Collaborative aka O-Well.

Generally, the churches that participated in O-Well are small in comparison with traditional churches. Their financial support is very limited resulting in small number of staff, if any, beyond the pastor to support the program. However, they were experiencing an unmanageable number of crises that appeared to be related to mental illness. It was determined that a peer support model would allow for greater reach across the

congregation; it would provide access to practical information and experience in determining appropriate referrals; peers could be used as first responders when the clergy was unavailable.

The statewide project trained the pastors in Mental Health First Aid and received positive feedback regarding its effectiveness, ease of understanding, content appropriateness, and most importantly the opportunity in small group discussions for people with lived experience to share their stories making the exercises more culturally relevant. Thus it was selected for use during the O-Well project. WRAP was chosen because it is a practice that incorporates insight and strategies for self care and in which the engagement of a team to support individuals after a crisis and a plan to mitigate future crises could be used. The churches needed a structured process to discuss recovery strategies and a means of intervening before the crisis gets beyond their ability to help.

The content of all the support groups were developed and delivered by people with lived experience with mental illness. The content was selected by people who expressed interest in the group and perceived the goals of the group compatible with their own.

5. Provide quantitative and qualitative data that show the effectiveness of the strategies. Include measures of effectiveness and data sources used.

The program used process data such as sign-in sheets, individual and group feedback to determine its effectiveness while developing the program. Participation in the program was a strong indicator of whether the program addressed the needs of the congregants and their communities and families. 129 people were trained in the adult version of MHFA. 25 people were trained in the youth version of MHFA. 8 people were certified as facilitators for MHFA. 13 people were trained in the 2 day WRAP and 11 became certified trainers during the 5 day WRAP training. The churches created 4 support groups each group was convened a minimum of 8 sessions with average attendance of 8 people per group. We also collected six hours of video with impact statements from participants and the facilitators.

REPLICATION OF PROGRAM DESIGN

6. How do you recommend replicating this Program Design?

The original program design contained a variety of phases that were challenging to implement. The churches found it difficult to implement this program and maintain their other normal duties. So it is recommended that the timeline for full implementation be extended to 24-27 months:

- a. Phase 1 – Mental Health Awareness Campaign (6 months)
 - i. Engage guest speakers to talk about the impact of mental illness, stress on the family community and individual
 - ii. Gain buy-in from senior clergy – conduct a special Mental Health First Aid and /or WRAP training for senior clergy
- b. Phase 2 – Building the Capacity to Respond (12 months)

- i. Identify people with lived experience in the congregation who can serve as peer support
 - ii. Train peers in Mental Health First Aid
 - iii. Train peers in WRAP
- c. Phase 3 – Create Ongoing Support Services (9 months)
 - i. Convene people with lived experience and trained MHFA and WRAP individuals
 - 1. Determine greatest needs in the congregation
 - 2. Identify effective strategies to address needs
 - ii. Develop and Implement one strategy with input and participation from peers
 - iii. Pilot test the strategy for 1 month
 - iv. Evaluate the outcomes and refine the strategy based upon input
 - v. implement the strategy for at least 6 months before initiating another pilot.

7. What are the essential elements to replicate this program?

The power and effectiveness of this design lies in its use of peers as a means of delivering services. The project expands access to prevention and early intervention strategies for LGBTQI2S individuals and their families by training natural sources of support within the community in which they live. The project utilized peers as the foundation to train trainers, develop curricula, the delivery of the content, and provide support. The use of peers reduces stigma related to mental illness, isolation, creates a community of informed volunteers who often report satisfaction and value in giving back to their community.

The training of the senior pastor / clergy is essential for buy-in and ongoing support within the church. Pastors serve as role models to the congregation. Their participation and validation will help sustain the program during challenges and uptake.

8. Identify staffing requirements: a) Job title; b) Role/ responsibilities with Full Time Employment (FTE); c)Required qualifications, certification and / or licensure.

Each of the support groups has a list of qualifications for the group facilitators:

Mental Health First Aider Support Group

- Facilitators must also be certified and have experience training in Mental Health First Aid.
- They must also have background in supporting mental health providers in self care and group process.
- Because this a peer run and peer developed curriculum, facilitators must have lived experience with an emotional crisis and /or mental illness. Family members and advocates may also serve in this role as well.
- Facilitators may also be specialists from various fields that offer expertise in supporting individuals with undiagnosed, untreated or poorly managed mental illness.

WRAP Anti-Burn Out Support Group

- All facilitators must also be certified WRAP facilitators

Well Abled Ministry

- This model utilizes a co-facilitator model, which requires at least one peer with lived experience and one facilitator who also has training as a social worker or therapist. This particular support group has been extremely successful because one facilitator was both a peer and trained in mental health.
- It also requires an advisor who can help keep the group on track when the facilitators.
- Facilitators should be trained in Mental Health First Aid and WRAP when possible.

Brutha's Rising

- It is recommended that there be more than two facilitators.
- Facilitators must be people with lived experience or a combination with experienced allies or family members.
- All the facilitators should be reflective of the target population.
- Practical experience and knowledge of the transgender community, services and the transition process is crucial.
- Services provided by the facilitators must be culturally competent and relevant to the community intended for service.
- Facilitators must be trained in Mental Health First Aid and Wellness Recovery Action Planning. More skilled facilitators may also have training in case management with experience accessing public social and medical services.
- Facilitators should also be flexible in their understanding of the process of transition, which is different for every individual. Facilitators must be comfortable with the pace of and final destination in the transition that is different for every individual.
- Facilitators must also be comfortable allowing the individual to describe their experience and the terms / pronouns used to define themselves.
- Finally, facilitators must have hands on experience supporting the needs of LGBTQI2S individuals and their families.

17. Identify the collaborators necessary to the success of the program.

It is recommended that churches attempting to implement this program connect with LGBTQI2S experts in their community. These experts can provide access to information and training to increase their ability to respond to the needs of LGBTQI2S individuals. Churches should also contact ACBHCS for information and access to trainings to increase their awareness of mental illness. In Alameda County churches seeking to implement this model should contact City of Refuge or New Revelation Community Church to coach them through the process.

18. Recommendations for resource, facilities, and infrastructure requirements needed for support:

- Technology and equipment needs - none
- Systems and services needs (e.g., billing, interpreter, etc.) – none
- Budget requirements – Churches should expect to invest \$10,000 in speakers, training of facilitators, special events to promote good mental health

- One - time costs (e.g., implementation and training) Wellness Recovery Action Planning facilitator training is somewhat costly and should be included in the budget. Mental Health First Aid training can be accessed for free through ACBHCS
- Other resources required for infrastructure support – a stipend should be set aside for volunteer incentives for peers who provide ongoing support. Food for groups is also an important incentive for participants.

NOTE: Attached are the curriculums for the four support groups developed by O-Well.

1. Mental Health First Aider Responder Support Group
2. WRAP: The Anti-burnout!
3. Well Abled Ministry Support Group
4. Brutha's Rising: Transgender Men of Color

MENTAL HEALTH FIRST AIDER RESPONDER SUPPORT GROUP CURRICULA OUTLINE

Overview:

After conducting a series of Mental Health First Aid trainings for LGBTQI2S individuals living with mental illness, allies and their families, the community quickly became aware of the number of people who were at risk of and/or experiencing a mental illness. They immediately began responding to those in crisis, resulting in a need for more training. In an effort to address the increased need for early intervention and referral, LGBTQI2S clergy, lay leaders, and people in helping professions were trained to train other and serve as first responders. They, too, became quickly overwhelmed by the number of people in their congregations and social networks who were struggling with emotional crises and mental illness. It was apparent that the MHFA trained facilitators needed support to address issues related to self care.

Purpose:

The purpose of this support group is to provide an encouraging, supportive and continuing education environment for trained Mental Health First Aiders (MHFA) who are using their skills to approach, assess and assist individuals with mental health challenges or in crisis during outreach and service provision to the community and within the church.

Curricula Design:

- Target Population / Who and What is this group designed to address?
 - The target population is MHFA who serve in communities where a significant percentage of clients have undiagnosed, untreated or poorly managed mental illness. These leaders are LGBTQI2S, most are African American and possess a particular sensitivity to the needs of this underserved population, although the clients are from all walks of life.

- Curricula design process (how was the curricula developed?)
 - The curriculum was developed over the course of 12 months during which a series of conversations were held with people who were trained in MHFA and who were attempting to use the strategies to address the needs of people at risk or living with mental illness and their families. MHFA generally identified the following as issues they would like to discuss:
 - their experiences in serving
 - challenges they faced
 - identified concerns about how to enhance their work
 - how to improve their skills

From there a specific format and topics were outlined and tested in actual settings with trained MHFA facilitators.

- Leader Qualifications – Who are the facilitator(s)
 - The facilitator for the development and implementation of the draft curriculum was Rev. Donna E. Allen, PhD the founder and Senior Pastor of New Revelation Community Church. Dr. Allen has over 25 years in pastoral experience. She is also a certified Mental Health First Aid Instructor, Staff Chaplain at Sutter Health Alta Bates Summit Medical Center, has completed a residency in Clinical Pastoral Education and a certified Wellness Recovery Action Plan Instructor.
 - Facilitators must also be certified and have experience training in Mental Health First Aid.
 - They must also have background in supporting mental health providers in self care and group process.
 - Because this a peer run and peer developed curriculum, facilitators must have lived experience with an emotional crisis and /or mental illness. Family members and advocates may also serve in this role as well.
 - Facilitators may also be specialists from various fields that offer expertise in supporting individuals with undiagnosed, untreated or poorly managed mental illness.
 - Finally, facilitators must have hands on experience supporting the needs of LGBTQI2S individuals and their families.

- Participant eligibility criteria
 - All participants must have received certification as Mental Health First Aiders within the past two years and have been working in environments that are open and affirming to the LGBTQI2S community and have a high population of individuals with undiagnosed, untreated or poorly managed mental illness.

- Time Allotted For Each Group
 - Each group is 60 minutes.

Curricula Description:

The MHFA Responder’s Support Group is a series of eight meetings held once per month. The meeting format is a peer led community defined practice that uses journaling, psycho-educational reading materials and discussion as a means of exploring the emotional and psychological impact of supporting people who live with mental illness on the provider of that support.

Group process is a facilitated open discussion giving participants an opportunity to share and reflect on especially challenging and or rewarding experiences in serving the clientele. Group activities also include, reading materials, role-play, and video, PowerPoint and written presentations that instruct on current information about mental health in underserved populations and evidence based practices for crisis intervention from research partners of National Mental Health First Aid USA.

This process allows for the participants to express their feelings and share their journey. The sharing of personal experiences is both cathartic and empowering. It creates a safe environment for the trained professionals who are present to discuss any concerns they have about their

interactions with clients. It creates an atmosphere for instructors and peers to validate their actions and to identify areas of growth as each is encouraged to use evidenced based best practices. The instruction component in the continuing education uses multiple teaching methods to address diverse learning modalities.

- Topics / activity for each group meeting and basic description
 - Meeting #1 - Introduction
 - Prayer/Centering Moment
 - Overview of the group
 - Rules/Guideline for Interaction/discussion - Step Up Step Back Group Communication Model
 - Warm Up Activity – Getting to Know You – Why do you do this work?
 - Guided Meditation for relaxation, de-stress, etc.
 - Skills Enhancement Introduction – During each session a time for skills development will be set aside. Introduce this component and solicit ideas from the group about which skills they would like to improve.
 - Continuing Education Discussion – review ALGEE
 - Close – moments of silence (deep breathing exercises)
 - Meeting #2
 - Prayer/Centering Moment
 - Review Rules/Guideline for Interaction/discussion - Step Up Step Back Group Communication Model
 - Warm Up Activity – Getting to Know You – Favorite Movie and Why?
 - Guided Meditation for relaxation, de-stress, etc.
 - Skills Enhancement – Meditation – basics for beginners
 - Continuing Education Discussion – A Brief Mental Health Checkup – The group may want to focus more on treating illnesses, both physical and mental, than on staying healthy. But the absence of mental illness does not necessarily mean good mental health. (Resource: American Psychiatric Association) Encourage the group to expand their thinking on this subject.
 - Close – moments of silence (deep breathing exercises)
 - Meeting #3
 - Prayer/Centering Moment
 - Review Rules/Guideline for Interaction/discussion - Step Up Step Back Group Communication Model
 - Warm Up Activity – Getting to Know You – Favorite Food and Why?
 - Guided Meditation for relaxation, de-stress, etc.
 - Skills Enhancement – Food Safety
 - Continuing Education Discussion – A Brief Mental Health Checkup
 - Close – moments of silence (deep breathing exercises)

- Meeting #4
 - Prayer/Centering Moment
 - Review Rules/Guideline for Interaction/discussion - Step Up Step Back Group Communication Model
 - Warm Up Activity – Getting to Know You – Favorite Movie and Why?
 - Guided Meditation for relaxation, de-stress, etc.
 - Skills Enhancement – Meditation – basics part 2
 - Continuing Education Discussion – A recent Washington Post article about how our criminal justice system deals with addictions and how even the best of intentions can have unintended consequences. Example: California voters unknowingly made a bad bargain when they voted to reform the way the courts treat people with addictions; less jail time, but also less leverage to get them to go into treatment programs. But like so many substance use issues, it turns out to be more complicated.
 - Close – moments of silence (deep breathing exercises)

- Meeting #5
 - Prayer/Centering Moment
 - Review Rules/Guideline for Interaction/discussion - Step Up Step Back Group Communication Model
 - Warm Up Activity – Getting to Know You – Tell A Joke!
 - Guided Meditation for relaxation, de-stress, etc.
 - Skills Enhancement – Conflict Resolution – 101
 - Continuing Education Discussion – View and discuss The University of Illinois, Center on Psychiatric Disability and Co-Occurring Medical Conditions exercise and information video for improving weight management and wellness. It is a modified version of the RENEW (Recovering Energy through Nutrition and Exercise for Weight Loss).
 - Close – moments of silence (deep breathing exercises)

- Meeting #6
 - Prayer/Centering Moment
 - Review Rules/Guideline for Interaction/discussion - Step Up Step Back Group Communication Model
 - Warm Up Activity – Getting to Know You – Favorite Childhood memory.
 - Guided Meditation for relaxation, de-stress, etc.
 - Skills Enhancement – cultural competency
 - Continuing Education Discussion – Review and discuss recent research published by the Department of Psychology, Howard University, Washington, DC on the influence of coping with perceived racism and stress on lipid levels in African Americans. The relationship between elevated levels of lipids and behavioral coping

responses to perceived racism suggests that African Americans may be at increased risk for cardiovascular disease due to the unique stress encountered by racism in our culture.

- Close – moments of silence (deep breathing exercises)

○ Meeting #7

- Prayer/Centering Moment
- Review Rules/Guideline for Interaction/discussion - Step Up Step Back Group Communication Model
- Warm Up Activity – Getting to Know You – Share something about yourself no one in the group knows!
- Guided Meditation for relaxation, de-stress, etc.
- Skills Enhancement – networking with community resource providers
- Continuing Education Discussion – View and discuss a video recording of “Stress and Health: The New “Apple a Day” Prescription” A Conversation with Drs. Herbert Benson and Gregory Fricchione, Benson-Henry Institute for Mind-Body Medicine at Massachusetts General Hospital

Note: The Benson-Henry Institute for Mind Body Medicine is a scientific and educational organization dedicated to research, teaching, and clinical application of mind-body medicine and its integration into all areas of health. Herbert Benson is a pioneer in mind-body medicine with a career spanning decades. BHI Director Gregory Fricchione is responsible for clinical, educational, and research efforts. In this exclusive interview with CIHS, Drs. Benson and Fricchione explain the science of stress and how stress management improves health for people with chronic physical, mental, and addiction disorders.

- Close – moments of silence (deep breathing exercises)

○ Meeting #8

- Prayer/Centering Moment
- Review Rules/Guideline for Interaction/discussion - Step Up Step Back Group Communication Model
- Warm Up Activity – Getting to Know You – How do you say goodbye?
- Guided Meditation for relaxation, de-stress, etc.
- Skills Enhancement – Meditation – basics for beginners
- Continuing Education Discussion – Why do I need Emotional Intelligence / Emotional Competence skills?
By learning the skills to manage your feelings, emotions can become something that empower you rather than sabotage your relationships, activities and careers. Guest Dr. Lona Flowers
- Close – moments of silence (deep breathing exercises)

WRAP: THE ANTI-BURN OUT!

CURRICULA OUTLINE

Overview:

- Purpose of the Support Group

The purpose of this group is to offer wellness tools and peer support to individuals working in community service.

Curricula Design:

Target Population / Who and What is this group designed to address?

Often the volunteer in a church outreach ministry are persons who have first hand experiences with mental illness and substance abuse. These individuals living in recovery are often the best persons to work in an outreach ministry because they have empathy with the clientele and can identify with the challenges they face. They however are especially vulnerable to burn out and falling into poor self care. This support group teaches the mental health recovery tool developed by Mary Ellen Copeland, known as WRAP – Wellness Recovery Action Plan as an aid to prevent burn out among the workers and to instill in them positive life skills and wellness practices for their overall wellbeing.

Curricula design process (how was the curricula developed?)

This curriculum is Mary Ellen's WRAP workshop divided into an eight session Mental Health Recovery and Wellness Recovery Action Planning group.

Leader Qualifications – Who are the facilitator(s)

Donna E. Allen, Linda Martin, Beautiful Wright, and Naki-Ta D. Thomas all of whom are certified WRAP facilitators trained by a Copeland Center trained Advanced Level WRAP Facilitator. All other facilitators must also be certified WRAP facilitators.

Participant Eligibility Criteria

Individuals volunteering in a faith based or community program that provides services to an underserved population interacting face to face with the client. The participants are individuals who have experienced mental health difficulties and are currently providing care services or doing advocacy work with persons at risk for mental health difficulties or living with mental illness.

Timeline:

- Duration of each group - 90 minutes.
- 9 sessions (1 introductory session and 8 instruction sessions) once per month

Curricula Description:

The WRAP program is an evidenced-base model for teaching mental health recovery skills to people who experience mental health difficulties, their family members and community and health care providers. The original instructions rely on the basic use of co-facilitation and group discussion. This curriculum enhances the impact of original model by integrating a peer led strategy. The participants utilize their own experience and the experience of others to make the experience more culturally relevant and replicable in their native environment.

The following is a description of the format and topics / activity for each group meeting.

- Introductory Session – defining what burn out is and why it happens. General discussion about wellness resources and discussion on why a wellness action plan is important.
 - Meeting #1 - Introduction
 - Overview of the group
 - Key Concepts in Recovery
 - Hope
 - Personal Responsibility
 - Education
 - Self-Advocacy
 - Support
 - Issues that need to be addressed:
 - exploring medical cause
 - medication management
 - Adjourn – moments of silence
 - Meeting #2
 - Review previous session topic
 - Begin developing a Wellness Recovery Action Plan: techniques and strategies for reducing difficulties, as well as for ongoing management and prevention, to be used in developing a WRAP:
 - Supports
 - Working with health care providers
 - Peer counseling
 - Counseling
 - Focusing
 - Stress reduction and relaxation techniques
 - Adjourn – moments of silence
 - Meeting #3
 - Review previous session topic

- Wellness Toolbox
 - Diversionary activities
 - Journaling
 - Music
 - Exercise
 - Diet
 - Light
 - Sleep
 - Adjusting and securing the environment
 - Daily planning
 - Adjourn – moments of silence
- Meeting #4
 - Review previous session topic
 - Developing Action Plans
 - Daily maintenance list
 - Triggers
 - Early warning signs
 - When things are breaking down
 - Adjourn – moments of silence
- Meeting #5
 - Review previous session topic
 - Crisis Planning – a plan that engages people who can provide support and gives supporters specific instructions on how to support you in getting well and staying well.
 - Adjourn – moments of silence
- Meeting #6
 - Review previous session topic
 - Addressing Specific Issues
 - Trauma
 - Building self-esteem
 - Suicide prevention
 - Changing negative thoughts to positive
 - Adjourn – moments of silence
- Meeting #7
 - Review previous session topic
 - Developing a lifestyle that enhances wellness
 - Careers and interests
 - Benefits
 - Refining your lifestyle
 - Adjourn – moments of silence

- Meeting #8
 - Review previous session topic
 - Motivation
 - Problem Solving
 - Closing ritual

WELL ABLED MINISTRY SUPPORT GROUP (WAM)

CURRICULA OUTLINE

Overview:

- Purpose of the Support Group
 - Vision Statement: The Well Abled Ministry (WAM) vision is to support, empower and encourage participants who have experience with visible and invisible physical challenges. WAM is a peer-to-peer support group whose desire is to address the emotional and spiritual healing of those members whose physical challenges have a significant impact on their mental health and well-being.

Curricula Design:

- Target Population / Who and What is this group designed to address?
 - WAM is a topical support group for persons with visible and invisible disabilities, their allies and caregivers.
- Curricula design process (how was the curricula developed?)
 - The curriculum was developed in conversation with participants/potential participants.
- Leader Qualifications – Who are the facilitator(s)
 - Minister Karen Lord-Nixon is its organizer and lead facilitator. A former social worker, early childhood educator and pre-school administrator, Karen suffered a brain illness (angioma) resulting in significant cognitive impairment, with co-occurring physiological and psychological effects. Her struggle and ongoing recovery are a source of strength, information and inspiration for the group. Karen is a Certified Senior Peer Advocate and has completed peer-to-peer MHFA. She will receive additional group facilitation training from the Pacific Center. The peers will choose and affirm a co-facilitator(s), and Rev. Dr. Toni Dunbar will serve as an ally/advisor.
 - This model utilizes a co-facilitator model, which requires at least one peer with lived experience and one facilitator who also has training as a social worker or therapist. This particular support group has been extremely successful because one facilitator was both a peer and trained in mental health.
 - It also requires an advisor who can help keep the group on track when the facilitators.
 - Facilitators should be trained in Mental Health First Aid and WRAP when possible.
- Participant eligibility criteria
 - Participation is limited to persons who self-identify as persons with visible or invisible illness. Group participation may be open to family members, caregivers and allies. However, primary membership should be for persons with visible or invisible illnesses. The initial group and its membership was designed to meet the needs of African American LGBTQ2S.

- Duration
 - Each group meeting is 90 minutes maximum in person, 60 minutes maximum online or by phone.

- Schedule
 - WAM meets on 1st & 3rd Fridays, 1:00pm-2:30pm. After six meetings (3 months) the group conducts a self-evaluation and revises its curriculum and/or schedule based on the results.

Curricula Description:

- Group Process/ style
 - WAM is community-designed and peer-led support group, utilizing discussion, consumer research, resource-sharing, lectures, and social events to decrease isolation. The development process, curriculum topics, and schedule are andragogically consistent. The core group is aware that they are undertaking an interdependent learning process for gaining community support and exercising self-care.

- Topics / activity for each group meeting and basic description
 - Core WAM participants developed a list of twelve topics to be covered, one topic per month.
 - Meeting #1
 - Overview & formulation of group agreements, e.g., rules/guidelines for Interaction
 - Review of mission & outreach materials
 - Discussion/theme: Family Life
 - Refreshments
 - Comments, requests, recommendations
 - Affirmation

 - Meeting #2
 - Mission & outreach materials distributed in print
 - Recitation of group agreements
 - Check-ins
 - Discussion/theme: Family Life, cont.
 - Refreshments
 - Comments, requests, recommendations
 - Affirmation

 - Meeting #3
 - Recitation of group agreements
 - Check-ins

- Discussion/theme: Coping Mechanisms
 - Refreshments
 - Comments, requests, recommendations
 - Affirmation
- Meeting #4
 - Recitation of group agreements
 - Check-ins
 - Discussion/theme: Coping Mechanisms, cont.
 - Refreshments
 - Comments, requests, recommendations
 - Affirmation
 - Meeting #5
 - Recitation of group agreements
 - Check-ins
 - Discussion/theme: Defining Yourself With Difference
 - Refreshments
 - Comments, requests, recommendations
 - Affirmation
 - Meeting #6
 - Recitation of group agreements
 - Check-ins
 - Discussion/theme: Defining Yourself With Difference, cont.
 - Group Self-Evaluation
 - Refreshments
 - Comments, requests, recommendations
 - Affirmation

Additional topics: Preparing for Doctor Visits; Self-Care & Recreation; Spiritual Practice; Disclosure; Choosing a Doctor; Peer Support

ADDENDUM 1

Outreach Material that explains the purpose of the group.

Well Abled Ministry

Why Well Abled Ministry (W.A.M.)?

- Do you find that people act surprised when you tell them you have a disability? Do they say, "But you don't look sick!" or ask "What's your disability really about?"
- Do you want support to move ahead in your life despite your disability? Do you want to support a friend or family member that has a medical condition? **Well, this ministry is a support group with you in mind!**

What is W.A.M.?

- W.A.M. is a support group where people with visible and invisible disabilities, such as Chronic Fatigue, Fibromyalgia, and other illnesses which impact the body and mind, come together to learn from one another and professionals how to become healthy – mentally, physically and spiritually. Together, we become empowered to achieve our individual desired goals in spite of these illnesses
- We come together to share our stories, encourage, support and grow in strength. We share wisdom and learn together. And together, we become more powerful!
- We socialize, share mutual interests, and offer a space for our loved ones to hear stories of the processes and challenges that other caring families experience. We share what works and what doesn't in a non-threatening, non-judgmental environment.

ADDENDUM 2

Outreach Flier used to recruit new participants and a reminder for returning participants.

Vision Statement

The Well Aabled Ministry (WAM) vision is to support, empower and encourage participants who have experience with visible and invisible physical challenges. WAM is a peer-to-peer facilitated support group whose desire is to address the emotional and spiritual healing of those members whose physical challenges have a significant impact on their mental health and well-being.

Join us

When: *1st and 3rd Sundays of each month*

Where: *8400 Enterprise Way, Oakland, CA*

Time: *11:00 AM to 12:30 PM*

Contact: *Min. Karen Lord-Nixon
turtlekay@aol.com*

Thought for the Day

"You may encounter many defeats, but you must not be defeated. In fact, it may be necessary to encounter the defeats, so you can know who you are, what you can rise from, how you can still come out of it."

(Maya Angelou)

Well Aabled Ministry



Resilience:

The courage to come back from visible and invisible illness

- **STRENGTH** - “We delight in the beauty of the butterfly, but rarely admit the changes it has gone through to achieve that beauty.” *(Maya Angelou)*
- **PURPOSE** -If you're reading this...Congratulations, you're alive. Life is precious...let's live it to the fullest with **health, hope** and **purpose**.
- **RELATIONSHIP** - Embrace your strengths and weaknesses- they play a key part in your growth. Develop relationship with The Creator and yourself, this is the foundation of everything.

Resilience→Optimism→Healing



Warmly sponsored by O-WELL, City of Refuge UCC, CIBHS & ACBHCS

ADDENDUM 4

The survey tool used to design the group.

WELL ABLED MINISTRY Survey

1) How interested are you in being a part of this type of group? On a scale of 1 to 5 (5 being very interested, 1 being not interested), indicate your interest.

2

2) If you are interested in this group, how often would you like to meet? Weekly, monthly, bi-monthly...?

Weekly

3) Do you have a preference day and time?

1:00

4) Would you like a cohort (a defined group) or a drop-in group?

Drop in

5) Given a choice would you like:

a) a professionally led group

b) a peer-to-peer group

c) a topical group (depression, education, etc.)

d) an open-ended group

6) What topics would you like to discuss?

One that helps you Daily
throw cups up + down

ADDENDUM 5

- *WAM created a banner and handout materials. To date, outreach has been conducted within the OWELL network of faith communities, at the TransExcellence Medical Clinic at City of Refuge UCC, and at Pacific School of Religion in Berkeley, CA.*



BRUTHA'S RISING

A CURRICULA DESIGNED TO ADDRESS THE NEEDS OF TRANSGENDER MEN OF COLOR

DEFINITIONS - This document uses many terms to describe individual identities and experiences. The following are working definitions of those terms.

Gender Identity

A person's internal, deeply-felt sense of being male, female, something other or in-between.

Gender Expression

An individual's characteristics and behaviors such as appearance, dress, mannerisms, speech patterns, and social interactions that are perceived as masculine or feminine.

Transgender

An umbrella term that can be used to describe people whose gender expression is non-conforming and/or whose gender identity is different from their birth assigned gender. Many transgender people identify as female- to-male (FTM) or male-to-female (MTF). People who transition from female to male may be referred to as "FTM" or "transgender men." People who transition from male to female may be referred to as "MTF" or "transgender women."

Gender Non-Conforming

A person who has, or is perceived to have, gender characteristics and/ or behaviors that do not conform to traditional or societal expectations.

Transition

The process of changing genders from one's birth assigned gender to one's gender identity. There are many different ways to transition. For some people, it is a complex process that takes place over a long period of time, while for others it is a one-or two-step process that happens more quickly. Transition may include "coming out": telling one's family, friends, and/or co-workers; changing one's name and/or sex on legal documents; accessing hormone therapy; and possibly accessing medically necessary surgical procedures.

OVERVIEW

Created by members of City of Refuge United Church of Christ, Brutha's Rising is a social network designed to address the needs of Transgender men of color. The church is located in the highly stressed urban community of East Oakland, a multi-ethnic community comprised of 28% African American, 26% white, 25% Hispanic (non-white), 16% Asian and other ethnicities make up the difference. According to 2013 federal poverty guidelines, a single person living in Oakland earning less than \$11,490 or a family of four earning less than \$23,550 are living in poverty. In 2013, 30% of children in Oakland lived in

households with incomes below the federal poverty level. Nearly 35% of children lived in households that receive some sort of public assistance like food stamps, SSI, or cash assistance.

In Oakland, “African-American and Asian males were almost twice as likely not to be participating in the labor force, (i.e., not employed and not looking for work) than their Latino and White counterparts.” Fifty-three percent of African American males and 45% of Asian males in Oakland were either unemployed or not in the labor force (i.e. looking for work). White males earn twice the average per capita income of all males in Alameda County. The average per capita income for White Males is \$56,267, compared to \$25,356 for African American males, \$28,205 for Asian males, and \$15,179 for Latino males.

The Oakland-Alameda County Alliance for Boys and Men of Color developed a fact sheet that provides summative information about the current status of boys and men of color in Oakland and Alameda County. Some of the data points include:

- Seventy-seven percent of males under the age of 18 in Alameda County are boys and young men of color.
- Boys and men of color are disproportionately represented among victims and perpetrators of shootings and homicides.
- In 2010, 30% of people killed in Oakland were young adults between the ages of 18 and 25. Although African Americans only account for 28% of Oakland’s population, they accounted for 60% to 78% of homicide victims between 2006 and 2010.

Oakland is also home to many gay and lesbian households, with 1,547 lesbian and 1,187 gay couples according to 2008-2012 American Community Survey data from the U.S. Census. National studies of adolescent youth indicate that 3% to 6% of youth identified as lesbian, gay or bisexual (LGB), reported same-sex attraction, or engaged in same-sex sexual activities. Recent studies found that the average age gay and lesbian teenagers first self-identify is between 13 and 16, compared to the 1980’s when the age was between 19 and 23. Self-identification at an earlier age can lead to the stigmatization of youth, harassment, and discrimination, exposing youth to rejection at home and at school.

According to the Transgender Law Center, transgender and gender non-conforming people experience overwhelming discrimination and marginalization in employment, housing, health care, and education based on their gender identity and/or expression. Increasingly, states and local jurisdictions are passing and enforcing non-discrimination laws and ordinances to protect people from workplace discrimination on the basis of gender identity and expression. Under the California’s Fair Employment and Housing Act of 2004 there are statewide protections for transgender individuals. However, 70% of transgender and gender non-conforming Californians continue to face discrimination, harassment and unemployment directly linked to their gender identity and/or expression.

Transgender individuals are twice as likely to hold a bachelor’s degree as compared to the general California population. However, they are also twice as likely to be living under the poverty line of \$10,400 when compared to general population. 1 in 5 report having been homeless since they first identified as transgender. 30% of the transgender community report postponing care for illness or preventive care due to disrespect and discrimination from doctors and other healthcare providers and 40% due to economic barriers. Transgender individuals also report a high number of violent crimes perpetrated against them as a result of their gender identity.

The City of Refuge congregations sits at the intersection of this diverse highly stressed community. The City of Refuge specializes in outreach to the LGBTQI2S community. Within its congregation it has witnessed an increase in the number of biological women of color who acknowledge their true gender identity and begin the process of transition. The age in which transition starts has become younger, often in the early teens.

The City of Refuge primarily attracts an African American population. African American communities, in particular spiritual communities, are just starting the complicated process of shedding its homo and trans phobias. It continues to struggle with acceptance and affirmation of the unique contributions of “OUT” LGBTQI2S families and individuals. It is rare to find safe haven for these populations within the walls of a predominant African American spiritual community. Brutha’s Rising is City of Refuge’s effort to respond to the needs of this ever increasing community who face the harsh realities of disparities related to being African American and the associated phobias related to being transgender.

PURPOSE

The purpose of Brutha’s Rising is to provide a safe place for transgender men to connect, share resources and information and provide emotional and spiritual support. It is intended to reduce social isolation, mitigate suicidal ideation, increase access to culturally competent and transgender friendly services and provide care coordination.

CURRICULUM DESIGN

Target Population

Brutha’s Rising was designed to address the specific needs of transgender men of color in located in California’s Bay Area in Alameda County. The people who participate in Brutha’s Rising are either at risk of an emotional or mental health crisis, experiencing an emotional or mental health crisis, or in recovery from a related mental health challenge. Most all report episodic or chronic depression or anxiety, and incidents of suicidal thoughts or actions. Some report challenges with substance use and psychotic episodes. Very few are formally engaged with behavioral health service providers. The majority struggle with identifying “trans” positive service providers. Many report challenges with housing, employment and are in need of public assistance. All are in some phase of transition: contemplation, hormone treatments, identity adoption, pre and post sexual re-assignment surgery.

Curriculum Design Process (How was the curricula developed?)

The curriculum was developed in conversation with participants/potential participants and facilitators. Brutha’s rising is less specific topic focused, but provides an opportunity for in-person and online interactions designed to support the mental and physical health of its participants. Choice of topics for discussions are driven by the imminent needs of the attending participants. Brutha’s Rising was designed with 2 methods of interaction, face to face and web based online interaction via Facebook

Leader Qualifications

All but one of the 4 Brutha’s Rising facilitators were transgender men of color. For others adopting this model it is recommended that there be more than two facilitators. Facilitators must be people with lived experience or a combination with experienced allies or family members. All the facilitators should be

reflective of the target population. Practical experience and knowledge of the transgender community, services and the transition process is crucial. Services provided by the facilitators must be culturally competent and relevant to the community intended for service. Facilitators must be trained in Mental Health First Aid and Wellness Recovery Action Planning. More skilled facilitators may also have training in case management with experience accessing public social and medical services. Facilitators should also be flexible in their understanding of the process of transition, which is different for every individual. Facilitators must be comfortable with the pace of and final destination in the transition that is different for every individual. Facilitators must also be comfortable allowing the individual to describe their experience and the terms / pronouns used to define themselves.

Participant Eligibility Criteria

Ideally participants should be those who identify as being in some phase of transition: contemplation, hormone treatments, identity adoption, pre and post sexual re-assignment surgery. However, individuals may also be in the exploratory phase in which they are still determining their gender identity. For practical reasons related to the possible extreme and varied nature of the topics discussed in the groups, it is recommended that participation be partitioned based upon age, for example children under the age of 16, 16-25, and 18 to older adults. These groups and their challenges are very different from each other. In order to assure the groups are culturally relevant, it is recommended the groups be organized based upon age.

Timeline:

Face to Face Meetings: Meet in person once a month for approximately two hours.

Online Meetings: Facebook interactions are ongoing, available 24 hrs/day.

CURRICULUM DESCRIPTION

Brutha's Rising is designed with 2 methods of interaction, face to face and web based online interaction via Facebook. Below is a description of the 2 models:

Face to Face Meetings: The group meets in person once a month. The once a month meetings are primarily check-ins regarding the mental and physical health of the participants, which also includes discussions regarding challenges faced by participants and strategies for overcoming them. Food and socialization create a warm environment in which participants are able to share and feel connected, reducing the sense of isolation and stress. The group often discuss the struggles related to the use of hormones, decisions and challenges regarding sexual re-assignment surgery, relationship and employment issues, social service needs and support. The choice of topics for the evening discussions are driven by the imminent needs of the attending participants. Sessions are usually held for 2-3 hours. There are four facilitators who also follow up and provide additional support outside of the group structure for individuals needing additional support.

Facebook Interface: There is a Facebook page designed and maintained by the group as well. The facilitators create posts that are public and can be viewed on the home page. However, more private exchanges are conducted between individuals who have been accepted as friends of the group and through private messaging. The posts are monitored by the four facilitators. The content is more random and social in nature. Friends check in as needed 24 hours a day / 7 days a week. However, it is not

uncommon for the site to be used as a call for help. Facilitators have been called upon for active support by Friends (members) who have become homeless and are looking for a place to stay. Other times Friends have reported feeling hopelessness, demonstrating suicidal ideation, or have experienced a violent crime or an incident of domestic violence. Facilitators read the posts and follow up with the individual to provide immediate support or to work with the person to access a higher level of care outside the scope of the facilitators, such as emergency medical services, law enforcement, or psychiatric hospitalization.



MISSION: Our mission is to maximize the recovery, resilience and wellness of all eligible Alameda County residents who are developing or experiencing serious mental health, alcohol or drug concerns.

VISION: We envision communities where all individuals and their families can successfully realize their potential and pursue their dreams, and where stigma and discrimination against those with mental health and/or alcohol and drug issues are remnants of the past.

VALUES: Access, Consumer & Family Empowerment, Best Practices, Health & Wellness, Culturally Responsive, Socially Inclusive.

Alameda County Behavioral Health Care Services

2000 Embarcadero Cove, Suite 400

Oakland, CA 94606

Tel: 510.567.8100, Fax: 510.567.8180

www.acbhcs.org