CALIFORNIA MENTAL HEALTH
STIGMA & DISCRIMINATION REDUCTION ADVISORY COMMITTEE

December 2, 2008 Meeting Summary

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1. Welcome

Barbara Marquez, Chief of Prevention and Early Intervention for the California Department of Mental Health (DMH), welcomed people to the second meeting of the California Mental Health Stigma and Discrimination Reduction Advisory Committee (SDRAC, AC for short), held at the Sacramento State Alumni Center in Sacramento.

Susan Sherry, Facilitator from the Center for Collaborative Policy (CCP), Sacramento State, reviewed the meeting objectives and walked AC members through the day's agenda, using the Phases of Our Work Together handout as a guide. The day's meeting would focus on visioning, education, and problem frameworks. All materials are posted online on the AC's website, http://www.dmh.ca.gov/PEIStatewideProjects/AdvisoryCommittee.asp

Susan noted that members had raised several process questions at the last meeting, including consultation with constituents, review of a final plan, translation of documents, public involvement, and building consensus. Susan reviewed these and DMH's intention to have answers likely on December 17. Susan added that the facilitators' most important job was to make sure everyone's perspectives were honored, and that no individual had a monopoly on truth.

2. Where have we come from…where are we going?

Susan moved the group into an exercise focusing on dreams. The aim was to avoid getting stuck on problems and instead focus on the mental health-related dreams people had for the year 2050. As a starting point, Greg Gollaher, graphic facilitator, wrote five cultural maxims on a large sheet of white paper posted on the wall. AC member Dr. Rocco Cheng also added one. The maxims included:

I have a dream

¡Sí, se puede! [1]

All are created equal

Te tutukitanga tuatahi [2]

鰥、寡、孤、獨、廢、疾者皆有所養 [3]

Nothing about us without us

AC members were asked to take a few minutes to write down their own dreams, and then shared these with the full group. A complete list of the dreams shared by AC members can be found in Appendix A.

3. Envisioning the Future

AC members next moved into a visioning exercise, focusing on what success would look like in 2019. In other words if strategies and recommended actions in the Advisory Committee's ten-year strategic plan were put into practice, what would the world look like in ten years, what would be happening, what would be completed? This would provide a way of identifying problems (and recommendations), but in a more hopeful manner than focusing on them directly. Members worked in small groups and then reported back to the full group.

A complete list of responses can be found in Appendix B.

4. Keynote Address: *Legal Protections again Discrimination*

Stuart Seaborn, Associate Managing Attorney, Disability Rights California, spoke on mental health and legally-defined discrimination. His talk covered numerous topics, including the Americans with Disabilities Act, California State Law, disclosure, NIMBYism, Health Care Privacy, Entitlements, and Cultural Competency. Mr. Seaborn's full presentation and slides, and the following Question and Answer session, were videorecorded and will be available shortly on the AC's website (listed above).

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[1] Yes, it can be done! The motto of the United Farm Workers, coined in 1972 by César Estrada Chávez and Dolores Huerta during César's 25-day fast in Phoenix, Arizona, and indicative of farm workers' struggle for social justice, equal rights, respect, and dignity.

[2] "Destination One," part of the New Zealand Mental Health Commission's Travel Guide, which aims for *He whenua whakamana i te hunga mate hinengaro kia tautika ai te noho, kia arohaina e te tangata, ä kiamau tona mana tangata* – A country in which people with mental illness have the personal power to gain equality, respect and rights.

[3] From the very old Chinese book LiYun about ideal society and community, from the chapter DaTung (world peace): Those who lose their wife, their husband, those who lose their parents at young age, or those who lose their offspring when they themselves are old, together with those who are disabled and others who are ill, will all be taken care of by society.

Questions, Comments, and Discussion

1. *Question: What if a college student has their first psychotic break after being admitted to a program – are there accommodations?*
    a. Answer: It is best to have the school be on notice that there is a disability-related reason for the student missing school or exams, so the law will protect the student if the school takes action without accommodation.
2. *Question: Are peer-operated centers that want to operate in communities protected by the Fair Housing Act?*
    a. Answer: If people are not living there that would be hard, but in many cases they will be covered by the Americans with Disabilities Act Title II. In some cases both will apply. The State also has good language in health and safety laws.
3. *Question: Are family members who have to take time off from work or school for a mental health crisis covered?*
    a. Answer: Generally the rule is that if you're in the hiring or promotion process the employer cannot deny this because you have a partner or child with a disability, but in terms of accommodations it's not likely to receive anything. I am not aware of legal protections for situations where people have to take time off from school for this.
4. *Question: When a job has the word "consumer" in the title, that is de facto self-disclosure because being a consumer is a requirement for obtaining the job. Is there protection for someone who has two jobs, one where they have a consumer-type position and another where they do not? Do you need to explicitly state you are a consumer?*
    a. Answer: If you have been demoted or passed over for promotion or been adversely treated based on that position title, you are protected.
5. *Comment: The Family Medical Leave Act (1993) provides protection for family members who have to take time off from work to have or adopt a child or care for an elderly parent. You are allowed up to 120 days of unpaid leave.*
6. *Question: Is a school district discriminating by providing assistance to an autistic child whose parents speak up, but not to other children who need assistance but whose parents do not speak up?*
    a. Answer: Special education law entitles each child to an individual education plan, and parents have a right to say if they feel the plan is not appropriate or adequate. If one could point to a distinction between groups of children with plans, there could be a discrimination argument.
7. *Question: Some communities do not have access and are discriminated first based on their race – they do not get a diagnoses – and then are discriminated against again. So at what point does the response, We do not know how to, or We can't, or We've tried and made gains but need to do better, at what point does this become in and of itself an act of discrimination, intentional or unintentional, against a community by, for example, a count provider? Maybe it's not against an individual, but it should be something this group wrestles with. For a lot of communities of color, this is ongoing. In other issues there may have been some gains, but we're seeing it again with mental health.*
    a. Answer: This is another example where mental health is the last frontier. In our agency we've done studies about service patterns based on race and ethnicity and community groups, and learned how to make arguments around those service

patterns. These haven't gone to court but have been raised with the Legislature and agencies that provide services. But we haven't done this with mental health, it would be very tough to prove in court and would require research and background information, but it is worth gathering the evidence because it can influence people that have purse strings.

8. *Comment: Three months ago we had a report on unequal provision of health services, which showed that clients with the same diagnosis do not get equal treatment. Some we may spend $3,000 on, others next to nothing.*
    a. Reply: We tend to argue that services should be individualized based on the client's needs. At the same time we recognize the huge disparities out there. In the developmental disability world, this has been addressed through regional service centers. But in mental health it requires more research, really looking at patterns, disabilities, behaviors, and comparisons with other ethnic groups.
9. *Question: I know the MHSA isn't usually considered a civil rights law even though it mandates using funds to end discrimination, and that's our charge here. In regulations issued last year there was controversy over a regulation that we considered discrimination, that allowed for MHSA funding of involuntary hospitalization at a law enforcement facility. We fought this with our partners and showed that African-American and Latino clients were disproportionately forced into treatment. But it's now in permanent regulations. How can we address this?*
    a. Answer: One can rely on existing discrimination statutes that federally may override the ADA, or at a minimum there may be something else in State law that can counter what's in those regulations. But apart from action in the courts, the work you're doing today needs to be done – having state agencies and advocacy organizations present in the same room, that's really how you get things done. We've learned that to move the State sometimes you have to work with it, sometimes that's the only way.
10. *Question: In employment, how do you address performance versus accommodations, particularly in small work environments where absenteeism or hours might put a real burden on remaining staff?*
    a. *Answer: If an employer can point to a legitimate reason for taking adverse action that's not discriminatory. But in terms of a small business or office where someone is absent even as a result of accommodation, the law allows for an undue burden analysis: the employer could argue that the department cannot function with this number of people during this many hours of the day. Some small employers are not covered by statute, but most employers are. It requires creativity to fight this kind of argument.*
11. *Question: With regard to hiring consumers to staff technology assistance centers, some counties say they will fill the positions but do not disclose whether someone is a consumer or family member. How can they be held accountable for fulfilling the MHSA thrust in hiring?*
    a. Answer: I tend to agree that there is no need to disclose this. You would have to look at creative or alternative ways to get that information reflected. Several agencies have voluntary acknowledgment by staff that they have disabilities. Those acknowledgments are kept confidential and only retained for the purpose of

numbers. They do not disclose who that person is. This may be one way to address the situation, but it is entirely voluntary.

5. Frameworks for Explaining Problems and Challenges

Julia Lee, facilitator, explained that problem frameworks help to organize intuitively information about how problems manifest. Kirsten Deichert, DMH, added that such a framework could help people distinguish stigma from discrimination, their origins and their results.

Committee members broke into small groups to review two draft problem frameworks generated by staff, one focusing on the developmental cycle of stigma and discrimination, and the other on the context and partners related to stigma and discrimination. Their feedback follows:

Developmental Cycle Framework

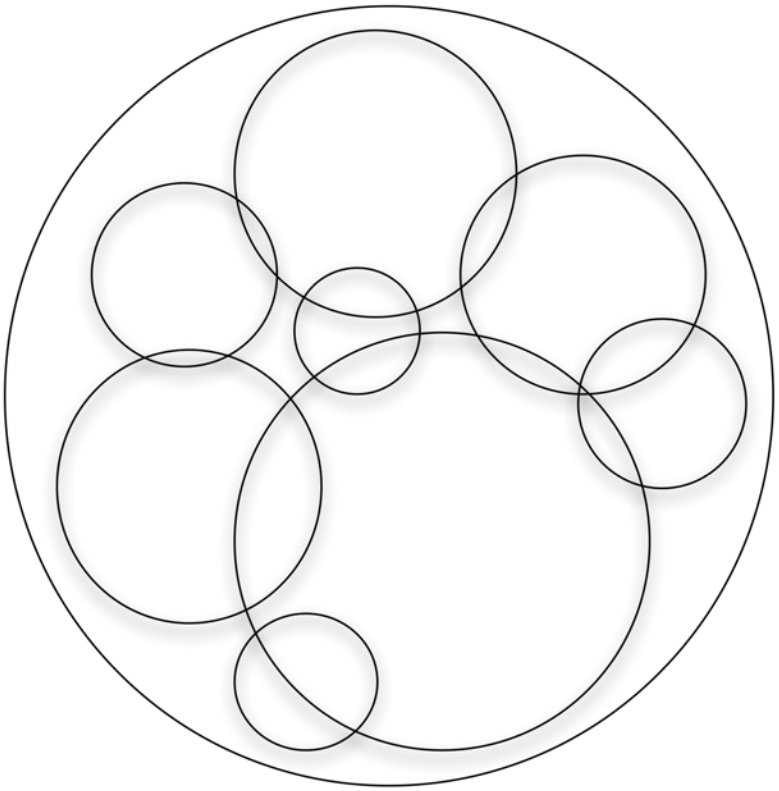
- It is not compelling
- It does not allow for the diversity of cultures and cultural beliefs and practices
- Language is missing as a phase
- It does not capture multiple oppressions, or how systems of inequality reinforce each other
- Recommendation: need to indicate how stigma and discrimination can reinforce negative stereotypes
- Recommendation: "mental health" should be broken down into emotional distress, social disturbance, etc
- Recommendation: culture arrows should point both ways, and all elements be interconnected
    - need to specify what kinds of cultures you're talking about, which helps indicate how they interact with those in the middle
    - add Context: Background and Upbringing
- Recommendation: include laws and regulations under Outcomes
- Recommendation: add (lack of) knowledge, understanding, awareness to Attitudes/Stereotypes
- Recommendation: add perceptions to Feelings
- Recommendation: add new step around labeling and language after Feelings
    - Language could also go with Attitudes
    - Language also needs to be disaggregated – it's different for children and transitional age youth than it is for older adults
    - Language is also tied to lived experience
- Recommendation: add Actions to behavior
    - Behavior also includes implicit, explicit, and micro-inequities
- Recommendation: there should be many circles to indicate how different groups interact with and influence another, and have different influence and power in society, with some circles larger or shaded to indicate this (see Graphic 1 below)
    - this would highlight the need to help groups with less power expand their base
- Recommendation: in addition to a cycle diagram, consider more of a two-dimensional graph or quadrants of "integration" and negative stereotyping/inappropriate behavior (see Graphic 2 below)

- Recommendation: indicate that an individual's response to being stigmatized or discriminated against, which points to the resources they have to respond to this

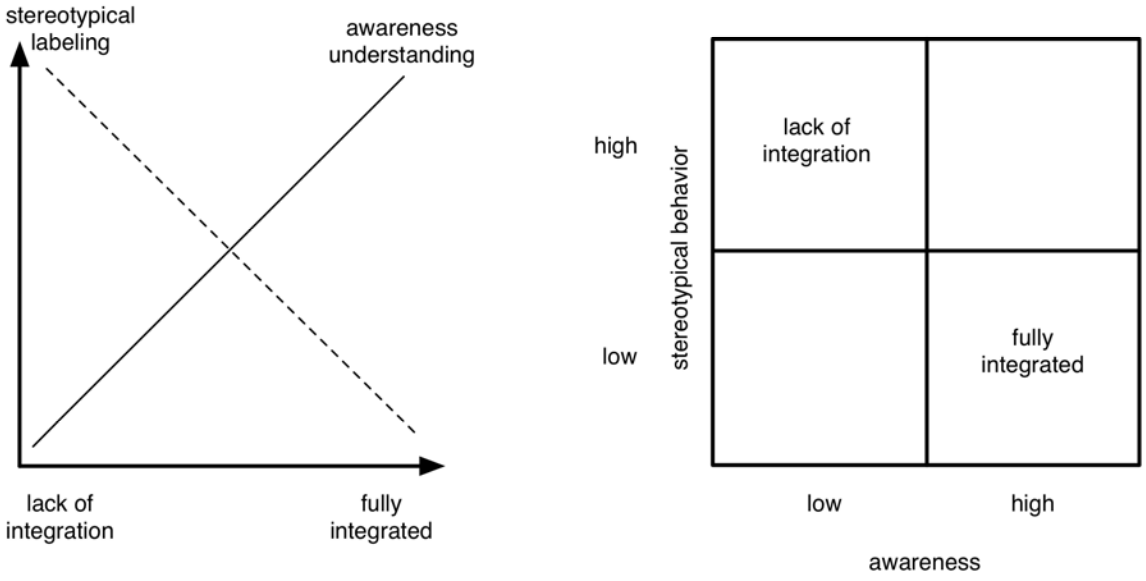
Context and Partners Framework

- It is inflexible – it is focused on the individual, and does not capture the variability and individual differences in relationships (e.g., where would a caregiver who's not a blood relative fit?)
    - The diagram should be more versatile so that families or cultural groups can also be in the center when appropriate – perhaps there need to be multiple diagrams, rather than having people argue about who is more stigmatized
- Diagrams in inherently restrictive and generalizing, and should be avoided
- It does not capture the diversity of lived experiences, e.g., how many different types of families exist
- It does not provide a way to indicate the relative importance of different contexts and relationships (e.g., community may be a small or large influence for different people, influence for younger versus older people)
- It does not show how relations might be mediated by particular contexts (e.g., the relationships of an individual as mediated through their family)
- It does not allow for alternative ways of acting and disclosing that do not involve others (e.g., writing, arts)
- It does not capture global influences – news, media, internet, TV, radio, etc. – or the very local influences of these sources
- Recommendation: daisy diagram with overlapping contexts, bolded for greater or lesser influence and/or positive or negative influence (see Graphic 3 below)
- Recommendation: need to include language as well as lifestyle issues - rural issues, veterans, demographics – under Cultural Group
- Recommendation: need to include churches and community health centers under Community
- Recommendation: need to include the role of government, the law, and religion under Society
- Recommendation: add another circle for Institutions/Industry
- Recommendation: the Community category could be further broken down – lay groups, community-based organizations, faith-based organizations
- Recommendation: consider how to illustrate things that are internalized and those that are external to the individual – these could be parallel
- Recommendation: link this diagram with future work around actions
- Recommendation: overlay this with the cycle diagram
- Recommendation: capture the various systems and institutions that participate in these activities, including legal frameworks
- Recommendation: capture the distinction between reasonable accountability and reasonable accommodation
- Recommendation: do not limit the framework to a circle diagram – other formats may be more appropriate (tables, grids)

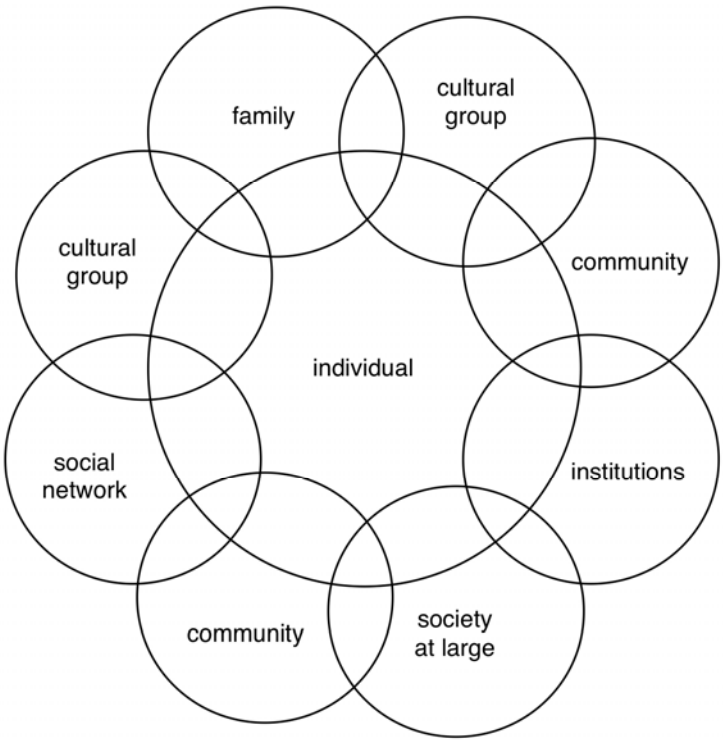
Graphic 1. Multiple Cultures in the Developmental Cycle



Graphic 2. Change over Time in the Developmental Cycle



Graphic 3. The Daisy Model of Context and Partners



6. Wrap Up

Julia asked members to read three items between now and the next meeting:

1) the definitions of stigma and discrimination distributed as part of the day's materials,
2) the annotated bibliography compiled by Kirsten Deichert (found in the reference section of each member's binder), and
3) the New Zealand national mental health strategic plan (found at the end of the reference section).

Julia noted that staff would also send out a survey the following day.

In closing Julia asked members to share their thoughts on what went well during the day's meeting, and on what they would like to change for future meetings. Feedback included:

PLUS

+ Sitting with unlike people and interacting with new people
+ Keeping on time
+ Sitting with similar voices
+ Videotaped training material for the future
+ Doing this debrief exercise

CHANGE

Δ Shortening introductions
Δ Keeping a handle on time
Δ Circulate the agenda ahead of time
Δ More working in like-like groups
Δ Spread out tables
Δ More happy food (sweets, dark chocolate)
Δ Make the CMHA study on old age and mental health available to everybody

The next meeting is Wednesday, December 17, 2008, and will be held again at the Sacramento State Alumni Center.

7. Attendance

Committee Members:
Khatera Aslami
Delphine Brody
Rocco Cheng
Rob Chittenden
Serena Clayton
Fran Edelstein
Pia Escudero
Luis Garcia
Marty Giffin
Tish Harris
Susan Henderson
Stacie Hiramoto
Lorna Jones
Janet King
Ruby Lim
Kenneth Logan
Matt Lord
Harriet Markell
Daniel McCarthy
Bonnie Milstein
Sabirah Mustafa
Marie Nitz
Janet Paine
Becky Perelli
Stephanie Ramos
Dede Ranahan
Sharon Rapport
Sean Rashkis
Matthew Reali
Emil Rodolfa
Cuco Rodriguez
Michael Roosevelt
Gregory Sancier
Ron Schraiber
Jenessa Shapiro
Hector Torres
Philip Traynor
Arcadio Viveros
Sue Watson
Stephanie Welch

DMH, OAC, and CCP Staff:
Cielo Avalos, DMH
Kirsten Deichert, DMH
Peggy Fish, California State Library
Dorian Fougères, CCP
Barbara Marquez, DMH
Julia Lee, CCP
Susan Sherry, CCP
Nicole Ugarte, CCP
Joan Waters, CCP
Beverly Whitcomb, OAC

Appendix A: Dreams for 2050

Topics:

1. Society
2. Children
3. Youth
4. Education
5. Access
6. Leadership and Communities
7. Consumers and Families
8. Social Marketing Campaigns
9. Litigation
10. Employment and Housing
11. Law Enforcement Response and Treatment

1. Society

- Every Californian understands what mental illness is and how it affects all of us and every Californian actively challenges stereotypes and racism.
- We are all in this stigma reduction effort together—it takes us all, everyone, to make it work
- The mental health system will be an instrument of human liberation and rather than a tool of social control
- People are not defined by health status
- No shame over having a disability for the person, the family, and the community
- Our society will look critically at engrained cultural practices of discrimination at people from different cultures and racism itself will be considered a mental illness, people who suffer from adverse conditions such as poverty or racism will not be blamed or labeled adversely because of the life they are forced to live because of those conditions, and privileged will be examined in the quest to eliminate racism, stigma, and discrimination
- The element of "fear" is dramatically reduced for those who discriminate and replaced by one of Stephen Covey's principles: seek to understand, then to be understood.
- Culture of compassion, respect for human dignity, and active support for human potential
- Everyone will have compassion for those with mental illness or emotional distress
- Mental illness is viewed the same way was other illnesses, across all cultures.
- To create an environment of dignity and respect for people who have any and all *medical* needs; which is to say not to exclude mental health needs
- Prevention -> Intervention -> Recovery for all
- Differences are considered enriching rather than "irregular," are utilized, and are celebrated rather than tolerated
- All people can have unusual behaviors; we increase understanding to promote acceptance. All people have limitations; we recognize that in others and ourselves.
- Society to be collaborative, problem solving for the benefit of all, and to look back to today and see that attitude was what was setting us back
- Collaboration thrives, divisiveness dies

2. Children

- Children will embrace differences in schools and communities and it will feel as satisfying for those at risk of exclusion as it is for those who might have excluded
- Children and adults will see beyond mental and physical differences and be able to recognize and valued people's strengths and skills. Schools will play an integral role in moving us forward in this vision

3. Youth

- All youth are treated as people, not cases or numbers, etc, based on their mental health status. "The beginning of every government starts with the education of the youth." – Pythagoras

4. Education

- Through education, we would end stigma

- Mental health would be as essential in our education system as reading, writing, and arithmetic
- All students with health challenges are educated in their home school/community, and the schools have the necessary resources and attitudes to accomplish what is asked of them
- School communities address the whole child—not just test scores—but social, emotional, and behavioral needs that impede success instead of "pushing students out" or labeling them and placing them in stigmatizing programs with limited resources, so *all* can reach their full potential, participating and producing in our democratic society
- With advancements in the mental health medical field, we will have rained a significant amount of knowledge regarding mental illness/disabilities, so along with education and access to treatment, stigma and discrimination will be only a part of past history

4. Access

- Regardless of the condition, people in need will have proper care, support, and resources to fulfill their potentials
- Establishments of access and elimination of barriers to mental health to mental health services (educational, cultural, linguistic, financial)
- Systemic change—equality in all systems of care, i.e. formularies and same-day visits.
- To end stigma for clients and families with mental illness and provide effective clinical treatment, including cultural and linguistic services.
- People can access (if they choose) a wide array of voluntary, self-directed, client-run, trauma-informed, culturally and linguistically competent services and support. Peer support is expanded and institutional models are phased out.
- Every person will have access to inexpensive, the best practice, culturally competent and linguistically appropriate mental health services.
- Mental health services are specifically targeted to particular ethnic groups.
- Same-day visit reimbursement for primary care and mental health visits, on the same day in FGHC, so individuals don't have to wait to be seen or qualify to go to Community Mental Health Services

5. Leadership and Communities

- Leadership truly emerges from the community so that the community owns the process and it is not imposed on the community
- All people are included and respected in the community and services are determined by the individual and are voluntary and available
- It would be an inexcusable act to exclude, or attempt to exclude, any individual or family from living, working, etc from living/thriving independently and freely in the community/environment of their choice simply because of being labeled as having a mental health challenge.

6. Consumers and Families

- Cultural competence and integration in the consumer and family movements
- To end stigma for clients and families with mental illness and provide effective clinical treatment, including cultural and linguistic services.

- Consumers and family members become the professionals, a focus on fulfilling the need, not focusing on the problem, and an expectations that people value mental health, cultural, and age differences as if they were assets rather than deficits
- Create an environment of self-care and support empowerment such that with one's health all things are possible.
- Clients/survivors of all ages and cultures, our friends and families live fulfilling, independent lives free of discrimination and stigma. Programs and services are always voluntary and without conditions
- Families impacted by mental health illness will be supported enough to enable them to remain emotionally connected as a family and to experience family recovery, wellness, and resilience

7. Social Marketing Campaigns

- The reduction of stigma and discrimination becomes a long term, effective, enculturated social marketing campaign, and (like wearing seatbelts, smoking cessation, and MADD) social, emotional, behavioral challenges and mental illness are fully accepted in our society

8. Litigation

- I can retire for doing *any* discrimination-based *litigation* because communities now embrace all individuals and resolve issues through direct, open, and accepting communication

9. Employment and Housing

- Meaningful employment should be an opportunity for all individuals, whether or not they have a disability. This embodies the Department of Rehabilitation's mission and values: employment, equality, and independence.
- Disclosure will not jeopardize employment, education, housing, etc.
- Adequate shelter and housing is considered a basic right and no one is left homeless. Housing is well integrated among all (people with disabilities and people without) and promotes safety and dignity.

10. Law Enforcement Response and Treatment

- Eliminate stigma of violent and criminal when discussing severely mentally ill. There is a system to provide alternatives to law enforcement response to those in crisis. Prevention and early intervention and family support, non-law enforcement response teams.
- Elimination of all locked, involuntary psychiatric institutions and all involuntary psychiatric treatment

Appendix B: Success in 2019

Topics:

1. Context Framework for Problems
2. Models for Change
3. Social Inclusion

4. Advocacy and Support Networks
5. Peer Programs
6. Engaging the Underserved
7. Integration of Sectors/Systems
8. Educational System
9. Workforce
10. Policy and Rights
11. Training
12. Partnerships to Address Discrimination
13. Self-Stigma
14. Disclosure
15. Public Attitudes – Myths
16. Media
17. Homelessness
18. Pharmaceutical Companies
19. Language

In 2019…

1. Context Framework for Problems

- People are looked at as total human beings originating as part of families, communities, and barrios – mental health involves more than just the individual
- Wellness support systems are available for consumers and family members
- The culture that insists of examining and classifying people as mentally "ill" is itself examined

2. Models for Change

- Recovery-based models based on strengths exist
- The DMH website shows not just treatments but all the wellness tools that are available, and has tutorials about wellness actions that affect the brain and brain tutorials so people get an insider's view rather than an outside label of "illness"

3. Social Inclusion

- Consumers have an opportunity to contribute to society through volunteering and working, are compensated at a living wage with full benefits, and are no longer isolated or socially excluded
- Involuntary treatment is eliminated in the MHSA and throughout society
- More consumers run businesses and are business partners

4. Advocacy & Support Networks

- There are lots of champions, a network of champions, to get the word out that stigma and discrimination are not okay
- People are so well educated about services that getting help from a friend or family or community is as letting someone with a hurt leg lean on your shoulder
- Policy, mental health and social service networks collaborate effectively

- Youth involvement grows so that youths are involved in decision-making on individual, local, State, and policy levels
- More success stories are highlighted in all different areas – arts, music, sports, dance – so that youth have role models across the board
- A chapter of Youth in Mind exists in each county so that youth can get guidance, leadership, and advocacy skills training through continuous summits
- Every county has peer programs
- The DMH website and best practices include/draw on the perspectives of leaders in education and in communities about how they've worked with youth and probation issues
- Youth and families are represented on all boards in California that deal with mental health explicitly or through cross-over
- Respite care for consumers and families is available in every county
- The President's new Freedom Commission mandates that consumers are at the center of mental health planning, services, and oversight

5. Peer Programs

- The number of peers is continuously increased so that when people get diagnosed for the first time they have a peer there to answer questions
- The value of and pay for people who provide peer programs is equal to other services in the mental health system
- Peer programs receive equal amounts of resources from local communities as other mental health services
- Peer-run programs offer self-directed care where individuals determine how they want to use money for their wellness

6. Engaging the Underserved

- Culturally-accessible service delivery centers exist – both the physical infrastructure and the programs therein
- Mental health services exist for documented and undocumented immigrants
- Disparities do not exist – people in all communities have equal resources and services that are appropriate to their communities
- No workforce shortage exists in ethnic and culturally diverse communities
- The student population of every professional training school reflects the ethnic diversity of California or loses funding
- A strategy exists in Latino and Asian communities for teaching communities and families to talk about shame and really deal with it – it's the source of stigma
- Every county keeps the community's core values in mind – not just what the State wants
- Society does not create the conditions – criminalization, disparities – that cause people to exhibit mental illness

7. Integration of Sectors/Systems

- Mental health issues are treated equally with physical health issues by medical providers and society at large, including substance abuse and other cross-disability diagnoses

- Mental health issues are integrated with medical health models, and everyone gets equal treatment and no funding difference between the Department of Health Services and Department of Mental Health exists
- Mental health is integrated in the public health system and crisis worker response teams are trained to respond, including regular trainings by clients and professionals and students and law enforcement
- Respite care for consumers and families is available in every county
- Mental health is integrated with the arts and all kinds of alternative treatments that allow people to express themselves however possible
- Mental health programs are more consumer-operated
- Federally Qualified Health Centers provide the same medication – based on the same current formularies – for people as Blue Cross
- The disparity between MHSA and outpatient services is eliminated – people with the same diagnosis get the same treatment and equal services
- The medical delivery system is perfected so it is responsive to client requests

8. Educational System

- Context trumps character – curricula that change the cultural context of preschools, schools, colleges, and work environments are implemented and sustained (Peace Builders and Building Effective Schools Together are examples)
- Educational leaders in California and school districts and schools have accepted that they need to educate and prepare children to be more accepting and embracing of differences, and provide the materials and strategies needed to do this
- Education funding is restructured to provide all the student support services and education needed for change
- Education starts with children and builds a school culture that fosters respect for differences
- Education about mental health extends all the way through college
- Teachers are trained and personally comfortable and supported in teaching about mental health issues and how to guide children in getting the help they need

9. Workforce

- There are an adequate number of adequately compensated and non-stigmatized service providers, advocates, peers, family members, and drop-in centers
- More providers are available to prescribe service, medication, and IT medical records

10. Policy and Rights

- Statewide and state-sanctioned discussions among political leaders address stigma and discrimination policy changes
- Single payer health care is a reality
- Everyone in the country has their right to health care and housing fulfilled
- The right to decent and accessible housing is once again a national policy
- Same-day visits are reimbursed
- Mandates for no longer segregating bathrooms are monitored and enforced

- Bathrooms in mental health facilities are no longer segregated because the ADA and fair employment and housing laws are now fully implemented
- The industrial medical complex supports mental health efforts politically and financially

11. Training

- Different best practices are promoted and used by more professionals
- Mental health professionals are no longer trained with deficit models
- Mental health is demystified – all levels of education and types of people (peers, resources, helpers, communities) are trained to identify mental health conditions, to not label them a bad thing, and to recognize that mental health is part of living and being human, just like physical health
- Trauma systems ask people, What happened? not, What's wrong with you?
- Stigma and discrimination are reduced by training people in traumatic brain injury and making connections between injuries and behavioral change
- Communities have more training about and treatment for people with mental health issues involving substance abuse

12. Partnerships to Address Discrimination

- Technical assistance, reasonable accommodations, and reasonable modifications make it possible for employers and educators and providers to deliver services
- System transformation: providers have changed and addressed their own stigmatizing practices
- A classification exists for the powerful people who discriminate and create environments for this – people that stigmatize and are racist and intolerant and prejudiced are themselves labeled
- People who go against the law and discriminate or support a discriminatory act, particularly public officials, are identified and made visible to the public
- Churches and ministers and religious environments do not provide moral justification for stigma and discrimination
- Jails and prisons cannot claim to be any form of mental health treatment facility
- Seclusion and restraints are eliminated in jails, prisons and hospitals
- Alternatives to 5150 provide support and safety best-suited to address the individual's request
- State mental hospitals are eliminated

13. Self-Stigma

- People do not feel shame and guilt when they receive a label – self-stigma is eliminated

14. Disclosure

- Prominent individuals from all communities have disclosed
- Funding, not just a mandate, exists to provide translation at clinics, and people get the services they need regardless of what their culture is
- Public disclosure of celebrities has reduced stigma and discrimination

- Coordinated support systems exist for people who feel like they are ready to disclose to serve as a "safety net", educate and encourage them, and support their ability to talk to other people so they can come out and disclose

15. Public Attitudes – Myths

- The connections between mental illness, violence, and dangerousness are broken through both proactive and reactive education program

16. Media

- Talk radio does not use phrases like "nut job"
- Sensationalism – using negative stories about mental health clients that promote stereotypes and discrimination to garner high ratings – has ended
- A successful campaign for changing culture and attitudes exists
- The media – announcements, radio, broadcast television, etc – is enlisted in changing culture and attitudes

17. Homelessness

- The State has dedicated resources to end homelessness, and prisons and jails no longer serve as warehouses for people
- Social and public funding exists to identify and address the root causes of homelessness, including interpersonal violence and the lack of affordable housing in California
- The definition of homeless is as inclusive as possible so that migrant farm workers can access homeless programs in communities throughout California

18. Pharmaceutical Companies

- There is independent oversight of pharmaceutical companies and conflicts of interest are eliminated through independent watchdog organizations at the local, State, and national levels
- Advocacy by pharmaceutical companies for specific forms of medication is eliminated

19. Language

- Language is sensitive to individual differences and needs and experiences – people are asked how they want to be addressed, what feels comfortable and right for them, how their condition should be referred to
- Language itself is no longer stigmatizing – people do not talk about mental health conditions as "illness" or "disease", "challenges" is replaced with "gifts" and "mental illness" with "mental wellness"
- Treatment is not limited to mental health providers – the entire language and vocabulary is changed so children and adults aren't worried about labels
- "Schizophrenia" is replaced with an entirely different term

Phases of Our Work Together

California Mental Health Stigma and Discrimination Advisory Committee

Throughout	Learning
December	Visioning
November/December	Problem Identification and Frameworks
December/January	Strategic Approaches and Directions
January/February	Recommended Actions
February	Public Workshops
February	Informational Update to MHSOAC
March	Revisions to Strategic Directions and Recommended Actions Based MHSOAC and Public Feedback
March	Committee's Plan Submitted to DMH
April	MHSOAC's Action on Plan

CALIFORNIA MENTAL HEALTH

STIGMA & DISCRIMINATION REDUCTION ADVISORY COMMITTEE

Lists of Strategies, Problems, Challenges, Dreams, & Successes Developed by Committee

Sources:

I. Survey Responses Regarding Strategies
II. Problems Identified at November 12, 2008 Meeting
III. Dreams for 2050 Identified at December 2, 2008 Meeting
IV. 2019 Success Identified at December 2, 2008 Meeting
V. Survey Responses Regarding Problems
VI. *Mental Health Services Oversight and Accountability Commission's Paper, June 2007 **(***developed by another committee)

I. Survey Responses Regarding Strategies

Topics:

1. Contact Approach
2. Education Approach
3. Internal Stigma
4. Context-Levels Of Intervention
5. Some Suggested Guiding Ideas
6. Social Inclusion
7. Theoretical Models
8. Consumers & Families (includes all age groups)
9. Mental Health System
10. Medical System
11. Funding
12. Cultural, Racial& Ethnic Approaches
13. Media
14. Political Leadership
15. Law Enforcement & Criminal Justice
16. Workforce
17. Disclosure (Workplace Or Communities)
18. Language
19. Housing
20. Homelessness
21. Educational System-Schools
22. Employers & Employment
23. Public Policy & Legal Protections

24. Research
25. Partners, Partnerships, Institutions & Power

II. List of Problems and Challenges Posted on the Wall During Lunch at November 12, 2008 Meeting

Topics:

1. Target Populations
2. Money and Resources
3. Medical and Mental Health Providers
4. Help-Seeking Barriers
5. Cultural and Racial Barriers
6. Children and Schools and Families
7. Discrimination
8. Empowerment against Self-Stigma
9. Approaches to this Strategic Plan and Process
10. Lack of Accessibility in Services

III. Dreams for 2050 Identified at December 2, 2008 Meeting

Topics:

1. Society
2. Children
3. Youth
4. Education
5. Access
6. Leadership and Communities
7. Consumers and Families
8. Social Marketing Campaigns
9. Litigation
10. Employment and Housing
11. Law Enforcement Response and Treatment

IV. 2019 Success Identified at December 2, 2008 Meeting

Topics:

1. Context Framework for Problems
2. Models for Change
3. Social Inclusion
4. Advocacy and Support Networks
5. Peer Programs
6. Engaging the Underserved
7. Integration of Sectors/Systems
8. Educational System
9. Workforce
10. Policy and Rights
11. Training
12. Partnerships to Address Discrimination
13. Self-Stigma
14. Disclosure
15. Public Attitudes – Myths
16. Media
17. Homelessness
18. Pharmaceutical Companies
19. Language

V. Survey Responses Regarding Problems

Topics:

1. Funding is not disbursed
2. Services aren't accessible, sufficiently funded, or prioritized
3. Services aren't the right type and/or aren't integrated
4. People don't seek help
5. Underrepresented communities aren't prioritized
6. Cultural communities have stigmatizing beliefs, attitudes
7. We need to target specific groups
8. We need to target children schools, and families
9. We need to target health and mental health service providers
10. We need to target employers
11. We need to change media behavior
12. We need to educate the public
13. We need to target people in the criminal justice system
14. We need to target older adults
15. Development of the Strategic Plan

16. Promote consumer involvement and empowerment, address internalized stigma
17. We need to target issues regarding housing
18. Collaboration
19. Research and evaluation are needed
20. Other observations

VI. Mental Health Services Oversight and Accountability Commission's Paper, June 2007

Focus Areas

1. People
   - 1A. Internalized Stigma in Children and Adults
   - 1B. People Facing Multiple Oppressions
   - 1C. Foster Children
   - 1D. Family Members and Caregivers
2. Systems
   - 2A. The Mental Health System
   - 2B. Access to Health and Mental Health Services
   - 2C. Educational Systems
3. Community
   - 3A. Violence Myths
   - 3B. Housing
   - 3C. Employment
   - 3D. Media

Suggested Guidance for Developing Strategic Directions

1. **Definition of Strategic Direction**: An overarching and broad call to action that provides clarity and guidance to diverse organizations and communities as they organize their efforts to reduce mental health stigma and discrimination.

2. **Optimal Number**: Limit the number of Strategic Directions to a manageable number to make the Plan user-friendly to a wide and diverse audience.

3. **Wording:** Start each of the Strategic Directions with an action word. This accentuates the importance of momentum. Examples: creating, advancing, empowering, etc.

4. **Length**: Use a phrase rather than a sentence.

5. **Useful Categories**: In developing the package of Strategic Directions, any identifiable action or sub-category should be able to have a "home."

6. **Instructive and Inclusive**: Taken as a package, the free-standing Strategic Directions provide a coherent but broad-level approach for reducing stigma and discrimination.

Note: Strategic Directions are the same as broad-level Goals.

The reason why the Suicide Prevention Committee selected the word "Strategic Direction" rather than the word "Goal" was because they believe that "Strategic Directions" telegraph a message of planned priorities (Strategic) and forward momentum (Direction).

Department of Mental Health Stigma & Discrimination Reduction Advisory Committee

Survey Responses on Strategies

Survey responses from advisory committee members regarding strategies are listed below by categories. The responses are based on the question: *What strategies do you think would best address California's mental health stigma and discrimination problem?* In some cases items were placed in more than one category when overlaps.

LIST OF CATEGORIES

1. Contact Approach
2. Education Approach
3. Internal Stigma
4. Context-Levels Of Intervention
5. Some Suggested Guiding Ideas
6. Social Inclusion
7. Theoretical Models
8. Consumers & Families (includes all age groups)
9. Mental Health System
10. Medical System
11. Funding
12. Cultural, Racial& Ethnic Approaches
13. Media
14. Political Leadership
15. Law Enforcement & Criminal Justice
16. Workforce
17. Disclosure (Workplace Or Communities)
18. Language
19. Housing
20. Homelessness
21. Educational System-Schools
22. Employers & Employment
23. Public Policy & Legal Protections
24. Research
25. Partners, Partnerships, Institutions & Power

CONTACT APPROACH

- Strong school-based interventions that include education, contact, strategies to change social norms
- Promote disclosure and contact
- Contact strategies like NAMI's "In Our Own Voice".
- Use of champions, individuals willing to make their illness and recovery known to others.
- Exposure to family members
- Exposure to individuals who can talk about their youth experiences
- Putting a face on issue by having spokespeople at Chambers of Commerce, realtor's convention, religious bodies, schools, etc.
- Local media campaigns and Patrick Corrigan's contact method.
- Support client and family organizations in using contact strategies with groups listed in addition to peers/leaders of those groups
    - Housing authority/ landlords
    - Mental and medical providers. educators - school administrators and teachers
    - Business leaders and commerce
    - Police/sheriffs/DAs
    - Local elected officials
- More locally based contacts, whether it be through the media, or people.
- Utilize mental health clients as the central speakers to reduce stigma and discrimination in presentations
- Contact model of face-to face interaction between clients and other community members in which clients have an opportunity to share personal narrative/stories about their recovery.
- Clients talking about their recommended strategies to overcome stigma and discrimination publicly not just amongst themselves.

EDUCATION APPROACH

- A strategy that explains the function of stigma and discrimination would serve all ethnic groups and sub-groups of the American citizenry
- Prevention / Intervention can eliminate much of the stigma by educating people with clinical facts and not falsehoods or misinformation
- Public relations campaign
- Raise awareness of violence toward persons with mental disabilities, including the homeless, LGBTQ persons and other high-risk populations. Develop and support a violence prevention agenda.
- Because organizations that discriminate and stigmatize, such as mental health providers and law enforcement agencies, are hierarchical, we need contact and education programs to convince the people at the top "hospital chief administrators, police chiefs" and key middle managers (HR staff, etc) along with rank and file nurses, officers, etc
- Education of public at large
- Use of video conferencing and distance learning to reach a large mass of people

- Development of material, brochures, etc. in a campaign mode for statewide distribution in key areas of the community
- Create a website specifically for stigma & discrimination and regularly maintain it to keep updated news and information available
- The public should be educated regarding the low-incidence, compared to the general population, of violent crime in the community; eliminates the myth that consumers are all violent
- Educate the public regarding the nature of mental health and their is no one individual that is alike or manages their symptoms the same
- Age-specific practices and approaches, like creating opportunities for creativity through different types of music and art while delivering MH education.
- By addressing Traumatic Brain Injuries (TBI) as an organic brain injury which leads to education related to behavioral issues as a result of the respective brain injuries
- Refocusing the mental health educational efforts with a mass campaign on trauma and trauma-informed care.
- Describing mental health issues as human challenges that can happen to anyone, which are not permanent, and teaching that self-determination is the route to recovery.

INTERNAL STIGMA

- Reduce internal stigma by enhancing personal skills, abilities, and self esteem, such as WRAP programs, job mentorship, and promoting independent living skills.
- Treat internalized stigma by focusing on a culture that is dependent on labeling some people as not as valued
- Developing the self-care and self-management an individual needs to prevent internalized stigma
- Have a major focus on internalized stigma and self-hate
- Address internal stigma

CONTEXT-LEVELS OF INTERVENTION

- Stigma needs to be approached on early stage/early intervention, also on 3 levels " individual, family, social"
- Expand the definition of community as anyone outside of self to increase the support network for consumers and non-consumers

SUGGESTED GUIDING IDEAS

- Continue to build relationship for various stakeholder with this advisory committee
- Prioritizing <u>a few strategies</u> and not trying to do everything all at once
- Clear message from this committee-whether that is in the form of a plan or definition
- One size does not fit all.
- Breaking down "hierarchies of oppression" among mental health stakeholders which end up pitting one group against another

- Give direction to counties on how to best spend resources to target stigma & discrimination
- Use of communities in this undertaking
- Look at other social movement such as tobacco for lessons learned on changing social norms.
- Identify a framework for implementing stigma programs (obtain local input on priorities, implement programs responsive to these priorities, evaluate the programs).
- Being careful not to "stigmatize the stigmatizers."
- If this plan is going to achieve anything, it is going to have to be focused and know who its audience is.
- In general I see the statewide project as developing resources and research findings that can be applied to s & d campaigns and efforts at the county/community levels. The exception would be a media campaign or something that could better be executed with statewide consistency.
- Use a collaborative approach
- Maximize resources
- Avoid duplication of services
- Ensure that the Consumer is always at the center
- Support Self-Determination.
- Involve general public in the feedback loop rather than limited to existing consumers and family members as those who do not come in will not be in current system
- Have mental health clients in the leadership role regarding anti-stigma and discrimination projects

SOCIAL INCLUSION

- Mainstream the attitude that all people even those supposedly with disabilities have gifts and talents, mainstream the attitude that those considered great in this society have disabilities and shortcomings that are not in the spotlight
- Strategies and recommendations that involve an individuals full-integration into the community
- Identifying best practices of successful community integration strategies

THEORETICAL MODELS

- Modify the promoter approach to address mental illness for cultural education, sensitivity and coping skills. Use an inclusionary approach that DOES NOT exclude cultural mythology and beliefs.
- The best methodology would be to address it in a medical model format.
- Consider a public health approach to stigma reduction
- Emphasize link between physical and mental health and eliminate barriers to receive treatment.
- Reconceptualization or reframing of mental health services. E.g. promoting more of a continuum of mental wellness (things we all need to do) to different types of treatment so as to destigmatize TREATMENT.
- Put a focus on mental well being rather than mental illness

- Work on merging mental health and medical care models into a general medical model
- Incorporate a "recovery model" as opposed to a "clinical model" in an individuals care in order to provide hope that they will recover and flexibility in their treatment
- Encourage all to live and support wellness in each other
- Full implementation of the Recovery Model with client directed services is central to eliminating sanism in the mental health system and a great first step for society, in general.
- Look at the history of changes ALREADY achieved related to mental health. We have come a long way. Do we want to continue on the medicalization route? What are the alternatives?
- Making more information available about alternative healing methods.

CONSUMERS & FAMILIES (includes all age groups)

- Addressing the ability of individuals with mental health disabilities receiving services without being isolated within their communities from these services
- Training concerning the elderly mentally ill
- For older adults in particular, the need for geriatric-trained professionals and programs such as Sr. Peer Counselors
- Target youth, given that attitudes and behavioral practices toward those with mental disorders start young
- Stigma with youth and the impact that it has keeping them from getting the appropriate help that is needed.
- Stigma and discrimination as it extends to families
- Education materials for parents regarding stigma and internalized stigma
- Encouraging communication and cooperation between family members and professionals, public and private.
- Involvement of families
- Exposure to individuals who can talk about their youth experiences
- Helping families/parents/caregivers know when to hold someone accountable and when to give them accommodation. HUGE dilemma. As a parent, I've had situations where I don't think even GOD would know how to decide what to do in a given situation.
- Programs that (train) and empower individuals to believe they can make a difference
- Empower individuals with a mental health disability to seek self-esteem through community participating events
- Family stigma and discrimination in the immediate and extended family can be addressed through sensitivity and skill building training. This would benefit everyone through an increased support system.
- Focusing on enhancing protective factors in targeted groups.
- Recognizing that Consumers require different levels and at various intensities of support
- Opportunities for consumers to be involved in mutual help, support
- Start groups for consumers to be involved in education and advocacy

- Addressing stigma and discriminated related to older adults.
- MHSA funding for promotion and expansion of consumer-operated peer support and self-help services

MENTAL HEALTH SYSTEM

- The first, primary and overwhelming focus and effort should be on the mental health system since it has pervasive stigma and discrimination (sanism) and it is a much more of a closed universe and we should be in the forefront ourselves in being the change we are advocating.
- Full implementation of the Recovery Model with client directed services is central to eliminating sanism in the mental health system and a great first step for society, in general.
- Transfer responsibility from law enforcement to mental health providers
- Provide early intervention
- School-based mental health services
- Same day reimbursement
- Culturally competent services
- Eliminate the DSM! No one is flawed- encourage and support differences in individuals
- Lifelong and full-integration of wellness practices in primary and mental health services
- Health care equals mental health care; the connection between both need to be equally addressed and given the same level of funding and attention in the medical community
- Meet an individual where they are before and whatever stage they enter "the system"
- Implement elements of cultural competence in all mental health programs: valuing diversity, cultural self-assessment, honoring the dynamics of difference, formalizing and disseminating cultural knowledge at all levels, and adapting to diversity
- Raise awareness of violence toward persons with mental disabilities, including the homeless, LGBTQ persons and other high-risk populations. Develop and support a violence prevention agenda.
- Require counties to have a stigma and discrimination reduction campaign at their local levels.
- Elimination of Mental Health Managed Care, Medical Necessity Criteria
- Decrease or elimination of involuntary treatments.
- ELIMINATE SECLUSION AND RESTRAINTS.
- MHSA needs to open funding up for those who have never been treated or need treatment again (i.e., not those for whom the treatment would be considered prevention or early intervention) or an effective stigma campaign will have disastrous results. People who finally ask for help won't find any unless they are living on streets or in jail.
- Use analogy of other illnesses to explain mental illness: self-awareness and self-care critical in partnership with professional care when needed; mental illnesses

aren't constant--they wax and wane like other illnesses; recurrences are not necessarily anyone's fault; etc.

- Treat substance abuse as a mental illness in all state programs
- Consider substance abuse a mental illness
- Require mental health parity among state programs
- Address same day visit reimbursements in FQHCs
- Reimbursement for Same Day Visits in a Federally Qualified Health Center
- Recruit mental health providers to participate in stigma reduction activities
- Integration of educational, mental health and substance abuse services for juveniles
- Look at the history of changes ALREADY achieved related to mental health. We have come a long way. Do we want to continue on the medicalization route? What are the alternatives?
- Integrate local mental health system with school system for provision of services to children and families
- Criminal justice and community, mental health, ADP services
- Create "Regional Center" like programs for children/families with mental health needs
- Meet an individual where their at before and whatever stage they enter "the system
- Coordination of mental health/alcohol and drug services
- Elimination of two-tiered systems i.e. in the MHSA and between dominant and minority cultures
- Ensure services in mental health system include support and pro-active development of job opportunities
- Develop accessible services
- Include in all campaigns the role of substance abuse in the lives of those with mental illness.
- Pursue integration of primary care and mental health services
- Integrate local mental health system with school system for provision of services to children and families
- Reconceptualization or reframing of mental health services. E.g. promoting more of a continuum of mental wellness (things we all need to do) to different types of treatment so as to destigmatize TREATMENT
- Ensure that parity is implemented fully and completely
- Being sure not to make "recovery" a source of internal stigma for those who are so sick recovery may not be possible. How do we define "recovery?" Can be different for everyone.
- Build within the mental health structure the inclusion of "drug courts" to reduce cyclical incarcerations
- The mental health system should model employee standards. Employees engaged in stigmatizing or discriminating behavior should experience repercussions in their performance reviews.
- Acknowledge the requirement for caseworkers within the FQHC system of care and reimburse for those services.

- Integrate Mental Health, Social Service and Education where client needs and services meet
- Continue activities that address culture change (to recovery-orientation) in existing mental health delivery system

MEDICAL SYSTEM

- Lifelong and full-integration of wellness practices in primary and mental health services
- Health care equals mental health care; the connection between both need to be equally addressed and given the same level of funding and attention in the medical community
- Integrated Behavioral Health in Primary Care
- Access to mental health services in a primary care environment
- Promote mental health parity in all medical insurance programs Strategies like parity, same day visits, etc. that treat mental health like part of "health", not separate.
- Provide info that illustrates the cost of not treating individuals with mental health problems.
- Pursue integration of primary care and mental health services
- Address and eliminate barriers (including professional territorial resistance) and initiate a plan for same-day reimbursement for PCP's.
- Allow primary care clinics to receive reimbursement for same day medical and mental health treatment.
- Update medical formularies so that all clients have access to the best medications to reduce symptoms and behaviors that increase stigma.
- CEUs and outreach to medical doctors (Cal Med Assn)

FUNDING

- Health care equals mental health care; the connection between both need to be equally addressed and given the same level of funding and attention in the medical community
- Get a committee to help counties disburse Prop 63 monies
- Firm funding that is appropriately spent
- Money
- Strategies to engage more Prop 63 funds towards this endeavor by and through the local counties
- Find a way for the state to keep money for statewide projects (easier).
- Maximize the Proposition 63 monies set aside for this purpose
- Tying funding to successful delivery of services to underserved communities.

CULTURAL, RACIAL & ETHNIC APPROACHES

- Projects should entail the realities of multiple oppressions that mental health clients may deal with, such as racism, sexism ageism, homophobia, etc.
- Cultural sensitivity to various groups is crucial in any projects to counter stigma and discrimination

- Conduct person to person outreach/education stigma reduction efforts that are culturally, age, and linguistically appropriate. Involve individuals/leaders from the community in getting the messages out, employing local heroes and "celebrities"
- Culturally competent services
- Implement elements of cultural competence in all mental health programs: valuing diversity, cultural self-assessment, honoring the dynamics of difference, formalizing and disseminating cultural knowledge at all levels, and adapting to diversity
- Promote understanding of the multiple barriers faced by ethnic and racial communities in accessing mental health care, tailored to each communities' needs, and design methods for reducing the barriers through culturally appropriate services
- A strategy that explains the function of stigma and discrimination would serve all ethnic groups and sub-groups of the American citizenry
- Change the mainstream culture to honor diversity of cultures and ways of being
- Provide support to people in hard to reach community (rural area)
- Provide good general mental health information, best if can be integrated to cultural practice
- Collaborate with ethnic media
- Cultural sensitivity training for providers
- Increase workforce that is bicultural and bilingual
- Focus on inclusion of multi-cultural populations and perspectives
- Provide services and materials in other languages.
- Reaching out to ethnic communities in a culturally competent manner
- Learn as much as possible about stigma & discrimination from a cultural context
- Empower service recipients
- Whatever the strategy, tailor the approach to fit different cultural communities.
- Cultural involvement
- Stigma reduction needs to take into account the cultural context
- Strategies must emerge from the communities being served and not imposed upon them.
- Dedicate mental health funds to intensive education and outreach to ethnic communities
- Training in White privilege to County Mental Health Directors, County staff, consumer advocates, and major providers
- Identify community support persons and cultural support persons who can provide support and self-advocacy...preferably a consumer
- Develop infrastructure for underrepresented communities
- Strategies that incorporate cultural pride, family involvement, and the retention of protective factors
- Need for culturally diverse education re mental health problems.
- Something focused on different ethnic communities
- Continue to advocate for more services and funding for such services in rural communities
- Support a contingency of rural providers to participate on this committee or get their input through an incentivized survey.

- Tying funding to successful delivery of services to underserved communities.
- Treat internalized stigma by focusing on a culture that is dependent on labeling some people as not as valued
- Recognizing that many clients have found a sense of community in subcultures, and that they should not be required to disown these affiliations in order to fulfill society's or their families expectations that they conform to mainstream cultural norms which is often considered the measure of success by mental health professionals.

MEDIA

- Protest negative media presentations of people identified as mentally ill, as well as encourage positive portrayals
- A media campaign that recognizes that mental health is a condition that in itself doesn't discriminate
- Media campaign with celebrity disclose their struggle
- Collaborate with ethnic media
- Identify key figures to be used to deliver the message that stigmatizing and discriminating against individuals is wrong.
- Putting a face on issue through media campaign
- Need to develop strategy to change media behavior insist on solutions and resources not just sensation
- Public relations campaign
- Forming a partnership with the media in their reporting
- Our governor has connections in Hollywood. Use him for access to media middle management to form a committee/council to execute the stigma reduction goals of this committee.
- Media involvement/social marketing
- Do public service announcements regarding mental health stigma
- Develop specific goals for media stigma reduction that include a postscript for a statewide number for referral for screenings of shows that include a mental illness component. Similar to the teen pregnancy reduction campaign.
- Media or PR strategies
- Positive public education using multi-media approaches.
- Extensive media campaigns such as those which were used to stop smoking, reduce stigma around AIDS, etc.
- Ethnic media must be involved in a effort to raise awareness of stigma and discrimination so that the communities knowledge and beliefs are impacted, leading to a change of attitudes and aspirations which in turn impacts behavior. An effective media campaign understands that it gets increasingly difficult as we move out toward behavior change.
- Media examples, media "stars," and media presence related to humanizing mental illness are all priorities
- Media campaign
- Public education campaigns
- Interventions with the media
- Design and fund multi-year public education campaign across all media

- Work closely with media to promote positive stories and images of individuals with mental health disabilities
- Media campaigns.
- Identifying the problem by utilizing all forms of media.
- Client produced public service announcements (PSA's) on TV and radio.
- A campaign called "Know the Warning Signs of Mentalism". Takes the equal and opposite approach to the one psychiatry uses to promote itself.

POLITICAL LEADERSHIP

- Governor and political/community leaders make issue important and speak out in a regular and sustained way
- Political leadership would continually speak out to community on issue

LAW ENFORCMENT & CRIMINAL JUSTICE

- Transfer responsibility from law enforcement to mental health providers
- Education of corrections officials
- Training programs for police and correctional officers
- Education for criminal justice partners including police, judges, probation, jail staff, etc.
- Courts partnering with mental health and ADP partners to address needs of mentally ill individuals
- Strategy for reintegration of mentally ill individuals into community services post jail/prison
- Allocation at county level of resources to treat/support mentally ill persons who have been/are involved with the criminal justice system (diversion, probation, parole, post-release)
- Training in mental health issues for juvenile court judges
- Need for prison reform (Juvenile and adults) so that treatment can be provided for mental health issues and substance abuse.
- Build within the mental health structure the inclusion of "drug courts" to reduce cyclical incarcerations
- Increase education of all law enforcement personnel re individuals with mental problems.
- Enhance police education of mental illness
- Law enforcement should be the last and not the first point of contact for a consumer in order to change the perception that all consumers are violent

WORKFORCE

- Require CEUs in stigma reduction for licensed professionals
- Increase the number of providers by higher education incentives (like loan forgiveness) to enter the field AND reimbursement for mid-level providers including MFT's.
- Increase training programs for school social work, school psychologist, school counseling and nurses

- Use federal/state funds to train mental health specialist from minority communities in our university training programs like federal NIMH training grants in 1960-1970's
- Increase the number and require the inclusion of a percentage of non-traditional providers to deliver mental health services.
- Make sure new mental health providers are not being trained in old stigmatizing attitudes.
- Education professionals and their organizations about recovery (i.e.-NASW, APA)
- Increase workforce that is bicultural and bilingual
- Cultural sensitivity training for providers
- Increase number of providers
- Stigma and discrimination reduction trainings are mandatory for all mental health providers.
- Using MHSA and other funding to offer more clients employment opportunities in mental health and peer-run programs.

DISCLOSURE (Workplace or communities)

- Strategies that support disclosure whether in the workplace or in communities.
- "Normalize" episodes of mental illness by building community support systems to encourage everyday members to self disclose.

LANGUAGE

- I believe the term "mental" is stigmatized; how about Organic Brain Disorder?
- Overhaul the language associated with mental illness and inject new terminology into the community
- Using another term for clients/survivors besides “consumers” because unlike the design and delivery of services and products, the public does not understand the term.

HOUSING

- Decriminalize the treatment and housing of adults/youth with mental health diagnosis and acting out behaviors
- Education of landlords and housing authorities
- Solidify and utilize effective anti-NIMBY strategies

HOMELESSNESS

- Developing a 10-Year Plan to end homelessness that includes resources and actions designed to reduce homelessness

EDUCATIONAL SYSTEM-SCHOOLS

- School-based mental health services
- Technical assistance available to employers, schools
- Normalize stages of instability as natural part of self-development. teach this in schools so instability is honored instead of disgraced
- Develop curriculum across all subject areas that addresses these issues.

- Target high schools and colleges. For example, WRAP in high schools and colleges.
- Trauma education
- Revamp State's health curriculum K-12
- Educate schools on both mental health for all students and how to meet needs of kids with MI
- Public education of all aspects of mental health/illness
- Active suicide prevention education, ties in to public education Mental health literacy for children (how to address, how to help with self- and public perception)
- Education on Mental Health throughout Educational System, so that stigma is addressed throughout child and youth development
- Include mental health education in curricula at all levels of teacher education
- Strong school-based interventions that include education, contact, strategies to change social norms
- Development of curricula and other interventions for use with children in school setting
- Promote wellness curriculum in schools
- Well developed education plan for all levels
- Stigma beginning in childhood and including families working in schools and child settings, learn relevant research
- Increase pupil support staffing in public schools
- Ensure that education funding in all levels of public education (k-12) was adequate to provide the student services necessary to educate and support help-seeking of students
- Early intervention in schools
- School funding for increased student support positions for every school/school district
- Every school has access to student support team: school social worker, school counselor, school psychologist, school nurse etc.
- Address stigma & discrimination issue within school (K-12) context), how to include teachers, administrators, pupil service workers, school boards, community organizations that affect behaviors toward children/families with emotional/behavioral issues.
- Education of teachers
- Development of curricula for use with teachers
- Provide mental health professionals to schools for early intervention.
- Increase funding for the expansion of AB3632 mental health services for all students in special education
- More education/training for school teachers regarding mental health
- Outreach to college students
- Promote "search and serve" programs for students in general education in schools and communities for children and youth in need of mental health services
- Include in provider higher education systems the internal and external stigma perpetuated through the psych education system.
- Mental health literacy for children (K-12)

- Create school based mental health/health programs in all school districts
- Include social skills training and pro-social behaviors towards others in elementary school curriculums
- Include mental health issues in school curriculum, especially in middle and high school courses
- Begin meetings in school districts on how to include teachers, parents, students, etc. in addressing stigma & discrimination
- Identify strategic role of schools AND the policy and resource support needed to make this role a reality
- Integrate Mental Health, Social Service and Education where client needs and services meet

EMPLOYERS & EMPLOYMENT

- Technical assistance available to employers, schools
- Offer more employment opportunities for ethnic minorities, youth, LGBTQ, etc.
- Provide more employment opportunities for consumers and family members.
- Protect MediCal for working disabled (reduces self-stigma to remain in workplace)
- Active stigma/discrimination programs in workplaces for workers
- Educate employers -- that hiring individuals based on their abilities is the first and foremost -- whether or not they have a disability
- Education of employment community (i.e. - chamber of commerce)
- Providing courses and classes for employers and employees
- Identification of best practices in working to reduce stigma concept among employers
- Find out groups of people need education about stigma & discrimination and get them to the table to work with them, i.e., employers
- Ensure services in mental health system include support and pro-active development of job opportunities
- More education for employers about myths of people with mental health diagnoses, and about accommodations.
- Strategies that support disclosure whether in the workplace or in communities.
- Work with Human Resource Managers and personnel to educate on mental health and discrimination policies
- Work with employers to hire individuals with mental disabilities, but help to make it a win/win situation.
- Education of employers
- Assistance with ADA dispensation for clients who are working full time and have episodic crises so they can return to their jobs without fear of losing their only source of income.

PUBLIC POLICY & LEGAL PROTECTIONS

- Integrate bathrooms at mental health facilities ending staff only restrooms as a concrete and symbolic act to eliminate the discredited "separate but equal" doctrine that perpetuates the so-called negative differentness of mental health clients and the us/them dichotomy between staff and mental health clients
- Promote compliance with and enforcement of existing laws, including Americans with Disabilities Act, the Supreme Court's Olmstead decision, the Fair Housing Act, and the Civil Rights Act among others
- Monitor abuses in institutional settings and develop collaborations to protect mental health clients from abuses, including seclusion and restraints.
- Establishing anti-discrimination reviews that are similar in their timing and impact to environmental impact reviews.
- Legal strategies for targeted issues of top priority (e.g., employment, housing - I don't know what is top priority)
- Clearly defining laws and rights of confidentiality
- Make the idea of mental health services a civil right like special education
- Educate legislators so the resources can be made available for education and treatment.
- Educate employers about civil rights laws
- Educating audiences (employers, educators) about civil rights protections and tools "Americans with Disabilities Act" accommodations and modifications
- Highlight agencies and/or individuals who promote stigma & discrimination reduction in the community
- Identify strategic role of schools AND the policy and resource support needed to make this role a reality
- Enforcement of disability and civil rights laws
- Create a 800# for people to report acts of mental health discrimination
- Expose entities that practice discriminatory or stigmatizing behavior - from media stories to elected officials pressured by HOAs, etc. to not site services
- Relying on individuals with psych dx's and their advocates to identify sources of discrimination and solutions.
- Incorporating the principles of the disability rights laws, e.g. Sec. 504, the Fair Housing Act, and the ADA.
- Enforcing the disability rights and civil rights laws to rectify intentional and unintended discriminatory policies and practices by the mental health and other state systems.
- Outlaw use of restraints
- Utilize civil rights techniques used historically in the United States to counter discrimination and gain inclusion
- Have real consequences for those who deny services, housing and employment
- Identify strategic role of schools AND the policy and resource support needed to make this role a reality
- Placing responsibility on individuals and organizations that perpetuate stigma and discrimination.

RESEARCH

- In general I see the statewide project as developing resources and research findings that can be applied to s & d campaigns and efforts at the county/community levels. The exception would be a media campaign or something that could better be executed with statewide consistency.
- Research into best approaches
- Examine why a culture or society stigmatizes certain behaviors
- Examine the mainstream cultures that historically gives power to only a few creating the need to stigmatize and devalue many to keep the power in the hands of a few
- Explain the origin of stigma-cultures that relegate power to only a few people are dependent on not allowing others to be self-determining of their lives
- Explain that stigma is the practice of one culture superimposing it viewpoints of other not allowing others to declare their own cultural worth
- Instituting a practice where others devalues themselves protects the mainstream culture from being scrutinized as having been the original perpetrators of making others feel unworthy
- Examine why a culture or society stigmatizes certain behaviors

PARTNERS, PARTNERSHIPS, INSTITUTIONS & POWER

- Target related systems as social services, children and family services, general medical, housing for reasons related to number 1 above (Integrate bathrooms at mental health facilities ending staff only restrooms as a concrete and symbolic act to eliminate the discredited "separate but equal" doctrine that perpetuates the so-called negative differentness of mental health clients and the us/them dichotomy between staff and mental health clients)
- A child's needs have to be addressed outside the academic world with a full-integration of social, coping, and self-empowerment skills at the earliest levels in their care to prevent self-stigma and early self-management of their health
- Stigma and discrimination keeps different groups fragmented and factionalized so the few with power do not need to work hard to protect their power
- Provide inoculation training for victims and organizations that work for victims.
- Target power groups who make decisions over quality of life issues for individuals and families with mental health challenges.
- Support client and family organizations in using contact strategies with groups listed in addition to peers/leaders of those groups
    - Housing authority/ landlords
    - Mental and medical providerseducators - school administrators and teachers
    - Business leaders and commerce
    - Police/sheriffs/DAs
    - Local elected officials
- Have constructive and egalitarian dialogues between clients, family members and professionals from the various disciplines
- Enlist private entities to raise awareness of stigma & discrimination through say...fundraisers or fairs for example

- Build solid partnerships with organizations, agencies, etc. on all levels (both public and private)
- CEUs and outreach to medical doctors (Cal Med Assn)
- Creating interagency council on homelessness
- Promote and include consumer run, non-profit organizations in every county.
- Placing responsibility on individuals and organizations that perpetuate stigma and discrimination.
- Make a commitment to not play into that by devaluing each other
- Monitor abuses in institutional settings and develop collaborations to protect mental health clients from abuses, including seclusion and restraints.
- Have constructive and egalitarian dialogues between family members and mental health clients
- Collaborate w/ ethnic groups or agencies serving them
- Address stigma perpetuated by individual groups vying for stakeholder
- Dialogues between clients and professionals, and professionals modeling wellness and recovery based.

Department of Mental Health Stigma & Discrimination Reduction Advisory Committee

Survey Responses on Strategies

Survey responses from advisory committee members regarding problems and challenges are listed below by categories. The responses are based on the question: *Now that we've had two meetings dealing with problems and challenges, please identify what you now think are the five most significant ones associated with mental health stigma and discrimination.* All responses are listed, regardless of similarities, with the exception of verbatim duplicates, indicated by an 'x'. More than one 'x' specify how many times the particular response was repeated.

LIST OF CATEGORIES

1. Funding is not disbursed
2. Services aren't accessible, sufficiently funded, or prioritized
3. Services aren't the right type and/or aren't integrated
4. People don't seek help
5. Underrepresented communities aren't prioritized
6. Cultural communities have stigmatizing beliefs, attitudes
7. We need to target specific groups
8. We need to target children, schools, and families
9. We need to target health and mental health service providers
10. We need to target employers
11. We need to change media behavior
12. We need to educate the public
13. We need to target people in the criminal justice system
14. We need to target older adults
15. Development of the Strategic Plan
16. Promote consumer involvement and empowerment, address internalized stigma
17. We need to target issues regarding housing
18. Collaboration
19. Research and evaluation are needed
20. Other observations

<u>Funding is not disbursed</u>

- Getting Prop 63 monies disbursed

<u>Services aren't accessible, sufficiently funded, or prioritized</u>

- Lack of accessibility of services **x x x x**

- Would stigma reduction be easier if services/resources were more accessible? Implications if true?
- Lack of services for co-occurring diagnoses, e.g. mental illness and development disabilities, CP, etc. If stigma interventions do increase help-seeking, existing service systems do not have the capacity to meet increased demand
- Limited accessibility in services
- If stigma interventions do increase help-seeking, existing service systems do not have the capacity to meet increased demand
- Increase access through non-traditional providers and include same-day visit reimbursement PCP's
- Mental health stakeholders competing among themselves for limited mental health services and resources
- How do smaller counties with limited resources develop effective stigma reduction campaigns?
- Getting mental health providers at the state and local levels to make this the highest priority by allocating resources and having a plan that the State and local levels **x**
- Money and resources **x**
- Service system and reimbursement protocols perpetuate discrimination and therefore stigma
- Limited funding directed to these issues
- Need to recognize need for mental health treatment for all ages (do not forget older adults)
- Counties will have little incentive to develop stigma programs when their existing services are being cut
- "Siloing" of resources
- Money and Resources

<u>Services aren't the right type and/or aren't integrated</u>

- Same-day visits in clinics are not allowed. We need integration services
- Integrating physical and mental health services for service delivery, insurance reimbursement, etc.
- How do we change policies and procedures that do not promote self-determination and increase the stigma that we can't make our own decisions
- Lack of services for co-occurring diagnoses, e.g. mental illness and development disabilities, CP, etc. If stigma interventions do increase help-seeking, existing service systems do not have the capacity to meet increased demand
- Lack of a comprehensive community integration strategy
- Need to eliminate silos of physical and mental health
- Integrating physical and mental health services for service delivery, insurance reimbursement, etc.
- System of care needs to change: mental health v. health care, availability of services in community clinics, need reimbursement, serve everyone regardless of Dx **x**
- Statewide and local community mental health system design and integration

- The mental health system does not give consumers the chance to be the drivers in seeking services. We need to promote policies and procedures that support self-determination
- There needs a place where you can go to meet all you needs without having to rely on referrals; less referrals lessen the risk of self-stigma by lessening the risk of receiving discriminatory treatment or being stigmatized at some point during contact
- Same day reimbursement.

<u>People don't seek help</u>

- Most stigma programs focus on changing attitudes of the public; much more work needs to be done to address stigma as a barrier to mental health treatment **x x x**
- Stigma as a barrier to seeking mental health services
- Significant help-seeking barriers for specific groups
- Stigma with youth and the impact it has keeping them from getting the appropriate help that is needed
- Help seeking barriers
- Cultural barriers to accessing services - multiple layers of stigma

<u>Underrepresented communities aren't prioritized</u>

- Major needs to build the infrastructure of underrepresented communities, and the need for equality **x**
- Recruit churches and religious groups to provide their congregations with information and strategies for the reduction of stigma and discrimination.
- Finding culturally appropriate practices and processes that lead to stigma reduction in underserved communities

<u>Cultural communities have stigmatizing beliefs, attitudes</u>

- Cultural and racial barriers **x x x**
- Stigma reduction needs to take into account the cultural context **x**
- To reach ethnic minority community we need to include ethnic media in our outreach campaign and not rely on commercial public firms **x x**
- Can we address how racism and historical trauma actually cause or exacerbate mental illness or mental health? (These also cause mental health disparities)
- How are we going to include communities of color and their perspective?
- Lack of sufficient cultural and ethnic engagement
- Discrimination and stigma are often more acute in communities of color. What approaches?
- Discrimination and stigma regarding different approaches to communities of color
- Ethnic communities must be integrated into the process so that they identify cultural and linguistic barriers and they identify solutions
- Current solutions have not applied to the ethnic communities because the current infrastructure isn't working for the ethnic community
- Addressing racism and historical trauma as major factors for mental health disparities
- Culturally specific issues

- Approach reductions through a cultural lens
- Racism and historical trauma cause or exacerbate mental illness
- Address multiple stigmas
- Helping individuals who have to deal with multiple stigmas (i.e. race, gender, language)
- Our outreach and education to ethnic minority communities need to be in their languages and need to be done by their consumers, family members and community members for it to be successful
- Conception of mental illness and mental health varies depending on culture and different experiences of privilege or no privilege-what cultural reference point are we going to use
- address how racism and historical trauma actually cause or exacerbate mental illness or mental health
- Develop culturally appropriate delivery systems
- Nomenclature-words frame concepts and approaches-how de we include perspectives from people from other cultures and other sub-sets different from the American mainstream

<u>We need to target specific groups</u>

- Target populations **x x**
- Interested in how best to impact those living with multiple sources of oppression (people of color, GLBTQI)
- Discrimination & Sigma re: mental illness is often more acute in communities of color
- There needs to be more emphasis on the perpetrators of stigma and discrimination in consequences for their behavior!
- Can we come up with a strategic plan that deals both with discrimination from racism and discrimination for having a mental illness
- How best to impact those living with multiple sources of oppression and the sources of that oppression

<u>We need to target children, schools, and families</u>

- Children, schools, and families **x x x**
- Stigma and discrimination impact children/youth and their families
- Addressing it at schools as part of curriculum
- Few family support groups and family resources
- Child and teacher attitudes in the school setting leading to bullying, social isolation, etc
- Address stigma and discrimination issue within school (K-12) context, how to include teachers, administrators, pupil service workers, school boards, community organizations, that affect behaviors toward children/families with emotional/behavioral issues. **x**
- Parents' reluctance to seek treatment for fear of stigma
- Children, youth, and their families still are not fully included in the delivery systems of care
- Children's internalized stigma

- Mental health literacy for children, how to address, how to help with self- and public perception **x**
- Prepare, instruct, and evaluate educators from preschool level for the college level on how to address issues related to stigma and discrimination. Provide these educators with relevant curriculum that crosses all subject areas.
- Stigma from the mental health system itself against family members as partners in recovery rather than the cause of the problem
- School-based services are underfunded and not available to all schools and their students
- Children/youth who have developmental disorder are often left out of mental health treatment options
- Mental health agencies often have their own biases when deciding which children/youth receive mental health services
- School support services: school social work, school psychology, school counselors, and school medical support are totally understaffed and underfunded in order to support the intention of Prop 63
- Stigma with youth and the impact it has keeping them from getting the appropriate help that is needed
- Getting the educational system on board to teach age-appropriate mental health concepts along with physical health concepts—for students, teachers, administrators, etc.
- Students with mental health challenges and their families have access to mental health services but the access depends on class, ethnic/language and economic status and school support
- Education has been somewhat left on the sidelines in addressing Prop 63
- Student support services are extremely underfunded and understaffed in most school districts and local schools
- Add stigma & discrimination courses to curricula of all state schools teaching medicine, health care, social services, education, architecture, etc.
- Including mental health in school's health curricula from kindergarten on
- Providing employment opportunities for the youth to change the system to what they see would be effective. Empowering the youth.

<u>We need to target health and mental health service providers</u>

- Target mental health providers (which ones?)
- Education of public and professional regarding mental health issues
- Address stigma issues in training of health professionals
- Plan needs to address significant challenges of stigma and discrimination within the professional and paraprofessional communities of mental health
- Stigma extant in medical community
- Stigma among primary and specialty health providers
- Pervasive stigma and discrimination in the mental health system; let's clean up our own house before we begin pontificating to other systems, groups and the general public

- Stigma and discrimination in related systems to the mental health system designed to assist people diagnosed with mental illnesses such as departments of social services, children and family services, general medical services, etc.
- Medical and Mental Health Provider
- Getting mental health providers to see the clients as the experts and not themselves.
- The professional as well as popular use of psychiatric related epithets to delegitimate, control and/or dehumanize a person or related group with the 'us/them' dichotomy

<u>We need to target employers</u>

- Addressing it with employers
- Stigma as it relates to employment and employment retention, including (1) employers local and Statewide, (2) vocational rehabilitation professionals, (3) through provision of training addressing stigma through available Statewide training resources currently funded through DMH/DOR
- Construct education to employers at top levels to recognize stigma and discrimination
- More education and information on accommodations must be given to employers
- Stigma in Employment
- Identification of best practices in working to reduce stigma concept among employers

<u>We need to change media behavior</u>

- No overall partnership with the media and their manner or reporting incidences of mental illness
- Not enough consistent public relations
- Change media behavior to reduce sensation
- More positive media attention (need champions)
- Media treatment of mental illness and SED
- Change media behavior
- Traditional media identifies experts as “agents of change” and listeners as “objects of change.” The “experts” tell us what the problems are and how to address them. We need to turn that around and bring listeners in as “agents of change” and let them identify what the stigma is and how to address it.
- Need strategy to change media behavior—solutions and resources not sensation
- To reach ethnic minority community we need to include ethnic media in our outreach campaign and not rely on commercial public firms **x x**
- Putting a "face" on mental illness: different ages, genders, cultures, occupations, etc.
- Link b/t mental illness and violence
- Profound cultural and organizational belief systems that entail dehumanizing and negating stereotypes and caricatures, so often reflected and perpetuated by the media

<u>We need to educate the public</u>

- Education of public and professional regarding mental health issues
- Increase the understanding of the full spectrum of mental illness that can include periods of illness, e.g. post partum depression or final exam anxiety
- The general population recognizing that anyone is at risk of developing or having a mental health crisis
- Changing public attitudes
- Emphasizing a public health approach in delivering information regarding stigma and discrimination as well as identifying attributes that lead people to stigmatize and discriminate
- Educating audiences (employers, educators) about civil rights protection and tools - ADA accommodations and modifications
- Discrimination
- The "us" against "them" behavior that separates consumers and non-consumers and removes equality as humans in the interaction
- Individuals who place themselves in a position to discriminate against others, needs to be educated about how their mental health issues cause them to behave in such a manner

<u>We need to target people in the criminal justice system</u>

- Stigma related to services/support for those who are mentally ill and in or released from the criminal justice system, housing, treatment, jobs
- Resources to address stigma and discrimination against mentally ill people in the criminal justice system
- Criminalization of mental illness
- Stigma of law enforcement agencies and within the CJ System

<u>We need to target older adults</u>

- The stigma and discrimination related to older adults is extensive
- Need to recognize need for mental health treatment for all ages (do not forget older adults)

<u>Development of the Strategic Plan</u>

- Approaches to this strategic plan and process **x x**
- Make sure this plan has a strategic focus and not trying to be everything to everyone **x**
- Working as a group, rather than a collection of individuals with personal agendas
- Identifying overarching values, principles and concepts that can be modified to fit particular groups' needs
- Develop partnerships with all state agencies - education, criminal justice, employment, housing, transportation, to incorporate MHSA principles and delivery of services
- Addressing stigma in environments where we all want to succeed--e.g., work, school, places of worship, housing
- How do we come up with a strategic plan that serves all citizens and not just those of the majority

Promote consumer involvement and empowerment, address internalized stigma

- How do we change policies and procedures that do not promote self-determination and increase the stigma that we can't make our own decisions
- The individuals who experience the greatest stigma and discrimination are often left out of stigma program development and policy work
- Involve people with experience of mental illness as "agents of change." People with experience of mental illness need to challenge stereotypes and discriminatory practices
- Address internal stigma between those in recovery and those with severe mental illness who have not experienced recovery
- Testimonials
- Children's internalized stigma
- There are not enough employment opportunities for consumers and family members that want to be involved in education and advocacy around the reduction of stigma and discrimination.
- Self-care and self-managing treatments that empower consumers
- Self-stigma - internally stigmatizing attitudes among individuals and family members
- Empowerment against self-stigma

We need to target issues regarding housing

- Stigma in Housing
- Homelessness and lack of state plans or resources
- Citing for services and housing - especially crisis stabilization and residential services critical to creating a FNC community based system- NIMBY

Collaboration

- Communication and collaboration across systems and stakeholder groups
- Lack of collaboration between state agencies
- Lack of collaboration between private and public sectors

Research and evaluation are needed

- Stigma interventions are generally not well evaluated, so it's not clear what programs actually work
- Most existing stigma interventions are not well evaluated, and their impact on behavior (not just attitudes) is largely unknown
- We don't know how to identify a problem and then select the most effective practices to reduce problem's impact
- ID sources and methods of discrimination, possibly by conducting Sec. 504/ADA Self Evaluations, and develop resolutions and enforcement strategies

Other observations

- Mental health and mental health diagnosis are stigmatized
- Occurs at multiple levels of society and across cultures
- Misunderstanding of what it means to be mentally ill

- Stigma and discrimination are as old as human beings. Complete elimination not realistic
- Recognizing mental health is on a continuum and not static, may affect everyone
- Language shapes attitudes, attitudes drive behaviors
- Basic human tendency to label the “other” or the “different” is a challenge to modify
- Deeply embedded prejudice, rooted in historical context
- A public health approach is needed but it takes a long time
- The professional and general adoption of the medical model with its deficit focus which decontexualizes and pathologize the individual so labeled so that people diagnosed with mental illness are often conceptualized as essentially disease entities ('the schizophrenic', 'the bipolor' 'the boderline', etc.) rather than as multifaceted sentient human beings; such negative conceptions are then internalized as self-stigma and self-hated for the person so diagnosed.
- Stigma/discrimination within systems (mental health, workplace)
- Be prepared to deal with the backlash regarding our committee's efforts by individuals and organizations that want to maintain their inappropriate beliefs and practices