
CALIFORNIA STRATEGIC PLAN ON REDUCING MENTAL HEALTH STIGMA AND DISCRIMINATION

DRAFT



CALIFORNIA DEPARTMENT OF

Mental Health

CALIFORNIA STRATEGIC PLAN ON REDUCING MENTAL HEALTH STIGMA AND DISCRIMINATION

BASED ON RECOMMENDATIONS OF THE
MENTAL HEALTH STIGMA AND DISCRIMINATION
REDUCTION ADVISORY COMMITTEE

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VISION STATEMENT

We envision physical and mental wellness for all Californians and a future where mental health labeling, stereotyping and discrimination belongs to the past.

We envision a future where people affected by mental health challenges are valued and supported in their wellness and recovery, education, housing, employment, health care, and other needs in order to live a fulfilling and productive life.

This vision of mental wellness will emerge through raising awareness, education, and concerted action at all levels.

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INTRODUCTION

There have been remarkable advances in understanding functions of the brain and treating mental disorders in the last 50 years. Yet the stigma of mental health continues to be a barrier for many individuals to seek needed treatment. Stigma, exclusionary acts, and discrimination against those with mental health challenges is widespread. Nearly half of adults in a nationally representative survey said they were unwilling to socialize with, work with, or live near people encountering mental health issues.¹ Additionally it is estimated that as many as 33 percent of children experiencing social, emotional, or behavioral difficulties have been the target of bullying in mainstream schools.²

The number of people affected by stigma is significant: In any given year, roughly one in every four adults will suffer from a diagnosable mental disorder, and nearly 2 out of every 10 children will experience some degree of an emotional or behavioral difficulty.³ Stigma, and the discrimination that can result from mental illness, can cause shame, despair, and hopelessness. Stigma can impede recovery, create fear and social isolation, and discourage individuals who need help from seeking it. Self-stigma, or the desire to avoid stigma, is estimated to influence 50 to 60 percent of individuals with mental health challenges from seeking treatment.⁴ Further, it is estimated that (research pending) of parents avoid seeking help for their children due to fears of labeling and stigmatizing. By rejecting or dropping out of mental health services, individuals can avoid taking on the stigmatizing label of mental illness.⁵ Failure to seek help can lead to fatal behavior: 90 percent of individuals who die by suicide have a diagnosable mental health or substance abuse problem.^{6,7}

Envisioning Change

The good news is that California is ready to fight stigma and discrimination associated with those who face mental health challenges. Reducing stigma and discrimination against people experiencing mental health challenges is a priority of the California Department of Mental Health (DMH) and the Mental Health Services Oversight and Accountability Commission (MHSOAC). In collaboration with the MHSOAC, DMH convened the California Mental Health Stigma and Discrimination Reduction Advisory Committee to develop a 10-year strategic plan to reduce stigma and discrimination against people with mental health challenges in California. This Committee consisted of a diverse group composed of consumers, family members, advocates, providers, clinicians, experts, researchers, and representatives from various community-based, non-profit, and government organizations.

The *California Strategic Plan on Reducing Mental Health Stigma and Discrimination* (Plan) is crafted with the vision that unfolds into four strategic directions and recommended actions. Recommended actions will target Californians of all ages and be designed to work successfully within California's diverse communities. The Plan addresses prevention and early intervention activities, including public education and

contact campaigns, to confront the fundamental causes of stigmatizing attitudes and discriminatory actions.

This 10-year Plan should serve as a blueprint for action at the local and state levels, as well as an informational resource for government, community-based organizations, consumer and family groups, and others. It serves as a resource document for individuals, both inside and outside the mental health field, who are dedicated to the complete social inclusion of people living with mental health challenges.

This Plan begins with a focused discussion in Part 1 on the challenges presented by stigma and discrimination related to mental health. Part 2 discusses several approaches to reducing stigma and discrimination. Part 3 contains the Plan's Core Principles, Strategic Directions, Recommended Actions, and next steps that are necessary to reduce stigma and discrimination in California.

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PART 1: REDUCING STIGMA AND DISCRIMINATION IN MENTAL HEALTH: CHALLENGES AND OPPORTUNITIES

What Is Stigma and Discrimination?

Stigma refers to attitudes and beliefs that lead people to reject, avoid or fear those they perceive as being different. Discrimination occurs when people and entities *act* upon these attitudes and beliefs in ways that can deprive others of their rights and life opportunities.⁸ Discrimination can include behaviors that result in the exclusion or marginalization of others, as well as illegal acts of abuse or actions that deprive people of their civil rights, access to fair housing options, opportunities for employment, education, and full participation in civic life.

Three major categories of mental health-related stigma exist:

- ‘Public stigma’ encompasses the attitudes and feelings expressed by the general public toward persons living with mental health challenges, or towards their family members.
- ‘Institutional stigma’ occurs when negative attitudes and behaviors about mental illness, including social, emotional, and behavioral problems, are incorporated into the policies, practices and cultures of large organizations, and social and educational systems.
- ‘Self-stigma’ occurs when an individual believes the disrespectful images that society, a community or peer group perpetuates.

Stigma is often reflected in commonly used language. Some of the synonyms and slang terms used to describe individuals with mental health challenges are among the first words young children use to discount other children they do not like, indicating how deeply entrenched stigmatization is in today’s culture.⁹ Clinical terms have also developed a stigmatizing effect for many mental health consumers, who object to being defined by a diagnosis. This Plan attempts to use non-stigmatizing terms that are currently preferred by consumers, although research studies discussed herein may use original terminology.

What Causes Mental Health Stigma?

Stigma often gets its start in thoughts and attitudes that negatively describe others considered to be different. This can lead to the creation of stereotypes. When people agree with a negative stereotype, they may develop feelings of anger, pity, or fear toward others. These feelings may lead to behaviors, such as avoidance, rejection, scorn, discrimination or abuse. Similarly, in self-stigma, individuals or groups may believe stereotypes about themselves and develop feelings of shame, anger, hopelessness or despair. As a result, they may refrain from seeking social support, work or treatment.¹⁰ Common stigmatizing attitudes and actions expressed toward those living with mental health challenges include aversion or fear, which results in the

tendency to shun them, or support policies of forced treatment and/or hospitalization. Another attitude or stereotype sees people with mental health challenges as childlike and needing to be cared for, which can lead to forced treatment practices and policies. These attitudes can be further accentuated by a lack of understanding about mental health issues. In addition, stereotypical portrayals in movies and in the news are influential in spreading fear and misunderstanding about persons living with a mental illness.¹¹

Stigma and discrimination occur within the complex ecology of our social environments. An individual's attitudes, beliefs and behaviors are influenced by the relationships of family, friends and peers; by the community environment of school, workplace, social networks and cultural groups; and by the greater society with its laws, governmental systems, institutions and economy. In addition, one person may belong to several different cultural groups with differing influences and varying stigmas. The mental wellness of individuals may be affected differently at various times in their life. In developing and implementing stigma and discrimination reduction measures, it is important to consider the issue from these multiple lenses.

How Stigma and Discrimination Is Experienced

Each individual may have varying degrees of susceptibility to stigma and discrimination. Being that everyone responds differently to stigma, some people may experience limited degrees of self-stigma in response to societal pressures, while others may respond with anger to being labeled.¹² More research is needed to understand why some individuals are more or less affected than others.

In addition, a community or cultural group may be more or less inclined to stigmatize someone with mental health challenges. The importance of looking at unique cultural approaches to stigma is particularly necessary in California, which is among the nation's most ethnically diverse state. California, according to 2007 state estimates, is 44 percent Caucasian, 36 percent Hispanic, 12 percent Asian, and six percent African-American, with Native Americans and Pacific Islanders each making up less than one percent of the estimated population.¹³

Studies to date support that different cultures experience stigma in different ways. For example, Asians are only one-quarter as likely as Caucasians to have sought outpatient treatment. In some Asian cultures, mental illness is seen as reflecting poorly on the entire family, diminishing marriage and economic prospects for other family members.¹⁴ One study found Native Americans and Caucasians holding similar attitudes toward individuals with mental health challenges, while Asians and Latinos held more stigmatizing attitudes. The study also found that stigmatizing attitudes among African Americans did not lessen after contact with those living with mental health challenges.¹⁵ More research is needed to develop a clearer understanding of cultural specifics of mental health stigma and discrimination and the culturally effective and appropriate means for reducing them.

Families, Friends and Caregivers

Stigma also affects the family members, companions and co-workers of those living with mental health challenges. Family members and caregivers are frequently judged responsible for a loved one's mental health challenges and treated with suspicion or disapproval. This is known as "stigma by association." For families and caregivers, this reinforces caretaker denial and/or creates fears that impede the pursuit of appropriate services and supports early in a child's development. In one study, family members reported experiencing social stigma and stigmatizing attitudes from mental health professionals.¹⁶

Children and Transition-Age Youth

Children with serious social, emotional, or behavioral challenges are exposed to peer exclusion, social isolation and bullying and other forms of abuse. Transition-age youth, aged 16 to 25, are particularly vulnerable to mental health stigma and discrimination given that 75 percent of all lifetime mental health disorders start by age 24.¹⁷ A recent study indicates that California college students are presenting mental health challenges with greater frequency and complexity.¹⁸ During this stressful transition period, youth with social, emotional, or behavioral may transition from foster care, the juvenile justice system or the children's mental health system into the world where adult service systems are their only option. When a youth turns 18, the sudden movement out into the adult world or to an adult facility with little support can be terrifying for the youth and challenging for family members.¹⁹

Addressing Multiple Stigmas

Many individuals, families and communities experience multiple burdens of stigma and discrimination, including youth and foster care; racial and ethnic communities; those who are lesbian, gay, bisexual, transgender or questioning; persons with physical disabilities; persons with co-occurring disorders; older adults; rural populations; and veterans.

Youth in Foster Care

An estimated 60 percent of California foster youth have social, emotional or behavioral challenges, often spawned by histories of family neglect and abuse.²⁰ Children and adolescents who are faced with mental health challenges and are in foster care experience multiple stigmas. In addition to stigma and discrimination related to their emotional and behavioral difficulties, youth are treated by their peers, the community and the system at large as being different because they are in foster care. According to the Little Hoover Commission report, youth in foster care are routinely denied adequate education, and mental and physical health care.²¹ Those in need of mental health services face additional barriers created by complexity in the foster care system.

Racial and Ethnic Communities

The United States Surgeon General and the President's New Freedom Commission (Commission) on Mental Health have identified public stigma as a key factor in problems of lack of access to mental health services for racial and ethnic communities.²² Problems include the lack of culturally competent services, including language services, financial barriers, and failure to respect and understand the histories, traditions, beliefs and values of racial and ethnic communities. The Commission cited the significant underrepresentation of minority populations in the mental health workforce as a barrier to access. The Commission also stated that as a result of these factors, Native Americans, African Americans, Asians, Pacific Islanders, Latinos and other racial and ethnic minorities bear a disproportionately high burden of disability from mental illness – not because of a higher prevalence or severity of illness in these populations, but from receiving less care and poorer quality of care.

Racism and race-based discrimination are stressful and adversely affect physical and mental health.²³ Individuals from ethnic and racial communities may encounter stigma and discrimination as they attempt to get help for their mental health challenges, often receiving differential treatment and poorer quality of care. Those who are underserved in the voluntary community system of mental health care, including racial and ethnic groups, particularly African-Americans and Native Americans, are overrepresented in coercive services involving involuntary inpatient hospitalization.²⁴ Racially and ethnically diverse children tend to receive mental health services through juvenile justice and child welfare systems more often than through schools or mental health settings.²⁵ Some communities, such as Latinos, are underrepresented in their use of mental health services and may seek treatment through non-mental health arenas, such as medical clinics or faith-based organizations.²⁶

While experiencing multiple stigmas, racial and ethnic communities may also maintain certain cultural based assets that can help counter stigma and the stresses of mental health challenges. These may include supportive families, strong community networks, spirituality, and religion.

Lesbian, Gay, Bisexual, Transgender, Questioning (LGBTQ) Community

The LGBTQ community faces significant stigma, and are also at high risk for becoming victims of physical violence and harassment. LGBTQ youths face harassment and possible abuse from family and peers when they first go public with their sexual orientation or gender identity. LGBT older adults fear accessing health and social services due to concerns about insensitive and discriminatory treatment. Also, they are more likely to live alone and less likely to have a caregiver should they fall ill, compared to heterosexual seniors.²⁷ These factors can increase feelings of isolation and loneliness which are risk factors for depression in later life.

Until 1973, homosexuality was defined as a mental illness by the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM), and some in the mental health field continue to view the gender identity of gays, lesbians and bisexuals as a mental illness, compounding the difficulties members of this community have experienced from the mental health field.

Studies have shown that the LGBTQ community has an increased risk for depression, substance abuse and suicide.²⁸ The social stigmas and social inequalities that lesbians and gays, in particular, experience may also place them at greater risk for psychological distress.²⁹

Persons with Physical Disabilities

Individuals with a physical disability in addition to having mental health challenges are among those grappling with multiple stigmas. While more research is needed, one study found that people who have a physical disability and a mental health challenge experience a greater degree of stigma and discrimination. In addition, the greater stigma they reported experiencing, the more likely they were to also report poor health or poor emotional well-being.³⁰

Persons with Co-Occurring Disorders

Individuals who experience a mental illness in addition to another co-occurring condition, for example, alcohol and substance abuse, face multiple stigmas. Studies show high rates of stigmatizing attitudes among the public toward those with drug- or alcohol-related disorders.³¹ Systemic discrimination also exists. Too often, individuals living with co-occurring disorders are treated for only one of the two disorders. Only 19 percent of people who have co-occurring disorders are treated for both disorders; 29 percent are not treated for either problem.³²

Older Adults

In today's society, growing older and experiencing a mental illness at the same time can impose barriers to improving one's mental and physical wellness and living a productive life. Common stigmas and stereotypes held by the public, professionals, family members and older adults themselves include the belief that depression is a normal part of aging, or that someone is too old to recover from a mental illness.³³ Because of such societal attitudes, mental illness in older adults may not be identified and treated, or older adults may avoid accessing mental health services. About 20 percent of persons 55 and older experience specific mental disorders not considered part of 'normal' aging. However, older adults have a low rate of mental health service use, with only 15 percent of those needing services receiving them.³⁴ Untreated depression is a significant risk factor for suicide in the elderly, and older adults are disproportionately likely to die by suicide.³⁵

Rural Populations

In rural areas, many people with mental health challenges have inadequate access to care, and face greater social stigma for seeking mental health services. While not necessarily a direct correlation, a conclusion from the New Freedom Commission indicates that older men and Native American youth who live in these rural areas experience a significantly higher suicide rate.³⁶

Veterans/Military

Active-duty military personnel have significantly higher rates of major depression, generalized anxiety and post traumatic stress disorder than the general population – as many as 17 percent of those stationed in Iraq and Afghanistan met the criteria for those three conditions. Of those personnel, less than 40 percent sought mental health care, and many reported being concerned about stigma and discrimination because of their mental health challenges.³⁷ Many current members of the military feel that seeking treatment for mental health challenges may jeopardize their careers. Returning veterans face challenges in learning how to navigate the Veteran Administration (VA) system to receive mental health services. Homelessness is an issue of particular concern to the veteran community. The VA estimates that approximately one-third of all adults who are homeless are veterans, and nearly half of homeless veterans have mental health challenges.³⁸ Homelessness in itself is highly stigmatizing; veterans who have mental health issues and are homeless face a dual stigma.

What are the Impacts of Stigma and Discrimination?

Public and Institutional Stigma and Discrimination

Individuals with mental health challenges may struggle with personal, professional and cultural relationships tainted by stigma and discrimination in almost every facet of daily life. Because of the tendency by many others to shun them, they may find themselves lacking the circle of friends, family and social networks that would typically provide camaraderie, joy and support. However, it is not uncommon that members of their support groups, including parents and other family members, also experience avoidance or blame, and may also be socially excluded.

Children with social, emotional or behavioral challenges may find themselves routinely treated differently by both the adults who work with them and their peers. For children, social avoidance may take the form of peer exclusion, taunting, shaming, bullying and physical abuse from other children. In one study, 33 percent of children with special needs who attended mainstream schools were targets of bullying, compared to eight percent of their classmates.³⁹ Studies show that childhood isolation and resulting depression has risen by (research pending).

Adults may be victimized in other ways. People with mental health challenges are at a much higher risk of being victims of violent crime than the general population.⁴⁰ The

research suggests that individuals with mental health challenges are more often the victim than the aggressor (updated research numbers pending).⁴¹

Stigma and discrimination may interfere with the ability of individuals living with mental health challenges to obtain housing and keep or find work, despite their ability to do the job. One in three mental health consumers reported being turned down for a job once their status became known. In some cases, job offers were rescinded when a history of mental health challenges was revealed.⁴² These difficulties can increase the chances of becoming homeless. In 2000, an estimated 75,000 Californians with mental health challenges needed housing.⁴³

Additionally, stigma and discrimination may prevent individuals with mental health challenges from participating fully in civic life: 44 states, including California, have constitutional language taking away the voting rights of individuals if they are found “mentally incompetent.”⁴⁴ Under California’s Election Code, this would happen if a conservator has been appointed for them, or they have been judged not competent to stand trial.

Self-Stigma

Experiencing the effects of stigma and discrimination can prompt feelings of low self-esteem, shame, anger, hopelessness and helplessness, and can fuel the cycle of self-stigma. Hopelessness and despair can lead individuals to take their lives. Once again, while there are many anecdotes and first-person accounts of living with stigma and discrimination, research to date has not yet calculated the numerical effects of these social and systemic pressures in terms of unemployment, homelessness, dropout rate, etc.

As mentioned above, in order to avoid the stigma of being labeled with a mental illness, many individuals may refrain from seeking treatment for their mental health challenges. Concerns with labeling apply to children and adolescents as well. Less than 30 percent of individuals with mental health challenges seek treatment, according to a large-scale epidemiological study.^{45,46} It should be noted, however, that stigma is not the sole reason individuals do not seek or continue treatment; treatment may not be available or accessible in or around their community.

Stigma Impacts the Mental Health Field

According to the United States Surgeon General, another reflection of the impact of stigma resides in the public’s reluctance to fund mental health programs and systems.⁴⁷ The public has generally ranked insurance coverage for mental health challenges below that for physical illnesses.⁴⁸ With California voters passing Proposition 63, the Mental Health Services Act, in 2004, and Congress’s passage of the Mental Health Parity legislation requiring the equal treatment of mental health by health insurance carriers and employers in September 2008, this picture may be changing for the better.

Where Does Stigma and Discrimination Occur?

Many experiences of stigma and discrimination occur in the community and schools where individuals encounter social exclusion and difficulties participating in school functions, and finding or keeping housing or employment.

Housing and Employment

Landlords have been shown to be far less likely to consider renting to individuals who've revealed they had received hospital mental health treatment⁴⁹ In addition, neighborhoods often organize to block housing projects that would accommodate individuals with mental health challenges. Called NIMBYism (Not in My Back Yard), this practice increases the costs and difficulties of creating desperately needed affordable housing for individuals living with mental health challenges. If the individuals end up homeless as a result, they will likely experience increased, or multiple stigmas. They will also face an increased threat of violence. In one survey, two-thirds of homeless people reported being victimized in the previous year. Seventy-five percent of the crimes were assaults, and 23 percent were rapes.⁵⁰

With regard to employment, a 1995 survey of U.S. employers showed that half would rarely employ someone with a psychiatric disability and almost one-quarter would dismiss someone who had not disclosed a mental illness.⁵¹ With the loss of work comes not only impoverishment, but the loss of a source of personal achievement and satisfaction.

The U.S. has laws prohibiting housing or employment discrimination against individuals because of their disability. The Federal Fair Housing Act prohibits both individual and community discrimination. The Americans with Disabilities Act (ADA) outlaws discrimination in employment, public services, transportation, and public accommodations. However, it may be difficult for individuals to establish evidence and find legal representation to seek redress. Funding to legal aid organizations has dwindled significantly, many people do not qualify for legal aid, and it can be a very arduous process to file a lawsuit against an employer or landlord.⁵²

Educational Systems

Educational institutions are another system where the effects of stigma and discrimination are multiplied. This includes the pre-schools, K-12 schools, and higher education campuses. Yet, schools are in a unique position to dispel misconceptions about social, emotional, behavioral disorders and mental illness, thus helping more students understand the facts and encourage help-seeking behavior. Despite various school efforts to address stigma and discrimination through a variety of programs and curricula addressing topics, ranging from general mental health education to bullying reduction, many consumers, family members and advocates see the educational system as multiplying the effects of stigma. Among the many issues raised, is the

growing concern about the ways in which students respond to and cope with the demands of growing up with a label.

However, time for mental health education in schools is becoming increasingly limited due to the focus on educational outcomes and achievement testing. Given the fact that one in five children and adolescents experiences the signs and symptoms of a DSM-IV disorder during the course of a year, schools are an ideal setting to address stigma and discrimination. Teachers, counselors and school staff require professional development opportunities related to common mental health concerns, promoting healthy social and emotional development, and implementing culturally competent strategies to address stigma and discrimination and related topics. Educational leadership is in a unique position to develop healthier, safer and more inclusive school cultures, e.g. implementing well established programs such as Building Effective Schools Together (BEST) which includes Positive Behavior Supports and Interventions that address the entire school population as well as more selective interventions.

Looking at the university level, constricting budgets and the growing requirements to accomplish more with fewer resources has led many college counseling centers to become more evolutionary than revolutionary. College counseling centers were founded in the 1950s to provide career counseling to veterans and other students. These centers eventually became broader in scope e.g., expanding diagnosis and assessment, increasing array of clinical services, psychoeducational outreach and prevention programs, and campus consultation, in the 1970s through the early 1980s.⁵³

Mental Health System

Studies have shown that stigma is prevalent among the mental health provider community, with many mental health care professionals harboring unconscious negative feelings about their clients.⁵⁴ When people encounter stigmatizing attitudes from mental health professionals, they may avoid seeking or continuing treatment.

One study of mental health professionals' attitudes toward integrating people with serious and persistent mental illness into the community found that members of mental health staff at outpatient psychiatric clinics held more exclusionary attitudes than staff in agencies providing residential services or advocating on behalf of people with severe and persistent mental illnesses.⁵⁵ Also, there may be institutional stigma and discrimination within the mental health system resulting in policies that can create inequities in access to and distribution of mental health resources relative to certain population groups.

Medical System

Individuals living with mental health challenges may face resistance when attempting to access basic and appropriate health care services. One study suggests that individuals receive fewer medical services, and are less likely to receive the same range under

their insurance benefit plan.⁵⁶ Healthcare providers, including physicians, may not recognize the signs and symptoms of a mental illness or be knowledgeable about adequate and effective treatment. For example, according to the National Institute of Mental Health (NIMH), 20 percent of older adults who committed suicide had visited their primary care physician on the same day, 40 percent within one week, and 70 percent within one month of the suicide.⁵⁷

Criminal Justice System

With the closure of many public mental hospitals, jails and prisons have become the largest mental facilities in the U.S., fueled by the increasing tendency to house individuals experiencing mental health challenges in correctional facilities.⁵⁸ The criminalization often gets its start when police, rather than the mental health system, respond to mental health crises. Police and prison workers are often not given adequate training needed to work effectively with individuals with mental health challenges, and jails are not designed to provide treatment and supportive services.⁵⁹

Sidebar:

Since 1955, 93.9 percent of the public psychiatric beds in California have been eliminated.⁶⁰ At the same time, county jail systems and emergency rooms have seen large influxes of individuals suffering from mental health challenges. Of the nearly 20,000 inmates in the California County Jail System, roughly 60 percent suffer from a mental health challenge. The Los Angeles Police Department reports that at the Twin Towers jails, 1,000 beds are filled nearly every night by patients with psychiatric conditions, more than in any mental institution west of the Mississippi.⁶¹

People exhibiting symptoms and signs of serious mental illness are more likely than others to be arrested by the police;⁶² people with mental illness tend to spend more time incarcerated than those without mental illness.⁶³ Of the 30,000 inmates in California jails and prisons who have a serious mental illness, the majority are thought to be nonviolent, low-level offenders who landed in the criminal justice system in part because they did not receive adequate community treatment.⁶⁴ Understanding how law enforcement is affected by stigma and the stress they experience in responding to mental health emergencies with little preparation or support is another important area for further inquiry and research.

Media

From the 1950s to the 1990s, the percentage of Americans who viewed individuals with mental health challenges as dangerous nearly doubled.⁶⁵ Observers, including the U.S. Surgeon General, have posited that such attitudes are influenced by portrayals in the media.

Despite the widespread view of dangerousness, the U.S. Surgeon General's 1999 report on mental health strongly emphasizes there is very little risk of violence or harm

to a stranger from casual contact with a person who has mental health challenges.⁶⁶ However, stigmatizing images of dangerousness abound in news and entertainment venues. A survey of more than 3,000 newspapers found 39 percent of the stories about mental illness focused on dangerousness and violence.⁶⁷

Other portrayals are merely degrading. One study of Disney's animated feature films found that 85 percent contained references to mental illness, mainly used to set apart and degrade characters.⁶⁸ Studies have found a clear connection between negative media portrayals of mental illness and public attitudes and stereotypes.⁶⁹ Since many people may learn about mental illness from the media and entertainment industries,⁷⁰ inaccurate portrayals and information can inadvertently promote stigma and discrimination.

Opportunities for the Future

In addressing stigma and discrimination toward people living with mental health challenges, there are significant obstacles, but also significant opportunities. California has the opportunity to learn from various approaches that other groups and communities have used to make strides against stigma and discrimination on other fronts, in battling racial discrimination and homophobia, or in the successful passage of the Americans with Disabilities Act.

We also have the opportunity to learn from successful and ambitious international efforts to counter stigma and discrimination associated with mental health issues in New Zealand, Scotland, England, Australia and Canada, as well as from those efforts here in the United States. Additionally, we have the opportunity to learn from the public health sector's broad-based approaches to changing attitudes and behaviors around other health issues such as anti-tobacco, promotion of seat belts, anti-drunk driving, violence prevention and obesity prevention. In Part 2 these opportunities are discussed in more depth.

PART 2: STRATEGIES, APPROACHES AND METHODS FOR REDUCING MENTAL HEALTH STIGMA AND DISCRIMINATION

Efforts in reducing mental health stigma and discrimination is a relatively new phenomenon, starting in the 1990's. Consequently, the body of research and evaluation to date on this emerging area is still relatively small. As California launches its efforts, what should guide it? What do we know about how to effectively prevent and reduce mental health stigma and discrimination long term?

This section examines those questions by combining two important sources of information. First are the social ecological model and social marketing approaches used to successfully alter behavior in areas such as tobacco control, suicide prevention and the spread of HIV. This information is augmented by lessons learned from many anti-stigma efforts both in the United States and internationally.

What Can We Learn from the Social Ecological Model and Social Marketing Approaches?

(Sidebar) Social ecological model (also referred to as Socio-ecological model) is a conceptual model that outlines how the health status of an individual is influenced not only by the attitudes and practices of that individual, but also by their personal relationships, as well as community and societal factors. It also describes the multiple levels of intervention, beginning with individual level change and culminating with societal change. Levels include:

- **Individual:** Personal beliefs, attitudes, behaviors or characteristics that influence health status.
- **Relationships:** a person's family, friends, and peers who have the potential to shape a person's behaviors and range of experiences.
- **Community:** Areas and organizations where social interactions occur, including schools, workplaces, churches and neighborhoods that influence a person's health.
- **Societal:** Larger scale influences on health such as economic policies, or religious and cultural beliefs.⁷¹

(Sidebar) Social marketing is a technique that uses commercial marketing methods to achieve social goals and encourage attitudinal and behavioral change.

The social ecological model and social marketing approaches have a successful track record when adequately funded, well-planned and fully implemented. For example, California has direct experience with successful social-ecological models to draw from in its Tobacco Control Program.

California Tobacco Control Program (Sidebar)

California's anti-tobacco effort, funded by the voter-approved Proposition 99 tobacco tax in 1988, is the nation's longest-running comprehensive tobacco control program and has established California as a cutting-edge world leader in the field. The \$90 million-a-year program sets a precedent for the state to develop a broad, multipronged, long-term campaign to change public attitudes and behavior for the public's benefit.

Over the first seven years of the program, adult smoking rates decreased by 40 percent and tobacco consumption decreased more than 65 percent. California now has the lowest smoking rate in the United States among people age 12 and older.⁷² Lung cancer incidence in California has been declining four times faster than the national average.⁷³

California accomplished these changes through a comprehensive approach, carefully developed to achieve the following goals: create a social milieu in which tobacco becomes less acceptable; counter pro-tobacco influence; reduce tobacco availability; reduce exposure to secondhand smoke; and provide smoking cessation services.

These goals are achieved through a three-pronged approach:

- Local and statewide anti-tobacco multi-language mass media campaigns;
- Creation and enforcement of tobacco control laws and policies (including passage of legislation raising tobacco taxes and banning smoking in restaurants and bars);
- Creation and promotion of a smoking cessation helpline, which provides services in many languages.

Important components include:

- Collaborative partnering with university researchers and state education officials;
- Support for grassroots program design and implementation by local agencies, community coalitions and organizations, statewide projects, ethnic networks, and schools.
- An extensive research and evaluation component, including monitoring of tobacco industry's marketing practices and influence on California's social, economic and health environment;
- Involving the entire public to reinforce the idea of a smoke-free society, and engaging the public from the beginning.⁷⁴

The social ecological model is more likely to sustain prevention efforts over time than any single intervention. The first level identifies biological and personal history factors that increase the likelihood of becoming a victim or perpetrator of violence. Some of these factors are age, education, income, substance use, or history of abuse. The second level includes factors that increase risk because of relationships with peers, intimate partners, and family members. A person's closest social circle-peers, partners

and family members-influences their behavior and contributes to their range of experience.

The Social Ecological Model⁷⁵



The third level explores the settings, such as schools, workplaces, and neighborhoods, in which social relationships occur and seeks to identify the characteristics of these settings that are associated with becoming victims or perpetrators of violence. The fourth level looks at the broad societal factors that help create a climate in which violence is encouraged or inhibited. These factors include social and cultural norms. Other large societal factors include the health, economic, educational and social policies that help to maintain economic or social inequalities between groups in society. Another example is the Air Force's successful suicide prevention program.⁷⁶

Air Force Suicide Prevention Program (Sidebar)

One example of a successful multipronged public health approach that involved reducing stigma is the Air Force Suicide Prevention Program. The comprehensive, communitywide prevention strategy was associated with a 33 percent reduction in Air Force suicides between 1996 and 2002, during a time when other military services did not experience similar changes.

The service-wide program was developed in the 1990s to counter an alarming rise in suicides among Air Force personnel from 10 to 16.4 suicides per 100,000. A major aim was to modify the culture of the USAF community, to remove the stigma of seeking help for a mental health or psychosocial problem. Air Force leaders believed that many of the suicides came after a long road of personal suffering, and this extended period of distress offered an opportunity for preventive intervention. The program included efforts to change values and to sustain the newly developed values.⁷⁷

Important components include:

- Leadership involvement, as USAF Chiefs of Staff sent periodic service-wide messages recognizing the courage and sound judgment of those who confronted difficult issues and sought professional help, and encouraged military units to provide care and support.⁷⁸

- Community education through "buddy care" training for military personnel.
- Required training curricula covered suicide risk factors, intervention skills and referral procedures.
- Requirements that all Air Force installations have a multidisciplinary team to respond to traumatic events, including suicides.
- Questionnaires and an online database enabling the Air Force to track risk factors.

Traditional social marketing practices make the “consumer” the central focus for planning and conducting a program. Translating this to the arena of mental health stigma and discrimination, social marketing practices would focus on those who have the attitudes and demonstrate these behaviors that need to be changed. Thus, those who stigmatize would become the “audience” being targeted for change.

Lessons learned from previous social marketing efforts stress the importance of strategically researching and identifying the intended audiences and the best strategies and methods to reach and influence them. Like commercial marketers, social marketers try to identify the desires and needs of these audiences, so change can be presented to them as an appealing “product” at a reasonable “price.” The price is what they will have to give up, such as the required changes in attitudes and behavior, to receive to benefits of the product, such as greater social inclusion.

Product and price are two of the "Four P's of Marketing." The other two, promotion and place, involve the way marketers appeal to the audience, and what channels or “places” they use to do so – the media, the community, etc.

What Can We Learn from Past Stigma and Discrimination Reduction Efforts?

Anti-stigma leaders drew from the successes and experiences of public health approaches and disability, civil rights and other anti-discrimination and human rights efforts when they launched their first campaigns in the 1990s. They have adapted these campaigns since, based on their successes and failures.

The first major anti-stigma campaign was international, launched in 1996 by the World Psychiatric Association with a pilot program in Canada that worked to increase positive mental health coverage in the media.⁷⁹ This *Open the Doors* stigma education campaign grew to include efforts in 19 countries and triggered other initiatives across the world in such countries as New Zealand, England and Scotland.

The bulk of early large-scale campaigns used national mass media advertising to educate the general public. In England, the Royal College of Psychiatrists in its five-year campaign urged the public to "*Stop! Think! Understand!*" In Scotland, a nationally sponsored campaign featured close-up pictures of individuals with mental health challenges, with the slogan "*see me.... I'm a person not a label.*" Early campaigns often also incorporated an effort to advocate for more accurate media portrayals of those with mental health challenges.

Over the years, anti-stigma campaigns have found that education is not enough. It produced a better informed public, but did not significantly reduce levels of discrimination. Campaigns have become more multifaceted, incorporating various approaches, including efforts to change policies and laws, involvement of individuals with mental health challenges at all program levels and in contact programs where they can talk about their personal experiences. Many campaigns have been modeled on the work of Patrick Corrigan of the University of Chicago Center for Psychiatric Rehabilitation and the Chicago Consortium for Stigma Research, who has argued for approaches that identify particular discriminatory populations and discriminatory behaviors as targets for campaigns and protest actions.⁸⁰

Today's campaigns also are often multilevel, involving both nationwide campaigns and regional or local activities involving grassroots organizations and local governments. They aim to influence the individual, family, community, system, state and national levels. In addition, campaigns are working to incorporate more thorough and reliable ways to benchmark and evaluate their efforts toward success. The "*Like Minds, Like Mine*" campaign, New Zealand's longest national campaign, is highly regarded, and has evolved in this way.

New Zealand: Like Minds, Like Mine (Sidebar)

New Zealand's national *Like Minds, Like Mine* program has drawn attention and praise for its comprehensive, multilevel, long-term, social marketing-based approach to countering stigma and discrimination. It is widely regarded as the most successful mental health anti-discrimination program.⁸¹ It is also the longest national program, in place since 1997.

In a 2006 campaign report, more than 50 percent of surveyed consumers reported reduced levels of stigma and discrimination from family, mental health services and the public, and about 50 percent reported a reduction in stigma and discrimination in the employment arena.⁸² After 11 years, the percentage of the public viewing those with mental health challenges as more dangerous than others had decreased by 14 percent.⁸³

The program has used a range of methods, including:

- A nationwide television and radio advertising campaign;
- Public speaking engagements by people with the experience of mental health challenges;
- Local programs such as photography and art exhibitions, marches and Maori cultural events;
- Media advocacy to disseminate positive personal stories and, through protests, guidelines for journalists and training for journalism students, efforts to encourage nondiscriminatory reporting; and
- Promotion of discrimination-prevention policies and equal access to housing, education and employment.

The program is a collaborative effort involving agencies, mental health service providers, consumer-controlled organizations and networks, and non-governmental organizations.⁸⁴ It includes national public relations efforts and regional promotional and training activities. Over time, it has adapted; it now incorporates an outcomes-based planning framework and is working to strengthen the role that people with experience of mental challenges play in the program's leadership, management and operation. The program evaluates its efforts through national surveys and focus group surveys. During its first five years, it was funded at about \$1,457,000 (in American dollars) annually. For comparison, New Zealand's population is about 12 percent of California.
www.likeminds.org.nz

Because of the intractable nature of attitudes, which are often hidden, and behaviors, which may be undertaken unconsciously, the impact of campaigns can take time. Thus, those planning and executing campaigns must be prepared for a long-term effort. For example, Scotland's "see me" mental health anti-stigma campaign assumes substantial change will require a generation.

The Hallmarks of a Successful Campaign

Based on the review of the literature, there are eight key characteristics or hallmarks of a potentially successful campaign. The more of these characteristics included in an effort, the higher the likelihood of success.

- Carefully planned and thought out approaches to targeting and influencing audiences, including both the general population and specific groups;
- Multifaceted, utilizing the full array of methods to achieve change;
- Multilevel, focused concurrently at the individual, family, community, organizational, and system levels, both locally and statewide;
- Focused on changing both attitudes and behaviors;
- Long-term, as attitudes and behaviors do not change quickly and reinforcement is necessary;
- Adequately funded;
- Actively involving key stakeholders and program partners both within and outside the mental health community; and
- Incorporating benchmarks and evaluation, with the results used to inform future efforts.^{85, 86, 87}

Overview of Strategic Methods

Once a stigma and discrimination reduction campaign has determined which of the hallmarks of success it is able to include in its effort, it then has a number of different tools at its disposal. Anti-stigma campaigns have used five primary methods, or interventions, for creating change in attitudes and behaviors. These methods can be used alone or in conjunction with one another. A comprehensive campaign will carefully examine the merits of each method. Past and existing stigma and discrimination reduction programs are used as examples of the range of tools available.

The five methods are:

- Education
- Direct Interpersonal Contact
- Advocacy, Public Policy and Legal Approaches
- Partnering, Networking and Coalition Building
- Support, Guidance and Technical Assistance

Education

Education can be targeted to the general public or a specific audience. It is a key feature of virtually every anti-stigma campaign.

Public Education

Public awareness campaigns have proved effective at altering behavior in the public health field, in areas such as breast cancer, HIV/AIDS and tobacco control in addition to the mental health stigma and discrimination reduction arena. A public education campaign can improve awareness and contribute to reducing stigmatizing attitudes. Successful campaigns require an enormous collaborative effort between agencies, community organizations, community leaders, advertising agency partners, and the media.⁸⁸ Content can be conveyed through advertisements, entertainment, or news, transmitted via television, radio, movies, CD-ROMs, newspapers, magazines, the Internet, brochures, advertising signs or clothes and accessories. Television ads encompasses the more affordable public service announcements, or PSAs, which are unfortunately often be aired during times when few people are watching, as well as paid advertising, which is more effective but more costly, as it enables the campaign to target specific audiences by airing at specific times.

In the United States, anti-stigma education campaigns have been sponsored by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA), with its *Campaign for Mental Health Recovery*. A non-profit group, *No Kidding, Me Too!* uses its celebrity advisory board (members include Ed Bagley, Jr., Jeff Bridges, Matt Dillon, Edie Falco among others) to promote messages of empowerment and acceptance.

United Kingdom: Changing Minds (Sidebar)

Changing Minds, an anti-stigma program launched by the Royal College of Psychiatrists, exemplifies the public education approach. The five-year program, which ran from 1998 to 2003, included multiple levels of public education to change stigma, with a special focus on family education. Target populations included doctors, children and young people, employers, the media and the general public. A substantial toolkit of materials was developed to help change attitudes and reduce stigma. These tools, which are generally still available, include articles, books, leaflets, booklets, fact sheets, DVDs, CD-ROMs for teachers of young people, slogan-bearing bookmarks, and comic books. The comic books, for 4-7-year-olds, discuss what it is like to be different: in "Peaches," children learn that no one will play with Peaches, the puppy who screeches, until she puts her bark to the rescue; in "Quackeline," they learn about the duck who wanted to be a swan, but learned how important it is to be yourself.
www.changingminds.co.uk

Other types of public education include community information sessions, workplace materials, lectures, classes and workshops.

Targeted Education

Social marketing and stigma reduction research have shown the benefits of tailoring content and materials to specific groups to increase a message's effectiveness.⁸⁹ Targeted campaigns can be focused on particular age groups such as children, adolescents, transition-age youth or older adults. Targeted campaigns for children are considered particularly important in order to influence stigmatizing attitudes and discriminatory behaviors before they are developed or become firmly established. The *National Mental Health Awareness Campaign* was a nationwide nonpartisan public education campaign launched as part of the 1999 White House Conference on Mental Health organized by Tipper Gore, wife of then-Vice President Al Gore. The campaign aired public service announcements geared toward adolescents on MTV and other popular teen outlets. The result was overwhelming. More than 12 million hits to its associated website, www.whatadifference.samhsa.gov, were reported in the program's first five months.⁹⁰

Campaigns may also target ethnic, racial or immigrant groups, or other types of communities, such as faith-based organizations. For example, SAMHSA has developed anti-stigma educational materials in Spanish.⁹¹ England conducted in 2004-2008 its anti-stigma campaign *Shift*, specifically targeted to Blacks and other ethnic communities.⁹² Mental Health Ministries in San Diego produces VHS and DVD media aimed at decreasing mental health-related stigma in faith-based communities.⁹³

Some campaigns target friends, parents, family members, and others who would be in contact with individuals experiencing mental health challenges. SAMHSA's *What a Difference* media campaign targeted transition-age youth, encouraging them to maintain their social contact with friends who have mental health challenges.⁹⁴

Other campaigns target groups who may be in a particular position of power to stigmatize or discriminate, such as employers, landlords, those working in the medical or mental health professions, members of the media, and decision-makers. The People with Disabilities Foundation in San Francisco has produced an educational video aimed at employers. The *Open the Doors* program in Boulder County, Colorado, has launched efforts to educate and change attitudes within the criminal justice system, which has resulted in curricula and training programs for police, probation officers, correctional officers, attorneys and judges.⁹⁵

Trainings, educational curricula, curricular changes and school learning programs are other examples of targeted educational efforts. In this area, an anti-stigma curriculum has been developed by the California Association of Social Rehabilitation Agencies for social work education programs. In Maryland, the Anti-Stigma Project's *On Our Own* targets stigma within mental health services with workshops that help break down barriers between consumers, family members, providers and administrators.⁹⁶ Using consumer trainers, the workshops have enabled participants on all sides to see issues from a number of different viewpoints and have reduced polarizing interactions between consumers and staff.⁹⁷ Similarly, The National Alliance on Mental Illness' (NAMI) 10-week *Provider Education Course* is taught by consumers and family members.

Direct Interpersonal Contact

Successful anti-stigma campaigns typically include vehicles to promote direct interpersonal contact with individuals living with mental health challenges. Direct interpersonal contact can mean a teaching session, a live drama performed in a classroom, or conversations with people in the course of everyday life.

Research, although limited, suggests that direct interpersonal contact may be an effective tool for reducing stigma.^{98, 99} Studies show that the contact must be carefully crafted to be effective in helping to dispel stigmatizing attitudes, as discussed further in the section on research and evaluation.

Many anti-stigma contact efforts offer presentations in which consumers share personal stories. *The Heard*, a speakers' bureau organized by the National Mental Health Awareness Campaign, features young people who present their personal stories of recovery from mental illness at schools and other public venues. The speakers deepen public understanding of mental illness recovery, serve as reminders that consumers must be active participants in their own care, and provide hope and empowerment for others who may be experiencing mental health issues of their own.¹⁰⁰

In California, consumer-driven *Stamp Out Stigma* uses an interactive panel of four to six speakers sharing their personal stories. The organization has given more than 1,300 presentations to audiences including businesses, policy makers, educators, doctors, and the general public through television and radio shows. In addition, the organization consults with law enforcement organizations and dentists.^{101, 102} NAMI has also organized a speakers' bureau, called *In Our Own Voice*.¹⁰³

Advocacy, Public Policy and Legal Approaches

Advocacy approaches have been widely used to challenge portrayals of mental illness in the media, to push for changes in laws and policies, and to ensure that enforcement of existing laws and policies.

Researchers with Scotland's national health department have argued that any effort to tackle discrimination, stigma and social exclusion needs to acknowledge the substantial power differences that exist between people with mental health challenges and those who discriminate against them. Reducing discrimination requires reducing these imbalances in social, economic and political power.¹⁰⁴

Anti-stigma advocacy has largely focused on influencing the media and working in the policy and legal arena. Advocacy may also take the form of community-wide efforts aimed at institutions or community norms, such as boycotts, rallies, write-in campaigns and other types of community organizing.

Media Advocacy

Media advocacy programs have been a popular and effective means of influencing and altering mental health-related content in movies, television programming and print media. This is considered a particularly important area for action as sensationalist news coverage and film portrayals are believed to be one of the main factors contributing to distorted public attitudes about individuals with mental health challenges.^{105, 106}

The largest such effort in the United States is NAMI's *StigmaBusters*. StigmaBusters and its network of nearly 20,000 advocates monitor and protest inaccurate or stigmatizing representations of mental illness on TV, film, print or other media. StigmaBusters played a role in 2000 in removing from the air the ABC television show "Wonderland," which focused on a psychiatric hospital. StigmaBusters directed its advocates to complain not only to producers and ABC TV management, but also to CEOs of sponsors.^{107, 108} Other U.S. organizations engaged in stigma busting include the New York-based *National Stigma Clearinghouse*. Similar media-focus efforts have been used in England, Scotland and Australia.

Award programs are another means of influencing media. Several U.S. anti-stigma efforts have included award programs. Currently, the *Voice Awards*, sponsored by SAMHSA and a number of partners, is an annual ceremony held in Los Angeles to recognize entertainment writers and producers for their accurate, dignified and respectful portrayals of people with mental health challenges.¹⁰⁹ The DiDi Hirsch Community Mental Health Center holds an annual *Erasing the Stigma Leadership Award* to honor those in Hollywood working to reduce stigma.¹¹⁰

Other media-related efforts include:

- The *Rosalynn Carter Fellowships for Mental Health Journalism*, a program at The Carter Center founded by former U.S. President Jimmy Carter and former first lady Rosalynn Carter;¹¹¹
- The *Mental Health Media Partnership*, a program of the National Mental Health Awareness Campaign which serves as an information bridge between mental health experts and the entertainment industry.¹¹²

Policy, Laws and Enforcement

The United States has some powerful antidiscrimination laws, including the Fair Housing Act and the Americans with Disabilities Act (ADA), considered by some to be the most comprehensive disability discrimination law in the world covering psychiatric disability.¹¹³ Yet, antidiscrimination efforts often also incorporate efforts to change public policy and regulations, to develop policy or legislation to further protect against discrimination, or efforts to enforce or seek redress through the courts under existing legislation. Additional methods under this category would be the use of systemic approaches like investigations, assessment or reviews designed to determine if existing laws, policies or procedures are complied with and being enforced. Some observers have argued that laws and policies are essential components to successfully counter stigma and discrimination.

Quote from Liz Sayce (Sidebar)

"Initiatives to reduce discrimination should make use of the iron fist of law within the velvet glove of persuasion." – Liz Sayce, former Director of Policy and Communications of England's Disability Rights Commission

A number of international anti-stigma efforts have incorporated new laws or policy changes. For example, the recently launched *Time to Change* anti-stigma campaign in England includes a component called Time to Challenge, which will file disability discrimination lawsuits on publicly important issues.¹¹⁴ Organizations such as the Bazelon Center for Mental Health Law and the Disability Rights Education and Defense Fund provide legal advocacy services in the interests of those with mental health challenges.

Partnering, Networking and Coalition Building

An important component of anti-stigma and discrimination campaigns is the coalition building of different individuals, organizations and sectors to work together towards a common goal. Several campaigns have been launched by a group of organizations, rather than one entity. For example, in Scotland, "see me..." was funded by the federal government, but run by an alliance of five Scottish mental health organizations.

England's recently launched *Time to Change* effort is funded through a lottery fund and led by three non-governmental organizations: Mental Health Media, Mind, and Rethink.

Support, Guidance and Technical Assistance

Support and guidance activities can take the form of support groups, counseling efforts, technical assistance, and empowerment strategies. NAMI has a *Connection Recovery Support Group* program, which offers consumer peer-support groups in many states where adults with mental health challenges can exchange coping strategies and successful stories of recovery.¹¹⁵

The SAMHSA ADS Center, otherwise known as the “Resource Center to Promote Acceptance, Dignity and Social Inclusion Associated with Mental Health,” offers a broad range of support services, including a website, information, training, technical assistance to help create social inclusion initiatives, as well as tools to help those with mental health challenges gain information about legal rights. The National Mental Health Consumers' Self-Help Clearinghouse in Philadelphia connects people to self-help and advocacy resources and offers training, curricula and technical assistance.

Many forms of empowerment are closely aligned with the methods described above under advocacy, including involvement in legal and policy action, protests and parades. Other empowerment strategies can include economic development projects offering jobs and income.

One example of an empowerment approach is the *Mad Pride* parade sponsored by MindFreedom International in locations around the world, from Eugene, Oregon to Cape Town, South Africa. These parades seek to celebrate the culture and human rights of mental health consumers.¹¹⁶ Activists and artists using the term “mad” in these types of endeavors see this as an act of reclaiming power over historically negative stereotypes.¹¹⁷ Arts-based activities are also common¹¹⁸ and include *Nothing To Hide: Mental Illness in the Family*, an award-winning touring photo exhibit developed by the nonprofit Family Diversity Project, which tells poignant stories of courageous individuals and their families whose lives are affected by mental illness.¹¹⁹

Research & Evaluation

More Research & Evaluation Is Needed to Know What Works Best

There is a dearth of research and evaluation findings to clearly establish what methods, or combination of methods will best aid in reducing stigma and discrimination towards those with mental health challenges.^{120, 121}

Mental health anti-stigma and discrimination programs have not received the kind of research and evaluation that more established, long term programs such as California's Tobacco Control Program have, or have not been able to show such dramatic achievements to date. For example, evaluators of Scotland's “see me....” program

found reductions afterwards in stigmatizing attitudes toward those with mental health challenges, but were unable to determine if the changes resulted from “see me...” or from a variety of other anti-stigma initiatives that occurred in Scotland at the same time.¹²² Scotland initially saw stigmatizing attitudes in surveys decline after its program launch, but later surveys showed those attitudes on the rise again.¹²³

Contact Has Been Shown to Be Effective, If Certain Conditions Are Met

Despite the lack of solid evidence, isolated studies have shown promising findings from programs that provided for contact with individuals living with mental health challenges. One study found that the NAMI program *In Our Own Voice*, which features presentations by individuals with mental health challenges, significantly decreased stigma compared to fact-based education provided by mental health professionals.¹²⁴ In another study, high school students showed less stigmatizing attitudes after receiving one-hour presentations by consumers.¹²⁵ Some researchers, while affirming that contact has tended to produce positive results, question the methodological quality of this work.¹²⁶ Some studies suggest the attitude changes prompted by contact may persist over time, from a week to a month afterwards, although at a reduced level.^{127 128}

Researchers developed and tested a particular mode of interaction among ethnically diverse students, called cooperative learning groups, as a way to implement the contact hypothesis successfully. There is a sizable body of evidence that demonstrates the effectiveness of cooperative learning groups for increasing attraction between members of different social categories, and the effects of these groups can be extended to include students with disabilities.¹²⁹

Researchers for New Zealand’s anti-stigma program have recommended that an educational construct be used to facilitate these contact conditions. Under this model, people who have experienced mental health challenges take on trainer roles affording equal status; the training is designed so that all the participants pursue mutual goals, actively cooperate and get to know each other. The information exchange focuses on disproving negative stereotypes. Initiatives in New Zealand and other countries that have taken this approach have reported positive results.¹³⁰

Research into contact has shown that, for it to be effective, certain conditions must be in place.

- The participants must meet as equals in status;
- They must have an opportunity to get to know each other;
- They must share information that challenges negative stereotypes;
- They must actively cooperate; and
- They must pursue a mutual goal.^{131, 132}

Start Early: Include Prevention and Early Intervention Efforts

Some studies have shown that children's attitudes towards mental illness become firmly established between grades six and eight, suggesting that early education and prevention efforts could help prevent the development of stigmatizing attitudes.¹³³ Some researchers have urged the development and implementation of school-based anti-stigma educational programs.¹³⁴ Schools can reach a large number of children, and children are more likely to accept lessons related to accepting others, some argue.¹³⁵

Education Can be Effective under Certain Conditions

Research has shown some education efforts have produced short-term improvement in attitudes.¹³⁶ Educational interventions may produce substantial and longer lasting changes in attitudes, if they emphasize give-and-take exchanges rather than a strict lecture format.¹³⁷ Experience in the health promotion field has shown that multiple exposures to educational materials may be required in order to produce long-term changes in attitudes and behavior. This underlines the importance of multifaceted and multilevel approaches that analyze the varying environments – family, community, society – of the target audiences.

Some Approaches May Cause Rebound Reactions

Some researchers are concerned that some efforts could backfire, and result in greater entrenchment of negative stereotypes. As attention is drawn to an ill-informed portrayal, the attention may make that image become more firmly entrenched in someone's mind, rather than a new, more appropriate image.¹³⁸

Evaluation Should Be an Integral Component of Any Program

Because of existing information gaps about the effectiveness of various anti-stigma and anti-discrimination approaches, carefully designed evaluation should be built into anti-stigma programs so learning can be shared.¹³⁹ Community participatory evaluation methodology is strongly encouraged.

Creating the Future in California

The upcoming section of the Plan, focuses on what Californians can do to relegate mental health stigma and discrimination to the past. This section is a call to action for communities, government, the private sector, businesses and non-profit organizations as well as Californians from all walks of life. The strategies and steps discussed ahead will require creativity, thoughtful planning and determination at both the local and state levels to make a difference.

PART 3: BLUEPRINT FOR REDUCING MENTAL HEALTH STIGMA AND DISCRIMINATION

The California Strategic Plan on Stigma and Discrimination Reduction serves as a blueprint for four strategic directions and corresponding recommended actions to reduce mental health stigma and discrimination behaviors. These recommendations are grounded in the data and evidence offered in the two preceding chapters and were refined through the course of many rich discussions of the California Mental Health Stigma and Discrimination Reduction Advisory Committee and through public workshops.

The Plan offers a comprehensive range of strategies, starting from promoting awareness and accountability, to changing attitudes, beliefs, and practices across systems, organizations, and communities, to enforcing the laws, and to increasing knowledge through research and evaluation. The programs and services generated from this Plan must go beyond traditional approaches. A population-based approach is essential and will require community-wide strategies and responsive organizational and environmental policies and practices. State and local partners spanning multiple disciplines and settings must work together to create a comprehensive multi-level approach needed to make a difference in California. Lastly, ongoing research and evaluation must be viewed as a keystone element to continuously review and assess the efforts and overall direction. The Plan represents the initial phase of this process.

About Core Principles, Strategic Directions, and Recommended Actions

Six core principles are embedded in all levels of planning, implementation, and evaluation. The Plan is further organized by two level of focus for reducing mental health stigma and discrimination: strategic directions and recommended actions.

The four strategic directions are broad levels of focus that serve as the central aim for the more specific recommended actions. These recommended actions are not an exhaustive list, but they emerged as priorities at this point in time to reduce mental health stigma and discrimination and its impact on individuals, families, and communities throughout California.

Taken together, the core principles, strategic directions, and recommended actions are intended to lay a foundation for a comprehensive approach to reducing mental health stigma and discrimination.

Core Principle 1: Implement culturally and linguistically competent strategies and programs that reduce disparities and reflect the values and beliefs of diverse populations.

Core Principle 2: Involve a broad spectrum of the public, including mental health consumers, family members, friends, caregivers, mental health and allied professionals, advocates, and other community members.

Core Principle 3: Employ a life span approach to effectively meet the needs of different age groups.

Core Principle 4: Address both personal, internalized experiences of stigma as well as institutional and public stigma and discrimination.

Core Principle 5: Use promising practices and proven models.

Core Principle 6: Recognize that treatment for those experiencing mental health challenges may work, and that the best results often come from voluntary programs which offer choice and options.

DRAFT

Strategic Direction 1: Creating a supportive environment for all consumers, family members, and the community at large by establishing social norms that recognize mental health is integral to everyone's wellbeing.

1.1 Create widespread understanding and recognition within the public and across all systems that:

- ❖ **Everyone at different points in their lives may experience different degrees of mental health from wellness to crisis;**
- ❖ **Persons living with mental health challenges have resilience and the capacity for recovery; and**
- ❖ **Successful mental health treatment models address the whole person.**

1.1.1 Form a local coalition of diverse representatives including those with mental health challenges to launch a community action plan to educate the public on mental health challenges and recovery.

1.1.2 Develop messages and relevant materials for the public that explains mental health challenges.

1.1.3 Change consumer information on mental health diagnoses and treatment to be reflective of, and reinforce the possibilities for recovery, resilience, and wellness.

1.1.4 Assess existing print and electronic media on mental health challenges and emotional disturbances to be reflective of recovery, resilience, and wellness.

1.1.5 Simplify and promote available web resources for reliable information that promotes non-stigmatizing mental health information.

1.1.6 Utilize mental health consumers and family members to raise awareness of the importance of mental health.

1.2 Change societal norms to be supportive of greater inclusion for individuals living with mental health challenges, which will create opportunities to choose early intervention and continued services without fear of stigma.

1.2.1 Identify how everyday language is used to reinforce stigma and discrimination toward those living with mental health challenges and substitute those words with non-stigmatizing and non-discriminatory language.

1.3 Prevent the development of stigma and labeling in future generations.

1.3.1 Develop and launch a community wide effort to promote the healthy social and emotional development of children.

1.3.2 Work with existing children's programs to assess and enhance educational programs for parents, early childhood educators and caregivers on the social and emotional development of children.

1.3.3 Work with teachers, parents, and school board members to implement school programs and policies that promote social inclusion.

1.4 Create opportunities and forums for strengthening relationships and understanding between consumers, family members, and the greater community.

1.4.1 Utilize established community networks to sponsor dialogues among consumers, family members, and the larger public about mental health issues.

1.4.2 Increase direct contact and dialogues between consumers, family members, and representatives of systems, institutions and organizations that affect the lives of those living with mental health challenges.

1.4.3 Create forums with specific organizations to create change, e.g. mental health providers, educational system personnel, medical professionals, the media, employers, landlords, etc.

1.4.4 Create roundtables in local communities to focus efforts on specific populations, e.g. older adults, foster children or veterans, or a specific topic, e.g. housing, employment or law enforcement.

1.5 Reduce the internalized self-stigma of individuals living with mental health challenges and their family members.

1.5.1 Assess, develop when necessary, and widely disseminate educational and training materials on how to combat mental health self stigma.

1.5.2 Adapt educational and training materials to the needs of the local community.

1.6 Recognize the importance of peer-to-peer and peer-run programs as a means for reducing stigma.

1.6.1 Assess, develop, and disseminate information on peer-to-peer programs and models.

1.6.2 Work with local and statewide mental health professional organizations to establish peer-to-peer support as a vital component of mental health treatment.

1.6.3 Develop local speakers' bureaus, presentations and forums that feature peers who are successfully dealing with mental health challenges.

- 1.6.4 Promote education and skills-based training for consumer and family empowerment to address such topics as communication, team work, state and local public policy, leadership, negotiation, and advocacy.
- 1.6.5 Utilize technology and other advancements to support groups or individuals who are geographically or emotionally isolated.
- 1.6.6 Enhance the skills of peers to be more effective trainers of mental health staff to better address client and family members culture in their recovery and wellness services and other relevant topics.
- 1.7 Address the multiple stigmas of persons living with mental health challenges who are also faced with discrimination based on their race, ethnicity, age, sex, sexual orientation, gender identity, physical disability, or other societal biases.**
- 1.7.1 Identify and disseminate successful models that are targeted to different cultural communities.
- 1.7.2 Engage those with multiple stigmas to identify specific successful strategies to reduce mental health stigma and discrimination in their community.
- 1.7.3 Educate substance abuse programs and mental health programs to better address the effects of stigma for individual encountering co-occurring disorders.
- 1.7.4 Work with racial and ethnic community groups to ensure that models and programs are culturally and linguistically competent and eliminate stigmatizing barriers.
- 1.8 Provide increased support for those closely involved with the lives of individuals facing mental health challenges.**
- 1.8.1 Assess and apply innovative technologies so that parents and caregivers can obtain accurate information, guidance and referrals to seek needed.
- 1.8.2 Better equip those who have routine contact with parents and caregivers, e.g., churches, youth programs, community centers, etc., about available mental health resources.
- 1.8.3 Establish training programs for teachers (pre-school to higher education) to work more effectively with student mental health.

Strategic Direction 2: Promoting awareness, accountability, and changes in values, practices, and procedures across systems and organizations that promote the respect and rights of people identified with mental health challenges.

2.1 Initiate systemic reviews to identify and address stigmatizing and discriminatory language, behaviors, practices and policies.

2.1.1 Encourage consumers, family members, and representatives from all of the major systems to jointly explore and understand how policies and procedures impact individuals living with mental health challenges.

2.1.2 Explore opportunities for communities to conduct a local review of one or more of the following systems and programs to identify behaviors, policies, and practices for areas of improvement: K- 12 education, local community college or university, area's medical system, area's mental health system, media, and law enforcement. The local community would disseminate its findings and insights to other local communities. Other communities would be encouraged to initiate similar reviews.

2.2 Establish developmentally appropriate prevention, recovery and wellness programs.

2.2.1 Work with the county mental health departments and other mental health providers to ensure that programs and facilities are provided and tailored to individuals of different ages.

2.3 Ensure that mental health services are offered in non-traditional, non-stigmatizing community sites that are accessible.

2.3.1 Develop and disseminate effective treatment practices for those with multiple stigmas so they are widely available through the medical and mental health systems.

2.3.2 Support greater ethnic diversity amongst mental health providers to better meet the need of consumers faced with multiple stigmas.

2.3.3 Assess the public financing and resource distribution of mental health services to determine how to better meet the service needs of populations experiencing multiple stigmas.

2.3.4 Co-locate primary care and mental health services.

2.3.5 Implement telemedicine technologies in rural communities and other areas.

2.4 Promote the dignity and safety of mental health consumers and their family members by training and educating law enforcement, first responders, other medical personnel, and the community at large to reduce stigmatizing attitudes and discriminating behavior by:

- ❖ **Educating the broader community about community alternatives available to assist with mental health-related crises;**
- ❖ **Utilizing informed consent as a means to ensure voluntary choice;**
- ❖ **Preparing and equipping law enforcement in responding to the needs of individuals in mental health-related crisis; and**
- ❖ **Reducing the need for the use of force and forced compliancy.**

- 2.4.1 Support the expansion of response programs at the local level to better meet the needs of individuals with mental health challenges, e.g., crisis residential programs, advanced directives, integrated community services teams.
- 2.4.2 Support and provide crisis intervention programs (Crisis Intervention Training) that provide first response personnel with alternative sites for individuals experiencing a mental health crisis.
- 2.4.3 Develop and widely disseminate educational information on de-escalation approaches and techniques for emergency room personnel, homeless shelter staff, and mental health providers.
- 2.4.4 Provide increased support, education, training, and guidance to in-patient care staff.
- 2.4.5 Provide anti-stigma education and resources to individuals within a rural community who routinely come into contact with a wide range of people, for example clergy, pharmacists, postal carriers, fire and police, school teachers, those who deliver meals-on-wheels.
- 2.4.6 Recognize and work to reduce the mutual stigma that exists between consumers, family members, and law enforcement.
- 2.4.7 Minimize the inappropriate use of 5150s.
- 2.4.8 Establish training requirements e.g., mandatory continuing education, in mental health issues for criminal justice professions that may have close contact with children and adults with mental health challenges.

2.5 Educate employers on the importance of mental health wellness for all employees.

- 2.5.1 Develop curriculum, trainings, websites and guidebooks to educate on mental health development and literacy, value of social inclusion, wellness, recovery and resilience, mental health community resources and other customized topics relating to stigma and discrimination reduction for employers. Involve mental health consumers in the development and delivery of trainings and other forms of educational out-reach.

- 2.5.2 Develop an educational campaign targeted to employers that emphasizes the financial benefits of a healthy workforce, both physically and mentally.
- 2.5.3 Provide a comprehensive list of community resources and referrals that employers can make available to employees under emotional stress.
- 2.6 Expand opportunities for employment, professional development, retention, and success of mental health consumers in public, non-profit and private sector workplaces by enforcing current laws and challenging hiring biases.**
- 2.6.1 Identify and disseminate strategies to promote the employment of individuals with mental health challenges.
- 2.6.2 Create local opportunities for networking and relationship building among consumers, family members, regional business leaders and other employers.
- 2.6.3 Convene mental health consumer forums and workshops to provide job-seeking skills, information on occupations for which demand is increasing, and educational and vocational opportunities to prepare for those careers.
- 2.6.4 Develop local and statewide efforts to explore opportunities for the employment of consumers and family members in the mental health professions.
- 2.6.5 Encourage employers to select employee health plans that offer mental health coverage.
- 2.6.6 Encourage large employers to offer an Employee Assistance and Counseling Program as part of their benefit package.
- 2.6.7 Enhance existing human resource anti-discrimination practices at the state and local level.
- 2.7 Eliminate discriminatory barriers in order to better meet the housing needs of mental health consumers by:**
- ❖ **Educating neighborhoods, landlords, and other local officials on the housing needs of mental health consumers;**
 - ❖ **Ensuring that the housing is well integrated into neighborhoods and dispersed geographically throughout the community and accommodates all levels of care; and**
 - ❖ **Focusing first on the provision of housing necessities and basic services for homeless individuals and those being released from institutional settings.**
- 2.7.1 Provide ongoing opportunities for consumers to meet, educate, interact with and develop relationships with private and elected officials.
- 2.7.2 Work with the county health departments to ensure that all residential housing meets local sanitary and other standards.

2.7.3 Support the expansion of local government services to assist consumers with housing issues.

2.8 Engage and educate the mainstream, ethnic, and interactive media as well as entertainment industries on:

- ❖ **Standards and guidelines to promote balanced and informed portrayals of people living with mental health challenges; and**
- ❖ **Ways to serve as a resource for communicating accurate and non-stigmatizing information to the public on mental health issues and community resources.**

2.8.1 Create an anti-stigma campaign that highlights that everyone at different points in their lives may experience some degree of mental health impact from wellness to crisis.

2.8.2 Develop tools to track and acknowledge print and electronic media sources for positive and balanced portrayals of individuals living with mental health challenges.

2.8.3 Develop strategies to reward the balanced portrayals.

2.8.4 Develop and disseminate materials designed for the media, which provide background materials on a range of mental health issues, including community resources, referral information, and reporting guidelines useful to the public.

2.8.5 Collaborate with college media sources to provide information, resources and referrals regarding mental health concerns.

2.8.6 Work with the local and / or statewide media to develop mental health programming as part of the “May is Mental Health Month.”

2.9 Create a more holistic approach to physical health and mental wellness by:

- ❖ **Promoting integrative delivery models of mental health and primary health care services; and**
- ❖ **Achieving parity between medical and mental health services in terms of coverage and financing.**

2.9.1 Sponsor local and statewide programs to encourage and support medical practitioners to screen for mental health risk factors and conditions as part of routine care and provide referrals to appropriate community mental health resources.

2.9.2 Assist in the detection of common problems such as depression, anxiety, alcohol and substance abuse, and childhood social emotional, and developmental problems.

2.9.3 Convene experts to discuss strategies for reducing stigma associated with the mental health and medial health care systems. Topics of discussion could include: The Mental Health Parity Act, Same Day Visit Reimbursement for community health centers and Federally Qualified Heath Centers; the medical necessity criteria under Managed Care Mental Health for County Mental Health; preauthorization requirements for mental health services; MediCal reimbursement for medical practitioners who provide mental health screenings.

2.10 Utilize spirituality and faith-based practices as tools for wellness and recovery.

2.10.1 Train providers on the value of spirituality in the wellness and recovery process and the contributions made by faith-based and other non-traditional providers.

2.10.2 Establish and/or enhance regional inter-faith-based networks throughout California to serve as a resource to practitioners and consumers on faith-based approaches and methodologies.

2.10.3 Create a category on existing or future resource sites to address faith-based best practices and models covering prevention through recovery services..

2.10.4 Utilize the multi-faith-based network to provide insight on different believes/values that can inform treatment approaches and or methodologies.

Strategic Directions #3: Upholding and advancing federal and state laws to identify and eliminate discriminatory practices.

3.1 Increase awareness and understanding of existing laws and regulations that protect individuals living with mental health challenges and their family members against discrimination.

3.1.1 Develop and widely disseminate user-friendly fact sheets for educational and training purposes on applicable state and federal laws, regulations pertaining to education, housing, employment, as well as the medical and mental health systems.

3.2 Promote the compliance and enforcement of current anti-discrimination laws and regulations.

3.2.1 Develop a local task force, including city and county counsels, to develop strategies for encouraging compliance with and enforcement of laws, regulations, and ordinances that impact individuals living with mental health challenges in the areas of housing, employment, public accommodation, etc.

3.2.3 Ensure implementation of existing privacy protections and confidentiality provisions for medical and mental health records at medical clinics, schools, and institutions of higher education.

3.2.4 Work with state agencies with appropriate jurisdictions to create joint statements offering legal opinions on specific areas of discrimination typically encountered by persons with mental health challenges in the areas of housing, employment, public accommodation, etc.

3.3 Explore how to enhance current statutes and regulations to further protect individuals and their family members from discrimination.

3.3.1 Develop a statewide committee with legal experts to evaluate existing laws and regulations for any embedded discriminatory provisions and gaps, and develop corrective strategies to address these problems.

3.3.2 Disseminate widely the findings regarding legal gaps in current laws and regulations as well as the embedded discriminatory language in current laws and regulations, together with the recommended corrective strategies.

3.3.3 Convene local workgroups including housing developers, housing agencies, community organizations, mental health providers, consumers and family members to develop strategies and recommendations for implementing local and county housing policies to improve the likelihood of creating housing projects for individuals living with mental health challenges.

- 3.4 Develop policies and mechanisms within the criminal justice system to more appropriately meet the needs of individuals with mental health challenges.**
- 3.4.1 Promote the expansion of mental health courts to prevent incarceration for those impacted by mental health challenges, where appropriate.
 - 3.4.2 Promote successful community re-integration models for incarcerated mental health consumers.
 - 3.4.3 Disseminate any court policies and other protocols developed by Council of California and the Administrative Office of the Courts to prevent the criminalization of persons with mental health challenges.
 - 3.4.4 Develop training standards for attorneys, which require competency of anti-discrimination laws and regulations that protect people with mental challenges.
 - 3.4.5 Create opportunities for state agencies and departments to identify opportunities to raise awareness of the rights of agency clients with mental health challenges.

Strategic Direction 4: Increasing knowledge of effective and promising programs and practices that reduce stigma and discrimination using methods that include community-led approaches.

4.1 Develop and implement a plan to address the information gaps on how to reduce stigma and discrimination in order to build effective and promising anti-stigma and anti-discrimination programs.

- 4.1.1 Compile and report data on the community's strengths and how to best use this information in program design and development.
- 4.1.2 Develop incentives to build partnerships between academic research and community-based research.
- 4.1.3 Determine what are the most successful approaches and methods in educating mental health students to decrease professional stigma, e.g., sensitivity training, stigma and discrimination awareness.

4.2 Increase community capacity to strengthen their skills and abilities to evaluate their own programs.

- 4.2.1 Identify funding streams for communities to enhance their research and evaluation skills.
- 4.2.2 Promote community participatory methods to support their involvement in the research process, e.g. training and using community members to collect and interpret data, which in turn promotes community ownership.

4.3 Ensure research and evaluation projects are adaptive and responsive to the community needs.

- 4.3.1 Research projects should be designed with input from the community to address data elements, methodology, sample size, over sampling of diverse populations, and other aspects as needed.
- 4.3.2 Ensure communities benefit from the research that they participate in.

4.4 Disseminate the lessons learned, promising practices and other findings.

- 4.4.1 Establish a resource center that ensures findings are easily accessible and widely disseminated.

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Copies of The California Strategic Plan on Reducing Mental Health Stigma and Discrimination and an Executive Summary of the Plan will be available for download from the California Department of Mental Health web site at www.dmh.ca.gov. Hard copies be requested by contacting the Office of State Level Programs via postal mail, e-mail, or telephone.

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