

**CALIFORNIA MENTAL HEALTH  
STIGMA & DISCRIMINATION REDUCTION ADVISORY COMMITTEE**

**WORKGROUP REFERENCE GUIDE**

February 3, 2009

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**\*\*Dear Advisory Committee Members, Invited Guests, & Interested Public,**

These materials correspond to the breakout groups you will choose from to develop recommended actions. Most of the materials are only 2-3 pages. You will be spending a few minutes today looking over those materials of interest to you. The ideas in these materials are only meant to provide you with background information and not limit your own ideas in any way. You will receive additional instructions on using this material today.

Sincerely,

The Facilitation Team

# I. SCHOOLS (K-12)

Reference Materials for Workgroups  
February 3, 2009

## (A) Annotated Bibliography<sup>1</sup>

Below are relevant findings for this work group on strategies included in the Annotated Bibliography, Volume 2.

### Children

1. Sometimes bullying is easy to notice, such as with hitting or name-calling, and other times it's hard to see, such as with leaving a person out or saying mean things behind someone's back. If you see someone who is being bullied, help them understand that it's not his or her fault. Additionally, telling is very important. Reporting that someone is getting bullies or hurt in some other way is not "tattling."<sup>124</sup>
2. Approximately 30 percent of all children and youth in grades 6 through 10 have been bullied or have bullied other children "sometimes" or more often within a semester (Nansel et al., 2001). Children who bully are more likely to report that they own guns for risky reasons, such as to gain respect or frighten others (Cunningham et al., 2000); and boys who were identified as bullies in middle school were four times as likely as their non-bullying peers to have more than one criminal conviction by age 24 (Olweus, 1993). There are many school-based bullying prevention programs. Although they vary in size and scope, the most promising programs incorporate the following characteristics: A focus on creating a school-side environment, or climate that discourages bullying; surveys of students to assess the nature and extent of bullying behavior and attitudes toward bullying, training to prepare staff to recognize and respond to bullying, development of consistent rules against bullying, review and enhancement of the school's disciplinary code related to bullying behavior, classroom activities to discuss issues related to bullying, integration of bullying prevention themes across the curriculum, individual and group work with children who have been bullied, individual work with children who have bullied their peers, involvement of parents in bullying prevention and intervention activities, and use of teacher or staff groups to increase staff knowledge and motivation related to bullying.<sup>125</sup>
3. A Canadian study interviewed experts at the Provincial Centre of Excellence for Child and Youth Mental Health, and identified why schools can help reduce stigma: 1) School is an obvious environment to reach a large number of children and youth to raise awareness of mental health. 2) School is an area where we can most effectively identify children and youth who may have (or may be at risk for) mental health difficulties. 3) Children (as compared to adults) are generally more likely to accept developmentally appropriate lessons relating to accepting others. 4) Interventions implemented at or through school could conceivably capitalize on the dynamics of peer pressure so influential in the lives of children and youth, who naturally socialize at school (e.g., recess; lunch break). The authors expect the results of their study to provide a strong foundation in creating effective school-based interventions, but there are still steps that we can take immediately to reduce stigma in our school settings and promote child and youth mental health.<sup>126</sup>
4. Most anti-stigma campaigns have been directed at adults or adolescents. This study targeted children in order to evaluate the effectiveness of a puppet program to reduce stigmatizing attitudes in grades 3-6 students. Children received a pre and posttest of their attitudes. The experimental group watched a series of three plays in which hand puppets portrayed individuals with schizophrenia, depression/anxiety, and dementia. The plays were designed to challenge stereotypes and erroneous beliefs regarding mental illness, while appealing to children. Scores for the children exposed to the puppet plays improved significantly on three of the six factors, including Separatism, Restrictiveness and Stigmatization. The study concludes that anti-stigma

<sup>1</sup> These items are copied and pasted from the lists that begin on p. 20 of this document:  
<http://www.dmh.ca.gov/PEIStatewideProjects/docs/Meetings/09Jan14/AnnotBiblioStigmaDiscriminationReductionVol2.pdf>

programs using puppetry show some effectiveness and should be further studied. One study found that children's attitudes towards mental illness changed significantly between grades 2 and 4, becoming quite stable between grades 6 and 8, and starting to resemble adult opinions (Weiss, 1985). A 1995 study (Spitzer & Cameron) found that children did not understand the term "mental illness" and instead used the word "crazy" to indicate the concept of mental illness. This only serves to highlight the need for quality educational programs to help children understand what "mental illness" truly means.<sup>127</sup>

#### Adolescents & Transition Age Youth

1. In a discussion of adolescent mental health in the United States, the author recommends a public health campaign, including but not limited to, combating stigma, public outreach to increase screening, improved access to care, improved mental health screening, referrals, increased adolescent specialists, and research.<sup>128</sup>
2. Four hundred and twenty-six high school students were given one-hour informational presentations by consumers and a local university faculty member. The presentations were developed by consumers and included facts about mental illness, symptoms, recovery strategies, and personal stories. Based on pre- and post-assessment questionnaires, students reported less stigmatizing views toward people with mental illness (i.e., pity, dangerousness, fear, help, segregation, avoidance) The researchers note that the results are limited in that they cannot predict future behavior toward people with mental illness, and only speak to self-reported attitudes.<sup>129</sup>

#### **(B) Mental Health Services Oversight & Accountability (MHSOAC) Work Group, June 2007<sup>2</sup>**

The MHSOAC's work group on stigma and discrimination drafted a report in June 2007 making preliminary recommendations. Included in the report's Appendix A are "ideas to be considered in strategic planning." Relevant items for this work group are listed below.

1. Partner with advocates for special education to promote appropriate access to a free and public education for all children with disabilities.
2. Provide teachers with in-service training and materials about mental health education.
3. Reduce bullying of emotionally disturbed students at school through collaboration with the California Dept. of Education's "Health Education Content Standards for California Public Schools."
4. Provide teachers and administrators with pertinent information and guidelines about bullying.
5. Create a kindergarten through grade twelve curriculums in conjunction with the California Department of Education's new "Health Education Content Standards for California Public Schools" for the content area "Mental, Emotional and Social Health."
6. Create interaction between agencies that work with racial and ethnic communities and high school counseling services.
7. Create client "contact programs" for graduate education schools in the areas of primary care, mental health care and alternative care.
8. Dedicate appropriate resources to ensure that stigma and discrimination efforts are designed in a culturally and linguistically appropriate manner to address California's diverse population.
9. Implement the five essential elements of cultural competence in all mental health programs: valuing diversity, cultural self-assessment, honoring the dynamics of difference, formalizing and disseminating cultural knowledge at all levels, and adapting to diversity.
10. Discourage educational institutions from expelling students with a mental health issue.

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<sup>2</sup> These items are copied and pasted from the lists that start on p. 51 of this document:  
<http://www.dmh.ca.gov/MHSOAC/docs/StigmaAndDiscriminationReport07Jun12.pdf>

### **(C) Committee Member Survey Responses<sup>3</sup>**

Online survey responses from advisory committee members were collected in response to the question: *What strategies do you think would best address California's mental health stigma and discrimination problem?* Relevant items for this work group are listed below.

1. School-based mental health services
2. Technical assistance available to employers, schools
3. Normalize stages of instability as natural part of self-development. teach this in schools so instability is honored instead of disgraced
4. Develop curriculum across all subject areas that addresses these issues.
5. Target high schools and colleges. For example, WRAP in high schools and colleges.
6. Trauma education
7. Revamp State's health curriculum K-12
8. Educate schools on both mental health for all students and how to meet needs of kids with MI
9. Public education of all aspects of mental health/illness
10. Active suicide prevention education, ties in to public education Mental health literacy for children (how to address, how to help with self- and public perception)
11. Education on Mental Health throughout Educational System, so that stigma is addressed throughout child and youth development
12. Include mental health education in curricula at all levels of teacher education
13. Strong school-based interventions that include education, contact, strategies to change social norms
14. Development of curricula and other interventions for use with children in school setting
15. Promote wellness curriculum in schools
16. Well developed education plan for all levels
17. Stigma beginning in childhood and including families working in schools and child settings, learn relevant research
18. Increase pupil support staffing in public schools
19. Ensure that education funding in all levels of public education (k-12) was adequate to provide the student services necessary to educate and support help-seeking of students
20. Early intervention in schools
21. School funding for increased student support positions for every school/school district
22. Every school has access to student support team: school social worker, school counselor, school psychologist, school nurse etc.
23. Address stigma & discrimination issue within school (K-12) context), how to include teachers, administrators, pupil service workers, school boards, community organizations that affect behaviors toward children/families with emotional/behavioral issues.
24. Education of teachers
25. Development of curricula for use with teachers
26. Provide mental health professionals to schools for early intervention.
27. Increase funding for the expansion of AB3632 mental health services for all students in special education
28. More education/training for school teachers regarding mental health
29. Outreach to college students
30. Promote "search and serve" programs for students in general education in schools and communities for children and youth in need of mental health services
31. Include in provider higher education systems the internal and external stigma perpetuated through the psych education system.
32. Mental health literacy for children (K-12)
33. Create school based mental health/health programs in all school districts

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<sup>3</sup> This item is simply copied and pasted from the lists that start on p. 24 of this document:  
<http://www.dmh.ca.gov/PEIStatewideProjects/docs/Meetings/08Dec17/Dec17MasterHandouts.pdf>

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

## II. HIGHER EDUCATION

Reference Materials for Workgroups  
February 3, 2009

### **(A) Annotated Bibliography<sup>4</sup>**

Below are relevant findings for this work group on strategies included in the Annotated Bibliography, Volume 2.

1. A sample of 193 graduate students had two study visits with an interval of 6 months and were randomly distributed into three study groups: some read anti-stigma printed materials, some studied an anti-stigma computer program, and the others in a control group. Scores significantly improved both the reading and computer program groups. Authors conclude that computers can be an effective means in changing attitudes of students toward psychiatric patients.<sup>91</sup>
2. A project with U.K. college students and mental health staff and consumers uses the performing arts to challenge stigma and promote social inclusion for people with mental health problems. Three years of evaluation data show the program successful in positively influencing students' attitudes, knowledge, and empathy, as well as positively affecting consumers' mood and feelings of achievement, confidence, and inclusion.<sup>98</sup>
3. A study investigated the effectiveness of the In Our Own Voice (IOOV) mental health education program in improving knowledge and attitudes about mental illnesses with 114 undergraduate students from George Mason University. Students completed three pre-test measures of knowledge and attitudes, attended either an IOOV presentation or a control presentation about psychology careers, and repeated the three measures following the presentation. Results indicated that the IOOV group showed significant positive change across time, as well as significantly greater improvement than a control group in their knowledge and attitude scores on all measures. These findings support the effectiveness of the IOOV program.<sup>107</sup>

### **(B) Mental Health Services Oversight & Accountability (MHSOAC) Work Group, June 2007<sup>5</sup>**

The MHSOAC's work group on stigma and discrimination drafted a report in June 2007 making preliminary recommendations. Included in the report's Appendix A are "ideas to be considered in strategic planning." Relevant items for this work group are listed below.

11. Partner with advocates for special education to promote appropriate access to a free and public education for all children with disabilities.
12. Provide teachers with in-service training and materials about mental health education.

<sup>4</sup> These items are copied and pasted from the lists that begin on p. 20 of this document:  
<http://www.dmh.ca.gov/PEIStatewideProjects/docs/Meetings/09Jan14/AnnotBiblioStigmaDiscriminationReductionVol2.pdf>

<sup>5</sup> These items are copied and pasted from the lists that start on p. 51 of this document:  
<http://www.dmh.ca.gov/MHSOAC/docs/StigmaAndDiscriminationReport07Jun12.pdf>

13. Reduce bullying of emotionally disturbed students at school through collaboration with the California Dept. of Education's "Health Education Content Standards for California Public Schools."
14. Provide teachers and administrators with pertinent information and guidelines about bullying.
15. Create a kindergarten through grade twelve curriculums in conjunction with the California Department of Education's new "Health Education Content Standards for California Public Schools" for the content area "Mental, Emotional and Social Health."
16. Create interaction between agencies that work with racial and ethnic communities and high school counseling services.
17. Create client "contact programs" for graduate education schools in the areas of primary care, mental health care and alternative care.
18. Dedicate appropriate resources to ensure that stigma and discrimination efforts are designed in a culturally and linguistically appropriate manner to address California's diverse population.
19. Implement the five essential elements of cultural competence in all mental health programs: valuing diversity, cultural self-assessment, honoring the dynamics of difference, formalizing and disseminating cultural knowledge at all levels, and adapting to diversity.
20. Discourage educational institutions from expelling students with a mental health issue.

### **(C) Committee Member Survey Responses<sup>6</sup>**

Online survey responses from advisory committee members were collected in response to the question: *What strategies do you think would best address California's mental health stigma and discrimination problem?* Relevant items for this work group are listed below.

These items were listed for "schools" and may or may not be relevant to institutions of higher education:

39. School-based mental health services
40. Technical assistance available to employers, schools
41. Normalize stages of instability as natural part of self-development. teach this in schools so instability is honored instead of disgraced
42. Develop curriculum across all subject areas that addresses these issues.
43. Target high schools and colleges. For example, WRAP in high schools and colleges.
44. Trauma education
45. Revamp State's health curriculum K-12
46. Educate schools on both mental health for all students and how to meet needs of kids with MI
47. Public education of all aspects of mental health/illness
48. Active suicide prevention education, ties in to public education Mental health literacy for children (how to address, how to help with self- and public perception)
49. Education on Mental Health throughout Educational System, so that stigma is addressed throughout child and youth development
50. Include mental health education in curricula at all levels of teacher education
51. Strong school-based interventions that include education, contact, strategies to change social norms
52. Development of curricula and other interventions for use with children in school setting
53. Promote wellness curriculum in schools
54. Well developed education plan for all levels
55. Stigma beginning in childhood and including families working in schools and child settings, learn relevant research
56. Increase pupil support staffing in public schools
57. Ensure that education funding in all levels of public education (k-12) was adequate to provide the student services necessary to educate and support help-seeking of students
58. Early intervention in schools
59. School funding for increased student support positions for every school/school district

<sup>6</sup> This item is simply copied and pasted from the lists that start on p. 24 of this document: <http://www.dmh.ca.gov/PEIStatewideProjects/docs/Meetings/08Dec17/Dec17MasterHandouts.pdf>

60. Every school has access to student support team: school social worker, school counselor, school psychologist, school nurse etc.
61. Address stigma & discrimination issue within school (K-12) context), how to include teachers, administrators, pupil service workers, school boards, community organizations that affect behaviors toward children/families with emotional/behavioral issues.
62. Education of teachers
63. Development of curricula for use with teachers
64. Provide mental health professionals to schools for early intervention.
65. Increase funding for the expansion of AB3632 mental health services for all students in special education
66. More education/training for school teachers regarding mental health
67. Outreach to college students
68. Promote "search and serve" programs for students in general education in schools and communities for children and youth in need of mental health services
69. Include in provider higher education systems the internal and external stigma perpetuated through the psych education system.
70. Mental health literacy for children (K-12)
71. Create school based mental health/health programs in all school districts
72. Include social skills training and pro-social behaviors towards others in elementary school curriculums
73. Include mental health issues in school curriculum, especially in middle and high school courses
74. Begin meetings in school districts on how to include teachers, parents, students, etc. in addressing stigma & discrimination
75. Identify strategic role of schools AND the policy and resource support needed to make this role a reality
76. Integrate Mental Health, Social Service and Education where client needs and services meet

### III. MEDICAL SYSTEM

Reference Materials for Workgroups  
February 3, 2009

#### **(A) Annotated Bibliography<sup>7</sup>**

Below are relevant findings for this work group on strategies included in the Annotated Bibliography, Volume 2.

1. A study of English medical students' attitudes found they had a less favorable response to patients in a vignette with a prior diagnosis of mental illness (depression or schizophrenia) than patients in vignettes with diabetes or no prior diagnosed medical condition. This was found to be the case even after controlling for students' clinical and psychiatric training. In particular, the students reported they would not be as happy to have them on their patient list, believed they would consume more time, and would be less likely to comply with advice and treatment.<sup>84</sup>
2. A study of an anti-stigma program for medical students indicated that which consists of education, contact, and viewing a film that depicts an individual with schizophrenia, can change attitudes towards people with schizophrenia. The anti-stigma program was carried out with first-year medical students (n=25). Students' attitudes towards people with schizophrenia were assessed before and after the program. In parallel, a control group of first-year medical students were questioned (n=35). Assessment was repeated after 1 month. Favorable attitudinal changes were observed in terms of 'belief about the etiology of schizophrenia', 'social distance to people with

<sup>7</sup> These items are copied and pasted from the lists that begin on p. 20 of this document:  
<http://www.dmh.ca.gov/PEIStatewideProjects/docs/Meetings/09Jan14/AnnotBiblioStigmaDiscriminationReductionVol2.pdf>

schizophrenia', and 'care and management of people with schizophrenia'. In contrast, no significant change was observed in the control group. Attitude changes tended to decrease at the 1-month follow up. These results suggest that attitudes towards schizophrenia could be changed favorably with this program. To sustain changed attitudes towards people with schizophrenia, anti-stigma programs should be offered on a regular basis.<sup>122</sup>

3. Primary care is "often the first line of defense for detection and treatment of mental health issues and is often the first point of contact for identifying and treating individuals who otherwise might face stigma, cultural or other barriers to accessing traditional mental health services."<sup>123</sup> Despite this, the California Primary Care Association has identified the following state policy barriers to increased access:
  - California does not avail itself to federal law which permits health clinics and centers to provide and receive reimbursement for Medi-Cal beneficiaries receiving both primary care and mental health care services in one same-day visit.
  - Marriage and Family Therapists (MFTs) are not recognized as reimbursable providers under Medi-Cal.
  - Health centers are not able to adequately fund and provide case management.
  - Regulations impose utilization limitations on health centers providing certain services, including psychology services.

#### **(B) Mental Health Services Oversight & Accountability (MHSOAC) Work Group, June 2007<sup>8</sup>**

The MHSOAC's work group on stigma and discrimination drafted a report in June 2007 making preliminary recommendations. Included in the report's Appendix A are "ideas to be considered in strategic planning."

*Appendix A did not include items specifically targeted to the medical system/primary care.*

#### **(C) Committee Member Survey Responses<sup>9</sup>**

Online survey responses from advisory committee members were collected in response to the question: *What strategies do you think would best address California's mental health stigma and discrimination problem?* Relevant items for this work group are listed below.

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

<sup>8</sup> These items are copied and pasted from the lists that start on p. 51 of this document:

<http://www.dmh.ca.gov/MHSOAC/docs/StigmaAndDiscriminationReport07Jun12.pdf>

<sup>9</sup> This item is simply copied and pasted from the lists that start on p. 24 of this document:

<http://www.dmh.ca.gov/PEIStatewideProjects/docs/Meetings/08Dec17/Dec17MasterHandouts.pdf>

## IV. MENTAL HEALTH SYSTEM

Reference Materials for Workgroups  
February 3, 2009

### **(A) Annotated Bibliography<sup>10</sup>**

Below are relevant findings for this work group on strategies included in the Annotated Bibliography, Volume 2.

1. A review and analysis of available literature in 2005 was conducted by a consulting group to New Zealand's efforts to reduce mental health stigma and discrimination. The review concluded that contact needs to involve more than simply encountering a member of a stigmatized group. Several conditions must be associated with the contact for it to be most effective (equal status, acquaintance potential, disconfirm negative stereotype, mutual goals, active cooperation). However, they note that these conditions are often not in place in interactions between mental health staff, consumers and family members since there is frequently a power differential. As such, it might explain why studies find that many mental health professionals harbor stigmatizing attitudes despite significant contact with mental health consumers. Additionally, studies demonstrate that training alone has not successfully generated ore positive attitudes among mental health professionals. The authors conclude that a more successful strategy for generating positive attitudes among mental health staff would be using consumer trainers who demonstrate that consumers can be high functioning, have strengths, and be successful with wellness and recovery.<sup>132</sup>

### **(B) Mental Health Services Oversight & Accountability (MHSOAC) Work Group, June 2007<sup>11</sup>**

The MHSOAC's work group on stigma and discrimination drafted a report in June 2007 making preliminary recommendations. Included in the report's Appendix A are "ideas to be considered in strategic planning." Relevant items for this work group are listed below.

#### Strategies for the Mental Health System

1. Promote strategies to shift involuntary services to services that are voluntary in nature.
2. Provide training and education to empower consumers to understand what quality mental health services involve and what they may expect from mental health care.
3. Monitor abuses in institutional settings and develop collaborations to protect mental health clients from abuses, including seclusion and restraints.
4. Monitor the state's compliance with the federal CRIPA Consent Judgment regarding abuse and discrimination in state hospitals.
5. Design interventions to ensure that when a person is hospitalized s/he does not lose his or her home, children, employment or belongings.
6. Inform people who are homeless of their right to keep their belongings if they are hospitalized, using a Possessions Advanced Directive to prevent hospital staff from throwing away a person's belongings.
7. Provide training to providers in the public mental health system as well as the primary care system about provider bias and reducing stigma and discrimination in treatment settings.
8. Make assertive efforts to outreach and include underserved populations into all aspects of the MHSOAC stakeholder process.

<sup>10</sup> These items are copied and pasted from the lists that begin on p. 20 of this document:

<http://www.dmh.ca.gov/PEIStatewideProjects/docs/Meetings/09Jan14/AnnotBiblioStigmaDiscriminationReductionVol2.pdf>

<sup>11</sup> These items are copied and pasted from the lists that start on p. 51 of this document:

<http://www.dmh.ca.gov/MHSOAC/docs/StigmaAndDiscriminationReport07Jun12.pdf>

9. Dedicate appropriate resources to ensure that stigma and discrimination efforts are designed in a culturally and linguistically appropriate manner to address California's diverse population.
10. Implement the five essential elements of cultural competence in all mental health programs: valuing diversity, cultural self-assessment, honoring the dynamics of difference, formalizing and disseminating cultural knowledge at all levels, and adapting to diversity.
11. Promote understanding of the multiple barriers faced by ethnic and racial communities in accessing mental health care, tailored to each community's needs, and design methods for reducing the barriers through culturally appropriate services.

#### Strategies for Creating Access to Health and Mental Health Services

21. Provide training and education to empower consumers to understand what quality mental health services involve and what they may expect from mental health care.
22. Provide client-led trainings for mental health professionals and service providers.
23. Design interventions to ensure that when a person is hospitalized s/he does not lose his or her home, children, employment or belongings
24. Inform people who are homeless of their right to keep their belongings if they are hospitalized, using a Possessions Advanced Directive to prevent hospital staff from throwing away a person's belongings.
25. Provide training to primary care providers to improve their diagnosis, responses and treatment of mental health problems.
26. Make assertive efforts to outreach and include underserved populations into all aspects of the MHS stakeholder process.
27. Dedicate appropriate resources to ensure that stigma and discrimination efforts are designed in a culturally and linguistically appropriate manner to address California's diverse population.
28. Implement the five essential elements of cultural competence in all mental health programs: valuing diversity, cultural self-assessment, honoring the dynamics of difference, formalizing and disseminating cultural knowledge at all levels, and adapting to diversity.
29. Promote understanding of the multiple barriers faced by ethnic and racial communities in accessing mental health care, tailored to each community's needs, and design methods for reducing the barriers through culturally appropriate services.

### **(C) Committee Member Survey Responses<sup>12</sup>**

Online survey responses from advisory committee members were collected in response to the question: *What strategies do you think would best address California's mental health stigma and discrimination problem?* Relevant items for this work group are listed below.

1. The first, primary and overwhelming focus and effort should be on the mental health system since it has pervasive stigma and discrimination (sanism) and it is a much more of a closed universe and we should be in the forefront ourselves in being the change we are advocating.
2. Full implementation of the Recovery Model with client directed services is central to eliminating sanism in the mental health system and a great first step for society, in general.
3. Transfer responsibility from law enforcement to mental health providers
4. Provide early intervention
5. School-based mental health services
6. Same day reimbursement
7. Culturally competent services
8. Eliminate the DSM! No one is flawed- encourage and support differences in individuals
9. Lifelong and full-integration of wellness practices in primary and mental health services
10. Health care equals mental health care; the connection between both need to be equally addressed and given the same level of funding and attention in the medical community

<sup>12</sup> This item is simply copied and pasted from the lists that start on p. 24 of this document: <http://www.dmh.ca.gov/PEIStatewideProjects/docs/Meetings/08Dec17/Dec17MasterHandouts.pdf>

11. Meet an individual where they are before and whatever stage they enter "the system"
12. Implement elements of cultural competence in all mental health programs: valuing diversity, cultural self-assessment, honoring the dynamics of difference, formalizing and disseminating cultural knowledge at all levels, and adapting to diversity
13. Raise awareness of violence toward persons with mental disabilities, including the homeless, LGBTQ persons and other high-risk populations. Develop and support a violence prevention agenda.
14. Require counties to have a stigma and discrimination reduction campaign at their local levels.
15. Elimination of Mental Health Managed Care, Medical Necessity Criteria
16. Decrease or elimination of involuntary treatments.
17. ELIMINATE SECLUSION AND RESTRAINTS.
18. MHSAs need to open funding up for those who have never been treated or need treatment again (i.e., not those for whom the treatment would be considered prevention or early intervention) or an effective stigma campaign will have disastrous results. People who finally ask for help won't find any unless they are living on streets or in jail.
19. Use analogy of other illnesses to explain mental illness: self-awareness and self-care critical in partnership with professional care when needed; mental illnesses aren't constant--they wax and wane like other illnesses; recurrences are not necessarily anyone's fault; etc.
20. Treat substance abuse as a mental illness in all state programs
21. Consider substance abuse a mental illness
22. Require mental health parity among state programs
23. Address same day visit reimbursements in FQHCs
24. Reimbursement for Same Day Visits in a Federally Qualified Health Center
25. Recruit mental health providers to participate in stigma reduction activities
26. Integration of educational, mental health and substance abuse services for juveniles
27. Look at the history of changes ALREADY achieved related to mental health. We have come a long way. Do we want to continue on the medicalization route? What are the alternatives?
28. Integrate local mental health system with school system for provision of services to children and families
29. Criminal justice and community, mental health, ADP services
30. Create "Regional Center" like programs for children/families with mental health needs
31. Meet an individual where their at before and whatever stage they enter "the system"
32. Coordination of mental health/alcohol and drug services
33. Elimination of two-tiered systems i.e. in the MHSAs and between dominant and minority cultures
34. Ensure services in mental health system include support and pro-active development of job opportunities
35. Develop accessible services
36. Include in all campaigns the role of substance abuse in the lives of those with mental illness.
37. Pursue integration of primary care and mental health services
38. Integrate local mental health system with school system for provision of services to children and families
39. Reconceptualization or reframing of mental health services. E.g. promoting more of a continuum of mental wellness (things we all need to do) to different types of treatment so as to destigmatize TREATMENT
40. Ensure that parity is implemented fully and completely
41. Being sure not to make "recovery" a source of internal stigma for those who are so sick recovery may not be possible. How do we define "recovery?" Can be different for everyone.
42. Build within the mental health structure the inclusion of "drug courts" to reduce cyclical incarcerations
43. The mental health system should model employee standards. Employees engaged in stigmatizing or discriminating behavior should experience repercussions in their performance reviews.
44. Acknowledge the requirement for caseworkers within the FQHC system of care and reimburse for those services.
45. Integrate Mental Health, Social Service and Education where client needs and services meet  
Continue activities that address culture change

46. Require CEUs in stigma reduction for licensed professionals
47. Increase the number of providers by higher education incentives (like loan forgiveness) to enter the field AND reimbursement for mid-level providers including MFT's.
48. Increase training programs for school social work, school psychologist, school counseling and nurses
49. Use federal/state funds to train mental health specialist from minority communities in our university training programs like federal NIMH training grants in 1960-1970's
50. Increase the number and require the inclusion of a percentage of non-traditional providers to deliver mental health services.
51. Make sure new mental health providers are not being trained in old stigmatizing attitudes.
52. Education professionals and their organizations about recovery (i.e.-NASW, APA)
53. Increase workforce that is bicultural and bilingual
54. Cultural sensitivity training for providers
55. Increase number of providers
56. Stigma and discrimination reduction trainings are mandatory for all mental health providers.

## V. HOUSING

Reference Materials for Workgroups  
February 3, 2009

### **(A) Annotated Bibliography<sup>13</sup>**

Below are relevant findings for this work group on strategies included in the Annotated Bibliography, Volume 2.

*None of the findings on strategies address housing and landlords specifically.*

### **(B) Mental Health Services Oversight & Accountability (MHSOAC) Work Group, June 2007<sup>14</sup>**

The MHSOAC's work group on stigma and discrimination drafted a report in June 2007 making preliminary recommendations. Included in the report's Appendix A are "ideas to be considered in strategic planning." Relevant items for this work group are listed below.

1. Develop strategies to reduce discrimination in permanent housing, including efforts targeting private landlords, housing authorities, nonprofit supportive housing managers and master tenants in shared rentals.
2. Develop strategies to reduce discrimination in emergency shelters for adults and families and transitional housing programs, including domestic violence shelters and "safe houses" for runaway youth.
3. Target efforts at decreasing community opposition to siting of housing for persons with mental illness.
4. Develop collaborations with other civil rights and disability organizations to address discrimination in housing.
5. Dedicate appropriate resources to ensure that stigma and discrimination efforts are designed in a culturally and linguistically appropriate manner to address California's diverse population.

<sup>13</sup> These items are copied and pasted from the lists that begin on p. 20 of this document:

<http://www.dmh.ca.gov/PEIStatewideProjects/docs/Meetings/09Jan14/AnnotBiblioStigmaDiscriminationReductionVol2.pdf>

<sup>14</sup> These items are copied and pasted from the lists that start on p. 51 of this document:

<http://www.dmh.ca.gov/MHSOAC/docs/StigmaAndDiscriminationReport07Jun12.pdf>

6. Implement the five essential elements of cultural competence in all mental health programs: valuing diversity, cultural self-assessment, honoring the dynamics of difference, formalizing and disseminating cultural knowledge at all levels, and adapting to diversity.

### **(C) Committee Member Survey Responses<sup>15</sup>**

Online survey responses from advisory committee members were collected in response to the question: *What strategies do you think would best address California's mental health stigma and discrimination problem?* Relevant items for this work group are listed below.

1. Decriminalize the treatment and housing of adults/youth with mental health diagnosis and acting out behaviors
2. Education of landlords and housing authorities
3. Solidify and utilize effective anti-NIMBY strategies
4. Developing a 10-Year Plan to end homelessness that includes resources and actions designed to reduce homelessness

## **VI. EMPLOYMENT & WORKPLACE**

Reference Materials for Workgroups  
February 3, 2009

### **(A) Annotated Bibliography<sup>16</sup>**

Below are relevant findings for this work group on strategies included in the Annotated Bibliography, Volume 2.

4. Researchers from King's College London present a variety of ideas and actions that may promote the social inclusion of people with mental illness at work, as well as actions at the local and national levels. They conclude that the strongest evidence currently is for direct social contact with people with mental illness, particularly in relation to police officers, school students, journalists, and the clergy.<sup>117</sup>
5. The authors review published data about the costs of doing business when mental illness is stigmatized in the workplace. To counter stigma among employees, authors recommend personal communication with co-workers with mental illness rather than education or anti-stigma messages.<sup>118</sup>

### **(B) Mental Health Services Oversight & Accountability (MHSOAC) Work Group, June 2007<sup>17</sup>**

The MHSOAC's work group on stigma and discrimination drafted a report in June 2007 making preliminary recommendations. Included in the report's Appendix A are "ideas to be considered in strategic planning." Relevant items for this work group are listed below.

1. Provide training for mental health clients in techniques to pursue competitive employment, to secure a "reasonable accommodation" for their disability, and to thrive in the workplace.

<sup>15</sup> This item is simply copied and pasted from the lists that start on p. 24 of this document:

<http://www.dmh.ca.gov/PEIStatewideProjects/docs/Meetings/08Dec17/Dec17MasterHandouts.pdf>

<sup>16</sup> These items are copied and pasted from the lists that begin on p. 20 of this document:

<http://www.dmh.ca.gov/PEIStatewideProjects/docs/Meetings/09Jan14/AnnotBiblioStigmaDiscriminationReductionVol2.pdf>

<sup>17</sup> These items are copied and pasted from the lists that start on p. 51 of this document:

<http://www.dmh.ca.gov/MHSOAC/docs/StigmaAndDiscriminationReport07Jun12.pdf>

2. Provide pre-employment training, ongoing training and supports for clients to enter the mental health workforce.
3. Provide training for county mental health departments on hiring and retaining clients in their workforce.
4. Establish strategies to educate officials and work to change county personnel policies that are not supportive of consumer employment.
5. Create incentives for counties to hire clients for the mental health workforce.
6. Create "contact" programs aimed at employers that take the person who has experienced or is experiencing mental ill health out of the "other" category (such as the Stamp Out Stigma program based in Belmont, California).
7. Dedicate appropriate resources to ensure that stigma and discrimination efforts are designed in a culturally and linguistically appropriate manner to address California's diverse population.
8. Implement the five essential elements of cultural competence in all mental health programs: valuing diversity, cultural self-assessment, honoring the dynamics of difference, formalizing and disseminating cultural knowledge at all levels, and adapting to diversity.
9. Provide a training program for businesses to be given through local chambers of commerce associations utilizing the Open Minds/ Open Doors employer literature -- <http://www.openmindsopendoors.com/upload/EmployerGuide.pdf>.
10. Create an awards program that recognizes California state businesses that have the best record in hiring and/or retaining people who have experienced or are experiencing mental health problems.

<b>(C) Committee Member Survey Responses<sup>18</sup></b>
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Online survey responses from advisory committee members were collected in response to the question: *What strategies do you think would best address California's mental health stigma and discrimination problem?* Relevant items for this work group are listed below.

12. Using MHSA and other funding to offer more clients employment opportunities in mental health and peer-run programs.
13. Strategies that support disclosure whether in the workplace or in communities.
14. Technical assistance available to employers, schools
15. Offer more employment opportunities for ethnic minorities, youth, LGBTQ, etc.
16. Provide more employment opportunities for consumers and family members.
17. Protect MediCal for working disabled (reduces self-stigma to remain in workplace)
18. Active stigma/discrimination programs in workplaces for workers
19. Educate employers -- that hiring individuals based on their abilities is the first and foremost -- whether or not they have a disability
20. Education of employment community (i.e. - chamber of commerce)
21. Providing courses and classes for employers and employees
22. Identification of best practices in working to reduce stigma concept among employers
23. Find out groups of people need education about stigma & discrimination and get them to the table to work with them, i.e., employers
24. Ensure services in mental health system include support and pro-active development of job opportunities
25. More education for employers about myths of people with mental health diagnoses, and about accommodations.
26. Strategies that support disclosure whether in the workplace or in communities.
27. Work with Human Resource Managers and personnel to educate on mental health and discrimination policies
28. Work with employers to hire individuals with mental disabilities, but help to make it a win/win situation.
29. Education of employers

<sup>18</sup> This item is simply copied and pasted from the lists that start on p. 24 of this document: <http://www.dmh.ca.gov/PEIStatewideProjects/docs/Meetings/08Dec17/Dec17MasterHandouts.pdf>

30. Assistance with ADA dispensation for clients who are working full time and have episodic crises so they can return to their jobs without fear of losing their only source of income.

## VII. MEDIA

Reference Materials for Workgroups  
February 3, 2009

### (A) Annotated Bibliography<sup>19</sup>

Below are relevant findings for this work group on strategies included in the Annotated Bibliography, Volume 2.

#### Messages

2. Instructing people to ignore or suppress negative thoughts and attitudes toward a particular group can have paradoxical rebound effects and stigma can be augmented rather than reduced.<sup>111</sup> In a study to test this assertion, it was found that instructing participants to suppress their stereotypes of people with severe mental illnesses reduced negative attitudes, but did not impact behavior, and that rebound effects did not occur.<sup>112</sup>
3. Referencing the book, "Psychiatric patient to citizen," (Sayce, Liz, 2001), the author describes four models for addressing stigma, discrimination, and/or social exclusion.
  - a. The favored model is "Disability Inclusion," in which discrimination in every arena must be addressed and the rights of people with mental health problems are promoted. The model promotes social inclusion on the grounds of civil rights – not just paternalistic "help." Disability is impairment + effects of socially imposed barriers and prejudices.
  - b. The "Brain Disease" model holds that mental illness is like any other, and people who are ill are not at fault. People may not believe this, or if they do, may adopt a paternalistic approach and see the person as a victim.
  - c. The "Libertarian" model holds that mental health consumers should have equal rights, and equal criminal responsibility. The concern here is that people stand more to lose than gain, especially in the workplace and courts.
  - d. The "Individual Growth" model holds that mental health and illness are on a spectrum, and that emotional distress, bereavement, and enduring psychosis are related experiences. The concern here is that it does not address the "us" (those with depression or anxiety) and "them" (those with schizophrenia, bipolar disorder, psychosis) dynamic.<sup>113</sup>
4. A study in 2006 compared American beliefs about mental illness with those found in a 1996 study. Despite the growing popularity of a medical view of mental illness, tolerance of people with mental illness has not increased. Specifically, genetic arguments applied to schizophrenia are associated with fears about violence. In contrast, genetic arguments applied to depression are associated with social acceptance. Genetic arguments are associated with recommending medical treatment, but not with perceived likelihood of improvement. In sum, the study found little change in overall levels of tolerance over time. The author concludes that the biomedical view of mental illness is unlikely to increase American's tolerance of people with mental illness.<sup>114</sup>
5. The authors reviewed literature worldwide to assess the effectiveness of psychosocial versus biogenetic messages about mental illness, and conclude that an evidence-based approach is needed to provide a range of alternatives to the "mental illness is an illness like any other" approach.<sup>115</sup>

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<sup>19</sup> These items are copied and pasted from the lists that begin on p. 20 of this document:  
<http://www.dmh.ca.gov/PEIStatewideProjects/docs/Meetings/09Jan14/AnnotBiblioStigmaDiscriminationReductionVol2.pdf>

6. A briefing paper commissioned by the World Health Organization asserts that, “We do not yet know which messages and models are most effective – and with which groups of people – in reducing discrimination and stigma.”<sup>116</sup>

#### Social Marketing as a Strategy: Lessons Learned

1. Conducted by researchers at the London School of Hygiene and Tropical Medicine and the National Social Marketing Centre, the review sought to examine the potential of social marketing approaches to contribute to both national and local health-related programs and social marketing campaigns.<sup>133</sup> Researchers collected and analyzed campaign and evaluation materials and conducted interviews with key informants of each program. Among the eleven campaigns reviewed was a national Department of Health mental health campaign (years 2000-03), “Mind out,” whose aim was to educate the general public about mental health issues and reduce discrimination towards consumers. Goals included promoting greater acceptance, dispelling myths and misconceptions, and supporting the network of local organizers engaged in promoting mental health. Target audiences were employers, young people, and the media. Strategies included a workplace toolkit; media guide for journalists; booklet, games, quizzes, and a web site for young people; and a photographic exhibition for the general public. The program targeted those with power (20 employers and 10 journalism schools) to change public attitudes and used a first-person voice. Findings for the “Mind Out” campaign included:
  - Process and audit research evaluation was conducted, but not outcomes. A “crude” evaluation of cost-effectiveness of the media work was to cost media coverage as if it had been purchased. This was a major contribution to the campaign’s discontinuation. Evaluation was built into the contract. However, the government’s Central Office of Information did not establish an evaluation framework, as requested; and
  - Relationship dynamics were challenging at times, including historic hostility between community stakeholders (competition rather than collaboration) and stakeholders tended to be united against the government.

#### **(B) Mental Health Services Oversight & Accountability (MHSOAC) Work Group, June 2007<sup>20</sup>**

The MHSOAC’s work group on stigma and discrimination drafted a report in June 2007 making preliminary recommendations. Included in the report’s Appendix A are “ideas to be considered in strategic planning.” Relevant items for this work group are listed below.

12. Promote suicide prevention, including awareness of the California Youth Suicide
13. Prevention Plan -- <http://www.cde.ca.gov/ls/cg/mh/suicideprevres.asp>.
14. Create “contact” programs aimed at the media that take the person who has experienced or is experiencing mental ill health out of the “other” category (such as the Stamp Out Stigma program based in Belmont, California).
15. Dedicate appropriate resources to ensure that stigma and discrimination efforts are designed in a culturally and linguistically appropriate manner to address California’s diverse population.
16. Implement the five essential elements of cultural competence in all mental health programs: valuing diversity, cultural self-assessment, honoring the dynamics of difference, formalizing and disseminating cultural knowledge at all levels, and adapting to diversity.
17. Employ ethnic and racial minority consultants, media outlets, and firms to assist in the development of stigma and discrimination campaigns.
18. Provide media guidelines on reporting/portraying mental illness, using advice similar to that of the American Foundation for Suicide Prevention (AFSP) or the World Health Organization (WHO).
19. Provide course instruction for college training programs of future media professionals.
20. Develop and disseminate materials depicting people with mental health issues from a positive, strengths-based perspective.

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<sup>20</sup> These items are copied and pasted from the lists that start on p. 51 of this document: <http://www.dmh.ca.gov/MHSOAC/docs/StigmaAndDiscriminationReport07Jun12.pdf>

## (C) Committee Member Survey Responses<sup>21</sup>

Online survey responses from advisory committee members were collected in response to the question: *What strategies do you think would best address California's mental health stigma and discrimination problem?* Relevant items for this work group are listed below.

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

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<sup>21</sup> This item is simply copied and pasted from the lists that start on p. 24 of this document:  
<http://www.dmh.ca.gov/PEIStatewideProjects/docs/Meetings/08Dec17/Dec17MasterHandouts.pdf>

## IIX. LAW ENFORCEMENT

Reference Materials for Workgroups  
February 3, 2009

### (A) Annotated Bibliography<sup>22</sup>

Below are relevant findings for this work group on strategies included in the Annotated Bibliography, Volume 2.

*None of the findings on strategies address law enforcement specifically.*

### (B) Mental Health Services Oversight & Accountability (MHSOAC) Work Group, June 2007<sup>23</sup>

The MHSOAC's work group on stigma and discrimination drafted a report in June 2007 making preliminary recommendations. Included in the report's Appendix A are "ideas to be considered in strategic planning." Relevant items for this work group are listed below.

7. Ensure that all law enforcement agencies have training in dealing with crisis situations, either using the CIT or similar models.
8. Develop collaboration with law enforcement agencies.

### (C) Committee Member Survey Responses<sup>24</sup>

Online survey responses from advisory committee members were collected in response to the question: *What strategies do you think would best address California's mental health stigma and discrimination problem?* Relevant items for this work group are listed below.

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

<sup>22</sup> These items are copied and pasted from the lists that begin on p. 20 of this document:

<http://www.dmh.ca.gov/PEIStatewideProjects/docs/Meetings/09Jan14/AnnotBiblioStigmaDiscriminationReductionVol2.pdf>

<sup>23</sup> These items are copied and pasted from the lists that start on p. 51 of this document:

<http://www.dmh.ca.gov/MHSOAC/docs/StigmaAndDiscriminationReport07Jun12.pdf>

<sup>24</sup> This item is simply copied and pasted from the lists that start on p. 24 of this document:

<http://www.dmh.ca.gov/PEIStatewideProjects/docs/Meetings/08Dec17/Dec17MasterHandouts.pdf>

## IX. LAW, PUBLIC POLICY & LEGAL SYSTEM

Reference Materials for Workgroups  
February 3, 2009

### (A) Annotated Bibliography<sup>25</sup>

Below are relevant findings for this work group on strategies included in the Annotated Bibliography, Volume 2.

*None of the findings on strategies address law, public policy, and the legal system specifically.*

### (B) Mental Health Services Oversight & Accountability (MHSOAC) Work Group, June 2007<sup>26</sup>

The MHSOAC's work group on stigma and discrimination drafted a report in June 2007 making preliminary recommendations. Included in the report's Appendix B is a list of items titled, "Developing a public policy and advocacy agenda." These items are listed below.

1. Promote compliance with and enforcement of existing laws, including Americans with Disabilities Act, the Supreme Court's Olmstead decision, the Fair Housing Act, and the Civil Rights Act among others.
2. Educate policymakers on the association between stigma and discrimination and the under-resourcing of the mental health system, and work toward appropriate funding of the system.
3. Support pending legislation on mental health parity, including California's AB 423 and the pending federal mental health parity act (HR 1367 and S 558 being considered in the current Congress).
4. Explore options for changing the "double bind" regulatory decisions that have prohibited the funding of the Children's System of Care with MHSA funds.
5. Explore legislation that supports hiring and retention of persons with mental health disabilities.
6. Advocate for increased oversight and higher standards in community board and care facilities.
7. Support statewide legislation to reduce the effects of NIMBYism.
8. Advocate to improve mental health and supportive services to children in the foster care system.
9. Develop a federal policy agenda to reduce discrimination, including challenging the institutional bias of Medi-Cal and Social Security Disability system rules that discourage employment.

### (C) Committee Member Survey Responses<sup>27</sup>

Online survey responses from advisory committee members were collected in response to the question: *What strategies do you think would best address California's mental health stigma and discrimination problem?* Relevant items for this work group are listed below.

#### Funding

1. Health care equals mental health care; the connection between both need to be equally addressed and given the same level of funding and attention in the medical community

<sup>25</sup> These items are copied and pasted from the lists that begin on p. 20 of this document:

<http://www.dmh.ca.gov/PEIStatewideProjects/docs/Meetings/09Jan14/AnnotBiblioStigmaDiscriminationReductionVol2.pdf>

<sup>26</sup> These items are copied and pasted from the lists that start on p. 58 of this document:

<http://www.dmh.ca.gov/MHSOAC/docs/StigmaAndDiscriminationReport07Jun12.pdf>

<sup>27</sup> This item is simply copied and pasted from the lists that start on p. 24 of this document:

<http://www.dmh.ca.gov/PEIStatewideProjects/docs/Meetings/08Dec17/Dec17MasterHandouts.pdf>

2. Get a committee to help counties disburse Prop 63 monies
3. Firm funding that is appropriately spent
4. Money
5. Strategies to engage more Prop 63 funds towards this endeavor by and through the local counties
6. Find a way for the state to keep money for statewide projects (easier).
7. Maximize the Proposition 63 monies set aside for this purpose
8. Tying funding to successful delivery of services to underserved communities.

#### Political Leadership

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

#### Public Policy & Legal Protections

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