

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

Compendium of  
Draft Core Principles and Strategic Directions  
and  
Facilitator Write-Ups of Break-Out Discussions  
From January 14 & February 3

**March 3, 2009**

**California Strategic Plan on  
Reducing Mental Health Stigma and Discrimination**

**DRAFT (03.03.09)  
Core Principles and Strategic Directions**

**Core Principles**

The following core principles shall be embedded in all levels of planning, programs, services, and evaluation of Strategic Directions and Recommended Actions within the California Strategic Plan on Reducing Mental Health Stigma and Discrimination:

- Implement culturally competent strategies and programs that reduce disparities and reflect the contexts within which people live.
- Meaningfully involve a diversity of mental health consumers, family members, friends, and caregivers.
- Employ a life span approach.
- Address both personal, internalized experiences of stigma as well as institutional and public stigma and discrimination.
- Broaden the spectrum of partners involved.
- Use evidence-based models and promising practices.
- Ensure the voluntary participation of mental health consumers in services, programs, and activities.

**Strategic Directions**

Reduce mental health stigma and discrimination by:

1. Creating inclusion and equality for all consumers and family members to fulfill their life goals and fully participate in their communities and society at-large;
2. Promoting awareness, accountability, and changes in attitudes, beliefs, and practices across systems, organizations, and communities;
3. Advancing public policy and enforcing the law to promote inclusion and equality, and eliminate discriminatory practices; and
4. Increasing knowledge through research and evaluation, including community-based participatory research and evaluation.

**TABLE OF CONTENTS**  
**Facilitator Write-ups from January 14 & February 3**

<b>WORKGROUP</b>	<b>PAGE</b>
<b>TARGET POPULATIONS: Discussed on January 14, 2009</b>	
Children	<b>4</b>
Transitional Age Youth	<b>10</b>
Adults	<b>14</b>
Older Adults	<b>17</b>
Racial and Ethnic Communities	<b>20</b>
Homeless	<b>23</b>
Co-Occurring Disorders	<b>25</b>
Rural Residents	<b>28</b>
<b>SYSTEMS &amp; ORGANIZATIONS: Discussed on February 3, 2009</b>	
Schools (K-12)	<b>32</b>
Medical System	<b>39</b>
Mental Health System (Group 1/ Group 2)	<b>42/45</b>
Housing	<b>52</b>
Employment and Workplace	<b>56</b>
Media	<b>59</b>
Law Enforcement	<b>63</b>
Law, Public Policy, and Legal System	<b>67</b>
Faith-Based Organizations	<b>71</b>

**Childrens Workgroup**  
**January 14, 2009**  
**Facilitator: Susan Sherry**

**INTRODUCTION**

For children with social, emotional, and behavioral challenges, stigma and discrimination means that these children frequently experience social exclusion, isolations, and acts of aggression and sometimes violence by other children. They are routinely treated differently than other children by both the adults who work with them and their peers.

Families of children with social, emotional, and behavioral difficulties suffer blame, judgment, and shame. The problems of siblings unfortunately are often overlooked because the family's focus is on the child with the more sever difficulties. Sometimes families scapegoat the child with the social, emotional, or behavioral difficulties, making these children the 'identified patient.'

The language of mental illness does not help these children. Using such labeling reinforces discrimination, which in turn reinforces denial, fear, and shame on the part of families and self-stigma on the part of these children. Rather than use mental illness language, it is more helpful and accurate to describe these children as experiencing social, emotional, or behavioral challenges.

Additionally, describing mental health along a continuum of wellness helps normalize children's social, emotional, and behavioral challenges and is a particularly helpful concept for families trying to understand their child's problem. The mental health continuum concept can be used on a universal basis for all children, and thus, is an important and responsible tool for reducing stigma and discrimination.

Lastly, it is very important that the California Plan for Mental Health Stigma and Discrimination Reduction model language that is supportive of children's healthy development and resilience and address children's mental health issues separately from stigma and discrimination toward adults.

**I. FAMILIES**

**A. Develop "informational intervention" programs that provide education and guidance to parents of children with social, emotional and behavioral challenges. Too often, parents and families desperately need accurate information and do not know where to turn for help.**

1. Create the expectation that meetings between parents and those in the community whose job it is to work with their children hold parent conferences at "family-friendly" times (e.g. evenings; weekends).
2. Promote home-visitation by teachers and schools.
3. Establish speakers bureaus around the state whose mission is to provide information and education to families and parents.
4. Establish a 1-800 statewide call-in number for parents needing

information and referrals for their children. This program would be similar to “advice nurses” that operate in the medical arena.

5. Provide training for “first responders” and “gate-keepers” on children’s mental health issues and on the resources available in the community to help parents. First responders and gate-keepers are those in the community that have routine contact with children (teachers, school administrators, recreation program staff, etc.).
6. For those professions that have routine contact with children and are also subject to a state licensing, establish a training requirement on childhood mental health issues.
7. In the development of the above educational programs, integrate information on child development, how children’s brains operate and how trauma adversely affects children.
8. Educate parents and families to pay as much attention to their children’s mental health as they do to their children’s physical health
9. Establish educational programs for preventing and reducing childhood mental health challenges that are universally available to all parents.
10. Encourage First 5 California to expand their statewide parent Tool Kit to include information to assist parents in identifying and addressing the mental health challenges of their children, including where to find other informational resources and where to go for help.

**B. Establish programs that provide support to the parents, care-givers and families of children with social, emotional and behavioral challenges.**

1. Develop an awareness campaign that commends and supports parents who seek and receive mental health assistance and services for their children and themselves.
2. Establish respite care programs for parents and care-givers.
3. Create programs designed to provide support to the siblings of these children.
4. Recruit leaders and persons with “pulpit power” to speak out about childhood mental health issues, the importance of social inclusion to a child’s development, and the need to respect the differences among children.

**II. COMMUNITIES**

**A. Initiate a multi-pronged effort that involves and engages an entire community to embrace, respect and support children with social, emotional and behavioral challenges and their families. Many parts of the community touch children’s lives – for example schools, sports teams, child care facilities, neighborhoods and the many places children naturally gather.**

1. Contact groups and organizations that have a mission and history of service work and “good deeds.” There is a wide range of such groups and organizations in the community, for example scout

- programs, neighborhood associations, chambers of commerce, social clubs, etc. Work with these organizations and groups to open their hearts and minds to accept these children and their families as vital parts of the community.
2. Initiate a community campaign emphasizing the value of embracing differences in all its many forms, including children who seem different than other children.
  3. Begin a dialogue with specific organizations and groups who have routine contact with children (teachers unions, bus drivers, facility recreational staff, etc.) to educate them on childhood mental health issue, the importance of respecting differences among children, and their critical role in promoting the healthy development of children.
  4. As part of a larger community effort, solicit the involvement of local radio and television stations. Educate them on childhood mental health issues and on the important role they could play in promoting social inclusion. Also explain to them that children who are isolated tend to spend more time listening to radio and watching television. So, their messages can also combat self-stigma in these children.
  5. Encourage local media to utilize children to carry the message of social inclusion. Children listen to other children more than to adults regarding messages on social inclusion.
  6. Establish a 1-800 statewide call-in number to report incidences of discrimination against families and children.

### **III. SCHOOLS**

#### **A. Establish programs, policies and practices to change the culture of K-12 education from one that isolates children with differences to one of social inclusion.**

1. Develop curricula, training and programs for teachers, administrators, school support staff, and students that teach the value of social inclusion. Use youth as part of the training, programs and curricular delivery. Use an asset and strength-based approach in the development of these efforts. These programs are particularly important because they would be directed at everyone in the school system -- not just children with problems. View these programs as an overall youth development program, which focuses on all children..
2. Establish a zero-tolerance policy regarding discrimination and bully in the schools., with strong direction for teachers to cultivate classroom environments that respects differences.
3. Establish school peer support programs that teach children to stand up to rejecting and demeaning behavior toward any student, especially students who may seem different.
4. Increase the number of school-based counselors, social workers, public

services personnel and community-based mental health providers on school campuses.

5. Provide for the funding of special education programs. These programs are often under or unfunded, even though under federal law schools are required to provide these services. (Some think this recommendation is too broad for this Plan.)
6. Share the trainings, curricula and other resources on social inclusion developed by public schools to private schools and extend requirements that pertain to public schools regarding childhood mental health services, education, and non-discriminatory practices to private schools.

#### **IV. PRIMARY CARE AND PEDIATRIC PRACTITIONERS**

##### **A. Develop strategies to motivate primary care and pediatric practitioners to integrate childhood mental health into the routine medical care of children.**

1. Establish programs that encourage relevant medical practitioners to include mental health in well-child check ups, provide education to parents if a child demonstrates or may be at risk for social, emotional or behavioral challenges and recommend to the parents the appropriate next steps for obtaining help for their child.
2. Develop trainings and written education materials to assist the appropriate medical practitioners understand, identify and treat childhood mental health problems as well as provide guidance, information and referrals to parents.
3. Distribute the existing children's mental health screening instrument developed by the State Department of Education to relevant medical practitioners.
4. Establish medical school and other health-related professional degree requirements for childhood mental health issues, including the identification and treatment of children with social, emotional and behavioral challenges.
5. Develop a strategy to establish Same Day Visit Reimbursement for community health centers and Federally Qualified Health Centers
6. Eliminate medical necessity criteria under Managed Care Mental health for County Mental Health
7. Support concept of integrating behavioral health services into primary care/ community health centers.

##### **B. Develop strategies to develop alliances between primary care and pediatric practitioners and the community on childhood mental health issues.**

1. Encourage relevant medical practitioners to create channels of communication with preschool and child care programs focusing on the identification of childhood mental health difficulties. And access to appropriate community resources.
2. Encourage parents, families and consumers to organize meetings with relevant medical practitioners to raise their awareness of childhood mental health issues.
3. Establish a community network of families, medical practitioners, schools,

human service workers and others with routine contact with children to meet on a regular basis to identify and implement strategies for reducing childhood mental health problems as well as stigma and discrimination that often accompanies childhood social, emotional and behavioral and problems.

**C. Establish enhanced MediCal reimbursement for medical practitioners how include mental health check-up into their care of children.**

**V. MEDIA AND MASS MARKETING**

**A. In their programming for children, encourage print media, radio, broadcast television and the video game industry to promote social inclusion and respect for children perceived as different.**

1. Establish organizations/ networks charged with identifying radio programs, television advertisements and televisions productions geared to children that sanction social exclusionary behavior, stigmatizing behavior, and /or violence toward those that are perceived as different, especially children with social, emotional and behavioral challenges. Contact these media to raise their awareness and work with them to promote positive social behavior in their programming.
2. Encourage media and other vehicles for mass marketing to utilize children to deliver messages promoting social inclusion and respect for children perceived as different. Children to children communication can be very effective.
3. Develop guidelines for the media reporting on childhood mental health issues. Use these guidelines to promote accurate and informed portrayals of children and adults living with mental health difficulties.

**C. Create an organization / network dedicated to working with the video game industry to reduce the level of violence and social exclusionary behavior in video games.**

**VI. FOSTER CHILDREN**

**The Children's Work Group recommends that a separate work group be formed to develop actions for Foster Children. The Children's Work Group also recommends that the work group on Foster Children contact youth organizations for insights and advice (e.g. Youth and Mind; CYC; California Youth Connection; UCAF; etc.). The Children's workgroup had the following recommendations:**

1. Develop and implement programs to educate foster care parents on issues relating to childhood social, emotional and behavioral challenges.

2. Develop a CASA program for foster care parents to enable them to advocate for foster care children.

Work with the foster care system to provide increased long-term consistency between a specific service provider /therapist and a foster child.

## **Transitional-Age Youth Workgroup**

**January 14, 2009**

**Facilitator: Dorian Fougères**

### **OVERARCHING RECOMMENDATIONS**

1. Ensure the meaningful involvement of transitional age youth in all phases of stigma and discrimination reduction policy and programs, from planning and design through implementation and evaluation.
2. Recognize the distinctiveness, importance, and vulnerability of transitional age youth at the highest levels of State government.
3. Shift from treating mental health in isolation to treating the whole person.
4. Develop a transitional age youth system of care, including wards in hospitals and treatment centers, that is separate from those for children, adults, and older adults.
  - a. The Adult Allies group that meets with the California Mental Health Director's Association has already been advocating for this, what's needed is county buy-in.
  - b. When a youth turns 18, the sudden movement from a child to adult facility can be terrifying and cause both internal and family stigma.
5. Normalize language so that the terms and descriptions of transitional age youth and associated facilities emphasize strengths, positives, and potentials.
  - a. For example, do not label a facility a "mental health center" (as does the MHSA) but rather a "community center." Transitional age youth avoid these because of the stigma. For example, using the term "kids" is derogatory.
  - b. San Bernardino County's transitional age youth centers are a good example – they help with jobs, education, resume building, and are not advertised as mental health locations. This is an example of the whole person philosophy.
  - c. Alameda County's Youth Uprising center is another good example
  - d. Normalizing language is a more general theme – mental illness is a spectrum and everyone experiences it, so more inclusive language is needed.
6. Ensure that programs and events involving transitional age youth are properly scheduled (i.e., during evenings and on weekends).
7. Communicate with transitional age youth using internet-based channels.
  - a. Australia's Reach Out platform has been tested and can easily be adapted to California.
8. Ensure that the aspects of this strategic plan that deal with transitional age youth are vetted with them.
  - a. One option is to work through the Mental Health Association's California Youth Empowerment Network (CAYEN)
9. *Vet these recommendations to transitional age youth directly and have them finalize the approach/strategies.*
10. *Ensure that strategies/approaches include language that supports historically marginalized youth groups, racial/ethnic, LBGTQ, foster youth, and juvenile justice.*

11. Consider including the Student Mental Health Initiative recommendations regarding college students

([http://www.dmh.ca.gov/MHSOAC/docs/Meetings/2007/StudentMentalHealthInitiative\\_091807.pdf](http://www.dmh.ca.gov/MHSOAC/docs/Meetings/2007/StudentMentalHealthInitiative_091807.pdf))

including:

- a. *Training: The grant program would fund training activities for students, faculty, staff or administrators to raise awareness of issues of mental health and wellness on college campuses. The training would be designed to improve recognition and responses to students experiencing mental distress, to reduce stigma and discrimination against persons who become identified with mental illness, and to promote a campus environment that enhances student success providing hope, supporting resiliency, and creating a healthy learning community.*
- b. *Peer-to-Peer Support: These activities would focus on mutual support, promoting acceptance of cultural diversity, disability, empowerment strategies, and reduction of the stigma associated with mental illness. Peer-to-peer services instill hope while teaching successful coping strategies and relaying information about how to navigate health and mental health systems. Such programs could also effectively address issues of trauma, loss, identity, relationships, homesickness, and achievement pressure and would provide mental health and emotional support that are defined useful by students themselves.*
- c. *Suicide Prevention: This project would be designed utilizing the resources and best-practices of the MHSA suicide prevention efforts or knowledge of the assigned workgroup but would focus specifically on addressing the unique needs, vulnerabilities and risk factors of university and college students, and would bring suicide prevention resources directly onto campuses to raise their profile among students and to make them as accessible, relevant and effective as possible.*

## **PEERS, PROGRAMS, AND FACILITIES RECOMMENDATIONS**

12. Hire transitional age youth to implement and run programs, centers, and facilities designed by and for them.

- a. San Bernardino has two facilities that involve and employ transitional age youth significantly, and that are contracted out to community-based agencies.
- b. Note that the word “contracting” is loaded and can imply many things. On the one hand, it can be used simply to indicate that facilities are not run by State or county staff. On the other, it can be used to indicate an exploitative labor relationship where employees do not accrue paid vacation and other benefits. In this way the term can create its own stigma and should be avoided.

13. Encourage peer-to-peer education for transitional age youth.

14. Involve transitional age youth in conducting outreach that reduces stigma between transitional age youth living with mental illness and those not.

15. Fund programs and events designed specifically for transitional age youth, particularly recovery programs.

16. Establish a statewide network for transitional age youth to exchange ideas, experiences, and expertise.
17. Establish a youth speaker’s bureau that travels to high schools and colleges and hosts open conversations and develops an ongoing presence.
  - a. Substance Abuse and Mental Health Services administration (SAMHSA)’s Eliminate Barriers Initiative (EDI) provides a toolkit for media and targets all parts of the community.
18. Host an annual statewide convention for transitional age youth “ambassadors” to exchange ideas, experiences, and expertise.

## **WORK ENVIRONMENT RECOMMENDATIONS**

19. Prepare adults to work with transitional age youth – to avoid treating them in a particular manner and to provide them with opportunities to succeed on their own merits.
  - a. Adults often speak down to transitional age youth and underestimate their capacity, so with is the critical word in this recommendation. Adults tend to pick and focus on youth that are already doing well.
  - b. *Do not assume that youth can’t do anything. Do not assume/expect/relay that youth can do everything. Provide adequate support and they will succeed.*
  - c. Adults often try to be cool and stop being adults, and this often backfires.
20. Have transitional age youth train and better prepare adults for working together.
  - a. Australia’s Reach Out program has a tested training curriculum based on “meaning, control, and connectedness” that has been prepared by transitional age youth for this purpose.
  - b. Program delivery by transitional age youth is critical.
  - c. Both transitional age youth and adults need to be prepared to work together.
  - d. *Make the environment comfortable for LGBTQ youth, provide trainings to staff and youth on current issues and topics important to this community.*

## **FOSTER YOUTH RECOMMENDATIONS**

21. Recognize that foster transitional age youth have additional dynamics at play, and additional stigma that goes along with foster care.
22. Ensure that foster transitional age youth have access to and control over the sharing of their own mental health records, particularly when being represented by Court Assigned Special Advocates.
  - a. One option is to specify an age at which they can control their records.
23. Require inter-agency coordination between courts, judges, and foster care facilities.

## **EDUCATION AND ADVOCACY RECOMMENDATIONS**

24. Provide education and training about transitional age youth and mental illness for educators in a variety of contexts.

- a. Teachers are in an awkward position because they have responsibility for the health and safety of their students (e.g., ensuring prescribed medications are taken).
  - b. Professors at community colleges are also in an awkward position because they have no direct responsibility over students, but have responsibility for helping to ensure campus safety.
25. At the county level, reorient the advocacy work of parents from deterring juvenile criminalization to emphasizing the strengths of and things that are helping transitional age youth.
- a. Advocacy that focuses on criminalization often comes across as controlling

**Adult Workgroup**  
**January 14, 2009**  
**Facilitator: Sue Woods**

As the broadest demographic in the mental health community, adults face diverse challenges across systems in society. In addition to internalized stigma, adults often feel helpless against organizations that are not equipped to offer opportunities for success and wellness. Adults in the mental health community strive for fairness in public policy, media, the criminal justice system, and in opportunities for services and employment.

Adults look to collaboration and education as the most effective tool for reducing mental health stigma and discrimination. By partnering individuals and organizations in a strength-based, peer supported strategy, consumers will become better informed of what is accessible to them, and those who collaborate with the mental health system will better understand the challenges the community faces.

**STIGMA & DISCRIMINATION STRATEGY**

- 1) Provide consumers with:
  - a. Strategies for resolving internal stigma
  - b. Training on community policy and laws regarding mental health
  - c. Train on Peer Support, strength-based
  - d. Leadership and Trainer Skills
- 2) Organize Consumers and Mental Health Professionals to partner and network to provide training and education to identified consumers, families, government, and community, utilizing new and existing resources

**EDUCATION & TRAINING**

Consumer/Family created and delivered or in Partnership with mental health professionals. Review training from effective programs and campaigns, then expand and convert to larger target audiences.

*Topics of training for Consumers/Families*

- Collaboration Skills
  - Communication
  - Teamwork
  - Self-respect
  - Respecting others
  - Assertiveness
  - Empowerment
- Community Advocacy, Systems Advocacy
  - County and state policy
  - Political systems
  - Leadership
  - Negotiation

- Consumer Rights
  - Discrimination
  - ADA
  - Access to services
  - Forensic
  - Conservatorship
- Custody Issues
  
- *Providers*
- Training graduate and undergraduate mental health students
- Training first responders in crisis intervention
- Training for Human Resources personnel
- “Respect” concerns (general practice)
- Educate Landlords
- Educate other Providers
  - Housing
  - Business
  - Employers
  - Law enforcement
  - Elected officials
  - Senior centers
  - Faith-based organizations
  - Media
  
- *Means/ Approaches of Education/Training*
- Dialogues between consumers and mental health professionals
- Create Speakers Bureau
- Storytelling
- Utilize video, photos, writing, WRAP groups, theatre, internet
- US + THEM = WE program

## **PUBLIC POLICY REVISIONS**

- Create state based policy establishing guidelines/training requirements for first responders
- Revise agency policies requiring a minimum % of employees be consumers (suggested 25% minimum)
- Review and change Human Resources rules to allow safe disclosure related to employment
- Change community care licensing to allow consumers with minor-non-employment related crimes to work in residential programs
- Change Human Resources policies to allow employment of consumers with minor/status offenses
- *Develop a strategy to establish Same Day Visit Reimbursement for community health centers and Federally Qualified Health Centers*

- *Eliminate medical necessity criteria under Managed Care Mental Health for County Mental Health*
- *Support concept of integrating behavioral health services into primary care / community health centers.*

## **MARKETING**

- Develop a budget and a timeline based on stigma and discrimination MHSA funds for a long term adult media campaign
- Hire a professional marketing firm to develop the media campaign in a culturally competent manner
- Share stories of:
  - Personal interest stories
  - Stories to counter stereotypes
  - Positive stories about MHSA
  - Families and clients
- Other Ideas:
  - Utilize NPR and local public radio
  - Develop consumer and family run TV and radio shows
  - Train families and consumers in how to use media
  - Tell our stories: in person, video, theatre, internet
- Use celebrities and “real people” in media campaign
- Identify effective locations and methods for message delivery

## **CRIMINAL JUSTICE**

- Train criminal justice professionals and offenders regarding:
  - Mental health
  - Access to legal and mental health systems
  - Housing
- Ensure a criminal justice background is not an intrinsic block to employment
  - can be an asset as experience in recovery, a better role model

## **OTHER**

- Creating partnerships among all organizations who serve the mental health community
- Identify current and effective programs, then ask Department of Mental Health to support local community efforts

## Older Adults Workgroup

January 14, 2009

Facilitator: Cielo Avalos & Beverly Whitcomb

1. **Education – develop an education *and training* plan to address self-stigma, public stigma, and institutional stigma and discrimination that will promote access to and use of mental health services**
  - **Older Adults**
    - Healthy aging is possible
    - Common stressors and responses
    - Solutions
  - **General Public (includes families)**
    - *The "Stamp Out Stigma" program is a model community education program in California to address self-stigma and public stigma, and to eliminate discrimination. It was developed and is implemented by consumers. Contact Carmen Lee for more information: [www.stampoutstigma.org](http://www.stampoutstigma.org); [CarmenSOS@aol.com](mailto:CarmenSOS@aol.com)*
    - *Use a model which emphasizes that everyone's health, including mental health, is on a continuum from prevention through serious illness, and that conditions move back and forth, over time and circumstances.*
    - *Develop Co-occurring groups specific to older adults.*
    - *Note: Frequently older adults are excluded from alcohol/drug rehab. groups because they are on multiple meds, including anti-anxiety drugs, for other conditions. They also report feeling out of place since many attendees are Prop 36 related younger people who have to attend these programs. Alcohol and prescription drug abuse are predicted to be huge problems for older adults in the coming years.*
  - **Service Providers**
    - Health Care (mental health, physical health, substance abuse)
      - Mandatory continuing education on cultural competency approaches
      - Resources available/assessment
    - Gatekeepers – “Keeping your distance is over-rated”
      - Pharmacists
      - Senior centers
      - Barber and beauty shops
      - Meals on Wheels
      - *Faith-based organizations/clergy*
2. **Marketing – Develop PSAs and media messages**

Develop a budget/timeline from Stigma & Discrimination MHSA funds for media campaign

  - Hire a professional marketing firm to develop a media campaign
  - Revisit the concept of the “tipping point” to identify locations, means, and methods for message delivery.

- Take advantage of the current bad economy to deliver no-fault media messages about what depression looks like
- If possible, use celebrities mixed with real people in media campaign
- Refer to the document "Mentally Health Aging: A Report on Overcoming Stigma for Older Americans" published by SAMHSA. *(Please include information from the "Mentally Health Aging" report in the Strategic Plan for Stigma and Discrimination Reduction, including the examples of educational and media campaigns along with the examples of media messages strategies, and target audiences to address self-stigma, public stigma and institutional stigma. This report also discusses the issue of ageism that can result in institutional discriminatory policies and bias in funding priorities. Examples of media messages include: "Treatment Works. Older adults with mental illness can improve and recover," "You deserve to feel well," "Strong mind, strong bodies," "Depression is not a normal part of aging" and more.*

### **3. Label Services to be culturally competent/acceptable to Older Adults**

- Name OA mental health with alternate wording (e.g. "Elder Wellness")
- Use verbiage OAs can relate to (e.g. "Battle fatigue" vs. "PTSD" or "depression")
- Normalize and externalize through language
- Goal: decreased self-stigma of OA population

### **4. Co-Locate Mental Health Services with services that are "acceptable" and "accessible" to older adults, to reduce stigma and improve access.**

- Combine primary care/mental health services in same location – be sensitive about labels
- *Provide mobile/in-home services for homebound seniors*
- *Utilize telephone, computer and other technologies to address stigma and promote access (i.e., telephone counseling.)*
- Locate certain services at senior centers, nursing homes, congregate living facilities (e.g. Del Webb)
  - Senior peer counseling
  - Support groups
  - Family/caregiver groups/workshops
  - Referral resources for other mental health services

### **5. Education – develop an education and training plan to address self-stigma, public stigma, and institutional stigma and discrimination that will promote access to and use of mental health services**

- **Older Adults**
  - Healthy aging is possible
  - Common stressors and responses
  - Solutions
- **General Public (includes families)**
  - *The "Stamp Out Stigma" program is a model community education program in California to address self-stigma and public stigma, and to*

*eliminate discrimination. It was developed and is implemented by consumers. Contact Carmen Lee for more information:*

*[www.stampoutstigma.org](http://www.stampoutstigma.org); [CarmenSOS@aol.com](mailto:CarmenSOS@aol.com)*

- **Service Providers**
  - Health Care (mental health, physical health, substance abuse)
    - Mandatory continuing education on cultural competency approaches
    - Resources available/assessment
  - Gatekeepers – “Keeping your distance is over-rated”
    - Pharmacists
    - Senior centers
    - Barber and beauty shops
    - Meals on Wheels
    - *Faith-based organizations/clergy*
    - *Others*

**5. Fairly distribute resources to Older Adults (*This addresses the issue of institutional discrimination and ageism as it relates to access and utilization of mental health services.*)**

- Older Adult SOC should be represented as a separate entity throughout MHSA (DMH, OAC, CMHDA) policy and program implementation
- Develop policy regarding Older Adult discrimination (e.g. some people avoid mental health clients out of fear of disruptive behavior)
- *Examine apparent disparities in access to public mental health services by older adults in general, as well as older adults from diverse populations. Understanding the reasons for these disparities is necessary as it might be a result of age bias/discrimination in mental health policy development, and budget allocation and expenditure decisions.*

## **Ethnic/Racial Communities Workgroup**

**January 14, 2009**

**Facilitator: Julia Lee**

**1. Increase the provision of culturally competent mental health services. Ethnic and racial communities experience less stigma when services and service delivery methods reflect, are consistent with, and are respectful of a person's culture and cultural values.** Corollary recommendations include:

- a. Develop effective practices for specific ethnic and racial populations, and distribute this information widely within the mental health, public health and medical systems. Draw on lessons learned from other successful public health efforts in ethnic communities that could be applicable to mental health (e.g. HIV, teen pregnancy, reproductive health, etc.).
- b. Allocate and protect funding for culturally competent services. Too often culturally appropriate services are the last to be implemented and the first to be eliminated in economic down-turns.
- c. Develop and conduct training programs for mental health providers in cultural competency, which includes a component that assists providers in understanding their own biases and stigmatizing attitudes and behaviors toward consumers and families from ethnic and racial communities.
- d. Establish an effort comprised of representative from diverse backgrounds, experiences and expertise to review and revise the current definitions of recovery and wellness so that these concepts are culturally-sensitive and include ethnic and racial communities' perspectives, beliefs and visions of mental health, family roles, wellness and recovery. Recognize role of preserving and supporting racial identity in recovery.
- e. Promote respect for and acceptance of traditional and cultural forms of healing within ethnic and racial communities. These forms of healing are not considered "alternative" by ethnic and racial communities. De-valuing such methods is not helpful to recovery and wellness for individuals from ethnic and racial communities.
- f. Implement cultural competency standards .to more objectively measure culturally competent services... Process indicators of cultural competency are not useful as they do not focus on outcomes, but rather on numbers and through-puts. Standards can lead to more accountability and transparency
- g. Conduct an assessment of the current mental health workforce to determine its capacity to serve ethnic and racial communities.

- h. Increase the numbers of mental health professionals from ethnic and racial communities through aggressive workforce development programs. Mental health professionals should reflect the ethnic and racial make up of the communities they serve. Ethnic and racial mental health providers should proportionally reflect the ethnic and racial population make-up of California.
- i. Hire more consumers and family members from ethnic and racial communities to work within the mental health system.
- j. Substantially increase the number of ethnic and racial representatives with mental health expertise who sit on state and local mental health policy boards, commissions and other policy-making bodies, including the policy and advisory bodies related to the implementation of MHSA.
- k. Implement Title VI language, (part of Civil Rights Act of 1964) as may apply to mental health stigma and discrimination regarding ethnic communities. Title VI prohibits discrimination on the basis of race, color, and national origin in programs and activities receiving federal financial assistance.

**2. Provide equitable allocation of and access to mental health resources and services to ethnic and racial communities, along with accountability measures to ensure disparities are rectified as one of the mental health systems' highest priorities. Increase the recognition within the mental health system and among policy-makers that ethnic and racial communities seeking mental health services face double stigma - racial prejudice and mental health stigma. This double societal stigma contributes to the severe lack mental health funding provided for ethnic and racial communities.**

- a. Conduct assessments and other studies to define the disparities (e.g. access, quality; availability; resource distribution, etc.) related to the mental health services provided to ethnic and racial populations and to identify ways to evaluate changes in the level of disparities over time.
- b. Fund population-specific programs to address service disparities within the multiple ethnic and racial communities in California.
- c. Evaluate statewide, local and other mental health system and organizational policies and funding for biases and potential discrimination toward ethnic and racial populations
- d. Develop a definition of “need” for funding that will foster greater equity in funding for ethnic and racial communities. For example, some populations may not be well reflected in standard measures such as census data.

- e. Develop oversight mechanisms at the local level to monitor equitable funding for ethnic and cultural communities.

**3. Develop programs that engage ethnic and racial populations in their own communities and contexts to identify how to reduce stigma and discrimination toward individuals and families experiencing mental health problems.**

**4. Provide mental health services to ethnic and racial communities at a lowest level of intensity possible (e.g. primary care physician rather than a mental health clinic) as these types of services are considerably more acceptable to racial and ethnic communities and thus less stigmatizing.**

## Homelessness Workgroup

January 14, 2009

Facilitator: Sam Magill

Initial discussions with stakeholders show that the issue of stigma and discrimination towards mental health issues in homeless populations is at its core an issue of *dual* stigmas. Stakeholders unanimously agreed that homeless populations, with or without mental health challenges, are heavily discriminated against by society at large. While mental health issues are a significant concern in homeless populations, stakeholders generally agreed that housing is the most important issue to address.

Some examples of stigma and discrimination towards homeless populations identified by the workgroup included:

- The myth that homelessness is a homogenous issue. Not all homeless individuals became homeless in the same way, and different parts of the homeless population have different needs.
- The “invisible” treatment of many homeless people by society at large.
- The difficulty of locating affordable housing developments in existing neighborhoods.
- The difficulty of obtaining medical or other services without a physical address.
- Lack of any homeless voices at public meetings, even if the policies being decided directly affect homeless populations
- The need to educate the medical community about the special needs of homeless individuals.
- The fact that homeless individuals and families are more likely to become victims of violence than society at large.

The significant discrimination towards homeless populations manifests itself in a variety of ways, and leads to several specific problems for individuals who also suffer from mental health problems. For example, stakeholders noted that individuals with mental health problems sometimes avoid first responders and case workers in fear of involuntary commitment.

The coincidence of a significant population of homeless individuals who also suffer from mental health issues is substantial and should not be overlooked, but mental health issues do not *per se* lead to homelessness and *visa versa*. For this reason, stakeholders suggested that the first and best strategy for addressing the dual stigmas of mental health problems and homelessness is to provide housing first. A number of programs, such as Housing First, exist to support this end. These programs should be voluntary, but only after a stable housing environment is established can individuals receive the treatment necessary to recover from any mental health problems.

In addition to the “housing first” principle, the National Coalition for the Homeless (NCH) developed five principles for ending homelessness:<sup>1</sup>

1. The McKinney Vento programs authorized by Congress in 1987 must be reauthorized and fully funded.
2. The supply of affordable housing available to the homeless must be dramatically increased.
3. Healthcare, education, and other services must be provided to all who need them.
4. Personal incomes must be sufficient to provide the basic necessities.
5. Discrimination against homeless people must be prevented.

The NCH reinforces many of the stakeholder’s statements that housing needs are of paramount importance in addressing homelessness issues in general. However, discrimination against homeless populations and access to basic services is also critically important when discussing homelessness in general, and more specifically the unique challenges facing homeless individuals who also suffer from mental health problems. Additional strategies identified by stakeholders to address the dual stigmas of mental health problems and homelessness include:

- Create a centralized clearinghouse database related to why people become homeless.
- Create a task force to look at how laws are written that discriminate against homeless people and expand enforcement mechanisms for existing anti-discrimination laws.
- Build capacity for client owned and operated housing, but not limit it to supportive housing and crisis alternatives.
- Develop specialized programs for partnership subgroups of homeless populations (i.e. veterans, older adults).
- Establish public awareness guidelines for first responders, case managers, therapists and community outreach staff that use an integrated approach towards the person (does not only see homelessness) during an assessment. Develop questionnaire where an assessor is required to initial to sign off.
- Fund legal advocacy to make sure the “Not In My Back Yard” (NIMBY) ideology does not succeed. Use residents within the community to talk to their peers about best practices.
- Peer lead MHSA public outreach efforts.
- Adopt a 10 year plan to end homelessness.

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<sup>1</sup> National Coalition for the Homeless (2007). *Entering the Third Decade of the National Response to Homelessness in America: A Consensus Statement on Five Fundamentals*. Retrieved January 15, 2009, from [http://www.nationalhomeless.org/publications/fivefundamentals/Five\\_Fundamentals\\_Statement.pdf](http://www.nationalhomeless.org/publications/fivefundamentals/Five_Fundamentals_Statement.pdf).

## **Co-Occurring Disorders Workgroup**

**January 14, 2009**

**Facilitator: Dorian Fougères**

### **OVERARCHING RECOMMENDATIONS**

1. Educate people that recovery from mental illness and disabilities is possible, and initial diagnoses can change over time.
2. Shift from treating mental health and disabilities in isolation to treating the whole person, as in public health.
3. Establish a continuum of care from support centers through crisis services through case management programs through recovery.
4. Normalize language so that the terms and descriptions of people with co-occurring disorders emphasize strengths, positives, and potentials.
5. Create opportunities for people living with co-occurring disorders to tell their stories in multiple arenas.
6. Adopt at the State and county levels a definition of “co-occurring disorder” that goes beyond substance abuse to include developmental, physical, and trauma-related disabilities.
  - a. The definition must be widely recognized and adopted for it to attract funding.

### **SYSTEMS AND AGENCY RECOMMENDATIONS**

7. Provide technical assistance and funding for education and training programs that reduce stigma and discrimination against people with co-occurring disorders in both the mental health and non-mental health systems (e.g., criminal justice, foster care).
8. Involve people living with co-occurring disorders in the development of such programs.
9. Develop a formal state process for coordinating and integrating the actions of State and county agencies that separate the treatment of mental illness and disabilities.
10. Collaborate with the Governor’s Prevention Advisory Committee and other major initiatives.
  - a. Examples include the Co-Occurring Joint Action Council, Harm Reduction Coalition, Substance Abuse and Mental Health Services administration (SAMHSA), National Alliance on Mental Illness (NAMI), California Network of Mental Health Clients (CNMHC), Twelve Step Council, Peace Office Standards and Training (POST), and National Association of State Mental Health Program Directors (NASMHPB).
11. Establish and fund inter-agency case management teams that review cases and help people living with co-occurring disorders navigate across systems.
  - a. Teams should include, but are not limited to, mental health, primary care, corrections, law enforcement, and housing agencies.
12. Require that MHSA Full Service Partnerships do not exclude people based on substance abuse and, conversely, require that substance abuse agencies to not exclude people living with mental illness.

## **RESPONSE AND TREATMENT RECOMMENDATIONS**

13. Promote the establishment of contact, training, education, and mentoring programs for emergency personnel that involve people on the street and people who have recovered.
  - a. Emergency personnel include but are not limited to paramedics, police, nurses, first responders, and emergency room doctors.
  - b. Contact models include Stamp Out Stigma and Paula Comunelli's Listening Well.
14. Inform all care and services for co-occurring disorders with sensitivity to trauma and harm reduction.
15. Require that law enforcement officers place people with co-occurring disorders and under the influence in detoxification in psychiatric facilities, and never in seclusion or restraints.
  - [COMMENT FROM AC MEMBER: This needs to be clarified/have greater specificity.]
16. Promote peer overdose prevention programs.
17. As part of a continuum of care, promote the adoption of Harm Reduction programs that focus on reducing harm to the self and others.

## **PEER-BASED RECOMMENDATIONS**

18. Promote the development of peer-based services throughout a continuum of care.
19. Provide both peer bridgers and inter-agency case managers as a routine procedure, from the moment when the emergency system is contacted, through the courts, recovery, and obtaining housing, employment, and psychiatric care.
  - a. Peer bridgers serve as liaisons to help people with co-occurring disorders navigate the multiple mental health and non-mental health systems.
  - b. The federal Mentally Ill Offender and Crime Reduction Act (S. 1194) of 2004 provides a foundation for this (it aims to improve access to mental health services for adult and juvenile non-violent offenders).
20. Promote the establishment and funding of peer-driven, peer-run crisis respite centers to help people with co-occurring disorders stay out of hospitals.
  - a. One model is Self-Help and Recovery Exchange in Los Angeles.
21. Provide peer-based training for hospital administrators and clinical directors.

## **LEGAL RECOMMENDATIONS**

22. Provide independent legal advocacy for people with co-occurring disorders in all contexts (e.g., primary care, addiction programs, halfway houses, twelve-step programs).
23. Promote the use of Mental Health Drug Courts that coordinate the efforts of the judiciary, prosecution, defense bar, probation, law enforcement, mental health, social service, and treatment communities.
24. Eliminate the legal barriers that prevent people with documented recovery from becoming peers and professionals.
  - a. Clearing criminal records is not enough – records need to be expunged.
25. Work with mental health courts, judge champions, and advocacy groups to lobby for the elimination of these barriers and a written process for restoring these civil rights.

26. Partner with civil rights groups to learn techniques and strategies for reducing discrimination, increasing solidarity, and transforming culture.
  - a. For example, NAACP, United Farm Workers, American Justice
27. Request the California Law Revision Commission to make recommendations to the Legislature to remove discriminatory language that is embedded in statute.
28. Require the State to develop a board that requires and oversees that State agencies accept people with documented recovery to work directly as peers.
29. In the housing sector, outlaw the discrimination against people with co-occurring disorders based on requirements for being absolutely clean, sober, and relapse-free.
30. Promote the adoption of Housing First programs that focus on providing housing regardless of co-occurring disorders.

### **EDUCATION RECOMMENDATIONS**

31. Require the curricula for mental and medical health degree programs to include an education and training component on co-occurring disorders and integrated treatment models.
32. Train higher education counselors, dormitory supervisors, and residence assistants how to recognize the symptoms and respond appropriately to co-occurring disorders.

## Rural Communities Workgroup

January 14, 2009

Facilitator: Sam Magill

Significant disparity exists between the levels of mental health services in urban vs. rural areas. Rural areas are faced with unique challenges related to access, transportation, technology, and funding levels.

Often, small clinics serve large areas of land. Transportation and physical access to mental health care become significant issues, as some consumers must travel 2-3 hours to their provider. The number of care provider choices available for consumers is substantially smaller than in urban areas as well. Innovative care that utilizes the use of technology (web conferencing, chat rooms, etc.) and peer support are critical in these areas to provide care and support on an as-needed basis.

Funding levels for mental health services also vary greatly between rural and urban areas. Public funding is generally determined by population density and per capita use. For rural consumers, this equates to fewer options, longer wait times, and greater distances to the nearest mental health provider.

In addition to service disparities, the size of rural communities creates stigma and discrimination problems not seen in urban areas. Because rural communities tend to be very small and “everyone knows everyone else,” consumers face the unique challenge of everyone in the community knowing about their illness. Because of this, family members may be less inclined to acknowledge mental health challenges at home or in public.

Specific actions to reduce stigma and discrimination in rural communities include:

NOTE: Common “themes” and general areas for improvement that emerged in workgroup discussions are in **bold**. Actions specific to those themes are bulleted.

### Funding

- Develop advocacy strategy to establish same day MediCal reimbursements for federally qualified health centers.
- Develop funding sources to establish technology *and* technology support to address stigma and discrimination reduction. This could include funding for internet support groups *and* internet connections for rural consumers.
- Address the fact that rural counties are exempt from some MHSA funding requirements.
- *Address rural vs. urban disparities in funding for mental health services. Oftentimes, funding for services is based on average overall facility use. Because fewer people use rural health and mental health services, these facilities receive less funding, even though the per capita use and need for services is the same as in densely populated areas. Isolation is greater in rural areas and services hard to come by because of transportation issues. In rural areas, it could be more useful to provide funding based on the size of the terrain rather than the*

*population. In El Dorado County, the “Divide” community is 412 square miles wide, which makes services difficult to access. Acknowledge that rural funding needs are different than urban needs, and should be specific to rural communities.*

- *Take advantage of the fact that small counties have a natural built in community collaboration and networking that bridges the cost and services that large counties do not have.*
- *Consider training community services staff/volunteers to do the outreach or referrals to hard-to-reach populations*
- *Develop “blended funding” sources (i.e., match mental health funding with other community funding like fire services).*
- *Eliminate the medical necessity criteria under managed care mental health for county mental health services.*

#### **Lack of Choice (in provider selection due to long travel distances)**

- *Create a menu of stigma reduction choices available in rural communities. Distribute these fliers/pamphlets at basic community services (grocery store, fire department, community pool, schools, etc...)*

#### **Other**

- *Ensure enforcement of the Americans with Disabilities Act (ADA), the Fair Housing Act, [housing], and other state and federal non-discrimination policies and laws. Enforcement of the ADA would ensure that customers and clients with mental and physical disabilities are able to access all merchant and government services. Enforcement of the Fair Housing Act would ensure that housing applicants would be treated equally by housing providers, would be able to gain access to mainstream and specialized housing, and would not be steered to housing that segregates disabled tenants from non-disabled tenants or that segregates based on type of disability. Enforcement of the Fair Housing Act would also ensure that disabled tenants are not evicted if the owner’s provision of reasonable accommodations and modifications eliminate the need and/or reason to evict.*
- *Educate the public that the lack of funding for mental health services compared to other health services IS discrimination.*
- *Identify stigma reduction programs that already exist and bring them into schools and other community services.*

#### **Outreach Methods**

- *Develop partnerships with agencies and organizations that have access to local rural communities/residences (schools, fire departments, police, etc). Provide support and stigma reduction information to these agencies so that they can be the primary provider of information and help spread the message*
- *Develop community based media campaigns (TV, radio, news, etc.) using local family/consumers as agents of change.*
- *Develop stigma and discrimination reduction activities in communities to eliminate class-based discrimination in mental health issues. Class based*

discrimination is often particularly prevalent in rural communities, where poverty tends to be more wide spread.

- Pair mental health presentations within community presentations about other topics.
- *Use local major TV stations that reach across 4-6 counties, putting a message that incorporates contact information for many local counties.*

### **Peer Support**

- Support and empower consumers/family members to implement stigma and discrimination reduction ideas through peer support networks in rural areas.
- Create groups for activities unrelated to mental health so that peers become more than their illness.

### **Stigma Issues Specific to Small Communities**

- Acknowledge that stigma associated with mental health issues may lead to physical isolation in rural communities.
- Acknowledge that families may actively isolate individuals with mental health issues to keep the community at large from knowing.
- Acknowledge that the small size of rural communities allows everyone in that community to know “everyone’s business.”

### **Technology**

- Use communication technology (radio, internet, etc) to address stigma reduction issues in rural areas.
- Utilize telemedicine to provide increased choice and access to mental health services in rural communities.

### **Training and Education**

- Teach non-stigmatizing language to mental health professionals.
- Provide advocacy training to consumers and family members.
- Provide stigma reduction training for basic community service providers such as postal workers, grocery store clerks, and first responders (i.e., “regular people” separate from the mental health system).
- Provide stigma reduction training for faith-based professionals and clergy members.
- Educate the community about *existing* ADA and other anti-discrimination laws AND the consequences of violating these laws.
- Educate rural court judges on mental health issues.
- *Introduce anti-stigma campaigns into elementary, middle, and high schools, and community colleges. The Southern Poverty Law Center has award-winning educational programming for anti-stigma campaigns. See, “Teaching Tolerance,” <http://www.splcenter.org/center/tt/teach.jsp>*

**Transportation**

- *Develop transportation networks for trips to health services. Research local community and county compliance with ADA requirements for para-transit, sidewalks, and equivalent services.*

Promote the co-location of medical and mental health services to reduce travel time in rural areas.

## **Schools (K-12) Workgroup**

**February 3, 2009**

**Facilitator: Sarah Rubin**

### **INTRODUCTION**

Members of the work group felt this topic should include, at a minimum, preschools, if not other programs serving children ages 0-5. In addition, it should cover Adult Ed, which is offered by school districts.

Relevant concepts and action Items generated in January by the Work Group on Children are affirmed and incorporated.

Educational institutions and educational employees are often unfamiliar with the continuum of health concept and are unschooled in cultural competency. Because of this, interactions by teachers or school staff with students experiencing social, emotional or behavioral challenges, or with students from minority communities, may increase those students' experience of isolation and social exclusion and harm their school performance. Extra outreach efforts may be needed to reach these students if they fall out of the system.

These students may be treated differently by other students at school, and may be subject to acts of aggression and violence. Incorporation of mental health literacy, anti-stigma and cultural competency material in the K-12 curriculum can help educate members of the student body and help reduce the perpetuation of harmful stereotypes.

Support systems for students experiencing social, emotional or behavioral challenges, as well as for parents, siblings and family systems of these students, and teachers, can help build self-esteem and relationships and reduce stigma.

Efforts to help such students can be undermined by lack of communication and collaboration between different institutions, such as the mental health and school systems, or schools and law enforcement.

### **ACTIONS**

#### **☐ *TEACHER/STAFF EDUCATION***

**A. Establish state credential requirements and training programs to educate new and existing teachers on the continuum of health concept and cultural competency.**

1. Work with the California Commission on Teacher Credentialing to add mental health credential requirements for teachers and administrators. Utilize a mental health curriculum produced by DMH. In making these changes, make sure to get buy-in from the California Teachers Association and any other key stakeholders.
2. Develop ongoing training through salary point classes on a continuum of mental health.
3. Develop cultural competence education for both teachers and staff to reduce chances that expectation will negatively affect student performance, and to

reduce the risk of ethnic children, or children in the minority, feeling isolated or out of sort. These feelings have led to mental illness in Native and other children.

- a. Example: The PBS series “Unnatural Causes...is inequality making us sick?” talks about the “Latino paradox” – immigrant families show better health when they’ve first arrived. The longer time they are here, the less connected they are to their culture of origin and they experience an increased risk factor for mental disturbance.

**B. Ensure that support is provided for teachers at the school site.**

1. Ensure teachers have on-site support groups.

□ ***CURRICULUM FOR STUDENTS***

**A. Develop and incorporate mental health concepts into the state curriculum.**

1. Develop a mental health literacy curriculum for K-12, with a grade/age appropriate anti-stigma program at each grade level.
2. Mandate mental health issues in all state curriculum areas, both for students and teachers.
3. Produce a handbook/primer for mental health literacy and combating stigma for school health education programs.
4. Develop programs that include components for students to teach mental health curriculum themselves, so they feel invested. Youth learn what they teach better than being told.
5. To better prepare graduating students entering the workforce or educational systems, incorporate in the curriculum an integrated wellness/recovery model approach that encompasses the "whole" person through the continuum of care.
6. Educational tools could include games and CD-ROMs, which are both educational and entertaining.

**B. Ensure that California school curriculum and materials do not perpetuate stereotypes about different cultures, which can lead to school failure and mental health problems.**

1. Develop and incorporate cultural competency concepts into the curriculum. The curriculum should reflect the strength of a student’s or community’s cultural roots. Research has proven (Unnatural Causes) that people culturally rooted are less at risk for mental illness.
  - a. Example: A Native American student who challenged the use of a book in class that referred to Native Americans as "savages" and had other stereotypical language was told by the teacher that she would not stop using the book, but that the student could be excused from class while it was being used. Later, the school produced a play based on the book, and once again, the student was removed from that activity. Such approaches produce feelings of exclusion. This student later developed mental health issues.
  - b. Resource: Oyate.org is a resource for educators to include Native American perspectives in the curriculum. Anti-native curriculum has

often been the source of first break for Native American children exhibiting mental disturbance. See oyate website.

2. Assure funding and resources to enable schools to utilize existing cultural competency programs.

**C. Involve teachers, students and staff in curriculum development.**

1. Include teacher participation in curriculum development.
2. Involve students, as curriculum recipients, in curriculum development.
3. Involve staff as well, with the intent of positively affecting entire school cultures.

**D. Develop curriculum resources and a support system.**

1. Create a clearinghouse hosted by the Department of Education website, including resource materials for students, teachers, parents and others, as well as best practices.
2. Ensure students have self-help support groups.
3. Create vocational tracks so all students are valued.

□ ***STUDENT SUPPORT***

**A. Develop mental health support programs for students with social, emotional and behavioral challenges.**

1. Create support groups for kids who are victims of bullying.
2. Create clubs for mental wellness -- students can get support without having to go to groups.
  - a. Example: Gay Straight Alliances
3. Create pullout programs to build self-esteem and relationships.
4. Develop after-school and lunch programs on cultural strength, values and wellness
5. Develop mentor programs.
6. School student support teams should include youths, so that students have a peer to relate to, and do not feel targeted or ganged up on.
  - a. Examples: youth advocate, peer mentor.
7. Develop programs that provide role models of those who have overcome
8. Include a leadership component in all student support services so students learn to become active agents of change.
9. Provide support for students in dependency/foster care systems who may be at higher risk.
10. Create a safety net for young adults (who are under 18, but are still "children" and need parental involvement) so they don't fall through the cracks.
11. Develop counselor training for awareness/support for transitional age youth and those "aging out" of foster care/dependency in late high school.
12. Make resources available everywhere at school: classroom, library, lunchroom, hallways. Youth will get used to seeing mental health resources, and this will normalize getting help.
13. Hold higher education institutions accountable for appropriate student mental

- health services
14. Involve students who are not un/underserved.
  15. Embed mental health services in school health programs.
  16. Use existing annual data from California Healthy Kids surveys to prepare information for students on subjects such as bullying, violence, substance abuse and depression that they want and need. Data is there already -- use it!

□ ***DIFFERENT LANGUAGE***

**This theme for schools incorporates the following concepts (with amendments as underlined) developed by the Workgroup on Children at the January 14, 2009 meeting:**

The language of mental illness does not help children/adolescents with social, emotional, and behavioral challenges. Using such labeling reinforces discrimination, which in turn reinforces denial, fear, and shame on the part of families and self-stigma on the part of these children/youths. Rather than use mental illness language, it is more helpful and accurate to describe these children and adolescents as experiencing social, emotional, or behavioral challenges.

Additionally, describing mental health along a continuum of wellness helps normalize children's and youths' social, emotional, and behavioral challenges and is a particularly helpful concept for families trying to understand their child's problem. The mental health continuum concept can be used on a universal basis for all children and adolescents, and thus, is an important and responsible tool for reducing stigma and discrimination.

Lastly, it is very important that the California Plan for Mental Health Stigma and Discrimination Reduction model language that is supportive of children's and adolescents' healthy development and resilience and address their mental health issues separately from stigma and discrimination toward adults.

**A. Incorporate these concepts about mental health language into the state schools curriculum.**

□ ***EDUCATE AND SUPPORT PARENTS/SIBLINGS/FAMILY SYSTEMS***

**A. Develop educational programs for parents on childhood mental health issues.**

1. Provide early education for parents. Support their participation in these programs by providing childcare and other services.
2. Expand well baby kits to incorporate social and emotional development, as well as information on resources.
3. Enhance school readiness materials to include mental health (address the whole child) and substance abuse.
4. Link to the American Pediatrics Association for two-way outreach and education.

**B. Develop support programs for parents, siblings and family systems of children with social, emotional and behavioral difficulties.**

1. Create organizations like the Regional Centers to support families.
2. Develop self-help support groups for families.
3. Support the development of a culture of parent/teacher partnerships.
4. Create outreach strategies such as peer outreach and parent facilitators.
5. Ensure outreach addresses stigma to support families seeking/needing help. Include parents with young children as one target of outreach. Utilize PSA's, media, brochures in outreach.
6. Utilize a learning model.

□ ***MONITORING AND ACCOUNTABILITY***

**A. Develop monitoring and accountability systems in education at the state and local levels to ensure that school-related mental health programs are efficiently achieving their assigned goals.**

1. Ensure that the state Education Code is compliant with the Mental Health Services Act, including both regular and special education.
2. Create a monitoring/accountability group at the state level. This group should include broad representatives of interest areas, including possibly the California Teachers Association, the American Federation of Teachers, county superintendents, the Department of Education, the Department of Mental Health, the statewide PTA, student representatives (high school age), a governing body of the mental health/psychology field, and Peace Officers Standards and Training.
3. Publish an accountability report card.
4. Ensure more parent involvement in monitoring and accountability at all levels.
5. At the local level, develop a student monitoring/accountability component. It may be possible to use existing advisory boards.
6. Student representation in monitoring/accountability efforts should include more than one student so that there is shared learning and experience.

□ ***INNER SYSTEM COLLABORATION, CONFLICT***

**A. Create a place where people can bring collaboration and conflict.**

1. Develop a committee, working group or other entity, such as an ombudsman's office, that serves to support collaboration and is a place to bring conflict.
2. Use a "system of care" approach with the same language. Find a term for this approach other than "system of care" or other mental health system terminology.
3. Re-institute/expand AB3015 to be a continuum.
  - a. Evaluate various models for this program.
  - b. Use a model that incorporates powerbrokers.
  - c. Consider for possible Prop 63 funding.

## □ ***AWARENESS***

### **A. Enhance communication and understanding between the educational and mental health systems.**

1. Develop programs to ensure that administrators in the educational and mental health systems each become familiar with what is happening in the other system and develop an understanding of the other system's language.
2. Develop programs to educate mental health administrators about the challenges that schools and teachers face and to encourage mental health system support for educational system goals of academic achievement and success.
3. Educate teachers and administrators.
4. Promote collaborative partnerships.

### **B. Develop programs to increase awareness about mental health issues.**

1. Develop awareness programs that include content about restraint, seclusion and the effects on children.
2. Educate officers about stereotypes, especially in regards to violence, i.e., people identified as mentally ill are not, in essence, more dangerous than the general population. Include content about others such stereotypes, such as incompetence.
3. Develop school speaker programs featuring: 1. Youths who have experienced mental health problems; 2. Broad presentations by youth or younger adults who have successfully dealt with mental health issues, discussing self-esteem, wellness and cultural values.
4. Develop awareness programs to promote/uplift/encourage the successes of individuals with mental health challenges.
5. Develop materials written by or featuring youth.
  - a. Example: National Mental Health Awareness Campaign
6. Utilize communication avenues to best reach young people, including new media materials such as podcasts.

## □ ***SEARCH AND SERVE***

### **A. Develop programs to reach students with mental health challenges who have fallen out of the system.**

1. Use previous search and serve programs as a model. Expand and improve the language and approaches.
2. Ensure the following groups are among those targeted: immigrants, refugees, the homeless, runaways.
3. Establish a student services support team at every school that includes a nurse, psychologist, counselor, social worker and student peers.
4. Use peer advocates (students trained to identify and assist youth and refer them to higher care if needed) to help connect with all youth and help through transitions to high school.

□ ***LAW ENFORCEMENT INTERACTIONS***

**Group members, after their discussion, agreed that a number of the below items might be incorporated in the Law Enforcement Group's list of actions.**

**A. Increase collaboration and coordination between education, law enforcement and other institutions and interests.**

1. Encourage collaborative partnerships with schools, staff, clinicians, parents, PTA's and juvenile probation toward enhanced quality of life for K-12 kids.
2. Create a culture in which police and members of law enforcement are seen as a support and resource, especially for kids being stigmatized.

**B. Encourage programs that increase knowledge and understanding among law enforcement, youth and individuals with mental health issues,**

1. Encourage crisis intervention training (CIT) for all. Develop training programs for law enforcement, presented by community members, on youth behavior, including youth with mental health issues.
2. Develop presentations by community members to youth about police criteria for killing/using force with youth, so youth can modify behavior.
3. Fund more mental health crisis response units.
4. Provide support and evaluation for officers' mental health state of mind.
5. Provide trauma-focused treatment, evaluation and education for police officers, who may be suffering from PTSD.
6. Develop programs in which police with mental health issues serve as role models for treatment.
7. Develop presentations by members of crisis intervention teams.

□ ***EMPLOYMENT/CAREER DEVELOPMENT***

**A. Increase career-related linkages between schools and the mental health sector that incorporate stigma and discrimination reduction content.**

1. Develop "magnet" programs to funnel high school students into mental health jobs. Make sure these programs have a critical focus on stigma and discrimination reduction.

Develop school-business partnerships

## **Medical System Workgroup**

**February 3, 2009**

**Facilitator: Sam Magill**

### **INTRODUCTION**

In today's society, a clear dichotomy exists between physiological (i.e., "medical) health care and mental health care. Medical care receives significant funding from the state and federal government even though the medical system is *primarily* privately owned. Mental health care receives less funding, and is typically among the first services to be reduced during budget crisis. Creating parity between medical and mental health training requirements, funding levels, and public perceptions is vital to reduce stigma and discrimination against mental health consumers. This will allow all patients (whether medical or mental health) to achieve "wellness" instead of physical or mental health only.

Specific actions and suggestions related to mental health stigma and discrimination include the following:

#### **Training**

The workgroup determined that additional training for doctors, nurses, and consumers about mental health issues and peer support options is the best way to address stigma and discrimination in the medical system. It was commonly agreed that all training include consumers wherever possible. Specific actions included:

- Develop mental health training for primary care physicians, including medical school and mandatory continuing education units (CEUs). Emergency room rotations in particular should include mental health training.
- Review the adequacy of training assessments/testing for psychiatrists.
- CEUs should include information on differential diagnosis (e.g., dementia, AOD, etc.)
- Develop training tools for doctors and nurses that include the important role family plays in consumer care, as well as the unique stressors families face as caregivers.
- Develop training tools to address the tendency to blame the parents of consumers or stigmatize them for their children's mental illnesses.
- Require training for doctors on the use of psychotropic medications, including their adverse affects and interactions with other drugs.
- Provide training for consumers to teach them about their rights regarding medical record privacy.
- Require Community Clinics to have behavioral health components as a requirement for licensure.

#### **Diagnosis and treatment**

The workgroup identified several actions specific to the diagnosis/treatment of mental health issues by primary care physicians and nurses. Specific actions included:

- Create (or include within existing) medical assessment tools specifically to diagnose mental health problems in older adults. This will help address the stigma

- that dementia and Alzheimer's are a normal part of aging, as opposed to mental health issues in their own right.
- Revise diagnostic tools to look at “health and wellness” instead of physical health issues *or* mental health issues (e.g. ICD vs. DSM).
  - Raise the profile of looking at, screening for, and addressing mental health issues in the context of getting *medical care* as opposed to *mental health care*

### **Mental/Physical Health Parity**

The workgroup determined that the disparity between physical healthcare and mental healthcare is in itself stigmatizing. The integration of primary care and mental healthcare is critical for addressing this problem. “Health and wellness” rather than physical *or* mental health should be the main driver of the medical system. Specific actions include:

- The integration of community health clinics and mental health services. Community health clinics serve as the first point of contact with the health care system for many consumers, and can provide early intervention/detect first breaks.
- Eliminate preauthorization requirements in health care settings to provide or refer for mental health services.
- Revise “same day reimbursement” requirements for primary care clinics to provide mental health services on the same visit as primary care.
- Review and modify policies that restrict primary care providers’ ability to serve people with mental health problems or those in crisis. “Primary care” providers should also include non-traditional providers with training such as faith-based/community based organizations).
- Establish an ongoing collaborative (that includes primary care providers) to continue working on stigma and discrimination reduction.
- The Department of Mental Health should develop partnerships with/liaisons to primary care associations, health insurance companies, and public healthcare agencies to reinforce the idea of “health and wellness.”
- Establish consultation relationships between primary care and mental health (e.g. primary care physicians consult with psychiatrists for older adults with mental health needs).

### **Action Compliance/Enforcement**

The workgroup agreed that responsible parties/enforcement mechanisms should be identified to ensure compliance with the actions discussed above. Specific actions included:

- Develop formalized recourse for consumers (such as an on-sight ombudsman) if physicians under treat their medical issues because the consumer also has a mental health diagnosis. At times, medical symptoms/complaints aren't believed, or are seen as mental health symptoms by physicians.
- The Department of Mental Health or other agency must ensure that parity between mental and medical health is being enforced. This agency should work with other public health agencies to expand parity wherever possible.
- Provide patients with information on patient's rights and the benefits of allowing them to exercise those rights.

**Peer-to-Peer Support**

Peer support is important in every facet of the medical/mental health interface. Peer-to-peer support actions included:

- Develop peer-to-peer self help support groups for medical issues at medical providers.

## **Mental Health System Workgroup**

**February 3, 2009**

**Facilitator: Dorian Fougères**

The mental health system is designed to help people living with mental illness to live a better life. Service providers, consumers, and family members interact regularly within the system. For consumers and family members, however, the system itself can be a source of stigma and discrimination despite its good intentions. Consumers regularly express feeling dehumanized when they enter the system, and being treated as if they are fundamentally and irreconcilably different from the people serving them. For consumers, this dichotomy between people living with and without mental illness is itself false and misleading; mental health is seen as a continuum, with everyone moving between and occupying different spaces along that continuum at different times in their life. Family members regularly express feeling shamed and blamed for illness, and being treated as if their experiences are invalid and do not count. For both consumers and family members with different cultural backgrounds, the conceptual framework for understanding and treating mental illness as an individual condition can be at odds with the beliefs and practices of their cultural communities, where social bonds and support are paramount. In these ways, the mental health system can discourage those it seems to help from seeking treatment and recovering.

Consumers and family members seek to reduce stigma and discrimination in the mental health system by reframing their interactions with service providers. They emphasize being treated as whole, dignified people, not medical specimens. They want their capacity for recovery to be recognized and actively supported, and feel peers should play a major role in designing and running systems of care. They desire choices and a direct say in the approach taken to treat them; treatment in all parts of the system should be voluntary. Family members desire respect and to have their lived expertise honored. Culturally appropriate services must be provided throughout the state, and the concept of mental health rethought to emphasize community integration, belonging, and inclusion. In this vision of California, the mental health system is a tool for the self-actualization of consumers and strengthening of families and communities.

### **EMPLOYMENT RECOMMENDATIONS**

1. Provide equal opportunities for the meaningful employment and professional development of consumers in the mental health system.
2. Increase the presence of consumers in management and leadership positions in the mental health system.

### **EDUCATION RECOMMENDATIONS**

3. Better prepare mental health professionals (including but not limited to nurses, doctors, providers, first responders) to work with people with mental illness by improving their graduate training curricula, including training about mental health consumer culture.

4. Involve mental health consumers in developing and delivering education about stigma and discrimination to professionals and communities.
  - a. For example, the NAMI Provider Education Course.
5. Require periodic, ongoing training for professionals who work with mental health consumers.
  - a. For example, the What Mental Health Professionals Need to Know series of conferences and lectures.

#### **AWARENESS RECOMMENDATIONS**

6. Advertise stories where consumers and professionals in the mental health system have positive and respectful relationships. For example, Canada's You Know Who I Am program.
  - a. Sharing individual stories can change people and raise their awareness.
7. Support the establishment of Community Awareness Committees in every county to reduce the stigma associated with mental illness.

#### **INTEGRATION AND COLLABORATION RECOMMENDATIONS**

8. Integrate medical care and mental health care, including non-traditional providers and agencies, so both types of services can be provided at the same time.
  - a. For example, primary care providers that are federally-qualified health centers.
  - b. Non-traditional treatment settings can be less stigmatizing.
9. Fund community health centers that provide integrated services.
10. Foster collaboration and integration between community-based organizations that work on mental health issues.
11. Create university internships for students to work in MHSA programs.

#### **FUNDING RECOMMENDATIONS**

12. Evaluate current mental health service programs and reallocate funding to those which adopt the new way of thinking about and treating mental illness described in the introductory paragraph.
  - a. Include consumers in the process of evaluating services.
13. Allow counties greater discretion in allocating MSHA funding so that outpatient services are not overemphasized.
14. Redirect resources to prevention and to recovery program.

#### **INVOLUNTARY TREATMENT RECOMMENDATIONS**

15. Encourage consumers to seek treatment by reallocating MHSA funding for involuntary treatment to alternatives like crisis centers, particularly those that are consumer-run.
  - a. Fear of and stigma associated with arrest and involuntary treatment prevent many consumers from seeking any treatment whatsoever.
  - b. No involuntary treatment anywhere.
16. Review county regulations on involuntary treatment and shift decision-making authority to people who know the clients, and include clients in decision-making.

17. Foster the appropriate emergency treatment of mental health consumers by shifting liability for supervision from law enforcement officers to appropriate professionals and facilities.
18. Ensure that mental health-related emergency calls are redirected from police first responders to licensed clinicians with adequate training and capacity for responding.
  - a. Law enforcement officers have on average 20 minutes to respond to a call, and are not able to treat people living with mental illness adequately in such a short time.
19. Ensure that police are paired with licensed clinicians when responding to mental health-related emergency calls.
  - a. Mental Health Mobile Evaluation Teams (METs) are an example of such pairing.
20. Build partnerships so that mental health consumers in crisis can be brought in by police officers and then evaluated for 5150 by licensed clinicians before any action is taken.
21. Reallocate a portion of emergency response funding to increase the number of licensed clinicians available to respond to and evaluate mental health emergencies.
22. Recognize that while involuntary treatment can ensure public safety and prevent tragedies and crimes in specific situations, it must be fully justified and properly used.
  - a. In minority communities, involuntary treatment can be the only way people living with mental illness enter the system.

#### **COURT SYSTEM RECOMMENDATIONS**

23. Educate judicial officers about mental illness diagnosis, risks associated with mental illness, recovery from mental illness, and evidence-based best practices for sentencing.
24. Reduce mental health discrimination and tailor services to consumers by integrating family, drug, homeless, and probation courts with mental health courts.
  - a. An example is SAMHSA's Prevention Pathways.
25. Promote the establishment of collaborative courts that promote accountability by combining judicial supervision with rehabilitation services that are rigorously monitored and focused on recovery.
  - a. Recognize that collaborative courts are distinct from "calendar" cases of a similar nature together in the regular calendar of a single judge, and from mental health/probate calendars that deal primarily with probate/estate matters and conservatorships.
26. Promote access to services at the lowest appropriate level.
  - a. Jails and prisons are expensive.

## **Mental Health System Workgroup**

**February 3, 2009**

**Facilitator: Susan Sherry**

**This write up has three major sections:**

- I. REDUCING STIGMA & DISCRIMINATION WITHIN THE OVERALL MENTAL HEALTH SYSTEM**
- II. REDUCING STIGMA & DISCRIMINATION TOWARD ETHNIC AND RACIAL COMMUNITIES**
- III. PREVENTING THE USE OF FORCE TOWARD INDIVIDUALS EXPERIENCING MENTAL HEALTH CRISES**

- I. REDUCING STIGMA & DISCRIMINATION WITHIN THE OVERALL MENTAL HEALTH SYSTEM**

**1. Develop and implement a range of specific strategies within the mental health system to make recovery and wellness the preeminent model for services and relationships with clients and family members. Corollary recommendations include:**

- a) Deepen the understanding within the mental health system, particularly among providers, policy-makers and advisory bodies, that recovery and wellness models are based on the innate potential of persons living with mental illness to heal, to make self-determined and informed choices about their treatment, and lead independent, productive and fulfilling lives. The recovery and wellness model emphasizes the use of strength-based assessments, treatment and service programs.
- b) Establish recovery, wellness-oriented and rehabilitative services as the standard of care in the mental health system and incorporate this approach into mental health provider degree and credentialing programs.
- c) Develop a unifying definition of recovery and wellness and specify particular services and methods that promote recovery and wellness. Include clients and family members in this definition and specification process.
- d) Change the language of mental health services and treatment from mental illness-oriented to recovery and wellness-oriented. This language would honor the universality of such human conditions such as fear, anxiety,

depression, and panic and reduce the use of stigmatizing terms applied to consumers and family members (e.g. border-line; enmeshed; symbiotic, over-involved; histrionic, etc).

- e) Develop and conduct training programs for mental health providers to learn more about strength-based recovery model, to enhance their recovery-based treatment methods, and to establish recovery-oriented and rehabilitative services as their standard of care. Incorporate clients and family members as part of the teams that conduct these trainings.
- f) Develop “contact” programs between providers, consumer and family members that build the interactions on an equal-status basis. For example, establish client-run training programs for mental health service providers on recovery and wellness methods.
- g) Establish programs to promote dialogues among consumers and providers regarding recovery and wellness. Establish similar dialogues among consumers and family members.
- h) Promote recovery and wellness models to consumers, families, policy-makers and the public at large by:
  - i. Establishing programs to promote active dialogues among family members and consumers regarding recovery and wellness.
  - ii. Developing a series of self –help tools for use by consumers and family members and offer more treatment and service programs for consumers that are self-directed.
  - iii. Provide information and training to policy-makers and advisory boards on recovery and wellness models.

## **2. Establish peer-to-peer services as a routine component of systems of care.**

- a) Dramatically increase the numbers peer-run mental health programs, both voluntary and ones operated by clients paid to manage the service.
- b) Use peer-to-peer programs as vehicles for building the capacity of consumer as well as to build partnerships among consumers, families and providers.
- c) Integrate peer-to-peer methods into workforce development strategies.

## **3. Increase the numbers of mental health providers, especially those from communities and populations living with double stigmas (e.g. ethnic and racial communities, LGBTQ) and/or from communities with special needs (older adults, veterans, rural.)**

**4. Develop public and system-wide awareness that providers of mental health also are stigmatized and that stigmatization is most visibly demonstrated by the lack of resources provided to the mental health system. Corollary recommendations include:**

- a) Provide resources to increase the mental health services and workforce.
- b) Increase the pay and training opportunities for mental health system personnel, particularly providers of services.
- c) Develop programs to assist mental health providers to address the stress caused by the demands of their work.
- d) Expand public reimbursement programs and private medical insurance to cover the service costs of a wider range of mental health providers.
- e) Revise government policies to allow primary care FQHCS to provide mental health services and to be able to be reimbursed for services provided on a same day basis.
- f) Allow Medi-Cal providers to be able to apply for Rehab Waivers

**5. Provide mental health services at sites that carry less of a stigma for consumers and family members, for example primary care physicians, medical offices, community clinics, school counselors, etc. This also has the important benefit of integrating the medical and mental health service systems.**

- a) Co-locate medical, mental health and other social services at the same site. This is particularly helpful for the older adult population.

**6. Review mental health systems' policies and practice to identify and then correct stigmatizing and discriminatory behavior toward consumers and families.**

- a) Seek out the guidance from consumers, families and communities on how to reduce stigma and discrimination.
- b) Develop programs to acknowledge and reduce mental health stigma and discrimination toward family members.
- c) Increase the numbers of consumer and family members on MHSA boards and advisory entities. Establish weekend and evening time slots for MHSA public briefings that are now done during typical work-time hours.

7. **Provide information for consumers and family members on how to navigate the mental health system as one way of combating self-stigma.**

## **II. REDUCING STIGMA & DISCRIMINATION TOWARD ETHNIC AND RACIAL COMMUNITIES**

**1. Increase the provision of culturally competent mental health services. Ethnic and racial communities experience less stigma when services and service delivery methods reflect, are consistent with, and are respectful of a person's culture and cultural values.** Corollary recommendations include:

- a. Develop effective practices for specific ethnic and racial populations, and distribute this information widely within the mental health, public health and medical systems. Draw on lessons learned from other successful public health efforts in ethnic communities that could be applicable to mental health (e.g. HIV, teen pregnancy, reproductive health, etc.).
- b. Allocate and protect funding for culturally competent services. Too often culturally appropriate services are the last to be implemented and the first to be eliminated in economic down-turns.
- c. Develop and conduct training programs for mental health providers in cultural competency, which includes a component that assists providers in understanding their own biases and stigmatizing attitudes and behaviors toward consumers and families from ethnic and racial communities.
- d. Establish an effort comprised of representative from diverse backgrounds, experiences and expertise to review and revise the current definitions of recovery and wellness so that these concepts are culturally-sensitive and include ethnic and racial communities' perspectives, beliefs and visions of mental health, family roles, wellness and recovery. Recognize role of preserving and supporting racial identity in recovery.
- e. Promote respect for and acceptance of traditional and cultural forms of healing within ethnic and racial communities. These forms of healing are not considered "alternative" by ethnic and racial communities. De-valuing such methods is not helpful to recovery and wellness for individuals from ethnic and racial communities.
- f. Implement cultural competency standards .to more objectively measure culturally competent services... Process indicators of cultural competency are not useful as they do not focus on outcomes, but rather on numbers and through-puts. Standards can lead to more accountability and transparency

g. Conduct an assessment of the current mental health workforce to determine its capacity to serve ethnic and racial communities.

h. Increase the numbers of mental health professionals from ethnic and racial communities through aggressive workforce development programs. Mental health professionals should reflect the ethnic and racial make up of the communities they serve. Ethnic and racial mental health providers should proportionally reflect the ethnic and racial population make-up of California.

i. Hire more consumers and family members from ethnic and racial communities to work within the mental health system.

j. Substantially increase the number of ethnic and racial representatives with mental health expertise who sit on state and local mental health policy boards, commissions and other policy-making bodies, including the policy and advisory bodies related to the implementation of MHSA.

k. Implement Title VI language, (part of Civil Rights Act of 1964) as may apply to mental health stigma and discrimination regarding ethnic communities. Title VI prohibits discrimination on the basis of race, color, and national origin in programs and activities receiving federal financial assistance.

**2. Provide equitable allocation of and access to mental health resources and services to ethnic and racial communities, along with accountability measures to ensure disparities are rectified as one of the mental health systems' highest priorities. Increase the recognition within the mental health system and among policy-makers that ethnic and racial communities seeking mental health services face double stigma - racial prejudice and mental health stigma. This double societal stigma contributes to the severe lack mental health funding provided for ethnic and racial communities.**

a. Conduct assessments and other studies to define the disparities (e.g. access, quality; availability; resource distribution, etc.) related to the mental health services provided to ethnic and racial populations and to identify ways to evaluate changes in the level of disparities over time.

b. Fund population-specific programs to address service disparities within the multiple ethnic and racial communities in California.

f. Evaluate statewide, local and other mental health system and organizational policies and funding for biases and potential discrimination toward ethnic and racial populations

- g. Develop a definition of “need” for funding that will foster greater equity in funding for ethnic and racial communities. For example, some populations may not be well reflected in standard measures such as census data.
- h. Develop oversight mechanisms at the local level to monitor equitable funding for ethnic and cultural communities.

**3. Develop programs that engage ethnic and racial populations in their own communities and contexts to identify how to reduce stigma and discrimination toward individuals and families experiencing mental health problems.**

**4. Provide mental health services to ethnic and racial communities at a lowest level of intensity possible (e.g. primary care physician rather than a mental health clinic) as these types of services are considerably more acceptable to racial and ethnic communities and thus less stigmatizing.**

### **III. PREVENTING THE USE OF FORCE TOWARD INDIVIDUALS EXPERIENCING MENTAL HEALTH CRISES**

**1. Develop strategies to prevent the need for force and forced compliancy, including the use of restraints, seclusion, and unnecessary medication or medical interventions, in responding to perceived or actual mental health-related emergencies. This includes preventing the need for 5150s by law enforcement officers.**

- a) Develop and widely disseminate, through written information, trainings, seminars, inclusion in curricular programs and other communication vehicles, de-escalation approaches and techniques known to diffuse perceived or actual mental-health emergencies. Information on how to respond to trauma would be a key part of this effort. Information and education opportunities regarding de-escalation would be designed for potential first contact individuals including those from law enforcement, emergency and psychiatric response, clinicians and mental health providers, emergency room personnel, homeless shelters, outpatient medical, families, and others in a position to be a first-responder in a mental health-related emergency,
- b) Fund residential and other crisis intervention programs that provide response personnel with alternatives sites for individual experiencing a mental health crisis other than jails, hospitals, emergency rooms and other similar facilities. There are several very successful programs in California to use as models, including
- c) Provide resources for law enforcement and other emergency response personnel to have immediate access to mental health clinicians, skilled in de-escalation and mental health emergency evaluation, who can accompany responders to a mental health-related emergency. Mental Health Mobile Evaluation Teams (METs) are

an example of such a program. If a clinician can not accompany the first responders to the emergency site, arrange for a trained clinician to be available to talk with and evaluate the status of the individual in crisis before any legal, site transfer, or other action is taken. In all of these situations, emphasize the need for shared-decision making with the individual in crises, and their family as appropriate.

- d) Integrate peer support from mental health consumers into the programs and operational protocols of agencies responsible for responding to mental health-related emergencies.
- e) Work with local emergency response agencies to identify situations where mental health-related emergency calls can be directed to trained clinicians rather than traditional first responders.
- f) Initiate an effort to review and revise county regulations and first responder protocols regarding emergency response to prevent the need for force and forced compliancy in responding to perceived or actual mental health-related emergencies. In this review, identify if individuals from ethnic, racial and other vulnerable populations (e.g. LGBTQ; youth, etc.) are treated differently than others and, if so, develop procedures for first responders to ensure that this does not continue. Along with this review, assess the potential for shifting the liability assumed by first responders in a mental health-related emergency to trained clinicians and mental health facilities as appropriate.

Develop and widely disseminate a synopsis of state and county laws and regulations on involuntary mental health care to emergency response personnel, emergency room personnel, hospitals, outpatient medical facilities, mental health professionals, families, and others who may respond to a mental health-related crisis.

**Housing Workgroup**  
**February 3, 2009**  
**Facilitator: Sue Woods**

**INTRODUCTION**

Housing is a fundamental need. *Housing First* was a universal theme expressed by the Work Group of four service providers and mental health professionals. The alternative is homelessness, which carries its own stigma. Unfortunately there are many challenges to providing and acquiring appropriate housing for consumers. The Work Group was asked to identify actions that could be taken to reduce discrimination and stigma against mental health consumers with regards to housing. The group, with added input from other meeting participants, agreed that the following topics need to be considered:

- Community acceptance
- Availability of affordable housing
- Service Models
- Types of Housing
- Regulations
- Education
- Advocacy
- Success criteria
- *Housing First!*

The following actions were recommended to reduce stigma and discrimination resulting from housing issues:

**COMMUNITY ACCEPTANCE**

The public often fears what it does not know. Mental health issues are easily ignored behind a shield of NIMBY-ism due to public fear and ignorance. Introducing the community to consumers gives the public a chance to meet and interact with individual consumers, allowing them to better understand mental health issues. This engagement hopefully leads to reducing discrimination and stigma. The Work Group recommended the following actions:

1. Reduce stigma and discrimination by bringing mental health providers, community members, residents/tenants, and developers/property managers together from conception through to the completion of the housing project. Increased interaction promotes understanding and reduces stigma and discrimination.
2. Take elected officials on tours of developments and service delivery models to introduce them to the facilities in their areas, the consumers utilizing the facilities, and the special needs of consumers. Educating elected officials is an important step in stigma and discrimination reduction.
3. Invite and utilize volunteers to assist at mental health developments. One model cited is “Gardening Angels” – community members who volunteer to work with

- consumers on a community garden at a given housing development. Gardening builds community. The interaction between community members and consumers reduces stigma.
4. Bring community professionals (ex. physicians, dentists, etc.) to mental health developments to improve interactions. Consumers, fearful of discrimination, can be reluctant to venture outside the development to obtain needed services from unknown providers.
  5. Create opportunities for consumers to interact with the community. An example provided was utilizing consumers to distribute disaster preparedness information to residents in their neighborhood.

## **FUNDING**

Funding is at the heart of delivery of housing services. Without funding, there is either inadequate or insufficient housing. Homeless populations are heavily discriminated against. To reduce discrimination and the stigma of homelessness, the Work Group recommended the following actions:

1. Establish a permanent funding source for affordable housing. Sponsor or support a legislative campaign for a permanent funding source.
2. Leverage the Mental Health Agency's funding to smooth out the spikes and gaps in variable funding streams.
3. Transform funding and disassociate it from site control and development priorities. Development priorities do not always match consumer's needs.
4. Create a single-source funding stream to facilitate the creation of housing by mental health agencies..
5. Simplify the process to use existing housing rather than building new housing. Currently the emphasis is on new development. Not only does it take more time to develop the property, but the current economic crisis has tightened credit - resulting in substantially fewer new development starts. There is a glut of existing housing that could be modified economically and expeditiously to meet the increase in demand.
6. Once housing is established, fund support services to ensure housing is maintained.

## **TYPES OF HOUSING**

To reduce both discrimination against consumers, and the internal stigma experienced by consumers, appropriate housing is fundamental. The Work Group recommended the following actions:

1. Meet consumers immediate housing needs (whether transitional, permanent, or emergency housing) to reduce the stigma of homelessness.

2. More completely integrate mental health housing into communities so as not to “billboard” consumers.
3. Promote mixed population housing to reduce stigma and promote acceptance.
4. Promote permanent housing to normalize living environments and change community perceptions. The goal is to eliminate stigma.
5. Don’t forget people “at risk” whose families need respite and supported housing for their family member.
6. Separate housing to provide specific services to specific populations.
7. Provide separate housing opportunities for young adults and older adults. Involve the young adults in the planning and development of ideas.
8. Provide housing options and funding for individuals with co-occurring disorders/issues (e.g. substance abuse and mental health challenges.)

## **REGULATIONS**

The world of mental health is governed by regulations. Regulations can work to support or prevent adequate housing. The Work Group recommended the following actions:

1. Analyze/study points of conflicting regulations at local, state, and federal levels. In some cases, accepting benefits from one program prevents eligibility in other programs. The example cited was acceptance of emergency housing rendered the consumer ineligible for long-term Section 8 housing.
2. Advocate to HUD for clear and consistent interpretation of regulations. This would lessen the likelihood of different interpretations by local agencies.
3. Change policies that are too lax – particularly ones that make it too easy for cities and counties to acquiesce to NIMBY-ism.

## **EDUCATION**

Reduction of discrimination and stigma can best be achieved by education. Surprisingly, not just the public needs to be educated, but also regulatory agency staff, service providers, property managers, and even consumers. The Work Group recommended the following actions:

1. Request the Department of Mental Health produce and disseminate guidance documents on stigma and discrimination to mental health clients in housing.
2. Educate the Department of Mental Health to not stigmatize consumers within housing.
3. Require that borrowers of State Housing funds must have property managers attend DMH sponsored training on mental health issues and reduction of stigma and discrimination.
4. Educate Housing Authority staff on mental health issues. Obtaining housing is not the end of the story for mental health consumers. Additional services are required for maintaining residency.
5. Create more opportunities to socialize and transition 30 – 50 year olds from institutionalized or board and care facilities to independent living.

6. Educate stakeholders and advocates.
7. Educate renters and landlords about their mutual responsibilities.

## **ADVOCACY**

Consumers are not always able to resolve housing issues by themselves, often leading to self-imposed internal stigma. Advocacy can support consumers by providing direct assistance, or by providing a consumer-friendly system. The Work Group recommended the following actions:

1. Create a Department of Mental Health Ombudsman position to assist with consumer housing issues.
2. Create cross-training for mental health advocates to understand Fair Housing issues, and Fair Housing advocates to understand mental health issues.
3. Create management level advocates within the Department of Mental Health and Fair Housing that will promote the effectiveness of peer-to-peer services.

## **SUCCESS**

How do you measure success? Can housing create healthy communities? Unfortunately the Work Group ran out of time before these questions could be answered and actions developed.

## **Employment & Workplace Workgroup**

**February 3, 2009**

**Facilitator: Sam Magill**

### **INTRODUCTION**

Mental health consumers in the workplace face a number of challenges that non-consumers do not. These challenges extend throughout the application/pre-employment process and into the every day tasks of employment. In addition to the negative view of mental health problems held by many non-consumers, consumers in the workplace may suffer from a self-stigmatizing view of any performance challenges they may have.

While stigma and discrimination in the workplace are significant challenges for consumers, employment itself can be a major factor in the recovery process. Creating employer awareness of mental health issues is critical for the success of consumers in any job. Employer education that consumers are an asset to the company is very important, and company “wellness” campaigns should focus on overall health, including mental health training similar to ergonomics adjustments.

Specific actions include:

### **Employment in the Mental Health Field**

- Establish positions for young adult consumers at the county level that are “real” positions and not token jobs. Policies should have clear expectations on what can be offered to younger people. This will help young consumers develop work experiences that they will be able to carry with them for their entire lives.
- Develop policy guidelines (within organizations and at the state level) that recognize the benefit of hiring consumers with real life experience for mental health positions.
- Hire consumers for positions other than typical “consumer” jobs.
- Train the mental health workforce in “client culture.”
- Use peer support groups within the mental health system for consumer employees.
- DMH should create a consumer mental health liaison to the California Department of Rehabilitation.
- Assign one DMH staff member to county mental health departments and school districts.

### **Internal Company Policies**

- Company personnel policies should see consumer life experiences as a desirable quality.
- Develop employee education about the necessary accommodations for mental health issues. Mental health training must highlight consumer success stories and acknowledge that they are part of the workforce.

- Mental health issues should be addressed from a business/profit perspective: providing consumers with peer support opportunities cuts treatment costs and boosts productivity.
- Develop internal company policies on disability discrimination and harassment that include illustrative examples of the consequences for breaking those policies. DMH should create a model to role out this policy.
- Recognize Certified Psychiatric Rehabilitation credentials for Medi-Cal Reimbursements.

### **Employment Partnerships**

- Private companies should interact with the mental health system to develop a consumer workforce development system.
- Examine the recommendations from the Consumer Employment Summit in 2008. A report from the Summit can be found online at <http://cmhda.org/go/MentalHealthServicesAct/WorkforceEducationandTrainingWET.aspx>.
- Utilize existing partnerships like the Workplace Partnership for Mental Health; [www.workplacementalhealth.org](http://www.workplacementalhealth.org).
- Develop partnerships between organized labor and existing consumer advocacy groups.
- Use the example of programs like “Us+Them=We” in San Bernardino County to bring working and non-working consumers together in the workplace.
- Partner with local chambers of commerce to develop anti-stigma/discrimination material.
- Investigate the Business Leadership Network for partnership opportunities.
- Senior employment programs could benefit from a partnership with mental health programs serving seniors.

### **Funding Issues**

- California should apply to Medicaid for workplace rehabilitation funds. Peers can bill for services within the workplace to maintain treatment flexibility.
- Fund contract programs within many types of organizations.
- Maintain adequate funding levels to ensure that new consumer employees can be hired for MHSA positions, instead of keeping existing staff employed and shifting them to the MHSA.
- Dedicate funding for ongoing mental health treatment and peer support once a consumer is hired. To reduce costs, utilize technology such as web conferencing in rural areas.

### **Training**

- Train consumers currently in recovery for professions in police, paramedic, housing, and other public safety professions.
- Use older adults to promote training regarding mental illness/mental health.

- Use peer trainers to put on “mental wellness” training in the workplace. The University of Southern California has funding available for consumers to “train trainers”. Due to county budget restrictions, private programs like this should be utilized wherever possible.

### **Other**

- Workplace stigma and discrimination reduction training should be flexible enough to apply to small businesses and large corporations.
- Investigate the AOD system, which integrated “recovery” many years ago.
- Create self employment options for consumers to avoid the issues of stigma and discrimination. Self employment provides consumers with the scheduling flexibility they may need when issues arise.
- Develop statewide policy changes regarding the licensing or background checks used for employing a consumer with past criminal history.
- Create opportunities for job sharing
- Document empirical evidence regarding the benefits of consumer employment and personal testimony.
- Stigma reduction campaigns should include employment issues related to family members.

### **Cultural Competency**

- Recognize and provide extra support for ethnically diverse consumer staff to ensure their success in the workplace.
- Recognize that consumers/family members of color may need more support than majority consumers.

Develop “culturally competent” concepts to accurately reflect the proportion of staff with disabilities.

**Media Workgroup**  
**February 3, 2009**  
**Facilitator: Julia Lee**

Participants in the media workgroup expressed deep concern that the public perceives people with mental illness as more violent than the overall public. However, in fact according to data this is not true. To combat this misperception the group recommends that alternative non-violent representations and information about people with mental illness be promoted in media. The term “violent” may not be a label that applies to all populations, such as children, where instead words like “weird” or “nerd” may be used. The various types of media including multi-media, alternative media (games, podcast, blogging, web) community media, commercial media, as well as film and televisions are all important in addressing stigma and discrimination reduction. Contact with the media should include proactive as well as reactive efforts. Some types of media may be more helpful in targeting particular populations such as alternate media in reaching youth or AM radio for some parts of the Latino community.

Big media campaigns can be expensive and research has not necessarily shown them to be particularly effective. The group recommends using grass roots and bottom up media approaches to target specific populations taking into consideration the differences in how ethnic communities and age groups may define mental illness. These grass roots efforts also offer the benefit of getting the client voice heard in the community as well as reaching transitional age youth and other marginalized groups. The power of television shows and films to reduce stigma and discrimination was also discussed.

DRAFT RECOMMENDED ACTIONS ON MEDIA

COMMUNITY BASED EFFORTS

1. Develop ethnically and culturally relevant grass roots and bottom up media efforts targeting specific populations, including opportunities for client voices to be heard in the community.
2. Develop drop-in media centers for youth, homeless, and low-income people, and communities of color. Examples are: Road Dawgz Youth Drop-In in San Francisco & Silicon Valley DeBug in San Jose.

COUNTY EFFORTS

3. Develop county specific lists of clients and family members to provide media with personal stories and information on mental illness and recovery.
4. Drive and inform statewide efforts based on media efforts in the counties.

5. Develop increased ties with community- based media and increase utilization of public service announcements.

#### STATEWIDE CAMPAIGN

6. Include consumers in the design, development, and evaluation of media efforts, leveraging ethnically and culturally relevant grassroots, bottom media efforts.
7. Utilize media and marketing professionals to complement the key role of consumers in the design, development, and evaluation of media efforts.
8. Address self-stigma in media efforts including information on self-help, recovery tools (e.g. WRAP), and self-acceptance.
9. Look at and borrow successful approaches from other campaigns such as reproductive health and AIDS.
10. Target media efforts to specific populations and feature individuals that will make an impact on that population.

#### *Accountability*

11. Develop a statewide mental health media ethics committee including: consumers, media, and mental health experts to respond and evaluate programming to reach out to local communities and media professionals and to develop a media ethics quarterly report.

#### *Training*

12. Develop media training for local communities on print and TV media including how to develop press releases.
13. Develop training for consumers to act as hosts for television and other media programs.

#### *Ethnic & Cultural Communities*

14. Ensure that differences in how various ethnic groups define mental illness is reflected in media efforts.
15. Work to overcome any negativity that may exist between traditional media and some ethnic communities that may minimize effectiveness of media efforts.
16. Identify communication models to communicate with ethnic cultural groups.

#### *Resources & Coordination*

17. Set up an Office to work directly with media that:
  - a. Fosters efforts such as cable TV's Cable Positive for HIV/AIDS.
  - b. Assures media campaigns meet recommended standards.

- c. Work to coordinate with local county campaigns.
  - d. Maintains website that includes/educates on wellness, signs and symptoms that is easily accessible to the media.
  - e. Develop a statewide hotline 1-800 number for both clients and community that can provide on county-by-county basis resources and expertise.
18. Develop a statewide resource guide that is regularly updated and customized by county that includes names of people and FAQ's and resource lists.
    - a. Include contacts such as: experts, local contacts, state level contacts, individuals experiencing mental illness taking into consideration need for media to have variety of contacts ranging from advocates to those that are neutral.
  19. Cultivate Media Champions by creating a group of journalists, editors, writers, ethnic media, and consumer reporters who have shown interest in mental health and providing with short conferences to educate them on mental health. Use a catchy positive name for this group to encourage participation.
  20. Connect media with client community events and other current events such as May is Mental Health Month.
  21. Provide media with history and evolution of client movement and it's connection to civil rights and produce a documentary on the history of the client movement in California.
  22. Develop outcomes for media campaigns resulting in *behavioral* changes among groups who are most likely to discriminate and contribute to prejudice.
  23. Develop a video presentation for K-12 to address stigma and discrimination that features characters of interest to children such as action heroes reflecting how children experience stigma and discriminations.
  24. Develop a depression awareness campaign targeting older adults to reduce stigma associated with depression, particularly older men that experience highest rate of suicide.
    - a. For older adults use champions such as Patty Duke and Glen Close.
  25. Provide *positive* feedback to media via letters, emails, honoring individuals, when see a positive, anti-stigma story.
  26. Develop statewide use of college campus radio and campus websites to portray positive mental health messages and as a means for educating and raising awareness.

*Film & TV Media*

27. Support efforts to embed clients in soap operas or other programs.
28. Develop end of the program “tag lines” to provide information on where to get mental health information.
29. Seek to cross-promote with programs within networks.

*Media Messages & Themes*

30. Develop messages for media that promote alternative “non-violent” representations of people with mental illness including:
  - a. “Take the crazy out of crazy”
  - b. Consumers are all walks of life, not necessarily distinguishable.
  - c. It’s happening in my family too.
  - d. “All” have mental health.
  - e. “Mental health matters” (particularly important message for transitional age youth)
  - f. “Depression is not a normal part of aging”...”Talk with your doctor”
  - g. Talking about civil rights issues when address stigma and discrimination.

## **Law Enforcement Workgroup**

**February 3, 2009**

**Facilitator: Dorian Fougères**

The law enforcement system is designed to ensure public safety and protect people in crisis from themselves. The interface between law enforcement officers and people living with mental illness, however, can be tense, especially given existing constraints on an emergency call and response. Officers have limited training, resources, and particularly limited time to serve people in crisis, yet mental illnesses are complex, diverse, and manifest differently in different people. Compounding these acute factors are the societal stereotypes, fears, and debates about people who live with mental illness, and pressure to “do something.” At the same time, mental health consumers are particularly vulnerable. They are more likely to be subject to violence than the general population, and those who enter the criminal justice system then face a double-stigma when they return to society. As a result, positive interactions between law enforcement and mental health consumers are irregular, and both groups continue to be criticized, stigmatized, and harmed by society and by each other.

Improving the interface of law enforcement, mental health consumers, and their families must recognize this social context. In discussions it was noted that California shifted the responsibility for mental illness from mental health institutions to law enforcement in 1969. A central question is whether California has realistic expectations of law enforcement, and whether law enforcement’s existing responsibilities and liabilities for mental health crises are appropriate.

Given the current responsibilities of law enforcement, consumers and family members seek to reduce stigma and discrimination by reframing their interactions with law enforcement personnel. The fundamental starting point is that both consumers and officers are human beings that deserve to be treated with respect and dignity, rather than stereotyped. Both consumers and officers are diverse groups of people, and cannot be lumped together as if they were all the same. People in both groups have been developing new ways of thinking and new ways of interacting that need to be recognized and supported. Issues of restraint and incarceration remain contested. But both groups agree on the need for new approach emphasizing long-term solutions, community-oriented policing, peer support, and partnering with mental health service providers and professionals.

### **EDUCATION AND TRAINING RECOMMENDATIONS**

27. Require mandatory training for law enforcement officers, from the highest through the lowest levels, including basic training at the police academy, on the following topics: sensitivity training; stereotype avoidance (particularly regarding violence); display behavior recognition; de-escalation techniques; and avoiding 5150.
28. Involve consumers and also families in designing and delivering education and training.

29. Train law enforcement officers to write case reports that emphasize appropriate diagnosis.
30. Require all State, county, and municipal law enforcement agencies to establish Crisis Intervention Teams as a best practice for increasing awareness and improving diagnosis of mental illness, thereby reducing violent interactions.
  - a. Santa Clara County has had marked success with this approach.
  - b. This is not feasible statewide. Other proven practices need to be in the plan. See Stafford, S. Policy Framework for Law Enforcement thesis available in CSUS Library.
31. Make the Peace Officers Standards and Training a statewide association.
32. Establish community education programs that cover a range of law enforcement interactions – not just criminal acts – and link mental health staff, consumers, families, and underserved and un-served populations.
33. Establish two-way training programs so law enforcement can learn about mental health issues at the same time as consumers, mental health providers, and communities learn about law enforcement mandates and constraints.
34. Establish peer-to-peer support groups for police officers

#### **COLLABORATION RECOMMENDATIONS**

35. Ensure that police are paired with licensed clinicians when responding to mental health-related emergency calls.
  - a. Mental Health Mobile Evaluation Teams (METs) are an example of such pairing.
  - b. When an emergency response includes police officers a community may feel stigmatized.
  - c. Response teams should be created that do not involve police officers.
36. Ensure that police officers who respond to mental health-related emergency calls disclose their identity and status.
37. Create a Police Dispatch Checklist which identifies whether a mental health issue is involved and provides a mechanism for pairing officers with licensed clinicians in real-time response.
38. Ensure that mental health-related emergency calls are redirected from police first responders to licensed clinicians with adequate training and capacity for responding.
39. Foster direct dialogue between peer and advocacy groups and law enforcement officers about best practices for emergency response.
40. Partner with trained mental health providers to provide services for incarcerated consumers.
  - a. UC Davis' partnership with the city provides an example.

#### **AWARENESS RECOMMENDATIONS**

41. Share examples of positive interactions and relationships between law enforcement and mental health consumers with families and communities.
  - a. The City of Santa Monica and NAMI both have some great examples of mutual education, partnerships, and improved quality of life for consumers.
  - b. Some law enforcement officers have significant experience with mental health consumers and treat them with dignity, respect and sensitivity.

42. Support the establishment of Community Awareness Committees in every county to reduce the stigma associated with mental illness.
43. Ensure that media coverage of mental health emergencies documents law enforcement actions in a clear and unbiased manner.

#### **INCARCERATION RECOMMENDATIONS**

44. Establish voluntary urgent care clinics as an intermediate step between emergency psychiatric services and jail.
45. Provide mental health consumers who are leaving jail with case management, relocation, housing, and employment support.
  - a. The PALS program is an example.

#### **LEGAL RECOMMENDATIONS**

46. Conduct a comprehensive reexamination of existing State and local government laws and ordinances for legal forms of discrimination and civil rights violations.
47. Compare the effectiveness of city ordinances that address homelessness.
  - a. Sacramento's recent ordinance allowing homeless camps is an example.

#### **COURT SYSTEM RECOMMENDATIONS**

48. Reexamine statutory and legal definitions of "dangerousness" to differentiate between low-level misdemeanors and more serious offences.
49. Expand the number of mental health courts in California.
50. Involve mental health consumers in the development and formation of court programs that help people seek services and reintegrate with their communities rather than going to jail.
51. Support court programs that promote individual responsibility and accountability by providing treatment resources and allowing consumers to make their own choices.
52. Establish a state policy for prosecuting mental health consumers at the lowest appropriate level.
  - a. For example, differentiate between someone who steals bread because they are starving, and someone who has committed a violent attack.
53. Ensure the integrity, oversight, and accountability of the court system.

#### **COMMUNITY ORGANIZING RECOMMENDATIONS**

54. Support the formation of diverse, community-based mental health coalitions that advocate for the integrity, oversight, and accountability of law enforcement as related to mental health.
  - a. San Jose's Coalition for Justice and Accountability is an example.
55. Establish mechanisms for the legal oversight by parole officers, families, and communities of law enforcement efforts involving mental health consumers.
56. Promote opportunities for meaningful, regular dialogue between community mental health organizations, law enforcement, and mental health providers about ways to improve institutional responses to mental health emergencies.

**FUNDING RECOMMENDATIONS**

57. Analyze the effectiveness of law enforcement programs and reallocate resources to those that adopt the aforementioned new approach.

**PROCESS RECOMMENDATIONS**

58. Regarding this process, review each Law Enforcement recommendation in light of the Actions from the Workgroup on Children (v1, 1/28/09)

# **Law, Public Policy, and Legal System Workgroup**

**February 3, 2009**

**Facilitator: Sue Woods**

## **INTRODUCTION**

Consumers and Mental Health Professionals are aware of inequities in the availability and delivery of services. These inequities are often discriminatory. They also cause stigma – external as well as internal, self-imposed stigma by consumers who feel discriminated against. The Work Group of nine consumers and mental health care professionals considered the following topics:

- Policy Issues
- Legislation
- Education
- Enforcement
- Institutional Discrimination (both age and class)

During the gallery walk, a suggestion was added to look at the law and public policy through the lens of *Actions from the Workgroup on Children version 1 (1/28/09)*.

The following actions were recommended to reduce stigma and discrimination resulting from the law, the legal system, and public policy:

## **POLICY**

Policies are intended to support consumers, programs, and delivery of services. Occasionally policies can lead to unintended consequences of stigma and discrimination. The Workgroup recommended the following actions to amend current policies.

7. Develop separate and detailed personnel policies for state (DMH) and local agencies to prevent harassment and discrimination based on:
  - a. Disability
  - b. Age
  - c. Race
  - d. Gender
  - e. Sexual orientation
  - f. Gender identity and expression
  - g. Religion

Include enforcement, accountability and consequences within the policy. This policy should become the model for all state agencies. In addition, DMH should model this policy for all agencies, organizations, and consumers.

8. As a condition of MHSA or other mental health funding, require periodic review of anti-discrimination policies (and the implementation of the policies) of protected classes – or risk loss of funding.

9. Develop policies regarding seclusion and restraint:
  - a. Eliminate seclusion and restraint. It stigmatizes consumers.
  - b. Require certified peer advocates intervention when a consumer is under seclusion and restraint.
  - c. Allow designation of a family member or friend who is allowed to visit the patient in seclusion and restraint.
10. Define the vague elements of “medical necessity” in the DMH guidelines on serving consumers who meet medical necessity criteria. Medical necessity rules are problematic in so far as they elevate clinician’s diagnostic assessments while invalidating client’s self-assessed needs and issues.
11. Require DMH to develop statewide medical necessity minimum standards.
12. Re-evaluate the purpose behind managed care mental health guidelines.
13. Revise the 5150 policy to:
  - a. Allow access of care between one’s primary care physician and the psychiatrist.
  - b. Allow consumers to refuse care from student interns and residents. Allowing control over one’s self reduces self-imposed internal stigma.
  - c. Allow clients to refuse forced treatment, including during the 72-hour hold, including weekends and holidays. Clients are routinely force-administered antipsychotics at the initial point of entry.
14. Create parity of patient rights between mental health and physical health.
15. Develop cultural competency of consumer rights.
16. Require cultural competency expertise when developing [policy or planning] programs.
17. Remove social rehab facility from CCL and transfer to DMH. CCL staff are not equipped to handle the mental health population. Educating CCL staff on stigma and discrimination has been ineffective to date. The personal biases of CCL staff are creating problems for SRF’s.
18. Repeal “quality of life” laws and ordinances at state and local levels that criminalize poverty and homelessness.
19. Support a statewide initiative to reduce stigma and discrimination in the workplace through development of mandatory posting requirements of material related to stigma and discrimination - similar to current requirements to post employment notices for minimum wages, workers comp, overtime, etc.
20. Recognize CPRP for Medi-Cal billing. This will reduce stigma and discrimination by giving consumers greater access to employment.
21. Include peer-to-peer self-help support groups as parallel elements of all types of service.
22. Limit the number of medications that can be prescribed to a patient to avoid over-medicating.
23. Develop a Transitional Age Youth system of care.
24. Encourage institutions to house Transitional Age Youth separate from children and adults.
25. Review sources of funding and how they are used to identify areas of duplication.
26. Develop assessment tools.
27. Develop a clearinghouse of resource materials.

## LEGISLATION

The Work Group members believed that some inequities require legislation to correct and provide for enforcement. The Workgroup recommended that the following actions be taken to sponsor new legislation that would amend or promulgate new laws.

1. Modify state and WIC laws to restore civil rights for ex-offenders for licensing purposes.
2. Strengthen the protection of Prop 63 MHSA funds.
3. Sponsor legislation to develop a state-mandated system of care for older adults – distinctive from the adult system of care.
4. Require competent representation by Public Defenders for mental health consumers (e.g. conservatorship). Consider separate mental health courts or attorneys dedicated to mental health issues.
5. Develop legal alternatives to conservatorships.
6. Provide state funding to expand County patient’s rights services.
7. Require the State to develop a viable Olmstead Plan.
8. Allow reimbursement for caseworkers in FQHCs – to assist with mental health conditions.
9. Allow for MFT reimbursement.
10. Develop a plan of action/strategy for “same day visit” reimbursement for both a primary care visit and a mental health visit. Memorialize in the FQHCs.

## EDUCATION

Many of the Work Group members passionately supported the concept that disability rights are civil rights. The Work Group recommended the following actions:

6. Educate everyone to understand that Disability Rights = Civil Rights
7. Re-evaluate the purpose behind the medical necessity criteria. Document exclusions and restrictions.
8. If Counties restrict medical necessity more than the State criteria, then need to be transparent and explain what criteria is being used.
9. Encourage more coordination, communication, and collaboration between disability rights and civil rights groups.
10. Provide birth to adult education programs to treat the whole child. Consumers are more than test scores.

## **ENFORCEMENT**

The Work Group felt strongly that disability rights should be enforced. In addition, several consumers believed that penalties should be assessed when rights are violated. The Work Group recommended the following actions:

1. Enforce disability rights as civil rights.
2. Develop an oversight entity to enforce accountability for discriminatory practices, including WIC violations. The goal is to promote, develop, and sustain equity in resource allocation and access to services.
3. Assess financial penalties when regulations are violated.

## **INSTITUTIONAL DISCRIMINATION**

Discrimination is thought to occur as a result of an institution's policies and practices. The Work Group recommended the following actions to reduce discrimination and stigma:

Re-evaluate an institution's policies to reduce institutional discrimination. Specific policies to evaluate include:

- Enforce delivery of culturally competent services that reduce disparities within the system.
- Weave cultural competence, as well as oversight and accountability, throughout mental health, police, health programs, etc.

Determine what mental health training is provided to prison personnel and what services are available to prisoners re: M.I. and AOD issues.

## Faith-Based Organizations Workgroup

February 3, 2009

Facilitator: Cielo Avalos

Theme 1: Establish and/or enhance a regional multi-faith-based network throughout California.

- Action 1: Education of clergy personnel using existing models (e.g. Familias Unidas Saben)
  - Assess training needs
  - Training components:
    - Sensitivity of different religious beliefs/practices
    - Raising awareness of age-related issues
    - Raising awareness of mental health issues to clergy (to bring the message to the congregation or community)
    - *Posted Note Comment: Use “Shadow Voices” DVD and similar materials to raise awareness (Shadow Voices features consumers who have “recovered” or are in recovery, challenges faced by consumers “in the system,” and a piece on faith-based issues)*
- Action 2: Use clergy personnel and or churches as a resource distribution site.
- Action 3: Include faith-based models when developing PEI promising practices. (survey communities for promising models)
- Action 4: Create a faith-based best practices category on existing or future resource site.
- Action 5- consider cross-collaboration with the faith communities, particularly for ethnic communities, whose faith may involve non-traditional or non-Christian faith communities in way that is most supportive of clients and their recovery.

Theme 2: Establish spirituality as a tool for wellness and recovery within the systems. Recognizing a client's faith as a support system and a resource for their wellness is an important component of service delivery.

- Action 1: Educating mental health providers about the value of spirituality in treating mental health conditions
  - Utilize the regional multi-faith-based network to provide insight on different beliefs/values that can inform treatment approaches and/or methodology.
- Action 2: Explore role/usefulness of spirituality during mental health assessment and provide resources as appropriate (e.g. listings of regional multi-faith-based network)