ANNOTATED BIBLIOGRAPHY
Volume II
Research Findings on Strategies for Reducing the Stigma and Discrimination Associated with Mental Illness

NOTES: This version presents additions to Volume I (additions are underlined). Resources contributed by Advisory Committee members are indicated with a star (★)

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I. Introduction

This annotated bibliography was developed from November 2008 through January 2009 by Kirsten Deichert, Office of External Affairs, California Department of Mental Health, with the skilled assistance of Jordan Blair, Graduate Student Assistant, for use in the development of the California Strategic Plan to Reduce Stigma and Discrimination. This is intended to complement the research described in, "Eliminating Stigma and Discrimination against Persons with Mental Health Disabilities: A Project of the Mental Health Services Act (MHSA)," which was submitted in June 2007 to the Mental Health Services Oversight and Accountability Commission[1]. That report includes a great deal of information and research findings to establish and describe the problems of stigma and discrimination. Section III of this annotated bibliography provides some additional detail to establish the problem, but focuses primarily on strategies for addressing the problem. Reviewing literature and research studies is an ongoing process as new information becomes available nearly every day. Therefore, this is not intended to be a complete representation of all that is known on the topic, but rather a preliminary volume of information that may be useful to individuals developing the California Strategic Plan to Reduce Stigma and Discrimination. Additional information will be added over time. Suggestions are welcome, and should be sent to kirsten.deichert@dmh.ca.gov.

II. Method

This annotated bibliography contains articles identified through database searches of Academic Search Complete, SocINDEX, MEDLINE, Education Research Complete, and Health Source. Articles were included in the annotated bibliography if they discussed and reached conclusions about the phenomena of stigma and discrimination, particularly toward people with mental illness, as well as reviewed the effectiveness of particular strategies to reduce the phenomena. Additional sources for information were American and other nations' governmental and non-profit web sites devoted to this topic.

III. Definitions

a. Stigma, Discrimination, Prejudice, and Stereotypes

- In a discussion of the variations in the definition of "stigma," the authors conclude that stigma exists when five interrelated components converge: (1) "people distinguish and label human differences;" (2) "dominant cultural beliefs link labeled persons to undesirable characteristics—to negative stereotypes;" (3) "labeled persons are placed in distinct categories so as to accomplish some degree of separation of 'us' from 'them;'" (4) "labeled persons experience status loss and discrimination that lead to unequal outcomes;" and (5) stigmatization is entirely contingent on access to social, economic, and political power that allows the identification of differentness, the construction of stereotypes, the separation of labeled persons into distinct categories, and the full execution of disapproval, rejection, exclusion, and discrimination." Therefore, the term "stigma" is applied within the context of a power situation.[2]
- In a discussion of the roots of stigmatization, the author argues that people continuously assess others as a matter of basic survival, and this is the basis for negative stigmatization that leads to discrimination and exclusion of people with mental illness. Humans constantly assess others to determine if they should be feared, are a competitor, will be a burden, are disturbing the equilibrium in the group, or could be a possible partner to mate or join.[3]

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[1] Available online at: *http://www.dmh.ca.gov/MHSOAC/docs/StigmaAndDiscriminationReport07Jun12.pdf*
[2] Link, B.G., Phelan, J.C. (2001). Conceptualizing stigma. *Annual Review of Sociology*, 27, 363-385.
[3] Jacobsson, L. (2002). The roots of stigmatization. *World Psychiatry*, 1(1), 25.

- In a discussion of what causes stigma, the author asserts that there are two fundamental elements: recognizing a differentiating "mark" (condition) and the subsequent devaluation of the person. In addition to stereotypes, prejudice, and discrimination, three other concepts perpetuate stigmatizing attitudes: the *visibility* of the mark/condition, the degree to which the person is perceived to have *control* of the mark/condition, and the extent to which it might *impact* others.[4]
- When describing discrimination, a briefing paper commissioned by the World Health Organization sites the United Nations: "Discrimination means unfair treatment. More specifically, it involves making any distinction, exclusion, restriction or preference that 'has the purpose or effect of nullifying or impairing the recognition, enjoyment or exercise by all persons, on an equal footing, of all rights and freedoms' (UN Human Rights Committee, General comment 18(37))." Additionally, the paper notes that discrimination can be both unintentional and intentional, and uses the term "structural discrimination" when it occurs at the level of organizations and institutions.[5]

b. Social Inclusion

- In an overview of voting rights for people with mental illness, the authors suggest that "social inclusion" means "equality of opportunity to access and participation in the rudimentary and fundamental functions of society," including healthcare access, employment, education, good housing, recovery of status and meaning, and reduced impact of disability.[6]
- In contrast, in the UK, the Prime Minister set up a Social Exclusion Unit (SEU) in December 1997. The SEU defines "social exclusion" as "a shorthand for what can happen when individuals or areas suffer from a combination of linked problems such as unemployment, poor skills, low incomes, poor housing, high crime environments, bad health and family breakdown."[7]

c. Social Marketing

- A commonly used definition of social marketing is: "The application of commercial marketing technologies to the analysis, planning, execution and evaluation of programs designed to influence the voluntary behavior of target audiences in order to improve their personal welfare and that of society."[8]

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[4] Arboleda-Flórez, J. (2002). What causes stigma? *World Psychiatry*, 1(1), 25-26.

[5] Health Scotland, World Health Organization Collaborating Centre (2008). *Stigma: An International Briefing Paper: Tackling the discrimination, stigma and social exclusion experienced by people with mental health problems and those close to them*, p. 3.

[6] Nash, M. (2002). Voting as a means of social inclusion for people with a mental illness. *Journal of Psychiatric and Mental Health Nursing*, 9, 697–703.

[7] Social Exclusion Unit (1998). *Preventing Social Exclusion: Social Exclusion and Why it Matters*, 1–12. http://www.cabinet-office.gov.uk/seu/

[8] Andreasen, A.R. (1995). *Marketing Social Change: Changing Behaviour to Promote Health, Social, Development, and the Environment*. Jossey-Bass Publications: San Francisco, CA.

IV. Establishing the Problem of Stigma and Discrimination

a. Consumers (Personal/Internalized Stigma)

- Children and adults with experience of mental illness are at high risk of internalizing stigma and suffering diminished self-esteem, confidence, and mastery in their own abilities.[9, 10]
- Fear of stigma and rejection can lead to limited social supports, poor life satisfaction, unemployment, or loss of income. A study of 70 members of a clubhouse program for people with mental illness found that perceptions of stigma strongly predicted self-esteem at follow-up when baseline self-esteem, depressive symptoms, demographic characteristics, and diagnosis were controlled for. The stigma associated with mental illness harms the self-esteem of many people who have serious mental illnesses. An important consequence of reducing stigma would be to improve the self-esteem of people who have mental illnesses.[11]
- Sixty women with borderline personality disorder and 30 women with social phobia who were recruited at three centers in Germany and Switzerland, completed stigma-related questionnaires. After depression and index diagnosis were controlled for, a low level of perceived discrimination and of the legitimacy of discrimination predicted high self-esteem and high empowerment. Identification with the group of people with mental illness did not predict self-esteem or empowerment.[12]
- Many people who would benefit from mental health services opt not to pursue them or fail to fully participate once they have begun. One of the reasons for this disconnect is stigma; namely, to avoid the label of mental illness and the harm it brings, people decide not to seek or fully participate in care.[13]
- Epidemiological studies in the United States suggest that stigma keeps 50 to 60 percent of people with mental health problems from seeking treatment.[14]
- In a review of the impact of mental health stigma, the authors conclude that research suggests that many mental health consumers become righteously angry about the prejudice they have experienced. Rather than reducing their self-esteem, experiences of stigma and discrimination empowers some consumers to change their roles in the mental health system and push for improvements in the quality of services.[15]

b. Family Members

- Family members of relatives with mental illness or drug dependence (or both) report that they are frequently harmed by public stigma. A national sample of 968 people were given a vignette describing a person with a health condition and a family member. Family stigma related to mental illnesses, such as schizophrenia, is not highly endorsed. Family stigma

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[9] Corrigan, P.W. (1998). The impact of stigma on severe mental illness. *Cognitive and behavioral practice*, 5, 201-222.

[10] Link, B.G. (1987). Understanding labeling effects in the area of mental disorders: An assessment of the efforts of expectations of rejection. *American Sociological Review*, 5, 96-112.

[11] Link, B.G., Stuening, E.L., Neese-Todd, S., et al. (2001). Stigma as a barrier to recovery: The consequences of stigma for the self-esteem of people with mental illnesses. *Psychiatric Services*, 52(12), 1621-1626.

[12] Rüsch, N., Lieb, K., Bohus, M., Corrigan, P.W. (2006). Self-stigma, empowerment, and perceived legitimacy of discrimination among women with mental illness. *Psychiatric Services*, 57(3), 399-402.

[13] Corrigan, P.W. (2004). How stigma interferes with mental health care. *American Psychologist*, 59(7), 614-625.

[14] Cooper, A.E., Corrigan, P.W., Watson, A.C. (2003). Mental illness stigma and care seeking. *Journal of Nervous and Mental Disease*, 191, 339-41.

[15] Corrigan, P.W., Watson, A.C. (2002). Understanding the impact of stigma on people with mental illness. *World Psychiatry*, 1(1), 16-20.

related to drug dependence, however, is worse than for other health conditions, with family members being blamed for both the onset and offset of a relative's disorder and likely to be socially shunned.[16]

- Focus group interviews with 122 members of advocacy groups from different parts of Germany found that discrimination and disadvantages encountered by relatives of schizophrenia patients reach far beyond the spheres of direct social interaction and social roles. The study revealed two additional domains in which relatives encounter stigmatization: structural discrimination and public images of mental illness. Furthermore, psychiatry has been identified as one important source of stigma. Relatives also suggested numerous anti-stigma interventions that can be grouped into five main categories: communication measures, support for the ill and their relatives, changes in mental health care, education and training, and control and supervision.[17]

c. Public Policy and Law

- "Societies in which there is less discrimination, and more acceptance of groups of people who are different, tend to be healthier as well as more just societies. Legal and policy changes that help people with mental health problems are likely to help everyone...The cost to society includes the los of skills and talents of people who experience mental health problems – skills that go to waste or are unused because of the discrimination excluding people from participating and contributing. Everyone – whether users of mental health services, those close to them, health professionals or advocacy organizations – can act as a force for change."[18]
- A study of American state legislation in 2002 found that legislation frequently confuses "incompetence" with "mental illness."[19]
- The author asserts that people who "adopt resistance strategies may actually face less stigma, experience less social harm, and be better able to cope with any discrimination." The author discusses that the legal protection against stigma is limited because it addresses behavior, but not the attitudes that produce behavior. Additionally, stigma may not take the form of overt acts. In America, since discrimination laws are tied to intent, judges "demand proof that a person actively disliked somebody and wanted to do harm, in order to show discrimination."[20]
- Most disability discrimination complaints are never investigated by government enforcement agencies.[21]
- In a review of research on the impact of mental health stigma, the authors conclude that most studies have "ignored the fact that stigma is inherent in the social structures that make up society. Stigma is evident in the way laws, social services, and the justice system are

[16] Corrigan P.W., Watson A.C., Miller F.E. (2006). Blame, shame, and contamination: the impact of mental illness and drug dependence stigma on family members. *Journal of Family Psychology*, 20(2), 239-46.

[17] Angermeyer M.C., Schulze B., Dietrich S. (2003). Courtesy stigma--a focus group study of relatives of schizophrenia patients. *Social Psychiatry and Psychiatric Epidemiology*, 38(10), 593-602.

[18] Health Scotland, World Health Organization Collaborating Centre (2008). *Stigma: A Guidebook for Action. Tackling the discrimination, stigma and social exclusion experienced by people with mental health problems and those close to them*, p. 6.

[19] Corrigan, P.W. et al. (2005). Structural stigma in state legislation. *Psychiatric Services*, 56:5.

[20] Burris, S. (2006). Stigma and the law. *The Lancet*, 367, 529-531.

[21] Moss, K., Phelan, J. (2001). Unfunded mandate: an empirical study of the implementation of the ADA by the Equal Employment Opportunity Commission. *Kansas Law Review*, 50, 1-110.

structured as well as ways in which resources are allocated. Research that focuses on the social structures that maintain stigma and strategies for changing them is sorely needed."[22]

d. Media

- A survey of over 3,000 newspapers found that 39% of stories about mental illness focused on dangerousness and violence, and were featured in the front section.[23]
- A study of over 1,700 newspaper articles found that cancer was used in a metaphorical way in only 1% of articles mentioning cancer, whereas schizophrenia was used metaphorically in 28% of articles that mentioned schizophrenia.[24]
- A study of 34 animated Disney films found that 85% contain verbal references to mental illness, with an average of 4.6 references per film. The references were mainly used to set apart and denigrate the characters to which they referred.[25]

e. Age Groups, Gender, and Education Levels

i. Children

- The authors reviewed literature on social cognitive development and ethnic prejudice and its implications on mental illness stigma. Children as young as three show some endorsement of stereotypes about people of color, which slowly increases and seems to peak around age five to six. Older children, interestingly, show lower rates of ethnic prejudice. Differences between mental illness and ethnicity-related stigma may influence the form of this relationship. Strategies that are reviewed include education, contact, social cognitive skills training, role-play for empathy, peer interaction, protest and consequences.[26]
- According to a report by the American Sociological Society, children with mental illness are more likely to be socially rejected than children with physical illness. In addition, parents are skeptical about their child having an association with a child with depressive symptoms.[27]
- A study of children between ages five and eleven found that children's understanding of mental illness increases with age, and the older children demonstrated a more sophisticated and accurate thinking of mental illness. The study found that girls exhibited more compassion and social acceptance than boys.[28]
- A 2002 survey in which respondents either answered questions about a vignette in which an adult had depression or one in which a child had depression found that Americans are more concerned about children's depression than adults.' Respondents' also saw a greater potential for violence among children than adults. While treatment of all types was more

[22] Corrigan, P.W., Watson, A.C. (2002). Understanding the impact of stigma on people with mental illness. *World Psychiatry*, 1(1), p. 18.
[23] Corrigan, P.W. et al. (2005). Newspaper stories as measures of structural stigma. *Psychiatric Services*, 56(5), 551-6.
[24] Duckworth, K. et al. (2003). Use of schizophrenia as a metaphor in US newspapers. *Psychiatric Services*, 54(10), 1402-4.
[25] Lawson, A. (2004). Mental illness in Disney animated films. *Canadian Journal of Psychiatry*, 49(5), 310-4.
[26] Corrigan, P.W., Watson, A.C. (2007). How children stigmatize people with mental illness. *International Journal of Social Psychiatry*, 53(6), 526-46.
[27] (2007) *Brown University Child & Adolescent Behavior Letter*, 23(5), 2.
[28] Fox, C., Buchanan-Barrow, E., Barrett, M. (2008). Children's understanding of mental illness: An exploratory study. *Child: Care, Health & Development*, 34(1), 10-18.

endorsed for children, significantly fewer recommended talking to family and friends about a child's mental health problem than an adult's mental health problem.[29]

- ★ Bullying is aggressive behavior that is intentional and that involves an imbalance of power or strength. Often, it is repeated over time. Bullying can take many forms, such as hitting, kicking, or shoving (physical bullying), teasing or name-calling (verbal bullying), intimidation through gestures or social exclusion (nonverbal bullying or emotional bullying), and sending insulting messages by text messaging or e-mail (cyberbullying). Children with learning disabilities are at a greater risk of being teased and physically bullied (Martlew & Hodson, 1991; Mishna, 2003; Nabuzoka & Smith, 1993; Thompson, Whiney, & Smith, 1994). Children with Attention Deficit Hyperactivity Disorder (ADHD) are more likely than other children to be bullied. They also are somewhat more likely than others to bully their peers (Unnever & Cornell, 2003). Children and youth who are bullied are more likely than other children to: be depressed, lonely, anxious; have low self-esteem; experience headaches, stomachaches, fatigue, poor appetites; be absent from school and dislike school; and think about suicide.

  Bullying may cross the line to become "disability harassment," which is illegal under Section 504 of the *Rehabilitation Act of 1973* and Title II of the *Americans with Disabilities Act of 1990*. According to the U.S. Department of Education, disability harassment is "intimidation or abusive behavior toward a student based on disability that creates a hostile environment by interfering with or denying a student's participation in or receipt of benefits, services, or opportunities in the institution's program" (U.S. Department of Education, 2000).[30]

ii. Adolescents & Transitional Age Youth

- A survey of nearly 4,000 Australian adults 18 and older found that young adults (18-24) were better than older adults (70+) at recognizing depression and schizophrenia, but slightly less so with schizophrenia. Older adults were more likely to believe that schizophrenia could be caused by character weakness, and less likely to view treatments as helpful. The researchers conclude that programs to improve mental health literacy should involve messages that appeal to the unique interests and pre-existing beliefs of both younger and older age groups.[31]
- A survey of 116 undergraduate students found:[32]
  - Stigmatization of schizophrenia significantly higher than of depression;
  - No impact by changing the psychiatric terminology for mental illness; and
  - Higher stigmatization among males than females.
- A study of 79 community college students found that they were less likely to seek services if they viewed people with mental illness as responsible for their disorder, did not pity them, reacted to them with anger, and were likely to withhold help.[33]

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[29] Perry, B.L., Pescosolido, B.A., Martin, J.K., McLeod, J.D., Jensen, P.S. (2007). Comparison of public attributions, attitudes, and stigma in regard to depression among children and adults. *Psychiatric Services*, 58(5), 632-5.

[30] Bullying Among Children and Youth with Disabilities and Special Needs. *Stop Bullying Now*. www.stopbullyingnow.hrsa.gov

[31] Farrer, L., Leach, L., Griffiths, KM, Christensen, H., Jorm, AF (2008). Age differences in mental health literacy. *BMC Public Health*, 8, 125.

[32] Mann, C.E. et al. (2004). Factors associated with stigmatization of persons with mental illness. *Psychiatric Services*, 55(2) 185-7.

- A study of 303 adolescents found that those who agreed that persons with mental illness are responsible for their illness and are dangerous demonstrated more discrimination. However, those who reported more familiarity with mental illness were more likely to endorse the stigma of mental illness.[34]
- An Internet-based survey of U.M. undergraduate and graduate students from year 2005 found demographic differences among students' perceptions of public stigma associated with mental health care seeking. The study found that perceived stigma was not significantly associated with utilizing mental health services.[35]
- A study with 274 eighth graders in an American suburban community found that boys had less mental health knowledge and experience, and higher mental health stigma, than girls. The authors recommend mental health education and services in middle school to reduce gender disparities by incorporating stigma reduction efforts that actively involve parents.[36]
- ★ The majority of adolescents who need mental health treatment do not receive it. Fewer than one in five (20%) of youth in the U.S. who need treatment actually receive it. Nearly one-quarter (73%) of youth in correctional facilities report a mental disorder during screening, with a slightly higher prevalence rate among girls than boys.[37]

iii. Adults

- A nationally representative sample of 968 individuals was asked to respond to a vignette describing a person with a health condition (schizophrenia, drug dependence, or emphysema) and his/her family member. The study found that women and people with higher education levels were less likely to endorse stigma, and nonwhite people were more likely to endorse stigma than whites.[38]

iv. Older Adults

- (Repeated from ii. above) A survey of nearly 4,000 Australian adults 18 and older found that young adults (18-24) were better than older adults (70+) at recognizing depression and schizophrenia, but slightly less so with schizophrenia. Older adults were more likely to believe that schizophrenia could be caused by character weakness, and less likely to view treatments as helpful. The researchers conclude that programs to improve mental health literacy should involve messages that appeal to the unique interests and pre-existing beliefs of both younger and older age groups.[39]
- ★ A federal report on overcoming stigma for older Americans indicates that 16 percent of older adults have a psychiatric disorder, that depression is associated with worse health outcomes, and that older adults have the highest suicide rate in the country. Additionally,

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[33] Cooper, A.E. et al. (2003). Mental illness stigma and care seeking. *The Journal of Nervous and Mental Disease*, 191(,5), 39-41.
[34] Corrigan, P.W. et al. (2005). How adolescents perceive the stigma of mental illness and alcohol abuse. *Psychiatric Services*, 56:5, 544-50.
[35] Golberstein, E., Eisenberg, D., Gollus, S.E. (2008). Perceived stigma and mental health care seeking. *Psychiatric Services*, 59(4), 392-399.
[36] Chandra, A., Minkovitz, C.S. (2006). Stigma starts early: Gender differences in teen willingness to use mental health services. *Journal of Adolescent Health*, 38(6), 754.
[37] Nebergall, M.L. Adolescent Mental Health in the United States.
[38] Corrigan P.W., Watson A.C. (2007). The stigma of psychiatric disorders and the gender, ethnicity, and education of the perceiver. *Community Mental Health Journal*, 43(5), 439-58.
[39] Farrer, L., Leach, L., Griffiths, KM, Christensen, H., Jorm, AF (2008). Age differences in mental health literacy. *BMC Public Health*, 8, 125.

older adults with mental disorders are at increased risk for inappropriate medication treatment, inappropriate prescription, are less likely to be treated with psychotherapy, and have a lower quality of general health care and increased mortality. Older adults have vast unmet needs for community treatment, with fewer than 3 percent receiving outpatient mental health treatment by specialty mental health providers.

- In terms of self-stigma, older adults may worry that identifying a need for mental health services could jeopardize their health care and insurance, financial security, and independence, and could lead to being declared incompetent or being institutionalized.
- Public stigma for older adults is found in the stereotypes that they are childish, resistant to change, stubborn, needy, untreatable, or not worth being treated. There is also a widely held myth that depression is "normal" to the aging process.
- Examples of institutional stigma toward older adults include their loss of driving privileges and inequitable funding allocations for older adult mental healthcare.
- As a result, society demonstrates this is in public ignorance of the issue, fewer health professionals specializing in older adult mental health, systematic marginalization of older adults with mental illnesses, and the absence of a national health policy on mental illnesses in older adults.[40]

f. Involuntary Treatment

- "Protection and Advocacy reported in 2003 that California follows the national trend: despite extensive federal reforms, 22 deaths occurred between 1999 and 2003 to people who were in seclusion and restraints." [41]
- A longitudinal study of 76 individuals court-ordered to outpatient treatment and a control group of 108 who were not were examined to test two competing perspectives on the role of stigma in coercive treatment. The first holds that stigma results from untreated mental illness symptoms. As such, providing access to treatment (even if coercive) will improve a person's symptoms, quality of life, and social acceptance. The second holds that stigma is worsened when a person is coercively treated because it removes them from the mainstream, decreases their self-esteem, and interferes with their recovery. Researchers concluded that both perspectives are needed. Participants ordered to outpatient treatment were no more likely to perceive they were being coerced, nor did they perceive more devaluation/discrimination. However, those with longer histories of involuntary treatment did feel more coerced. Being ordered to outpatient treatment was associated with improvements in social functioning and quality of life. The study did not find evidence that the presence or absence of psychotic symptoms determined stigma, quality of life, or perceptions of coercion. Finally, perceived coercion was associated with increased devaluation-discrimination and decreased quality of life.[42]

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[40] Center for Mental Health Services, Substance Abuse and Mental Health Services Administration (2005). *Mentally Health Aging: A Report on Overcoming Stigma for Older Americans*. DHHS Pub. No. (SMA) 05-3988. Rockville, MD.

[41] Corrigan, P.W., Watson, A.C. (2007). How children stigmatize people with mental illness. *International Journal of Social Psychiatry*, 53(6), 526-46.

[42] Link, B., Castille, D.M., Stuber, J. (2008). Stigma and coercion in the context of outpatient treatment for people with mental illnesses. *Social Science and Medicine*, In press, doi:10.1016/j.socscimed.2008.03.015.

g. Ethnic Groups

- "The lack of appropriate language services is one of the major barriers to accessing the mental health system…Federal and state laws, including the Civil Rights Act of 1964, grant rights to equal access to services and require that language services be provided free of charge. But despite these protections, discrimination in access because of language barriers continues to be a significant roadblock to treatment in the mental health system."[43]
- "While underserved in the voluntary community system of mental health care, minority groups, particularly African-Americans and Native Americans, are overrepresented in coercive services involving involuntary inpatient hospitalization. In particular, African-Americans are disproportionately diagnosed with schizophrenia in many cases where a correct diagnosis is depression or bipolar disorder, resulting in incorrect treatment. Physicians are also less likely to prescribe the newer generation antidepressant or antipsychotic medications to African-Americans who need them…People of color receive higher doses of high side-effect medications, are subject to more involuntary medications, and are subjected to restraints at higher rates than whites. Longstanding federal anti-discrimination laws prohibit this treatment, but they have rarely been used to challenge practices in the mental health system." [44]
- A study of community college students found that, at baseline, African Americans and Asians perceived people with mental illness as more dangerous and wanted more segregation than Caucasians, and Latinos perceived people with mental illness as less dangerous and wanted less segregation than Caucasians. Similar patterns emerged post-intervention, except that Asians' perceptions changed significantly such that they tended to perceive people with mental illness as least dangerous of all the racial/ethnic groups. These findings suggest that racial/ethnic background may help to shape mental illness stigma, and that targeting anti-stigma interventions to racial/ethnic background of participants may be helpful.[45]
- The study utilized data generated from 30 individuals across 6 focus groups of Latino outpatients receiving antidepressants. Perceptions of stigma were related to both the diagnosis of depression and use of antidepressant medication. Antidepressant use was seen as implying more severe illness, weakness or failure to cope with problems, and being under the effects of a drug.[46]
- Ethnic and racial differences in the stigma associated with mental illness in the general population were examined among a sample of 1,468 individuals. The study found that Asian and Hispanic respondents perceived people with mental illness as significantly more dangerous than did white respondents. Increased contact with mentally ill people was associated with lower levels of perceived dangerousness among white respondents, but not among black respondents.[47]
- In a study of 8,090 persons ages 15 to 54 on attitudes toward seeking mental health services, African Americans reported more positive attitudes toward seeking professional help for

[43] Mildred, L. (2007). Eliminating the stigma and discrimination against persons with mental health disabilities: A project of the Mental Health Services Act.

[44] Mildred, L. (2007). Eliminating the stigma and discrimination against persons with mental health disabilities: A project of the Mental Health Services Act.

[45] Rao D., Feinglass J., Corrigan P. (2007). Racial and ethnic disparities in mental illness stigma, *Journal of Nervous and Mental Disease*,195(12), 1020-3.

[46] Interian A., Martinez I.E., Guarnaccia P.J., Vega W.A., Escobar J.I. (2007). A qualitative analysis of the perception of stigma among Latinos receiving antidepressants. *Psychiatric Services*, 58(12), 1591-4.

[47] Whaley, A. (1997). Ethnic and racial differences in perceptions of dangerousness of persons with mental illness. *Psychiatric Services*, 48, 1328-1330.

emotional problems and talking about personal problems with a professional than their white counterparts. Additionally, African Americans reported less embarrassment if friends knew they were getting professional help than whites.[48]

- In a discussion of the literature about mental health service utilization among low-income African American adolescents, the author concludes that "African American parents are more likely than white parents to expect providers to lack knowledge of treatment methods for working with their children, find providers untrustworthy and disrespectful, expect providers to give poor care, and lack appropriate knowledge with regards to what mental health professionals do and how interventions help."[49]
- A study of 1,444 respondents to the 1996 General Social Survey compared beliefs about mental illness among African Americans and whites, and found that African Americans are more likely than whites to reject the idea that mental illnesses are caused by either genetics or an unhealthy family upbringing. The authors suggest that this may be due to genetic- and family-based explanations that have historically been used to justify African Americans' disadvantaged positions in society. The study also found that African American respondents with lower education levels were more likely to agree that mental illness can result from "bad character." In a review of literature on African Americans' beliefs about mental illness, the authors also conclude that African Americans may be more likely than whites to: believe that mental illness is the result of God's will, turn to prayer more often or consult religious leaders for help with personal or psychological problems, emphasize the importance of prayer and willpower in overcoming psychiatric problems, and perceive their race as being "strong people who can cope with life problems."[50]
- Focus groups with 65 Mexican American students in San Antonio, Texas found that teens identify social withdrawal as an early symptom of depression, as well as feelings of shame, hiding, and a lack of desire to seek help. Shame or fear associated with depression were particularly mentioned by the male teens (e.g., "People think that guys, that if they talk about it, they think that other people might think they're gay."). Many students identified shame as one of the reasons they would rather self-treat depression with drugs or music and avoid disclosing their problem to anyone. The teens reported they are more likely to talk to each other about depression than a parent, school professional or mental health professional.[51]
- There is great stigma and shame about mental health problems and receiving treatment among Asian Americans.[52] For example, Chinese society tends to believe that mental illness can affect a family's good name over generations and can cause the entire family to be shamed and lose face.[53,54] Persons who seek professional help for mental health problems can be seen as immature, weak, or lacking self-discipline. Families may discourage individuals from getting professional help because they may believe the problem is

[48] Diala, C.C., Muntaner, C., Walrath, C., Nickerson, K., LaVeist, T., Leaf, P. (2001). Racial/ethnic differences in attitudes toward seeking professional mental health services. *American Journal of Public Health*, 91(5), 805-7.

[49] Copeland, V.C., (2006). Disparities in mental health service utilization among low-income African American adolescents: Closing the gap by enhancing practitioner's competence. *Child and Adolescent Social Work Journal*, 23(4), p. 421.

[50] Schnittker, J., Freese, J., Powell, B. (2000). Nature, nurture, neither, nor: Black-white differences in beliefs about the causes and appropriate treatment of mental illness. *Social Forces*, 78(3), 1101-30.

[51] Fornos, L.B., Seguin Mika, V., Bayles, B., Seranno, A.C., Jimenez, R.L., Villareal, R. (2005). A qualitative study of Mexican American adolescents and depression. *Journal of School Health*, 75(5), 162-170.

[52] Surgeon General (2001). *Mental health: Culture, race, ethnicity.* Supplement to Mental Health: A report of the Surgeon General. Washington, D.C.: Government Printing Office.

[53] Tabora, B., Flaskerud, J.H. (1994). Depression among Chinese Americans: a review of the literature. *Issues in Mental Health Nursing*, 15, 569-84.

[54] Tabora, B., Flaskerud, J.H. (1997). Mental health beliefs, practices, and knowledge of Chinese American immigrant women. *Issues in Mental Health Nursing*, 18, 173-89.

punishment from God/spirits due to the family's bad behavior, that seeking help could reveal to others that the family has hereditary problems, or that it suggests bad parenting. [55]

- Asian Americans are much less likely than whites and other minority groups to seek treatment for mental health problems, and when they do, they stop their treatment at greater rates than whites.[56,57,58]
- An internet survey on stigma beliefs with depression was completed by 38,656 individuals, ages 16 and older, to compare the beliefs of Asian Americans and whites. Asian Americans had greater stigma beliefs than whites for mental disorders relating to friends, employer, and family. Family stigma was found to be predominantly present among Asian Americans, with only 29% having no concerns about family stigma. An age difference was found in that Asian Americans under age 16 have greater stigma related to family; the authors suggest this is due to their awareness of parents' and other family members' traditional beliefs about mental illnesses. Asian Americans under age 16 are less concerned with stigma from friends and employers; the authors suggest this may be because younger Asian Americans are more acculturated.[59]
- ★ Latinos in the U.S. often face critical disparities in overall health, and mental health in particular. Often, Latinos interact with the health care system only when they are ill and in their most vulnerable state. These disparities include lack of health insurance, limited English proficiency and low-quality care. Latino immigrants face additional stressors related to their immigration status and/or acculturation process, as well as isolation in the absence of family support. In terms of unique experiences of mental illness, Latinos tend to experience depression in the form of body aches and pains, despite medical treatment, or describe depression as feeling nervous or tired. While Latinos are greatly underserved for mental healthcare needs, they are more likely to seek treatment in non-mental health settings such as health care or faith-based. Additional barriers to mental health care is a lack of knowledge of where to seek treatment, lack of proximity to services, transportation problems, and a serious dearth of Spanish-speaking and culturally competent personnel in treatment settings and hotlines. Suicide is also a major risk for Latinos, compared to others in the U.S.[60]
- ★ This paper explicates the stigma of mental illness as it is experience by four ethnic minority groups in the United States. Concerns about prejudice and discrimination among individuals who suffer burdens related to mental illness are delineated. It is proposed that ethnic minority groups, who already confront prejudice and discrimination because of their group affiliation, suffer double stigma when faced with the burdens of mental illness. The potency of the stigma of the burdens of mental illness is one reason why some ethnic minority group members who would benefit from mental health services elect not to seek or adequately participate in treatment. The combination of stigma and membership in an ethnic minority group can impede treatment and well-being, creating preventable and treatable mortalities and morbidities. Psychiatric services are more often sough by Caucasians than

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[55] Uba, L. (1994). *Asian Americans: personality patterns, identity, and mental health.* New York: Guilford Press.

[56] Leong, F.T., Lau, A.S. (2001). Barriers to providing effective mental health services to Asian Americans. *Mental Health Services Research*, 3, 201-14.

[57] Surgeon General (1999). *Mental Health: A report of the Surgeon General*. Washington, D.C., Government Printing Office.

[58] Zhang, A.Y., Snowden, L.R., Sue, S. (1998). Differences between Asian and white Americans' help seeking and utilization patterns in the Los Angeles area. *Journal of Community Psychology*, 26, 317-26.

[59] Fogel, J., Ford, D. (2005). Stigma beliefs of Asian Americans with depression in an Internet sample. *Canadian Journal of Psychiatry*, 50(8), 470-8.

[60] National Council of La Raza, Institute for Hispanic Health (2005). *Critical Disparities in Latino Mental Health: Transforming Research into Action.*

by African American, American Indian and Alaska Native, Asian American, and Hispanic American groups (Byrd & Clayton, 2001; Jones, 2003; Smedley et al., 2003; Smedley & Smedly, 2005; U.S. Department of Health and Human Services, 1999). Nurse researches and practitioners must provide health literacy information for the public and for individuals and families who endure the burden of mental illness. Health policymakers must support research that informs health professionals about the social determinants of health, including mortality and morbidity. Research should move beyond the current "racial and ethnic" categories that are typically used in research, and begin to focus more on local groupings/variable for the purpose of better understanding health beliefs and behaviors.[61]

- While instruments are now available to quantify the scope and impact of stigma experienced by people with a mental illness, "much remains to be done to validate their use in different cultural settings and to ensure they are sensitive to change."[62]
- This paper explores the role of racial bias toward Blacks in interracial relationships, and in racial disparities in health care in the United States. In a national survey, 57% of Blacks said that discrimination occurs "often" or "very often" in Blacks' interactions with White physicians (Malat & Hamilton, 2006). One notable example of experimental research on treatment disparities is a study by Schulman et al. (199). Primary care physicians at a national conference viewed video tapes of actors playing the role of patients complaining about chest pain. The gender and ethnicity of the patients (Black or White) were systematically manipulated. Of interest to racial interaction, Schulman et al. (1999) found that Blacks were significantly less likely to be referred for further testing than were Whites. Although the validity of this experimental study has been questioned (e.g., Arber et al., 2006), the results are quite consistent with findings from archival studies of differences in the treatment of Black and White cardiology patients (see, for example, Vaccarino et al., 2005). LaVeist, Nuru-Jeter, and Jones (2003) reported that Black patients were more likely to schedule appointments with their physicians and were less likely to postpone or delay these appointments when they had a Black physician rather than a White physician, even after controlling for health status. Because of the nature and complexity of contemporary racism, traditional techniques for eliminating racial bias are ineffective for combating subtle bias. Aversive racists already recognize prejudice as detrimental, but do not recognize that they are prejudiced.[63]
- A sample of 101 American Indians (age 15-21 years) who had thought about or attempted suicide were asked open-ended questions about barriers to seeking formal and informal help while suicidal. The 74 participants who avoided at least one type of help most commonly reported internal factors, such as embarrassment, lack of problem recognition, a belief that nobody could help, and self-reliance. Structural barriers, such as lack of money or service availability, were only rarely cited. Findings indicate that efforts to increase help seeking among young, suicidal American Indians should target beliefs about emotional problems and help seeking. Research indicates that 14% to 30% of American Indian adolescents, particularly high school students, attempt suicide (Blum, Harmon, Harris, Bergeisen, & Resnick, 1992; Borowsky, Resnick, Ireland & Blum, 1999; Freedenthal & Stiffman, 2004; Grossman, Milligan, & Deyo, 1991; Howard-Pitney, LaFromboise, Basil, September, & Johnson, 1992), compared to 4 to 10% of adolescents in the general population (Resnick et

[61] Gary, F. (2005). Stigma: Barrier to Mental Health Care Among Ethnic Minorities. *Issues in Mental Health Nursing*. (26), 979-999.

[62] Stuart, H. (2008). Fighting the stigma caused by mental disorders: past perspectives, present activities, and future directions. *World Psychiatry*, 7, p. 187.

[63] Dovidio, J., Penner, L., Albrecht, T., Norton, A., Gaertner, S., Shelton, J., (2008). Disparities and distrust: The implications of psychological processes for understanding racial disparities in health and health care. *Social Science & Medicine*. (67), 478-486.

al., 1997; Substance Abuse and Mental Health Services Administration, 2002). A Denver survey of 374 American Indians age 17 to 54 years at various social service agencies found that an inability to locate or pay for services was a key impediment to seeking professional help for mental health problems (King, 1999). Almost one third of participants who avoided at least one type of help gave reasons related to stigma, embarrassment, and fears of others' knowing. About one in five participants who avoided at least one type of help said they had believed that nobody could or would help them, whether because of potential helpers' incompetence, disinterest, or inability to understand. About 12% of participants who avoided at least one type of help said they did not seek any help because they feared the potential consequences, aside from stigma and embarrassment, of disclosing their suicidal thoughts or suicide attempt. Most commonly, in four of the nine cases where fear was a factor, participants' fears concerned being involuntarily committed to a psychiatric hospital.[64]

- The analysis in this study is based on a nationally representative sample of 583 Caucasian and 82 African American participants in a vignette experiment about people living with mental illness. While African Americans were more likely than Caucasians to believe that mental health professionals could help individuals with schizophrenia and major depression, they were also more likely to believe mental health problems would improve on their own. Two recent nationally representative studies (Diala et al. 2001; and Schnittker et al. 2005) show that African Americans in the general public reported more positive attitudes than Caucasians about whether they would feel comfortable seeking mental health care. Schnittker et al. (2000) found that whereas African Americans were more likely than Caucasians to believe that mental illness is a result of "bad character," they were less likely to endorse genetic and other biological explanations. Even though studies consistently demonstrate that African American underutilize voluntary mental health services (e.g., Want et al. 2005), this study's findings strongly suggest that this under-utilization is not driven by skepticism about the effectiveness of treatment. For Caucasians, the belief about the effectiveness of professional mental health care is partially contingent upon beliefs that the said illness is serious an unlikely to improve without treatment. On the other hand, African Americans' strong endorsement of professional services is seemingly not influenced by their notions of mental illness severity and natural course. Research suggests that African American are more likely to seek extended family networks and spiritual help when faced with emotional problems (Blank et al. 2002). If the goal is to improve service utilization for African Americans, the results of this research suggest the focus of outreach efforts should be on educating communities about the course of mental illness and its potentially chronic nature.[65]

h. Violence

- Authors find that rates of victimization for individuals with severe psychiatric disorders are shown to be high and far greater than those for the general population, despite the heterogeneity of studies in terms of sample characteristics, measures, methods and analyses. Certain types of factors - clinical, treatment, contextual - raise the probability of becoming a

[64] Freedenthal, S., Stiffman, A. (2007). They Might Think I Was Crazy": Young American Indian's Reason for Not Seeking Help When Suicidal. *Journal of Adolescent Research*. 22(1), 58-77.

[65] Anglin, D., Alberti, P., Link, B., Phelan, J. (2008). Racial Differences in Beliefs About the Effectiveness and Necessity of Mental Health Treatment. *American Journal of Community Psychology*. (42), 17-24.

victim, as does the fact of having already been the author or the victim of a misdemeanor or crime.[66]

i. Sexual Orientation

- "For most of the history of this country, homosexuals have been… forced into treatment, been hospitalized against their will…"[67]

j. Mental Health Staff

- A study of 120 registered or assistant nurses in Sweden found that somatic care, to a higher degree than nursing staff in mental health, reported more negative attitudes with regard to people with schizophrenia as being more dangerous and unpredictable. In contrast, professional experience, intimacy with mental illness and type of care organization were found to be more associated with attitudes to specific mental illnesses concerning the prospect of improvement with treatment and the prospect of recovery.[68]
- Responses from 122 nurses indicated that psychiatric nursing is the least preferred specialty of 10 areas and psychiatric nurses were least likely to be described as skilled, logical, dynamic, and respected. The findings suggest that psychiatric nursing may be stigmatized by association.[69]
- A comparison of two representative Swiss samples, one comprising of 90 psychiatrists, the other including 786 individuals of the general population, found that psychiatrists' attitudes were significantly more positive than that of the general population. The statement that mental health facilities devalue a residential area has revealed most agreement. Psychiatrists and the public do not differ in their social distance to mentally ill people. Among both samples, the level of social distance increases the more the situation described implies "social closeness". The authors conclude that using psychiatrists as role models or opinion leaders in anti-stigma campaigns cannot be realized without accompanying actions. Psychiatrists must be aware that their attitudes do not differ from the general public and, thus, they should improve their knowledge about stigma and discrimination towards people with mental illnesses.[70]
- A survey of 1,073 mental health professionals and 1,737 members of the public found that psychiatrists had more negative stereotypes than the general population, but accepted restrictions toward people with mental illness 3 times less often than the public. Most professionals were able to recognize cases of schizophrenia and depression, but 1 in 4 psychiatrists and psychologists also considered the non-case as mentally ill. The study concludes that the better knowledge of mental health professionals and their support of

[66] Lovell A.M., Cook J., Velpry L. (2008). Violence towards people with severe mental disorders: A review of the literature and of related concepts. *Revue d'épidémiologie et de santé publique*, 56(3), 197-207.
[67] Platt, T. (2000). Religion, sexuality and social work. Unpublished paper.
[68] Björkman T., Angelman T., Jönsson M. (2008). Attitudes towards people with mental illness: a cross-sectional study among nursing staff in psychiatric and somatic care. *Scandinavian Journal of Caring Sciences*, 22(2), 170-7.
[69] Halter M.J. (2008). Perceived characteristics of psychiatric nurses: stigma by association. *Archives of Psychiatric Nursing*, 22(1), 20-6.
[70] Lauber C., Anthony M., Ajdacic-Gross V., Rössler W. (2004). What about psychiatrists' attitude to mentally ill people? *European Psychiatry*, 19(7), 423-7.

individual rights neither entail fewer stereotypes nor enhance the willingness to closely interact with mentally ill people.[71]

- A study of mental health professionals' attitudes toward community integration of people with serious and persistent mental illness found that mental health staff at outpatient psychiatric clinics hold more exclusionary attitudes than staff in agencies providing residential services or advocating on behalf of people with severe and persistent mental illnesses.[72]

k. Rural vs. Urban

- In a study of 200 people from metropolitan and adjacent non-metropolitan counties in Arkansas found that rural residents with a history of depressive symptoms labeled people who sought professional help for depression somewhat more negatively. The more negative the labeling of a vignette about depression, the less likely depressed rural residents were to have sought professional help. The authors conclude that it is the labeling associated with seeking treatment – not the disorder itself – that predicts whether rural people with depression have sought professional help. As such, the public image of people who seek treatment for depressive symptoms needs to be a focus.[73]

l. Workplace

- Analysis of the 1994-95 National Health Interview Survey-Disability Supplement found that workers' self-reports of stigmatizing experiences in the labor market appear to be consistent with econometric measures on the effect of stigma on wages, suggesting that workers know when they are being discriminating against.[74]
- Compared with persons with different types of general medical disorders, those with mental disorders have the strongest stigma rankings, lowest employability rankings, and largest productivity-adjusted wage differentials.[75]
- Among the 117 businesses interviewed, 68% make an effort to hire minorities, 41% make an effort to hire people with general medical disorders, but only 33% made an effort to hire persons with mental disorders.[76]
- A 1995 survey of US employers showed that half would rarely employ someone with a psychiatric disability and almost a quarter would dismiss someone who had not disclosed a mental illness.[77]

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[71] Nordt C, Rössler W, Lauber C. (2006). Attitudes of mental health professionals toward people with schizophrenia and major depression. *Schizophrenia Bulletin*, 32(4), 709-14.

[72] Modovan, V. (2007). Attitudes of mental health workers toward community integration of the persons with serious and persistent mental illness. *American Journal of Psychiatric Rehabilitation*, 10(1), 19-30.

[73] Rost, K., Smith, G.R., Taylor, J.L. (1993). Rural-urban differences in stigma and the use of care for depressive disorders. *Journal of Rural Health*, 9(1), 57-62.

[74] Baldwin, M., Marcus, S.C. (2006). Perceived and measures stigma among workers with serious mental illness. *Psychiatric Services*, 57(3), 388-392.

[75] Baldwin, M.L., Johnson, W.G. (2004). Labor market discrimination against men with disabilities. *Journal of Human Resources*, 29, 1-19.

[76] Sheid, T.L. (2000). Compliance with the ADA and employment of those with mental disabilities in Employment, Disability, and the Americans with Disabilities Act: Issues in Law, Public Policy, and Research. Edited by Blanck PD, Northwestern University Press.

[77] Manning, C., White, P.D. (1995). Attitudes of employers to the mentally ill. *Psychiatry Bulletin*, 19, 541-543.

- One in three mental health consumers in the US report being turned down for a job once their psychiatric status became known, and in some cases, job offers were rescinded when a psychiatric history was revealed.[78,79]
- Employers are less likely to hire people with mental disorders into executive positions.[80]
- Mental disorders are the second most common basis for charges of discrimination and workplace harassment under the ADA.[81] Of the 263 disability cases brought to trial in 2004, only 2% favored the employee. Of the 54 cases that were brought by people with mental disabilities, 76% favored the employer, 24% were unresolved, and none favored the employee.[82]
- Human resource officers in UK companies were provided vignettes of job applicants that were identical, except for their diagnoses. A label of depression significantly reduced the chances of employment, based on perceptions of poor work performance, but not based upon expectations of future absenteeism.[83]

m. Primary Care Physicians

- 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.[84]
- A paper discusses factors associated with low rates of help-seeking and poorer quality of physical healthcare among people with mental illnesses. Evidence is reviewed on the associations between low rates of mental health literacy, negative attitudes towards people with mental illness, and reluctance to seek help by people who consider that they may have a mental disorder. People with mental illness often report encountering negative attitudes among mental health staff about their prognosis, associated in part with 'physician bias'. 'Diagnostic overshadowing' appears to be common in general health care settings, meaning the misattribution of physical illness signs and symptoms to concurrent mental disorders, leading to underdiagnosis and mistreatment of the physical conditions.

  Service users often rate mental health staff as one of the groups which most stigmatizes mentally ill people (Pinfold, Thornicroft, Huxley, & Farmer, 2005). Studies from several countries have consistently found that even after a family member has developed clear-cut signs of a psychotic disorder, on average it is over a year until the unwell person first receives assessment and treatment (Black et al., 2001, Compton, Kaslow, & Walker, 2004;

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[78] Wahl, O.F. (1999). Mental health consumers' experiences of stigma. *Schizophrenia Bulletin*, 25, 567-478.
[79] Walh, O.F. (1999). Telling is risky business. Piscataway, NJ: Rutgers University Press.
[80] Nicholas, G. (1998). Workplace effects on the stigmatization of depression. *Journal of Occupational Environment Medicine*, 40, 793-800.
[81] Scheid, T.L. (1999). Employment of individuals with mental disabilities: business response to the ADA's challenge. *Behavioral Science and Law*, 17, 73-91.
[82] Allbright, A.L. (2004). Employment decisions under the ADA Title I – survey update. *Mental and Physical Disability Law Report*, 29, 513-516.
[83] Glozier, N. (1998). Workplace effects of the stigmatization of depression. *Journal of Occupational Environment Medicine*, 40(9), 793-800.
[84] Dixon, R.P, Roberts, L.M., Lawrie, S., Jones, L.A., Humphreys, M.S. (2008). Medical students' attitudes to psychiatric illness in primary care. *Medical Education*, 42(11), 1080-1087.

Johannessen et al., 2001). People who wait longer than average before receiving care are more likely to be young, old, male, poorly educated, or a member of a racial/ethnic minority (Wang et al., 2005a). Only about a third (41%) of people who had experienced mental illness in the previous year had received any treatment: 12% from a psychiatrist, 16% from a non-psychiatric mental health specialist, 23% treated by a general medical practitioner, 8% from a social services professional, and 7% from a complementary or alternative medical provider. Black people with a mental illness are more likely to seek help if their families are supportive, and if a family member has had a positive personal experience of mental health care.

For several decades it has been recognized that having been admitted to a psychiatric hospital can have an adverse effect on a person's reputation (Foffman, 1963; Goffman 1968; Gove & Fain, 1973). It is widely believed that psychiatrists use diagnostic labels in a cavalier way (Sartorius, 2002). Similarly it is often believed that psychiatrists tend to use medications rather than psychological treatments, and that these drugs have unpleasant or even dangerous side-effects (National Institute for Clinical Excellence (NICE), 2004).

Medical students had clear preferences for particular categories of patients, and were less sympathetic toward those whom they believed to be undeserving of treatment because they were responsible for their condition, for example people with eating disorders (Fleming & Szmukler, 1992; Wiese, Wilson, Jones, & Neises, 1992).

The parts of the general health system that seems to be most despised by many people with mental illness are the casualty (emergency room, accident and emergency) departments (Mazeh, Melamed, & Barak, 2003). The first issues it that people who attend after harming themselves very often feel deliberately punished by staff. The second theme that emerges about casualty departments is that people going there for help report that they yare not treated with respect.

The single biggest factor which leads to stopping contact with mental health services, according to a Danish study, is dissatisfaction with the care received (Tehrani, Krussel, Borg, & Munk-Jorgensen, 1995). Dropout rates are higher for people who believe that psychiatric treatments are rarely effective, who are embarrassed to be seen by a mental health professional, or who are prescribed with medication without any psychological treatment (Edlund et al., 2002).[85]

n. General Public

- The 1996 General Social Survey, administered to 1,444 adults in the United States, found that more than half are unwilling to spend an evening socializing with, work next to, or have a family member marry a person with mental illness.[86] In addition, the survey found that, despite the fact that recent studies have been unable to demonstrate the effectiveness of

[85] Thornicroft, G., Rose, D., Kassam, A. (2007). Discrimination in health care against people with mental illness. *International Review of Psychiatry*. 19(2), 113-122.

[86] Martin, J.K., Pescosolido, B.A., Tuch, S.A. (2000). Of fear and loathing: the role of 'disturbing behavior', labels, and causal attributions in shaping public attitudes toward people with mental illness. *Journal of Pers Soc Psychol*, 13, 289-299.

mandatory treatment, more than 40% of respondents agreed that people with schizophrenia should be forced into treatment.[87]

V. Strategies to Address the Problem of Stigma and Discrimination

a. General

- In 1997, the New Zealand Mental Health Commission compared how discrimination had been tackled in other areas (physical disability, color, age, size, sexual preference) and concluded six lessons learned that would be useful to reducing discrimination against people with mental illness. Specifically, they suggest that people with mental illness:
    - Need an enforceable and accessible legal framework to support people's rights to be in place;
    - Have to be able to assert their rights easily;
    - Must be involved in decision-making about policy and practices which affect them; and
    - Need to be more visible and society has to have positive experiences of this.

  Additionally, agencies have to spell out what they are going to do to make sure people with mental illness are treated fairly, and then do it. Last, positive discrimination and political activism might be necessary.[88]
- A briefing paper commissioned by the World Health Organization suggests that any tactic to tackle discrimination, stigma and social exclusion needs to "acknowledge how the big the power differences are between people with mental health problems and those who discriminate against them. Reducing discrimination must aim to reduce these imbalances in social, economic and political power between people with mental health problems and other citizens."[89] Additionally, while we know research is limited in this area, efforts can be enhanced when "tactics are used together and strengthen one another and are further combined with or embedded within wider work on social inclusion, equality and human rights."[90]
- 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.[91]
- A study in which a random sample among 163 individuals viewed a documentary about schizophrenia were found to make more benign attributions about schizophrenia (e.g., less likely to blame individuals with schizophrenia for the disorder), but did not change general

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[87] Pescosolido, B., Monahan., J., Link B. et al. (1999). The public's view of the competence, dangerousness, and need for legal coercion of persons with mental health problems. *American Journal of Public Health*, 89, 1339-45.

[88] Mental Health Commission of New Zealand (1998). *A travel guide for people on the journeys towards equality, respect, and rights for people who experience mental illness.* Retrieved January 12, 2007, from http://www.mhc.govt.nz/publications/1998/Travel-Guide.html.

[89] Health Scotland, World Health Organization Collaborating Centre (2008). *Stigma: An International Briefing Paper*, p. 11.

[90] Ibid, p. 20.

[91] Finkelstein J., Lapshin O., Wasserman E. (2008). Randomized study of different anti-stigma media. *Patient Education and Counseling*, 71(2), 204-14.

attitudes about schizophrenia (e.g., perceived dangerousness) or increase participants' intentions to interact with persons with schizophrenia.[92]

- In a five-year follow-up study of the "Changing Minds" campaign in England, researchers found (small) reductions in the percentages of stigmatizing opinions about mental illness, with the greatest proportion of negative opinions in the 16-19 year-old age group. Respondents with higher educations were less likely than others to express negative views.[93]
- An evaluation of a "Mental Health Awareness in Action" program in England, including educational interventions, found that personal contact was predictive of positive changes in knowledge and attitudes for school students, but not police officers or community adults. The key active ingredient was the testimonies of service users about their experience of mental health problems and contact with a range of services.[94]
- An evaluation of "Beyondblue," a national depression initiative in Australia, during 2000-2004 found that there is insufficient evidence to directly ascertain whether, during the life of the initiative, there has been a decrease in the levels of stigma and discrimination experienced by people with depression.[95]
- A review of prior research concluded that contact with people with mental illness who do not fit the feared stereotype are often viewed as the exception to the stereotype. The author argues that the "solution to stigma will come from more effective treatments of mental illnesses, rather than voluntary or cajoled benevolence."[96]
- In a study of 165 participants, it was found that participants who watched an accurate and empathetic movie portrayal of schizophrenia had increased knowledge, but those who also watched an educational trailer had increased knowledge and decreased stigma.[97]
- 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.[98]
- Research suggests that stigma may be reduced by three approaches: protest, education, and contact. The authors describe 3 programs that adapt these approaches for mass audiences (StigmaBusters: protest, Elimination of Barriers Initiative: education/social marketing, In Our Own Voice: contact), for which preliminary research offers initial support for the feasibility and impact of these programs.[99]
- <u>A study of 244 participants to measure the impact of videotaped education and contact on the stigma of mental illness found that the education videotape had limited effects, but</u>

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[92] Penn, D.L. et al. (2003). The effects of a documentary film about schizophrenia on psychiatric stigma. *Schizophrenia Bulletin*, 29:2, 383-91.

[93] Crisp, A., Gelder, M., Goddard, E., Meltzer, H. (2005). Stigmatization of people with mental illnesses: a follow-up study within the Changing Minds campaign of the Royal College of Psychiatrists. *World Psychiatry*, 4(2), 106-113.

[94] Pinfold, V., Thornicroft, G., Huxley, P., Farmer, P. (2005). Active ingredients in anti-stigma programmes in mental health. *International Review of Psychiatry*, 17(2), 123-131.

[95] Pirkis, J. (2004). *An independent evaluation report of beyondblue: the national depression initiative.* University of Melbourne School of Population Health.

[96] Davidson, M. (2002). What else can we do to combat stigma? *World Psychiatry*, 1(1), 22-23.

[97] Ritterfield, U., Seung-A, J. (2006). Addressing media stigma for people experiencing mental illness using an entertainment-education strategy. *Journal of Health Psychology*, 11(2), 247-267.

[98] Twardzicki, M. (2008). Challenging stigma around mental illness and promoting social inclusion using the performing arts. *Journal of the Royal Society of Health*, 128(2), 68-72.

[99] Corrigan, P., Gelb, B. (2006). Three programs that use mass approaches to challenge the stigma of mental illness. *Psychiatric Services*, 57(3), 393-398.

watching the contact videotape showed significant improvements in the stigma attitudes of pity, empowerment, coercion, and segregation at post-test and at one-week follow-up.[100]

- The World Psychiatric Association has conducted a program against the stigma associated with schizophrenia in nineteen countries since 1996. At the ten-year mark of the program, the following lessons have been learned through experience and research:
    - The program has to be long lasting and not a campaign. Changing profoundly imbedded attitudes, social systems, and laws cannot be changed overnight.
    - The program must retain the loyalty of those who work on it, helped largely by stating the overarching goals broadly with specific plans for immediate, local applications that can be modest in size and have a good chance of success.
    - The program must deal with the daily problems experienced by people who have the illness and their family.
    - The program should involve other partners and not be an affair of the mental health service system alone.
    - The program should employ consumers and their families in the day-to-day functions of the program.
    - It was critical to develop a model of stigma and discrimination change that can be easily understood and applied in the planning and evaluation processes.
    - Include components to prevent fatigue and burnout of the long-term program.
    - Utilize modern technology, but also organize face-to-face encounters among participants of the program.
    - Provide tools to help newcomers to the program and to facilitate the decisions of those who might be hesitant to participate.
    - Evaluation must be done in relation to improvements in areas that are identified by consumers and family members, as well as by measuring changes in behavior and situations – not simply changes in attitudes or knowledge.
    - These programs can be launched in any country and is richly rewarding for those involved.[101]
- The National Institute for Mental Health in England conducted a review of studies on mental health anti-stigma and discrimination activities, concluding that effective approaches:
    - Involve users and carers throughout the design, delivery, monitoring and evaluation process;
    - Support local activities combining a variety of methods and settings;
    - Address behavior change by developing an environment of intolerance to prejudice and ensure sustainability through policy and legislation;
    - Use clear consistent messages in targeted ways to specific audiences;
    - Ensure sustainability through long term planning and funding; and
    - Appropriately monitor and evaluate the programs.[102]
- An expert consensus panel selected 36 exemplary programs from among 102 nominations. A descriptive analysis and summary of the shared qualities of exemplary programs are provided. One inescapable conclusion form this descriptive analysis is that no single message or approach to reducing discrimination and stigma will have the desired impact or be acceptable to all constituents. The principles that were of particular importance to the panel were inclusion; empowerment; human and civil rights; recovery; choice; self-

[100] Corrigan, P.W., Larson, J., Sells, M., Niessen, N., Watson, A.C. (2007). Will filmed presentations of education and contact diminish mental illness stigma? *Community Mental Health Journal*, 43(2), 171-81.

[101] Sartorious, N. (2006). Lessons from a 10-year global programme against stigma and discrimination because of an illness. *Psychology, Health & Medicine*, 11(3), 383-388.

[102] National Institute for Mental Health in England (2004). *Scoping review on mental health anti stigma and discrimination: Current activities and what works.*

determination; and respect for different philosophies and perspectives regarding psychiatric disorders, medication, treatment, and related issues. Work on antistigma and antidiscrimination activities should empower, heal, engage, and otherwise contribute to the pride and well-being of the participants. Connections and embeddedness within the community – and coalitions and collaborations with local, State, and national partners – increase impact, contribute vitality and stability, and otherwise enhance exemplary programs. Prevention and wellness are recognized and promoted within outstanding programs. Drama and humor can express what is otherwise inexpressible or difficult to convey. Both quality and quantity of reach, visibility, and impact are of value in exemplary programs. Programs in schools; training and consultation with providers, political decision makers, and researches; and radio and television programs are examples cited by the panel.[103]

- A recent study found that the National Alliance for Mentally Ill *"In Our Own Voice" (IOOV)* presentation significantly decreased stigma for bipolar disorder compared to psychoeducation. Possible mechanisms behind IOOV's effect include positive contact with individuals with mental disorders and greater stigma associated with biomedical models of mental disorders emphasized in the psychoeducation condition. Those in the IOOV condition demonstrated significant positive pre-post changes on three variables: knowledge about mental illness, positive attitudes about individuals with mental illness, and willingness to accept individuals with mental illness.[104]
- One study examined how two types of public education programs influenced how the public perceived persons with mental illness, their potential for violence, and the stigma of mental illness. A questionnaire presented a very short, neutral statement about a man who has been hospitalized for schizophrenia, followed by 27 items that measured participants' responses. Persons in the education-about-violence group consistently demonstrated more negative attitudes and behavioral decisions toward persons with mental illness. Participants who completed programs that educate the public on this association reported that persons with mental illness are more dangerous and should be feared… tended to endorse treatment programs that segregate persons with mental illness form the community and that promote coercive or mandated treatments, and were more likely to withhold help from people with mental illness an avoid them socially.[105]
- An Australian study conducted between 1998 and 2004 in a random and representative population sample examined the changes in mental health literacy and treatment seeking of those with major depression, both with and without suicidal ideation, and those who were neither depressed nor suicidal. Results indicated that there was marked improvement in mental health literacy for all three groups, although there was less change for those most in need of intervention (i.e., those with major depression and suicidal ideation). Furthermore, there were fewer changes in appropriate treatment seeking in those with major depression and suicidal ideation. These findings are consistent with literature reporting limited problem solving and decision making in those who are suicidal, and indicate that there are limits to broad-based community education programs. Since 1998, there have been determined efforts in Australia at government, professional, charity, and industry levels to enhance public knowledge about the ubiquity of mental disorders, particularly depression, and the

[103] Estorff, S., Penn, D., Toporek, J. (2004). From Stigma to Discrimination: An Analysis of Community Efforts To Reduce the Negative Consequences of Having a Psychiatric Disorder and Label. *Schizophrenia Bulleting* 30(3): 493-509.

[104] Rusch L., Kanter, J., Angelone, A., Ridley, R. (2008). The Impact of In Our Own Voice on Stigma. American Journal of Psychiatric Rehabilitation, 11: 373-389.

[105] Corrigan, P., Watson, A., Warpinski, A., Gracia, G. (2004). Implications of Educating the Public on Mental Illness, Violence, and Stigma. *Psychiatric Services*, 55(5), 577-580.

effectiveness and availability of treatment. The common ground in these differing research approaches is that those who are suicidal perceive a limited range of options, with not only a reduced problem-solving ability, but an apparent inability to utilize extra information such as that provided by broad community initiatives to enhance mental health literacy.[106]

- 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.[107]
- Researchers in London interviewed 46 consumers to find out how they perceived stigma. In this group, people with psychosis or dug dependence reported more feelings and experiences of stigma with direct discrimination. People in this group with a personality disorder, depression, or anxiety were more likely to report patronizing attitudes, but less likely to say that they had experienced discrimination. While stigma is sometimes used to describe an attitude or label, the word discrimination refers to a behavior. According to Corrigan (2004), stigma campaigns usually focus on protest, education, and contact. One study that looked at anti-stigma education programs led by consumers found that contact with a person who has a mental health condition is a more effective way to change attitudes than other kinds of anti-stigma education (Corrigan, 2002). Negative (anti-stigma) campaigns may inadvertently be harmful to people with mental illness.[108]
- A report summarizing the approach taken by one mental health organization in England asserts that people will stop discriminating when they acknowledge they too may be personally affected in the future. Strategies to produce improved public mental health literacy, positive attitudes and less discriminatory actions towards people with mental health problems use five main strategies to initiate change: Address structural barriers – campaign for policy changes; Education; Improved treatment options and outcomes; Promote contact; and Service user empowerment. An anti-discrimination education project must consist of: clear aims and objectives and a well defined conceptual approach, clearly defined target audience who are willing to work with you, appropriate methodology for achieving its aims and objectives, and an evaluation strategy to monitor its efforts in an appropriate way. If any one of these components is missing or under-represented, the project will be less effective.[109]
- 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:
    - Participants should include members of different groups who have equal status;

[106] Goldney, R., Fisher, L. (2008). Have Broad-Based Community and Professional Education Programs Influenced Mental Health Literacy and Treatment Seeking of those with Major Depression and Suicidal Ideation? *Suicide and Life-Threatening Behavior*, 38(2), 129-142.

[107] Wood, A., Wahl, O. (2006). Evaluating the Effectiveness of a Consumer-Provided Mental Health Recovery Education Presentation. *Psychiatric Rehabilitation Journal*. 30(1): 46-53.

[108] Garrison, E. (2006). Anti-Stigma Literature Review: Learning from others about what works. Multnomah County Department of County Human Services.

[109] Mental Health Awareness in Action Project. How Can We Make Mental Health Education Work?

- The interaction must afford acquaintance potential (the opportunity for individuals to get to know one another);
- Information exchanged must disconfirm a negative stereotype;
- Participants must pursue mutual goals; and
- Participants must actively cooperate with one another.[110]

b. Messages

- 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.[111] 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.[112]
- Referencing the book, "*Psychiatric patient to citizen*," (Sayce, Liz, 2001), the author describes four models for addressing stigma, discrimination, and/or social exclusion.
    - 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.
    - 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.
    - 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.
    - 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.[113]

[110] Case Consulting, Ltd. (2005). The power of contact: project to counter stigma and discrimination associated with mental illness. New Zealand.
[111] Monteith, M.J., Sherman, J.W., Devine, P.G. (1998). Suppression as a stereotype control strategy. *Personality and Social Psychology Review*, 2, 63-82.
[112] Penn, D.L., Corrigan, P.W. (2002). *Schizophrenia Research*, 55(3), 269-276.
[113] Byrne, P. (2003). Stigma, discrimination or social exclusion? In *Reducing Stigma and Discrimination: What Works?* Conference Report from Rethink/Institute of Psychiatry conference on June 26, 2003 in England, 7.

- 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.[114]
- 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.[115]
- 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."[116]

c. Workplace

- 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.[117]
- 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.[118]

d. Consumers (Personal/Internalized Stigma)

- The author described presentations made by three psychiatry residents at American Psychiatric Association's Institute on Psychiatric Services, which included descriptions of existing anti-stigma programs. The article describes the presenters' recommendations that psychiatry training directors are urged to discuss stigma with their trainees, psychiatrists to ask patients about experiences encountering stigma, and include consumers ("the experts") in anti-stigma efforts.[119]
- Consumer advocates believe that common messages used are ineffective. For example, stating that mental illness is a disease like any other tends to emphasize that treatment

[114] Schnittker, J. (2008). An uncertain revolution: Why the rise of a genetic model of mental illness has not increased tolerance. *Social Science and Medicine*, 67(9), 1370-1381.
[115] Read, J., Haslam, N., Sayce, L., Davies, E. (2006). Prejudice and schizophrenia: a review of the 'mental illness is an illness like any other approach.' *Acta Psychiatrica Scandanavica*, 114(5), 303-318.
[116] Health Scotland, World Health Organization Collaborating Centre (2008), *Stigma: An International Briefing Paper*, p. 20.
[117] Thornicroft, G., Brohan, E., Kassam, A., Lewis-Homes, E. (2008). Reducing stigma and discrimination: Candidate interventions. *International Journal of Mental Health Systems*, 2(3).
[118] Gelb, B., Corrigan, PW. (2008). How managers can lower mental illness costs by reducing stigma. *Business Horizons*, 51(4), 293-300.
[119] Bender, E. (2006). Patient input crucial to defeating stigma. *Psychiatric News*, 41(22), 9.

(medication compliance) is needed, and does not account for the role of environmental conditions or traumatic experiences in mental illness. It does not reflect the negative side effects of medications, nor the dependence on the mental health system that can be fostered. Stating that stigma keeps people from seeking services does not reflect the reality that voluntary, affordable, varied, outpatient services may not be available to every person seeking assistance.[120]

- "Empowerment strategies are effective in reducing self-stigma (protests, parades, economic development projects, belonging to a family self-help group). Empowerment strategies work in reducing self-stigma. Forms of empowerment are protests and parades (anti-psychiatry advocacy or Mad Pride parades, for example), economic development projects that offer employment and income, belonging to a family self-help group, or becoming involved in consumer peer support where, in both cases, people are free to talk openly among themselves away from negative social judgments. Members of these groups exchange coping strategies..."[121]

e. Primary Care

- 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 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.[122]

f. Public Policy & Law

- ★ 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."[123] 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.

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[120] Brody, D. (2007). *Normal people don't want to know us: First hand experiences on stigma and discrimination.* California Network of Mental Health Clients – Bay Area Region.

[121] Everett, B. (2006). Stigma: The Hidden Killer. Mood Disorders Society of Canada.

[122] Altindag A, Yanik M, Ucok A, Alptekin K, Ozkan M. (2006). Effects of an antistigma program on medical students' attitudes towards people with schizophrenia. *Psychiatry Clin Neurosci*., 60(3), 283-8.

[123] California Primary Care Association (CPCA). *CPCA Policy Priorities Related to the Promotion of Integrated Behavioral Health*, p. 1.

- Health centers are not able to adequate fund and provide case management.
- Regulations impose utilization limitations on health centers providing certain services, including psychology services.

g. Age Groups

i. Children

- ★ 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."[124]
- ★ 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.[125]
- ★ 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.[126]
- 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

[124] What Can Students and Youth Do to "Lend a Hand?" *Stop Bulling Now.* www.stopbullyingnow.hrsa.gov
[125] The Scope and Impact of Bullying. *Stop Bulling Now.* www.stopbullyingnow.hrsa.gov
[126] Levesque, P., Schachter, H. (2006). Sticks and Stones: Breaking the stigma of child and youth mental helath difficulties through our schools. *The Provincial Centre of Excellence for Child and Youth Mental Health.*

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 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.[127]

ii. Adolescents & Transition Age Youth

- ★ 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.[128]
- ★ 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.[129]

iii. Older Adults

- ★ A federal report on overcoming stigma for older Americans recommends two central initiatives to combat stigma and discrimination against older adults with mental illnesses:
  - (1) Empower and educate older adults with mental illnesses, especially those who are isolated, and reach those who work with them, who volunteer to help them, and those who provide physical and mental health care for them. This includes:
    - Working with partners already working in this area;
    - Partnering with community-based organizations and faith based organizations that target older adults;
    - Peer counseling, peer support, and mentoring programs;
    - Engaging home health aides, meals-on-wheels volunteers, and health care providers;
    - Including a multicultural approach; and

[127] Pitre, N., Stewart, S., Adams, S., Bedard, T., Landry, S. (2007). The use of puppets with elementary school children in reducing stigmatizing attitues towards mental illness. *Journal of Mental Health*. 16(3), 415-429.

[128] Nebergall, M.L. *Adolescent Mental Health in the United States.*

[129] Spagnolo, A.B., Murphy, A.A., Librera, L. (2008). Reducing stigma by meeting and learning from people with mental illnesses. *Psychiatric Rehabilitation Journal*, 31(3), 186-93.

        - Promoting messages that older adults with mental illnesses can improve and recover.
    - (2) Educate the public on mental health and aging, including the older adults themselves, their spouse, siblings, and children. This includes:
        - Projecting the image of health aging and raising expectations of continued good health in the later years;
        - Targeting the "sandwich generation" of children of older adults who are much more likely to seek or demand services even for themselves; and
        - Dispelling myths that depression and mental illness are "normal" for older adults.[130]

h. Ethnic Groups

- ★ The National Council of La Raza makes recommendations for improving mental health services for Latinos, which include, but are not limited to:
    - Increasing access, especially for vulnerable children, youth, and the elderly, to comprehensive, culturally- and linguistically-relevant mental health care;
    - Training health care providers to detect mental health problems among Latinos, understanding the importance of family-centered treatment and care models, and allowing time to develop trust;
    - Increasing the number of culturally- and linguistically-relevant Spanish-speaking providers at all levels of mental health care;
    - Using peer educators (*promotores*) with current or previous mental illness who have undergone treatment to educate the new consumer prior to or between doctor visits, which can also diminish stigma related to mental health problems;
    - Including Spanish-language materials;
    - Including forms of treatment proven to be effective with Latino populations;
    - Integrating mental health into overall health care treatment;
    - Collaborating with community-based services; and
    - Social marketing, including local and national celebrities, to break down stigma, raise awareness, educate the community, and promote early access to services.[131]

i. Mental Health Staff

- 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

[130] Center for Mental Health Services, Substance Abuse and Mental Health Services Administration (2005). *Mentally Health Aging: A Report on Overcoming Stigma for Older Americans*. DHHS Pub. No. (SMA) 05-3988. Rockville, MD.

[131] National Council of La Raza, Institute for Hispanic Health (2005). *Critical Disparities in Latino Mental Health: Transforming Research into Action.*

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.[132]

VI. Social Marketing as a Strategy: Lessons Learned

- 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.[133] 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.

  General conclusions for all 11 campaigns included:
    - Scoping and strategy work, including audience segmentation, message exchange, and competition analysis, should be independently commissioned rather than relying on small-scale qualitative efforts;
    - Advertising/PR agencies should not direct research, especially since their concern is often limited to short-term rather than longer-term effects;
    - A common failing was insufficient attention being paid to non-target audiences, having research focused primarily on the primary target group;
    - Making more nuanced distinctions between population categories (audience segmentation) that move beyond demographics was lacking. Greater focus on lifestyle, motivational, and attitudinal research in segmenting audiences is needed;
    - Dual branding and partnership marketing (associating a health issue with a commercial brand identity) were not fully utilized, despite audience research finding differences in lifestyles, motivations, and attitudes among target groups. Campaigns often used one generic campaign;

[132] Case Consulting, Ltd. (2005). The power of contact: project to counter stigma and discrimination associated with mental illness. New Zealand.

[133] Wellings, K., Crosier, A., McVey, D., Jennings, T. (2006). National Social Marketing Centre. *National health-related campaigns review: A review of 11 national campaigns.*

- Exchange is challenging in social marketing because it often involves giving up a tempting/pleasurable behavior for little obvious gain or a valued personal behavior has to be giving up/not started. Cost/benefit ratio may not be as obvious, and the costs may be perceived as distant from or unrelated to current behavior (especially for young audiences). Immediate benefits of behavior change must be emphasized;
- There is a shift away from hard-hitting imagery and fear-related messages. Research urges conditional use of these approaches where the threat is seen to be real and pointers to preventative action/information/services are provided to support individual change;
- Supplementing traditional advertising with PR and direct marketing, such as responding to news stories, was not as utilized as it could have been. Opportunities to use media advocacy were not utilized;
- Some campaigns did not recognize that social marketing stresses the importance of communications integrating into a broader preventative strategy, including fiscal, economic, and legislative measures;
- Having a broad network of shareholders that can include local action is a strength, but very large networks have the potential to impact a campaign's organization, execution speed, and treatment given to an issue. Very large networks may need extensive consultation, can stifle creativity, and may be challenging for advertising agencies. Changing stakeholder involvement/collaboration from a process to an outcome is beneficial;
- Campaigns often lacked integration within and across government departments. Isolated from wider government strategies, campaign expectations to change behavior may have been unreasonable;
- Research designs that showed attribution of effect were rare. As a result, short-term gains in awareness, attitude changed, and brand recognition were given disproportionate weight for measuring campaign success. There was insufficient strategic research to define the most appropriate indicators at the outset and an absence of baseline data from which to measure progress;
- In order to maintain a public health focus (rather than political or other goals), a credible panel of public health experts should be included in the advisory group;
- Clear boundaries are needed to avoid perception that policy is determined by commercial agencies, and government communications staff should make more of a contribution to strategic development of campaigns;
- Elected officials may be drawn into campaigns where the subject is controversial, but can reduce freedom and censor the campaign;
- Government should use its brand selectively, as the public (especially young people) may not look first to governmental agencies on some subjects. Government branding can be needed if scientific evidence needs to be authoritatively presented. Hidden or covert government involvement may be more effective in some campaigns;
- Establishing a new and effective brand is expensive, so costs/benefits should be thoroughly analyzed;
- Joining national and local efforts is valuable since some resources are held at the local level, services are delivered at the local level, and national efforts can be reinforced by local action. Good communications with and support to locals and using nationally produced generic messages and materials (with autonomy at the local level) are useful. Too much control from the center can restrict the reach of the campaign and limit application of materials at the local level; and
- Improving sustainability can be achieved by demonstrating effectiveness, establishing mechanisms to build objectives into local performance indicators, continuing local efforts after campaign end, and involving key individuals over the long term.

VII. Research Agenda Issues

- "The evidence base addressing 'what works' for anti-discrimination actions in mental health is poorly developed. We can learn lessons from other rights based movements – race, gender, sexuality, disability – but here too the evidence base is on the whole weak. Much more needs to be done to build a robust knowledge base of effective anti-discrimination actions."[134]
- A briefing paper commissioned by the World Health Organization sites the United Nations concludes that "we need more research on what actions tackle (discrimination, stigma and social exclusion) most effectively…The gaps in the evidence base, however, underline how important it is for activities…to build in both research and evaluation" so that we might learn as much as possible about what is most effective and share our learning with others. Despite the lack of evidence of whether an activity may be effective, the paper urges readers to act now and measure the impact of what is attempted.[135]
- There are a number of problems with studies in the area of stigma and discrimination.
    - Many studies examined the effects of previous self-reported contact with people on their own stigma, rather than how contact changes stigma prospectively.
    - Studies of direct contact often take place in a contrived laboratory situation, or as part of a course and/or training program.
    - It is not well understood exactly how contact reduces stigma, and theories about this have not been adequately tested.[136]
- The number of health sciences studies in Europe and the United States focusing on social inequalities has sharply increased over the last two decades, but this surge has not occurred to such an extent in studies of mental health inequalities.[137]

[134] Thornicroft, G. (2003). An evidence base for anti-discrimination actions. In *Reducing Stigma and Discrimination: What Works?* Conference Report from Rethink/Institute of Psychiatry conference on June 26, 2003 in England, 6.

[135] Health Scotland, World Health Organization Collaborating Centre (2008), *Stigma: An International Briefing Paper*, p. 10.

[136] Penn, D.L., Couture, S.M. (2002). Strategies for reducing stigma toward persons with mental illness. *World Psychiatry*, 1(1), 20-21.

[137] Muntaner, C. (1999). Teaching social inequalities in health: barriers and opportunities. *Scandinavian Journal of Public Health*, 27, 161-5.