JULY - SEPT 2020

CULTURAL COMPETENCE NEWSLETTER

COUNTY OF SAN LUIS OBISPO

County of San Luis Obispo - Health Agency

Cultural Competence

Introduction

Nestor Veloz-Passalacqua, M.P.P.
Cultural Competence Coordinator &
Ethnic Services Manager

Dear Reader,

Thank you for reading and taking the time to be involved in the important subject of cultural competence. It is the mission of the Cultural Competence Committee to provide relevant and updated information about this subject and connect the community with necessary knowledge to instill best practices. The Cultural Competence Committee (CCC) publishes the newsletter on a quarterly basis and keeps our mental health partners informed about events, trainings, and relevant information pertinent to our community. In this and future editions, we will be reporting information regarding mental health and culturally and linguistically competent services and programs in our community. The newsletter also introduces the cultural competence committee members and specific topics related to mental health in the context of cultural applications.

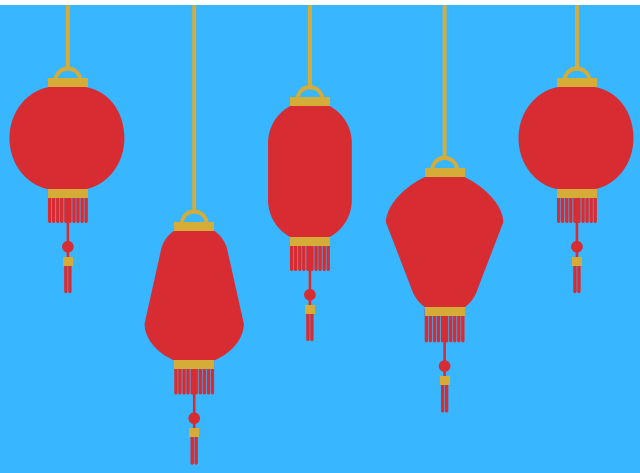
The CCC continues to assess, advise, implement, support, and monitor policies and programs that ensure effective services and program provisions in all cross-cultural situations. The committee members, representing diverse cultural and professional backgrounds and other special interests, will continue to provide input and insight to the community in order to create a safe and welcoming environment for all.

As we continue to adapt and change in the face of hardship, the Committee is dedicated to bridge inequity and disparity gaps and find ways to bring cultural awareness to serve our community. Thank you for taking the time to read this and the upcoming newsletters.

Sincerely,

Nestor Veloz-Passalacqua, M.P.P.
ESM & Cultural Competence Coordinator

Cultural Competence Committee



Members:

Amanda Corcoran, L.C.S.W. Behavioral Health Clinician II, Drug & Alcohol Services
Amber Trigueros, L.M.F.T. Behavioral Health Clinician
Anne Robin, L.M.F.T. Behavioral Health Administrator
Annika Michetti, Behavioral Health Program Supervisor, Drug & Alcohol Services
Barry Johnson, TMHA Division Director, Education and Advocacy
Bonita Thomas, PAAT Member, Peer Advisory and Advocacy Team
Desiree Troxell, L.M.F.T. Patients Rights Advocate
Gabriel Granados, Behavioral Health Specialist II
Jay Bettergarcia, Ph.D., Professor & Director of QCARES
Jill Rietjens, L.M.F.T. Behavioral Health Division Manager
Joe Madsen, TMHA Division Director, Housing Programs and Forensic Services Director
Katherine Soule, Ph.D., Director UC Cooperative Extension & Youth, Families, & Communities
Kiana Shelton, L.C.S.W. Behavioral Health Clinician
Lashelle Burch, Licensed Clinician Social Worker, Atascadero State Hospital
Laura Zarate, Secretary II Behavioral Health
Leticia Palafox, Behavioral Health Specialist I, Latino Outreach Program
Lilia Rangel-Reyes, Tri-Counties Regional
Marcy Paric, Ph.D., Behavioral Health Board Vice Chair
Maria Ordunez-Lara, L.M.F.T. Licensed Advanced Alcohol & Drug Counselor
Maria Troy, R.N., B.S., M.P.A. Promotores
Marne Anna Trevisano, Ed.D, Ph.D., Psychologist
Michelle Call, Executive Director Gala Pride and Diversity Center
Nasseem Rouhani, Health Education Specialist, Public Health Department
Nestor Veloz-Passalacqua, M.P.P. Cultural Competence Coordinator & Ethnic Services Manager
Tabitha Castillo, Administrative Assistance, Veterans Service Office
Tania Resendiz, Behavioral Health Clinician II, Drug & Alcohol Services

Cultural Competence

In this Issue:

Disparities Within Minority Mental Health

National Alliance on Mental Health | nami.org

Have you ever tried to unlock a door that wouldn't open? At first, you think you might be doing something wrong. Maybe there's a trick to it. You pull the key back a little—doesn't work. You wiggle the key—doesn't work. You keep trying, but the door stays locked. After a while, you realize the problem isn't you, it's the key.

This is what it's like for minorities trying to access mental health care.

As hard as it is for anyone to get proper mental health care in the United States, it's even harder for racial, ethnic, religious and gender minorities. Not only are there the problems most of us experience—issues with insurance, long wait times, difficulty finding specialists, sky-rocketing deductibles and co-pays—but there are added burdens of access and quality-of-care.

https://www.nami.org/Blogs/NAMI-Blog/July-2017/Disparities-Within-Minority-Mental-Health-Care

Why is this happening?

"Mental Health: A Report of the Surgeon General" states: "Despite the existence of effective treatments, disparities lie in the availability, accessibility and quality of mental health services for racial and ethnic minorities." This report talks about the lack of large-scale research that applies specifically to minority populations. Research is necessary to gain information about prevention, access, service delivery and quality-of-care. And the scary thing is: This report came out in 1999 and its findings still hold true today 18 years later—research and information about minority mental health is still severely lacking.

In "Eliminating Mental Health Disparities by 2020: Everyone's Actions Matter," Regina Bussing and Faye A. Gary write: "In the decade since the Surgeon General's landmark publication, its basic findings of striking disparities for minorities in mental health services have not changed. As shown in the most recent National Healthcare Quality and Disparities Reports, racial and ethnic minorities still have less access to mental health services than whites, and when they receive care, it is more likely to be of poorer quality."

There are many reasons why minorities aren't getting proper care. Here are some of them:

- A lack of availability
- Transportation issues, difficulty finding childcare/taking time off work
- The belief that mental health treatment "doesn't work"
- The high level of mental health stigma in minority populations
- A mental health system weighted heavily towards non-minority values and culture norms
- Racism, bias, and discrimination in treatment settings
- Language barriers and an insufficient number of providers who speak languages other than English
- A lack of adequate health insurance coverage (and even for people with insurance, high deductibles and co-pays make it difficult to afford)

How can we help change the status quo?

The mental health system is flawed. We all know that and many of us have experienced it personally. But all mental health advocates should band together in improving the status quo for those who are the least likely to both seek and receive treatment. Those who are most vulnerable to the systemic disparities of getting help. Those who only get the spotlight for one month out of the year. Together, we need to raise the bar for better mental health care for everyone, especially minorities.

https://www.nami.org/Blogs/NAMI-Blog/July-2017/Disparities-Within-Minority-Mental-Health-Care

You can get started by doing the following:

- Encourage mental health organizations to include minorities on staff or boards of directors.
- Write, call or talk to legislators—both local and federal—to support efforts to improve access to and the quality of mental health services in your area.
- Be a spokesperson when there is an opportunity to speak out on behalf of minority mental health.
- Share information you've learned about accessing quality care to others.
- Try to be more open and understanding towards what minority communities might be experiencing that you might not.

Whether you have personally experienced the challenges associated with minority mental health or whether you are advocating for a better mental health system, anyone can help make a difference. Opening the doors to quality mental health care for minorities is challenging, but we can all do our part in making the right keys for easier access and quality care.

https://www.nami.org/Blogs/NAMI-Blog/July-2017/Disparities-Within-Minority-Mental-Health-Care

6 Self-Care Steps for a Pandemic – Always Important, Now Essential

Harvard Medical School | health.harvard.edu

Airline attendants say it well: if the plane hits turbulence and the oxygen masks come down, place a mask on yourself first before turning to help others. This is absolutely critical. If we don't, we may not be able to help anyone. Well, we've all hit the same turbulence, folks, and we all need to take good care of ourselves, our bodies, and our minds. Healthcare providers on the front lines of the coronavirus pandemic absolutely have to be functioning well in order to do their jobs well. At such a stressful time, with so much change and uncertainty, combined with the pressures of patient care during this pandemic, it almost seems like too much. How are people like doctors holding it together? Could we all learn from their tips on coping?

This week, I reached out to my colleagues in the Massachusetts General Hospital Healthy Lifestyle Program to find out. We're all primary care physicians within the Division of General Internal Medicine who have been urgently redeployed to new and different jobs, such as staffing our makeshift COVID-19 surge clinics, learning new technology to provide much-needed telehealth, and creating serious illness plans with our most at-risk patients.

https://www.health.harvard.edu/blog/6-self-care-steps-for-a-pandemic-always-important-now-essential-2020041619563

During a period when stress and fear are running high, these six strategies from my colleagues can help.

Acknowledge the turbulence

Ben Crocker, MD, is the medical director of a large primary care practice and a healthy lifestyle advocate. "Social distancing and the loss of work and/or routine are tremendous pressures, both physically and psychologically," he says. "At the same time, our society tends to specifically reward heroic efforts that show that we can continue to perform at the same level, all while keeping a brave face. Many people are struggling to work full-time remotely while simultaneously caring full-time for their family at home. Those who continue to work on the front lines may feel the need to overload their schedules, or commit to too much."

His advice on this is relevant to everyone, not just front-line providers. Check in, he urges. Mourn your losses. And check out, too. "Check in with yourself," says Dr. Crocker. With so much news and instructions flying around about what to do and how to do it, take time to listen to what your body and mind need.

During such frantic times we may tend to ignore acknowledging the loss of "the way things were." We forget to mourn, or grieve, or simply express our sadness about not being able to socialize, see a close friend, attend a favorite exercise class, interact with neighbors and family, or worship collectively. Grant yourself the time and space to acknowledge your loss. This can help you stay grounded with the current state of life. "And allow yourself to physically, mentally, emotionally check out on a regular basis," he adds. "Intentionally create 'shutdown' time in your schedule. This can be healthy time alone, for meditation and quietude."

Fuel your body with healthy food

Helen Delichatsios, MD, has a degree in nutrition and runs healthy cooking classes for her patients. "In times such as these, nutrition and healthy eating can easily fall to the wayside," she says. "However, if anything, it is more important than ever to appropriately fuel our bodies and to do so in a mindful way. We have increased physical and mental stress, and healthy eating is vital in supporting our immune system to stave off illness and recuperate faster if we fall ill."

https://www.health.harvard.edu/blog/6-self-care-steps-for-a-pandemic-always-important-now-essential-2020041619563

Anne Thorndike, MD, usually works in the cardiometabolic center, helping people at high risk for heart disease change the way they eat and live. "We're all eating at home more," she notes. "This is a great time to explore new recipes you've been meaning to try. Be creative with what you have stocked in the house. Plan your grocery list so you have the basics on hand for healthy meals. Frozen vegetables and fruits are a great option when you can't buy fresh produce on a regular basis."

Amy Wheeler, MD, is also certified in obesity medicine and runs healthy lifestyle sessions for patients. At home, she's been adapting healthy recipes she usually makes with fresh ingredients by using simple substitutes. Try her easy, adaptable recipe for Quarantine Chili for a family of five: "Last night, I diced an onion and potato, then added one chicken breast cut in chunks, 1/2 small can diced green chilies, 1/4 cup salsa, 3 to 4 teaspoons paprika, 1 teaspoon cumin, a sprinkle of cheese, some leftover rice, 1 can yellow corn, and 1 can tomatoes. Once the chicken is cooked, try a dollop of Greek yogurt on top instead of sour cream." Use fresh ingredients if you have them, or canned or frozen if you don't. Goes nicely with tortillas, but it's also great right out of a bowl.

Move your body

"We are all spending less time commuting, driving our kids around, and doing errands," says Dr. Thorndike. "Use the extra time to take a walk or do some exercise at home. Even housework can be a way to be physically active!" Dr. Wheeler finds it helps to set SMART goals: Specific, Measurable, Achievable, Relevant, Timed. These are by definition small steps that are easy to achieve, and thus fuel motivation.

https://www.health.harvard.edu/blog/6-self-care-steps-for-a-pandemic-always-important-now-essential-2020041619563

"I have been making little SMART goals for myself," she says. "Daily goals like 'I will take a 20-minute walk outside at 10 am today, while wearing my mask and performing social distancing.' Or 'I will find three flowers with different colors on my walk.' Helps me get out of my PJs, off the laptop, and appreciating nature — very relaxing!"

Prioritize sleep

Our bodies need sufficient sleep in order to function. Me, I've been working hard to keep a schedule, setting my alarm for my usual early morning time, and going to bed just after my kids. This helps to ensure I get a solid eight hours of sleep, so that I'll be at my best when I'm called into clinic.

It can help to see the light — and dark (literally). "Spend time outside in nature," Dr. Crocker suggests. "Exposure to the visible diurnal rhythms of the day/night is an added benefit."

Find ways to connect socially

Dr. Delichatsios loves to cook at home and has been having virtual dinner parties. "Why don't you invite some people over for dinner?" she suggests "In our family, we call them FaceTime Dinners, Zoom Dinners, or Skype Dinners. These platforms have allowed us to 'go out to dinner' and connect with many friends and families, when before we were often too busy to meet up in person."

https://www.health.harvard.edu/blog/6-self-care-steps-for-a-pandemic-always-important-now-essential-2020041619563

Dr. Crocker has a great suggestion that can be a win-win for working parents and their relatives. “With school out, if you have kids and any extended family, invite the relative (grandparent, aunt, uncle) to teach an online lesson once a week on the same topic or a rotating topic. Allow that special bonding time between your child and their relative to unburden your time.” He also found a way to continue choir singing from home. “Try a different way of connecting with friends and colleagues — a chat room, or Zoom meeting over a meal. I joined a 20-voice choir that I’ve never physically sung with and sang in a recorded five-part arrangement — all from my home!”

Find ways to ease stress

Everything you’ve read to this point can help you manage stress and anxiety. Eating healthy, being active, and getting enough sleep all help us to mitigate the effects of stress and anxiety on our bodies. One more technique is positive thinking. Remembering and acknowledging the good in our lives is a powerfully positive action. “Practicing gratitude for what we still have — our health, our families, our homes, food, whatever it may be — rather than rehearsing the daily ‘loss’ of life and routine as we know it, is an important health practice,” notes Dr. Crocker.

In our household, we take turns saying grace before we eat dinner. One part of grace is to state something we’re grateful for, and usually it ends up being a bunch of things, sometimes silly ones like our cats cuddling with us, or the sun shining. But it always makes us smile!

https://www.health.harvard.edu/blog/6-self-care-steps-for-a-pandemic-always-important-now-essential-2020041619563

What is Addiction?

AddictionCenter | addictioncenter.com

Addiction is a chronic, relapsing brain disease defined by a physical and psychological dependence on drugs, alcohol or a behavior. When an addictive disorder has formed, a person will pursue their toxic habits despite putting themselves or others in harm's way. While it can be tempting to try a drug or addictive activity for the first time, it's all too easy for things to go south – especially in the case of drug and alcohol abuse. When a person consumes a substance repeatedly over time, they begin building a tolerance. A tolerance occurs when you need to use larger amounts of drugs or alcohol to achieve the same effects as when you started. Prolonged substance abuse can result in a dangerous cycle of addiction — where a person needs to continue using drugs or alcohol in order to avoid the uncomfortable symptoms of withdrawal. By the time a person realizes they have a problem, drugs or alcohol have already seized control, causing them to prioritize its use over everything else that was once important in their lives. No one ever plans to become addicted. There are countless reasons why someone would try a substance or behavior. Some are driven by curiosity and peer pressure, while others are looking for a way to relieve stress. Children who grow up in environments where drugs and alcohol are present have a greater risk of developing a substance abuse disorder down the road. Other factors that might steer a person toward harmful substance use behavior include genetics and mental health disorders.

https://www.addictioncenter.com/addiction/

Addiction and the Brain

Excessive substance abuse affects many parts of the body, but the organ most impacted is the brain. When a person consumes a substance such as drugs or alcohol, their brain produces large amounts of dopamine, which triggers the brain's reward system. After repeated drug use, the brain is unable to produce normal amounts of dopamine on its own. This means that a person will struggle to find enjoyment in pleasurable activities – like spending time with friends or family – when they are not under the influence of drugs or alcohol.

If you or a loved one is struggling with a drug dependency, it's vital to seek treatment as soon as possible. All too often people try to get better on their own, but this can be difficult and in some cases dangerous.

Recognizing and Understanding Addiction

Identifying a substance abuse problem can be a complicated process. While some signs of addictive behaviors are obvious, others are more difficult to recognize. Many people who realize they have a problem will try to hide it from family and friends, making it harder to tell whether someone is struggling.

The Difference Between Addiction and Dependence

The terms "addiction" and "dependence" are often confused or used interchangeably. While there is some overlap, it's important to understand the major differences between the two. A dependence is present when someone develops a physical tolerance to a substance. They may experience withdrawal symptoms if they stop using the drug altogether. Usually, a dependency is resolved by slowly tapering off the use of a particular substance. On the other hand, an addiction occurs when extensive drug or alcohol use has caused a person's brain chemistry to change. Addictions manifest themselves as uncontrollable cravings to use drugs, despite doing harm to oneself or others. The only way to overcome an addiction is through treatment.

Diagnosing an Addiction

Identifying addiction is like diagnosing any other illness. The patient is examined for symptoms meeting specific, scientific criteria defining the illness in question. One of the best tools for spotting addiction is the Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association.

https://www.addictioncenter.com/addiction/

The criteria outlined in the DSM are generally accepted and used by professionals to help determine the presence and severity of a substance use disorder. They include:

- **Lack of control**
  - The substance is used in larger amounts or over a longer time than the person originally intended.
- **Desire to limit use**
  - Wanting to cut back on use but being unable to do so.
- **Time spent**
  - A considerable amount of time is spent trying to acquire a substance.
- **Cravings**
  - The user experiences an intense desire or urge to use their drug.
- **Lack of responsibility**
  - Substance use takes priority over work, school or home obligations.
- **Problems with relationships**
  - Interpersonal relationships are consistently strained from drug use.
- **Loss of interest**
  - User stops engaging in important social or recreational activities in favor of drug use.
- **Dangerous use**
  - Continued use despite dangerous circumstances.
- **Worsening situations**
  - Continued use despite worsened physical or psychological problems.
- **Tolerance**
  - A need for larger amounts of the substance to achieve desired effects.
- **Withdrawal**
  - This can be physical and emotional. Side effects may include: anxiety, irritability, nausea and vomiting.

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Warning Signs of Addiction

Addictions begin with experimentation with a substance. There are many reasons someone might initially try a drug, including curiosity, peer pressure or stress and problems at work or home.

If you are concerned someone you care about is struggling with addiction, there are several red flags you can look for. However, it's important to remember everyone is different; it may be harder to detect an addiction in some people than in others. That being said, here are some general warning signs to be aware of:

- Ignoring commitments or responsibilities
- Problems at work, school or at home
- Unexplained absences
- Appearing to have a new set of friends
- Considerable monetary fluctuations
- Staying up later than usual or sleeping in longer
- Lapses in concentration or memory
- Being oddly secretive about parts of personal life
- Withdrawal from normal social contacts
- Sudden mood swings and change in behavior
- Unusual lack of motivation
- Weight loss or changes in physical appearance

No one expects to develop an addiction when they begin experimenting. However, continued experimentation can lead to addiction, often without the person realizing they have become addicted until they try to stop.

Addiction Statistics

Millions of Americans struggle with some form of addiction. If you are one of them, know you are not alone—and that many treatment options exist to help you overcome your addiction.

20
million Americans

Over 20 million Americans over the age of 12 have an addiction (excluding tobacco).

100
people per day

100 people die every day from an overdose. This rate has tripled in the past 20 years.

5
million visits

Over 5 million of emergency room visits in 2011 were related to drugs or alcohol.

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The Controlled Substances Act

The Controlled Substances Act (CSA) is a law that regulates legal and illegal drugs in the United States. Under the CSA, drugs are categorized into different "schedules" according to a drug's perceived dangerousness and potential for dependence. For example, heroin is classified as a schedule I drug because of its illegal status and extremely addictive qualities. In contrast, legal medications, such as over-the-counter pain relievers and cough suppressants, are categorized under schedule V because of their low chances for abuse.

The CSA's drug scheduling system exists for several reasons. In common cases, the system is used by judges to help them determine sentences for drug-related crimes. It is also helpful for medical professionals when writing prescriptions.

Polydrug Use

A majority of people who seek treatment for a substance use disorder are struggling with a dependence on more than one type of substance. Polydrug use involves the consumption of one type of substance with another. This is often done to intensify the effects of a certain drug or achieve a stronger high.

In some cases, a person may take a stimulant, such as Adderall, to counteract the sedative effects of an opioid such as oxycodone. However, mixing multiple types of drugs together is extremely dangerous, and can potentially lead to overdose and death.

The Top 10 Most Common Addictions

Millions of people around the world struggle with substance abuse. Some of the most common drugs that impede people's lives include:

- Nicotine
- Alcohol
- Marijuana
- Painkillers
- Cocaine
- Heroin
- Benzodiazepines
- Stimulants
- Inhalants
- Sedatives (barbiturates)

https://www.addictioncenter.com/addiction/

Suicide and Suicide Prevention

PSYCOM | psycom.net

Suicide is defined as intentionally taking one's own life and comes from the Latin suicidium, which literally means "to kill oneself." It tends to carry different traits depending on the culture. Historically, and still today in some locations, suicide is considered a criminal offense, a religious taboo, and, in some cases, an act of honor (e.g., kamikaze and suicide bombings).

Literally speaking, suicide or completed suicide is the successful act of intentionally causing one's own death. Attempted suicide is an attempt to take one's life that does not end in death, rather self-injury. Assisted suicide, a controversial topic in the medical field, is defined as an individual helping another individual in bringing about their own death by providing them with the means to carry it out or by providing advice on how to do it. Suicide is the 10th leading cause of death worldwide1 and rates of completed suicide are higher in men than women—with men up to four times more likely to kill themselves than women. According to the CDC, male deaths represent 79% of all US suicides.2 However, the rates for non-fatal attempted suicide are four times more likely in women than men and are more common in young adults/adolescents.

https://www.psycom.net/depression.central.suicide.html

Suicide is the second leading cause of death for individuals aged 15 to 34 and in 2017, 47,000 lives were lost to suicide—that's one death every 11 minutes.

10 Leading Causes of Death by Age Group, United States – 2017

	Age Groups										
Rank	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65+	Total
1	Congenital Anomalies 4,580	Unintentional Injury 1,267	Unintentional Injury 718	Unintentional Injury 860	Unintentional Injury 13,441	Unintentional Injury 25,669	Unintentional Injury 22,828	Malignant Neoplasms 39,266	Malignant Neoplasms 114,810	Heart Disease 519,052	Heart Disease 647,457
2	Short Gestation 3,749	Congenital Anomalies 424	Malignant Neoplasms 418	Suicide 517	Suicide 6,252	Suicide 7,948	Malignant Neoplasms 10,900	Heart Disease 32,658	Heart Disease 80,102	Malignant Neoplasms 427,896	Malignant Neoplasms 599,108
3	Maternal Pregnancy Comp. 1,432	Malignant Neoplasms 325	Congenital Anomalies 188	Malignant Neoplasms 437	Homicide 4,905	Homicide 5,488	Heart Disease 10,401	Unintentional Injury 24,461	Unintentional Injury 23,408	Chronic Low. Respiratory Disease 136,139	Unintentional Injury 169,936
4	SIDS 1,363	Homicide 303	Homicide 154	Congenital Anomalies 191	Malignant Neoplasms 1,374	Heart Disease 3,681	Suicide 7,335	Suicide 8,561	Chronic Low. Respiratory Disease 18,667	Cerebro-vascular 125,653	Chronic Low. Respiratory Disease 160,201
5	Unintentional Injury 1,317	Heart Disease 127	Heart Disease 75	Homicide 178	Heart Disease 913	Malignant Neoplasms 3,616	Homicide 3,351	Liver Disease 8,312	Diabetes Mellitus 14,904	Alzheimer's Disease 120,107	Cerebro-vascular 146,383
6	Placenta Cord. Membranes 843	Influenza & Pneumonia 104	Influenza & Pneumonia 62	Heart Disease 104	Congenital Anomalies 355	Liver Disease 918	Liver Disease 3,000	Diabetes Mellitus 6,409	Liver Disease 13,737	Diabetes Mellitus 59,020	Alzheimer's Disease 121,404
7	Bacterial Sepsis 592	Cerebro-vascular 66	Chronic Low. Respiratory Disease 59	Chronic Low Respiratory Disease 75	Diabetes Mellitus 248	Diabetes Mellitus 823	Diabetes Mellitus 2,118	Cerebro-vascular 5,198	Cerebro-vascular 12,708	Unintentional Injury 55,951	Diabetes Mellitus 83,564
8	Circulatory System Disease 449	Septicemia 48	Cerebro-vascular 41	Cerebro-vascular 56	Influenza & Pneumonia 190	Cerebro-vascular 593	Cerebro-vascular 1,811	Chronic Low. Respiratory Disease 3,975	Suicide 7,982	Influenza & Pneumonia 46,862	Influenza & Pneumonia 55,672
9	Respiratory Distress 440	Benign Neoplasms 44	Septicemia 33	Influenza & Pneumonia 51	Chronic Low. Respiratory Disease 188	HIV 513	Septicemia 854	Septicemia 2,441	Septicemia 5,838	Nephritis 41,670	Nephritis 50,633
10	Neonatal Hemorrhage 379	Perinatal Period 42	Benign Neoplasms 31	Benign Neoplasms 31	Complicated Pregnancy 168	Complicated Pregnancy 512	HIV 831	Homicide 2,275	Nephritis 5,671	Parkinson's Disease 31,177	Suicide 47,173

Data Source: National Vital Statistics System, National Center for Health Statistics, CDC.
Produced by: National Center for Injury Prevention and Control, CDC using WISQARS™.

Centers for Disease Control and Prevention
National Center for Injury Prevention and Control

Risk Factors

The most cited risk factors for suicide include psychiatric disorders, genetics, substance abuse, and family and social situations. Oftentimes, psychiatric factors and substance abuse co-exist. Access to weapons and other methods of suicide also increase risk. For example, rates of suicide in homes with guns are greater than in homes without them.

Mental disorders play an overwhelming role in the increased risk of suicide—with estimates suggesting up to 90% of individuals who take their own life suffer from some type of psychiatric disorder. Risk of suicide for individuals suffering from mental disorders drastically decreases once admitted to treatment. The mental disorders with the greatest prevalence of suicide risk associated with them include major depressive disorder, bipolar disorder, schizophrenia, personality disorders, post traumatic stress disorder, and eating disorders. Individuals suffering from major depressive disorder and bipolar disorder are at the highest risk of suicide—with risk of suicide increasing 20-fold.

https://www.psycom.net/depression.central.suicide.html

Behind major depressive disorder and bipolar disorder, substance abuse ranks as the second-highest risk factor for suicide. Statistics indicate that alcoholism is present at the time of death in up to 61% of completed suicide cases. Heroin and cocaine use is also a common risk factor for suicide, with heroin users having a 14-fold greater risk of suicide and cocaine users having a higher risk of suicide during withdrawal drug use. Cannabis use has not been found to increase suicide risk among users.

Genetics is thought to play a role in risk of suicide—such that a family history of suicide tends to indicate an increased risk of suicide among other family members—accounting for up to 55% of suicidal behaviors. Family history of mental disorders and substance abuse is also a risk factor for suicide. In a similar respect, exposure to suicide (e.g., watching a family member commit suicide or finding their body) is also indicative of an increased risk of suicidal behavior. Family and socio-economic problems are also contributing factors to suicide risk. Unemployment, homelessness, poverty, childhood sexual abuse, social isolation, loss of a loved one, and other life stresses can all increase the likelihood of suicide. Sexual abuse alone is thought to contribute to 20% of the overall risk of suicide.

Epidemiology

According to the CDC, general statistics on suicide include the following:

- Every day, approximately 105 Americans die due to suicide
- Overall suicide rates increased 28% from 2000 to 2015
- One person dies by suicide every 12.3 minutes in the United States
- There is one completed suicide for every 25 attempted suicide attempts
- In the elderly, there is one suicide for every 4 attempted suicide attempts
- Suicide is the 10th leading cause of death in the United States across all ages
- In the United States, rates of suicide are highest among Whites, American Indians, and Alaska Natives

https://www.psycom.net/depression.central.suicide.html

Gender Differences

- Males are four times more likely than females to commit suicide
- Females are more likely to have thoughts of suicide
- Females are four times more likely than men to attempt suicide
- Males are most likely to use firearms to commit suicide
- Females are most likely to use poisoning to commit suicide

Age Differences

- 1 in 100,000 children ages 10 to 14 die by suicide each year
- 7 in 100,000 adolescents ages 15 to 19 die by suicide each year
- 12.7 in 100,000 young adults ages 20 to 24 die by suicide each year

Prevention

Suicide prevention methods and treatment are based on patient risk factors. Treatments are prescribed in light of underlying conditions in addition to prevention of suicidal thoughts and acts. If you are suffering from a mental disorder, a treatment plan to treat this condition is implemented first. One of the most common suicide prevention techniques is psychotherapy— also known as talk therapy —in the form of Cognitive Behavioral Therapy (CBT) or Dialectical Behavior Therapy (DBT).

Cognitive Behavioral Therapy is a common treatment option for individuals suffering from a variety of mental disorders. In this method of psychotherapy, you are taught new ways of dealing with stress and stressful life experiences. In this manner, when thoughts of suicide arise, you can redirect those thoughts and cope with them in a different way than attempting to take your own life.

Dialectical Behavior Therapy is used to help an individual recognize disruptive or unhealthy feelings or actions. In relation, this therapy method then introduces techniques on how to deal with difficult or troubling situations. More research is needed on psychotherapy related to suicide prevention though, as DBT, in particular, has been shown to decrease the prevalence of attempted suicide but has shown no effect on completed suicides.

Medications can also be prescribed as a prevention method to suicide; however, controversy exists in this method, as many medications used in the treatment of mental disorders include increased risk of suicide as a side effect. Antidepressants especially carry a risk of a potential increase in suicidal thoughts and behavior—but this risk might be dependent on age.

https://www.psycom.net/depression.central.suicide.html

Clinical research has shown that young adults increase their risk of suicide and suicidal thoughts when taking antidepressants, but in older individuals, this side effect diminishes.

Increased awareness among doctors is also a prevention technique. Research indicates that many individuals who have completed suicide or attempted suicide did seek medical attention in the year prior; however, warning signs may have been missed. Increased education and awareness among medical professionals might decrease suicide rates in the future.

Popular "crisis hotlines" have not received solid data indications in the research that suggest their use is effective or not. Though, one positive side effect of these hotlines is that they are generally well-known which increases the general population's awareness of suicide. In an additional effort to bring awareness to suicide and risk factors associated with suicide, September 10 has been observed as World Suicide Prevention Day in partnership with the International Association for Suicide Prevention and the World Health Organization.

If You Need Help

If you are suicidal, call the National Suicide Prevention Lifeline at **1-800-273-TALK** (8255), available 24 hours a day, 7 days a week. Anyone can call toll free and all calls are confidential.

If you know of someone who is suicidal, do not leave the person alone. Attempt to get them immediate help from their medical provider, hospital, or call 911. Remove access to dangerous items, such as firearms, medications, or other potential risks.

https://www.psycom.net/depression.central.suicide.html

Mental Health History

Health Care Reform and Primary Care: The Growing Importance of the Community Health Center

Eli Y. Adashi, M.D., H. Jack Geiger, M.D., and Michael D. Fine, M.D.
New England Journal of Medicine

During the debate over U.S. health care reform, relatively little attention was paid to the long-established network of community health centers (CHCs) in the United States. And yet this unique national asset constitutes a critical element of any reform intent on expanding access to health care through a primary care portal. With an eye toward meeting the primary care needs of an estimated 32 million newly insured Americans, the recently passed Patient Protection and Affordable Care Act underwrites the CHCs and enables them to serve nearly 20 million new patients while adding an estimated 15,000 providers to their staffs by 2015. The "new" CHCs have arrived.

Launched in 1965 by the Office of Economic Opportunity as a component of President Lyndon Johnson's War on Poverty, the very first CHCs — in urban Columbia Point (Boston) and rural Mound Bayou (Mississippi) — were designed to reduce or eliminate health disparities that affected racial and ethnic minority groups, the poor, and the uninsured. The CHCs were to constitute a key component of the national public safety net, focused simultaneously on the care of individual patients and on the health status of their overall target populations. With their host communities involved in their governance, the centers were to be "of the people, by the people, for the people."

https://www.nejm.org/doi/full/10.1056/NEJMp1003729

Now operating at more than 8000 sites, both urban and rural, in every state and territory, run by about 1200 CHC grantees, the centers are the medical home to 20 million Americans, 5% of the current U.S. population. Federally funded under the authority of the Public Health Service Act, the nonprofit CHCs are administered by the U.S. Health Resources and Services Administration. Support from federal (and frequently state, county, and city) grants notwithstanding, CHCs must meet budget requirements through fees for services rendered to insured patients and "pay-as-you-can" (sliding-scale) collections from the uninsured (who account for 40% of patients served). No one is turned away, regardless of ability to pay. The CHCs are dedicated to the delivery of primary medical, dental, behavioral, and social services to medically underserved populations in medically underserved areas. Marked by a substantial representation of young women and children, the characteristic patient mix includes geographically isolated, migrant, and urban (including homeless) constituencies that are often estranged by linguistic and cultural barriers. Seven of 10 CHC patients live in poverty, and well over half are members of minority groups; the CHC is often the sole health care provider available to these patients.

Beyond their commitment to the uninsured, the CHCs have always welcomed the insured in need of high-quality primary care. At present, 35% of CHC patients are beneficiaries of Medicaid, and 25% are beneficiaries of Medicare or enrollees in private health plans. With the advent of health care reform, the percentage of insured people frequenting CHCs will undoubtedly grow: the impending expansion of Medicaid and the establishment of health insurance exchanges will see to that. The CHCs are thus likely to further cement their role as the bedrock of primary care for all while remaining the provider of last resort for the uninsured.

Ever since their inception, CHCs have received substantial legislative attention, in a remarkable display of bipartisan harmony. In the face of a national crisis in primary care, sequential legislative initiatives have sought to expand and strengthen the CHC paradigm. The need for such expansion has always been clear. As recently as 2009, the Government Accountability Office reported that 43% of medically underserved areas continue to lack a CHC site.1 Intent on doubling the number of CHCs, Congress and President George W. Bush doubled the annual appropriation to $2.1 billion by fiscal year 2008. More recently, Congress and President Barack Obama, by way of the American Recovery and Reinvestment Act of 2009 (ARRA), directed an additional one-time appropriation of $2 billion to the CHCs. Commensurate support ($300 million) has been extended to the National Health Services Corps (NHSC), an indispensable CHC partner responsible for recruiting and placing health care professionals in "health professional shortage areas" (HPSAs). An additional $47.6 million has been dedicated to primary care training programs for residents, medical students, physician assistants, and dentists.

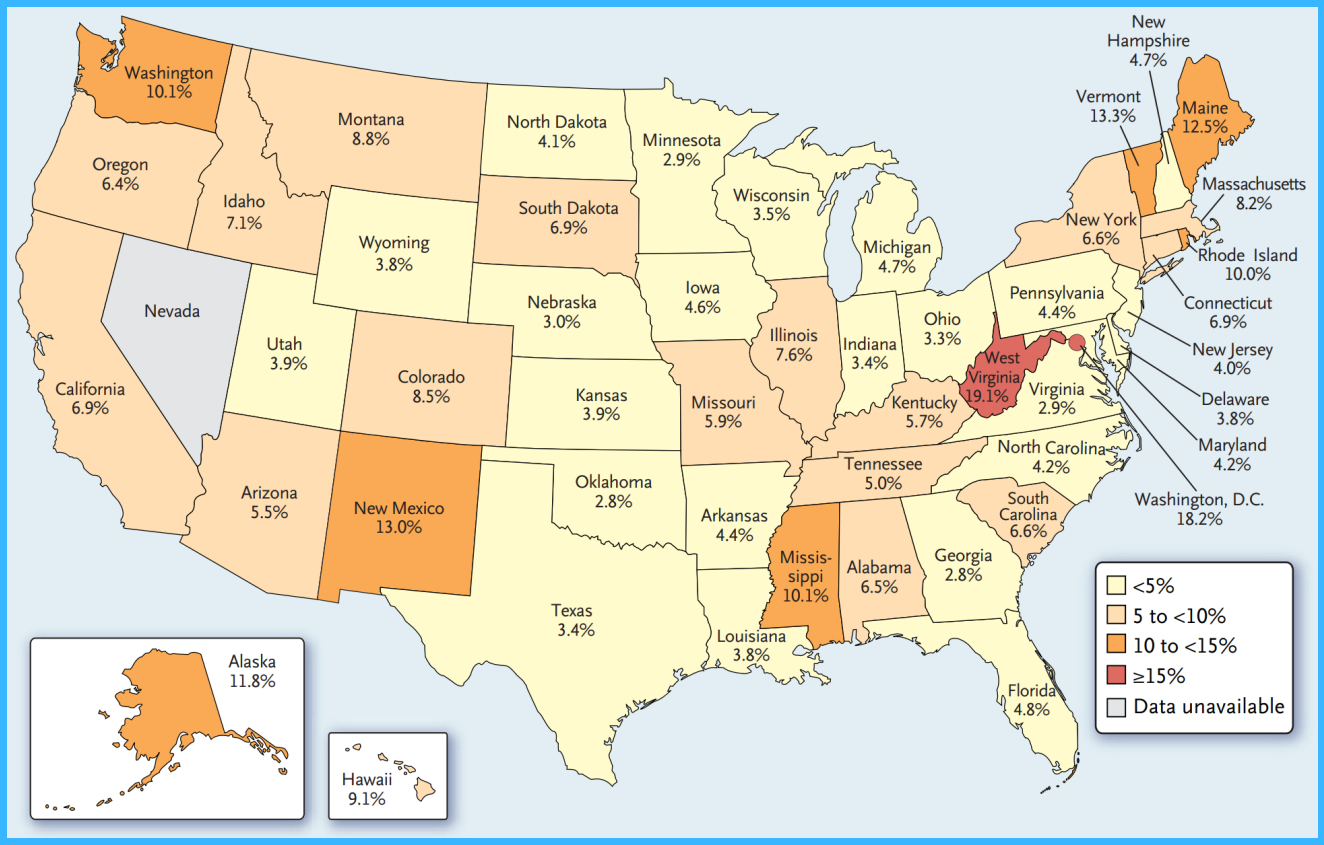
https://www.nejm.org/doi/full/10.1056/NEJMp1003729

Most important, the recently passed health care reform law appropriated $12.5 billion for the expansion of the CHCs and the NHSC over 5 years, beginning in 2011. In their new steady state, with 15,000 additional primary care providers in HPSAs, the CHCs may well be entrusted with the primary health care of 40 million Americans — thereby ensuring that most medically disenfranchised Americans receive care. Finally, the health care reform law established a new Title III grant program ($230 million over 5 years) for community-based teaching programs and authorized a new Title VII grant program for the development of primary care residency training programs in CHCs.

The CHCs have demonstrated their ability to deliver affordable, comprehensive, coordinated, patient-centered care in facilities physically proximate to the patients who need it. CHCs pride themselves equally on providing community-accountable and culturally competent care aimed at reducing health disparities associated with poverty, race, language, and culture. Indeed, CHCs offer translation, interpretation, and transportation services as well as assistance to patients eligible to apply for Medicaid or the Children's Health Insurance Program (CHIP). With multidisciplinary teams replete with primary care providers, behavioral health professionals, dentists and dental hygienists, pharmacists, and health and nutrition educators, as well as social workers, CHCs are well equipped to address acute care challenges as well as a broad swath of needs for coordinated disease prevention and health maintenance. Perhaps most important, CHCs offer high-quality health care, as assessed against that provided in other health care settings and national benchmarks.

Challenges abound, of course. The recent economic downturn has resulted in a further swelling of the ranks of the uninsured. Belt tightening in state Medicaid and CHIP programs is placing ever-growing pressures on CHCs' financial sufficiency. Other challenges include ongoing needs for infrastructure capital and reimbursement policies that undervalue primary care services. Perennial challenges in recruiting and retaining providers, resulting in part from outdated noncompetitive compensation schemes, continue to hinder optimal staffing of CHCs with primary care practitioners. Equally unrelenting is the difficulty of securing specialty referrals in the face of geographic isolation and increases in the numbers of specialty providers who choose not to care for the uninsured or not to participate in Medicaid- or Medicare-sponsored health plans. In addition, many CHCs have yet to broadly embrace health information technology. Going forward, the health care reform law and the ARRA are expected to ameliorate some of these challenges by reducing the rolls of the uninsured, offering capital for the renewal and expansion of the CHC infrastructure, enhancing the compensation of primary care providers, and underwriting and facilitating the adoption of information technology.

https://www.nejm.org/doi/full/10.1056/NEJMp1003729



Data on total numbers of CHC patients in each state are from the National Association of Community Health Centers, which based these numbers on the 2008 Uniform Data System, Bureau of Primary Health Care, Health Resources and Services Administration, Department of Health and Human Services; data on the population in each state are from the U.S. Census Bureau.

Yet as the United States seeks to optimize primary care, in part by advancing the concept of the "patient-centered medical home" (PCMH), some of the key values of the CHC model — a wholeperson orientation, accessibility, affordability, high quality, and accountability — could well inform tomorrow's primary care paradigm for all Americans. Despite the challenges they face, the CHCs are already built on a premise resembling that of the PCMH, a holistic concept encompassing highly accessible, coordinated, and continuous team-driven delivery of primary care that relies on the use of decision-support tools and ongoing quality measurement and improvement. The compatibility between the CHC and PCMH approaches was not lost on the Commonwealth Fund, Qualis Health, and the MacColl Institute for Healthcare Innovation at the Group Health Research Institute when they decided to sponsor a demonstration project called the Safety Net Medical Home Initiative, which seeks to help primary care safety-net clinics qualify as highperforming PCMHs. If successful, this demonstration project may well yield a replicable national model for implementing the PCMH that could have an impact far beyond that of the extant CHC network.

https://www.nejm.org/doi/full/10.1056/NEJMp1003729

Dates to Remember

July

- *National Minority Mental Health Month*
- *International Self-Care Day (July 24)*

August

- *National Health Center Week (Aug. 2-8)*

September

- *National Recovery Month*
- *National Suicide Prevention Week (Sept. 6-12)*
- *World Suicide Prevention Day (Sept. 10)*

Resources

DRUG & ALCOHOL SERVICES

SAN LUIS OBISPO ADULT
2180 Johnson Ave.,
San Luis Obispo, CA 93401
805-781-4275

SAN LUIS OBISPO YOUTH
277 South St., Suite T,
San Luis Obispo, 93401
805-781-4754

PASO ROBLES YOUTH AND ADULT
1763 Ramada Drive
Paso Robles, CA 93446
805-226-3200

ATASCADERO YOUTH AND ADULT
5575 Hospital Drive
Atascadero, CA 93422
805-461-6080

PREVENTION & OUTREACH
277 South St.,
San Luis Obispo, CA 93401
805-781-4754

MENTAL HEALTH SERVICES

SAN LUIS OBISPO YOUTH 0-5 MARTHA'S PLACE CHILDREN'S ASSESSMENT CENTER
2925 McMillan Avenue
San Luis Obispo, CA 93401
805-781-4948

SAN LUIS OBISPO YOUTH
1989 Vicente Avenue
San Luis Obispo, 93401
805-781-4179

SAN LUIS OBISPO ADULT
2178 Johnson Avenue
Paso Robles, CA 93446
805-781-4700

SAN LUIS OBISPO PSYCHIATRIC HEALTH FACILITY
2178 Johnson Avenue
San Luis Obispo, CA 93401
805-781-4711

ARROYO GRANDE YOUTH
345 S. Halcyon,
Arroyo Grande, CA 93420
805-473-7060

ARROYO GRANDE ADULT
1350 East Grand Avenue
Arroyo Grande, CA 93420
805-474-2154

ATASCADERO YOUTH AND ADULT
5575 Hospital Drive
Atascadero, CA 93422
805-461-6060

SERVICES AFFIRMING FAMILY EMPOWERMENT (SAFE)
1086 Grand Avenue
Arroyo Grande, CA 93420
805-474-2105

RESOURCES IN THE COMMUNITY

TRANSITIONS-MENTAL HEALTH ASSOCIATION
784 High St.,
San Luis Obispo, CA 93401
805-540-6500

COMMUNITY ACTION PARTNERSHIP OF SAN LUIS OBISPO (CAPSLO)
1030 Southwood Dr.,
San Luis Obispo, 93401
805-544-4355

THE LINK FAMILY RESOURCE CENTER
6500 Morro Rd. #A
Atascadero, CA 93422
805-466-5404

CENTER FOR FAMILY STRENGTHENING (CFS)
3480 Higuera St., Suite 100
San Luis Obispo, CA 93401
805-543-6216

STAND STRONG NOW
51 Zaca Lane, Suite 150
San Luis Obispo, CA 93401
805-781-6400

WILSHIRE COMMUNITY SERVICES
285 South St., Suite J
San Luis Obispo, CA 93401
805-547-7025

COMMUNITY COUNSELING CENTER
1129 Marsh St.,
San Luis Obispo, CA 93401
805-543-7969

FAMILY CARE NETWORK
1255 Kendall Rd.,
San Luis Obispo, CA 93401
805-781-3535

RESPECT, INSPIRE, SUPPORT, EMPOWER (RISE)
LGBTQ Healthy Relationship Support Group
805-226-6791

ACCESS SUPPORT NETWORK (ASN)
1320 Nipomo St.,
San Luis Obispo, CA 93401
805-781-3660

The Gala Pride and Diversity Center
805-541-4252

TRANZ-CENTRAL COAST
SLO & North County Support Groups
805-242-3821

Local COVID-19 Resources

For more information, please visit:
www.readyslo.org

SLO County positive case details - detailed breakdown of the status of current COVID-19 cases in San Luis Obispo County.

Testing information - information about when and where to get tested for COVID-19.

Face covering guidelines - information and guidance regarding recommended methods of face covering to protect from COVID-19.

Information for healthcare providers - request resources and testing (licensed medical providers only).

Cal Poly Alternate Care Site - details regarding the alternate care site located on the Cal Poly San Luis Obispo campus.

Local Services and Assistance Programs - list of links to get connected with local services and government assistance programs.

Food and Prescription Delivery - a San Luis Obispo County program to deliver food and prescriptions to qualified self-isolating residents.

Individuals and Families - COVID-19 information for individuals and families in San Luis Obispo County.

Businesses/Workplaces - COVID-19 information for businesses and workplaces in San Luis Obispo County.

COVID Status & Public Orders - timeline of significant events, including emergency proclamations, declarations, orders, shelter at home information, and media releases.

Impacted Services - list of impacted services in San Luis Obispo County.

Resources - more COVID-19 resources and materials.

LGBTQ+ Community at Higher Risk for COVID-19 Complications

Katherine Soule, PhD | UC Cooperative Extension

The coronavirus crisis is revealing inequities in public health that arise out of social factors. Raising awareness among LGBTQ+ individuals about COVID-19 is one of 85 research projects selected for funding by the University of California to lessen the pandemic's impact.

"LGBTQ+ individuals are at increased risk for severe illness from a COVID-19 infection," said Katherine Soule, UC Cooperative Extension youth, families and communities advisor, who is leading the project. "We are partnering with LGBTQ+ serving organizations, health care providers, government agencies and decisionmakers to develop an educational campaign. Our goal is to increase the quality of healthcare services for LGBTQ+ individuals."

https://www.slocounty.ca.gov/Departments/UC-Cooperative-Extension.aspx

The team is working with community partners across the state to deliver the information through social media, online training and other means of information sharing.

One reason that lesbian, gay, bisexual, transgender and queer people are vulnerable to more COVID-19 complications is that they are likely to postpone medical care due to fears of stigmatization. Also, LGBTQ+ individuals report poor quality healthcare and abuse in healthcare facilities, which may deter them from seeing a doctor. In addition, LGBTQ+ individuals are also hesitant to reveal or discuss their gender identity and/or sexual orientation, which can lead to inadequate treatment, care and access to essential services. At the same time, LGBTQ+ individuals are at higher risk of having underlying chronic medical conditions, such as asthma, cancer or HIV. LGBTQ+ people over age 65 are also more likely to suffer from poverty, physical conditions and mental health conditions that put them at higher risk during the COVID-19 crisis.

“Consequentially, healthcare professionals and medical providers need to be prepared to effectively communicate, engage with and treat LGBTQ+ individuals during this crisis,” Soule said.

Working with LGBTQ+ organizations and health care institutions, Soule and two student interns are leading an effort to develop a campaign to increase awareness among LGBTQ+ individuals of their heightened risk during the COVID-19 crisis. For healthcare providers, they are raising awareness of LGBTQ+ terminology and issues to improve their competency in treating LGBTQ+ patients.

https://www.slocounty.ca.gov/Departments/UC-Cooperative-Extension.aspx

Although statistics on the death toll and infection rates are tracked for race and ethnicity, they are not tracked for LGBTQ+. “The systemic decision to not track sexual orientation and gender identity is one of the reasons why this high-risk population is both more vulnerable and mostly invisible,” Soule said.

“Increasing awareness of these issues by healthcare providers, medical professionals, and community service organizations is vital during the COVID-19 crisis to support positive health outcomes of LGBTQ+ individuals," she said.

Her two student interns are 4-H alumni: Danielle Pacheco, a Smittcamp honors student at California State University, Fresno, and Trent Baldwin, a Monterey County native majoring in community extension education at The Ohio State University.

“I am pursuing a career in medicine and feel strongly about addressing the needs that marginalized communities face in the midst of the COVID-19 crisis,” Pacheco said. “I am also passionate about LGBTQ+ issues as I am a member of that community. This project is a great way to support the community I love as well as being able to work on something I am passionate about.”

Baldwin said, “Through my time in the 4-H program, I developed a passion for LGBTQ+ youth development and extension work. I worked for a time with Ohio 4-H on their LGBTQ+ Youth Dialogue event. I'm excited to be involved and to get extension work experience in this topic!”

The team is also seeking community partners to deliver the information through social media, online training and other means of information sharing.

Learn More:

UC Awards $2 Million in Critical Research Seed Funding for COVID-19 High-Risk Populations

Newly Funded COVID-19 Research Aims to Protect the Most Vulnerable

Useful Tips for Assisting Individuals with Hearing Loss

In an effort to keep people with hearing loss safe when visiting a medical facility and when everyone is wearing a mask, we have the following suggestions.

- Be patient
- Speak slowly and clearly, be prepared to repeat
- Enunciate
- Don't drop your voice at the end of a sentence
- Allow patients to bring someone to interpret, if possible
- Use a whiteboard
- Written instructions are always helpful
- Masks with a clear view of your mouth can be ordered from https://safenclear.com/product/communicator-box/

If you would like more information on supporting individuals with hearing loss, please refer to these resources:

https://www.nad.org/wp-content/uploads/2020/03/COVID-19-Hospital-Communications-Access-1.pdf

https://www.nad.org/covid19-communication-medical-access-for-deaf-hard-of-hearing/

Cultural Competence Committee

COUNTY of SAN LUIS OBISPO

County of San Luis Obispo Health Agency