

CALIFORNIA STRATEGIC PLAN ON REDUCING MENTAL HEALTH STIGMA AND DISCRIMINATION



CALIFORNIA STRATEGIC PLAN ON REDUCING MENTAL HEALTH STIGMA AND DISCRIMINATION

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

For comments or questions on this Draft Plan, please contact:

Jordan Blair

California Department of Mental Health

Office of the Director

1600 Ninth Street, Room 151

Sacramento, CA 95814

(916) 654-2309

Jordan.Blair@dmh.ca.gov

TABLE OF CONTENTS

| | |
|-------------------------------------------------------------------------------------------------------------|-----------|
| Acknowledgements..... | 4 |
| Vision..... | 8 |
| Introduction..... | 9 |
| Part 1: Reducing Stigma and Discrimination in Mental Health: Challenges and Opportunities..... | 11 |
| What is Stigma and Discrimination?..... | 11 |
| How Stigma and Discrimination are experienced..... | 12 |
| Addressing Multiple Stigmas..... | 13 |
| What are the Impacts of Stigma and Discrimination?..... | 16 |
| Where Do Stigma and Discrimination Occur?..... | 18 |
| Opportunities for the Future..... | 22 |
| Part 2: Strategies, Approaches and Methods for Reducing Mental Health Stigma and Discrimination..... | 23 |
| What Can We Learn from Past Stigma and Discrimination Reduction Efforts?..... | 23 |
| The Hallmarks of a Successful Campaign..... | 25 |
| Overview of Strategic Methods..... | 26 |
| Research and Evaluation: What Has Worked Best?..... | 32 |
| Other Research Findings..... | 33 |
| Creating the Future in California..... | 34 |
| Part 3: Blueprint for Reducing Mental Health Stigma and Discrimination..... | 36 |
| About Core Principles, Strategic Direction, and Recommended Actions..... | 36 |
| Core Principles..... | 36 |
| Strategic Direction 1..... | 38 |
| Strategic Direction 2..... | 43 |
| Strategic Direction 3..... | 51 |
| Strategic Direction 4..... | 54 |
| References..... | 56 |

ACKNOWLEDGEMENTS

CALIFORNIA STIGMA AND DISCRIMINATION REDUCTION ADVISORY COMMITTEE

Jennifer Alvidrez, Ph.D.

UCSF Dept of Psychiatry

Khatera Aslami

Peers Envisioning and Engaging in Recovery Services

Alex Brisco

Alameda County Health Care Services Agency

Delphine Brody

California Network of Mental Health Clients

Rocco Cheng, Ph.D

Pacific Clinics

Rob Chittenden

Disability Rights California

Serena Clayton, Ph.D.

California School Health Centers Association

Kita S. Curry, Ph.D.

Didi Hirsch Community Mental Health Center

Natalia Deeb-Sossa, Ph.D.

UC Davis Center for Reducing Health Disparities

Fran Edelstein, Ph.D.

California Alliance of Child and Family Services

Pia Escudero, LCSW

Los Angeles Unified School District, School Mental Health Services

Dr. Luis M. Garcia

Pacific Clinics

Marty Giffin, Ph.D.

San Diego Center for Children

Lisa Harris, RAI

California Department of Rehabilitation

Patricia “Tish” Harris

Shasta Consortium of Community Health Centers

Susan Henderson

Disability Rights Education and Defense Fund

Elisa Herrera

Latino Leadership Council, Placer Campaign for Community Wellness

Stephen P. Hinshaw, Ph.D.

UC Berkeley Department of Psychology

Stacie Hiramoto, MSW

California Council of Community Mental Health Agencies

Lorna D. Jones

Community Vocational Enterprises

Janet King

Native American Health Center

Ruby Lim, MSW

California Department of Rehabilitation

Kenneth Logan

Mental Health Association—SAFE program

Matt Lord

Daniel's Place, Youth In Mind, CMHACY

Tracy C. Love

California Network of Mental Health Clients

Jay Mahler

Alameda County Behavioral Health Center

Harriet Markell

California Council of Community Mental Health Agencies

Daniel McCarthy, MSW, LCSW, PPSC

California Association of School Social Workers

Arnulfo Medina

Racial and Ethnic Mental Health Disparities Coalition/CA Youth Empowerment Network

Bonnie Milstein

Civil Rights Consultant

Karen Moen

*Center for Families, Children, and the Courts
Judicial Council of California—Administrative
Office of the Courts*

CALIFORNIA STIGMA AND DISCRIMINATION REDUCTION ADVISORY COMMITTEE

Sabirah Mustafa

Pool of Consumer Champions

Marie Nitz, RN, MFT

Older Adult Advocate

Janet E. Paine, MHA

Family HealthCare Network

Becky Perelli, RN, MS

West Valley College

Stephanie Ramos

*Racial and Ethnic Mental Health Disparities
Coalition/CA Youth Empowerment Network*

Dede Ranahan

NAMI California

Sharon Rapport

Corporation for Supportive Housing

Sean Rashkis

*Disability Rights California, Sacramento
Regional Office*

Charles Robbins

The Trevor Project

Refugio “Cuco” Rodriguez

*Alcohol, Drug, and Mental Health Services,
Santa Barbara County*

Michael Roosevelt

*Center for Families, Children, and the Courts
Judicial Council of California—Administrative
Office of the Courts*

Emil Rudolfa, Ph.D.

*UC Davis Counseling and Psychological
Services*

Officer Gregory H. Sancier, Ph.D.

San Jose Police Crisis Management Unit

Ron Schraiber

Los Angeles County Mental Health Department

Steve Segura

Sacramento Police Department (retired)

Diane Shively

*United Advocates for Children and Families of
California*

Jenessa Shapiro

UC Los Angeles Department of Psychology

Alysa Solomon, Ph.D.

Los Angeles County Mental Health Department

Sheryle Stafford

*California Association of Social Rehabilitation
Agencies*

Hector Torres

Indian Health Council, Inc.

Philip Traynor, MPA

Radio Bilingüe

Arcadio Viveros

Radio Bilingüe

Sue Watson

*California Network of Mental Health Clients
(CNMHC)*

Stephanie Welch, MSW

California Mental Health Directors Association

Jennifer Whitney-Tucker

TMG Studios, Positive Paradigms Consulting

SUPPORT TO THE COMMITTEE AND PLAN

The following individuals provided support for the Advisory Committee and development of the Plan

CONSULTING SUBJECT MATTER EXPERTS

Maryann Leshin
Enterprise Community

Barbara Lurie
Mental Health Media Partnership

Danny Marquez
Crossroads Diversified Services, Inc.

Officer Robert Martinez
Santa Monica Police Dept.

Joyce Mitchell
Ross Campbell, Inc.

Zach Olmstead
Housing California

Jason Robison
SHARE!

Ted Ross
Ross-Campbell, Inc

Stuart Seaborn
Disability Rights California

Michelle White
Consultant

Captain Al Venegas
Santa Monica Police Dept.

DEPARTMENT OF MENTAL HEALTH STAFF

BARBARA MARQUEZ
Chief, Statewide Programs

NANCY KINCAID
Assistant Director, Communications
and External Relations

Lead Project Staff:

JORDAN BLAIR

KIRSTEN DEICHERT

Other staff who contributed:

CIELO AVALOS

SANDRA BLACK

MARY GLASS

ZOEY TODD

JENNIFER TURNER

JUSTIN WHITCOMB

TINA WOOTON

MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION

BEVERLY WHITCOMB
Mental Health Program Administrator

FACILITATION TEAM

Center for Collaborative Policy
California State University, Sacramento

SUSAN SHERRY
Executive Director

JULIA LEE
Facilitator

DORIAN FOUGÈRES
Facilitator

NICOLE UGARTE
Public Outreach Coordinator

ARIEL AMBRUSTER
Writer

PLAN SUPPORT

JANICE LOWEN AGEE
Editor

PEGGY FISH
California State Library

VISION STATEMENT

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

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

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

INTRODUCTION

According to the landmark 1999 United States Surgeon General Report, “stigma is the most formidable obstacle to progress in the arena of mental illness and health.” People with mental health challenges often remark how stigma and discrimination against them can even be worse than their mental health condition. Stigma and discrimination can shatter hopes of recovery and social inclusion and leave the person devastated and socially and personally isolated. While there have been remarkable advances in understanding functions of the brain and treating mental disorders in the last 50 years, the stigma of mental health illness continues to impoverish the lives of people with mental health challenge, and will continue to be a barrier for many individuals to seek needed treatment and related assistance.

Stigma, exclusionary acts, and discrimination against those with mental health challenges are widespread. Nearly half of adults in a nationally representative survey said they were unwilling to socialize with, work with, or live near people with mental health issues.¹ Additionally, it is estimated that as many as 33 percent of children experiencing social, emotional, or behavioral difficulties have been the target of bullying in mainstream schools.² The number of people affected by stigma is significant: In any given year, roughly one in every four adults and older adults will suffer from a diagnosable mental disorder, and nearly one out of every five children will experience some degree of an emotional or behavioral difficulty.³

Stigma, and the discrimination that can result from mental illness, can cause shame, despair, and hopelessness. Stigma can impede recovery, create fear and social isolation, and discourage individuals who need help from seeking it. Self-stigma, or the desire to avoid stigma, is estimated to influence 50 to 60 percent of individuals with mental health challenges from seeking treatment, although other factors such as the fear of involuntary treatment may also lead others to avoid treatment.⁴ Further, some parents avoid seeking help for their children due to fears of labeling and stigmatizing. By rejecting or dropping out of mental health services, individuals can avoid taking on the stigmatizing label of mental illness.⁵ However, failure to seek help can often lead to fatal behavior: 90 percent of individuals who die by suicide have a diagnosable mental health or substance abuse problem.^{6,7} For society to benefit from the advancements of modern mental health interventions, we must deal with the effect of stigma and discrimination.

Envisioning Change

The good news is that California is ready to fight stigma and discrimination associated with mental health challenges. Reducing stigma and discrimination related to mental health challenges is a priority of the California Department of Mental Health (DMH) and the Mental Health Services Oversight and Accountability Commission (MHSOAC). In collaboration with the MHSOAC, the DMH convened the California Mental Health Stigma and Discrimination Reduction Advisory Committee to develop a ten-year

strategic plan to accomplish this goal. This Committee consisted of a diverse group composed of consumers, family members, advocates, providers, clinicians, experts, researchers, and representatives from various community-based, non-profit, and government organizations.

Sidebar:

Our vision for the future is one in which differences of expression, culture and belief are accepted, embraced or celebrated, where the widespread interpersonal and institutional violence and abuse that once gave rise to shame, fear and internalized oppression have been banished to the past. We see the coming decades as ripe with potential, because in that future, people are valued for how they imagine and achieve their dreams, rather than defined by labels or stereotypes.

Out of our desire for equality and dignity for people who face and overcome mental health challenges comes a vision of partnerships with community stakeholders at all levels, and a California that provides an environment of understanding, compassion, and awareness in which social justice, accountability, mutual support and community collaborations have overcome the oppressions and hierarchies that once separated us, uplifting us all.

- California Networks of Mental Health Clients

The *California Strategic Plan on Reducing Mental Health Stigma and Discrimination* (Plan) crafts a vision that unfolds into four strategic directions and multiple recommended actions. Recommended actions target Californians of all ages and diverse backgrounds. The Plan addresses prevention and early intervention activities, including public education and contact campaigns, to confront the fundamental causes of stigmatizing attitudes and discriminatory actions. This ten-year Plan provides a blueprint for action at the local and state levels, as well as an informational resource for government, community-based organizations, consumer and family groups, and others. It serves as a resource document for individuals, both within and outside of the mental health field, who are dedicated to ensuring the complete social inclusion of people of all ages living with mental health challenges.

This Plan begins with a focused discussion in Part 1 on the challenges presented by stigma and discrimination related to mental health. Part 2 discusses several strategies, approaches, and methods to reduce stigma and discrimination. Part 3 contains the Plan's core principles, strategic directions, recommended actions, and next steps that are necessary to move towards the actions needed to reduce stigma and discrimination in California.

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

What Is Stigma and Discrimination?

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

Three major categories of mental health-related stigma exist:

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

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

What Causes Stigma Against Those with Mental Health Difficulties?

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

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

Stigma and discrimination occur within our everyday social environment. Attitudes, beliefs, and behaviors about mental health are influenced by family members, friends, and peers; through community setting such as school, work, in social networks and cultural groups; and by public laws, governmental systems, institutions and the economy. One person may belong to several different groups and within each cultural group experience different influences and varying stigmas. In developing and implementing stigma and discrimination reduction measures, it is important to consider the issue from these multiple lenses.

How Stigma and Discrimination Are Experienced

Each individual has varying degrees of susceptibility to stigma and discrimination. Since everyone responds differently to stigma, some will experience limited degrees of self-stigma in response to societal pressures, while others may be impacted deeply, responding by withdrawing, shame, and/or anger.¹² More research is needed to understand why some individuals are more or less affected than others.

Various community or cultural groups may be more or less inclined to stigmatize someone with mental health challenges. Looking at unique cultural approaches to stigma is particularly necessary in California, which is among the nation's most ethnically diverse states, and anticipated to become even more diverse in the near future. California, according to 2007 estimates, is 44 percent Caucasian, 36 percent Hispanic, 12 percent Asian, and six percent African-American, with Native Americans and Pacific Islanders each making up less than one percent of the population.¹³

Studies to date suggest that various culture groups often experience and express stigma differently. For example, in some Asian cultures, mental illness is seen as reflecting poorly on the entire family, diminishing marriage and economic prospects for other family members.¹⁴ Studies have found that Native Americans and Caucasians hold similar attitudes toward individuals with mental health challenges, while Asians and Latinos held more stigmatizing attitudes. One study also found that stigmatizing attitudes among African Americans did not lessen after contact with those living with mental health challenges.¹⁵ More research is needed to develop a clearer understanding of cultural specifics of mental health stigma and discrimination and the culturally appropriate and effective means for reducing them.

Families, Friends and Caregivers

Stigma also affects the family members, companions and co-workers of those living with mental health conditions. Family members and caregivers are frequently judged responsible for a loved one's mental health challenges and treated with suspicion or disapproval. Parents in particular are often blamed for causing a child's emotional difficulties and internalize that stigma, contributing to isolation of the child and family members. This is known as "stigma by association." For families and caregivers, this may result in their denial of the situation, or create fears that impede the pursuit of early intervention services and support for the child's development. In one study, family members reported experiencing social stigma and stigmatizing attitudes from mental health professionals.¹⁶

Children and Transition-Age Youth

Children under the age of 15 with serious social, emotional, or behavioral challenges may experience peer exclusion, social isolation and bullying and other forms of abuse in both school and community settings. Their behaviors may contribute to poor academic and/or social functioning, which can further stigmatize a child. This may also be exacerbated by mental health assessments and diagnoses that too often focus on weaknesses and problems exclusively, rather than also addressing a child's strengths, interests, dreams, and goals.

Transition-age youth, aged 16 to 25, are also vulnerable to mental health stigma and discrimination given that at this developmental stage peer opinion and media messages are extremely important and influential. It is reported that 75 percent of all lifetime mental health disorders start by age 24.¹⁷ A recent study indicates that California college students are presenting mental health challenges with greater frequency and complexity.¹⁸ At the University of California, San Diego, the number of psychiatric hospital admittances more than doubled between the 2001-2002 and the 2004-2005 school years.¹⁹ During this stressful transition period, youth with social, emotional, or behavioral problems may transition from foster care, the juvenile justice system or the children's mental health system into the world where adult service systems are their only option. When a youth turns 18, he or she now has the right to refuse services. Refusal of such services may permanently reduce the likelihood of positive outcomes. At the same time, the sudden movement into the adult world or to an adult facility with little support can be terrifying for the youth and challenging for family members.²⁰

Addressing Multiple Stigmas

Many individuals, families and communities experience the burden of multiple burdens of stigmatizing conditions, situations, and discrimination, including children and youth being in special education or foster care; racial and ethnic communities; those who are lesbian, gay, bisexual, transgender or questioning; persons with physical disabilities; persons with co-occurring disorders; older adults; rural populations; and veterans.

Youth in Foster Care

Children and adolescents who face mental health conditions and are in foster care, experience multiple stigmas. An estimated 60 percent of California foster youth have social, emotional or behavioral challenges, often related to the trauma of neglect and abuse experienced by family members or the foster care system.²¹ In addition to stigma and discrimination related to their emotional and behavioral difficulties, youth are treated by their peers, the community and the system at large as being different because they are in foster care. According to a 2003 Little Hoover Commission report, youth in foster care are routinely denied adequate education, and mental and physical health care.²² Children and youth in need of mental health services face additional barriers created by complexity in the foster care system.

Racial and Ethnic Communities

The United States Surgeon General and the President's New Freedom Commission on Mental Health (Commission) have identified public stigma as a key factor in problems of lack of access to mental health services for racial and ethnic communities.²³ Problems include the lack of culturally competent services, including language services, financial barriers, and failure to respect and understand the histories, traditions, beliefs and values of racial and ethnic communities. The Commission cited the significant underrepresentation of minority populations in the mental health workforce as another barrier to access. The Commission also stated that as a result of these factors, Native Americans, African Americans, Asians, Pacific Islanders, Latinos and other racial and ethnic minorities bear a disproportionately high burden of disability from mental illness – not because of a higher prevalence or severity of illness in these populations, but from receiving less care, inappropriate care, and poorer quality of care.

Racism and race-based discrimination are stressful and adversely affect physical and mental health.²⁴ Individuals from ethnic and racial communities may encounter stigma and discrimination as they attempt to get help for their mental health conditions, often receiving differential treatment and poorer quality of care. Those who are underserved in the voluntary community system of mental health care, including racial and ethnic groups, particularly African-Americans and Native Americans, are overrepresented in coercive services involving involuntary inpatient hospitalization.²⁵ Racially and ethnically diverse children tend to receive mental health services through juvenile justice and child welfare systems more often than through schools or mental health settings.²⁶ Some communities, such as Latinos, are underrepresented in their use of mental health services and they experience many barriers to treatment including language barriers and a lack of culturally competent procedures. Additionally, they may seek treatment through non-mental health arenas, such as medical clinics or faith-based organizations.²⁷

In spite of experiencing multiple stigmas, some racial and ethnic communities may have certain culture-based assets that can help counter stigma and the stresses of mental health conditions. These may include supportive families, strong community networks,

spirituality, and religion.

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

The LGBTQ community continues to face significant stigma and is also at high risk for becoming victims of physical violence and harassment, particularly in non-urban areas. LGBTQ youths may face harassment and possible abuse from family and peers, and are particularly vulnerable when they first go public with their sexual orientation or gender identity. LGBTQ older adults may avoid accessing health and social services due to concerns about insensitive and discriminatory treatment. Also, they are more likely to live alone and less likely to have a caregiver should they fall ill, compared to heterosexual seniors.²⁸ These factors can increase feelings of isolation and loneliness, which are risk factors for depression in later life.

Until 1973, homosexuality was defined as a mental illness by the American Psychiatric Association's Diagnostic and Statistic Manual of Mental Disorders (DSM), and the manual continues to include multiple categories that define non-hetero-normative gender identity as a mental illness, compounding the difficulties that children, teens, and adults with non-conforming gender identities experience from the mental health field.

Studies have shown that the LGBTQ community has an increased risk for depression, substance abuse and suicide.²⁹ The social stigmas and discrimination that lesbian and gay people experience may also place them at greater risk for psychological distress.³⁰

Persons with Physical Disabilities

Individuals with physical disabilities in addition to having mental health challenges are among those faced with multiple stigmas. While more research is needed, one study found that people who have a physical disability and a mental health condition experience a greater degree of stigma and discrimination. In addition, the greater level of or degree of stigma they reported experiencing, the more likely they were to also report poor health or poor emotional well-being.³¹

Persons with Co-Occurring Disorders

Individuals who experience a mental illness in addition to an addiction, emotional, or behavioral condition, such as alcohol or substance abuse or an addiction to gambling, i.e., a co-occurring disorder, face multiple stigmas. Studies show high rates of stigmatizing attitudes among the public toward those with drug- or alcohol-related disorders.³² Systemic discrimination against individuals with co-occurring disorders also exists. Too often, individuals living with co-occurring disorders are treated for only one of the two disorders. Only 19 percent of people who have co-occurring disorders are treated for both disorders; 29 percent are not treated for either problem.³³

Older Adults

In today's society, growing older and experiencing a mental illness at the same time can impose barriers to improving one's mental and physical wellness and living a productive life. Common stereotypes held by the public, professionals, family members and older adults themselves include the belief that depression is a normal part of aging, or that someone is too old to recover from a mental illness.³⁴ Because of such societal attitudes, mental illness in older adults may not be identified and treated, or older adults may avoid accessing mental health services. About 20 percent of persons 55 and older experience specific mental disorders not considered part of "normal" aging. However, older adults have a low rate of mental health service use, with only 15 percent of those needing services receiving them.³⁵ Other reasons for older adults not seeking help sometime include a lack of necessary transportation or financial hardship. Untreated depression is a significant risk factor for suicide in the elderly, and older adults are disproportionately likely to die by suicide.³⁶

Rural Populations

In rural areas, access to adequate mental health services can be more problematic, and the social stigma of accessing such services can be greater. A conclusion from the New Freedom Commission indicates that older men and Native American youth who live in these rural areas experience a significantly higher suicide rate.³⁷

Veterans/Military

Active-duty military personnel have significantly higher rates of major depression, generalized anxiety, and post traumatic stress disorder than the general population – as many as 17 percent of those stationed in Iraq and Afghanistan met the criteria for one of those three conditions. Of those military personnel, fewer than 40 percent sought mental health care, and many reported being concerned about stigma and discrimination because of their mental health challenges.³⁸ Many current members of the military believe that seeking treatment for mental health challenges may jeopardize their careers. Returning veterans face challenges in navigating the Veteran Administration (VA) system to access mental health services. Homelessness is a particular concern to the veteran community. The VA estimates that approximately one-third of all adults who are homeless are veterans, and that nearly half of all homeless veterans have mental health challenges.³⁹ Homelessness in itself is highly stigmatizing; homeless veterans with mental health issues face a dual stigma.

What are the Impacts of Stigma and Discrimination?

Public and Institutional Stigma and Discrimination

Individuals with mental health problems may struggle with personal, professional and cultural relationships tainted by stigma and discrimination in almost every facet of daily life. Because of the tendency by many others to shun individuals with mental health

conditions, they may find themselves lacking the circle of friends, family and social networks that would typically provide camaraderie, joy and support. Further, it is not uncommon that members of their support groups, including parents and other family members, also experience stigma in the form of avoidance, blame, and social exclusion.

Children with social, emotional or behavioral challenges may find themselves routinely treated differently by both the adults who work with them and their peers. This social avoidance may take the form of peer exclusion, taunting, shaming, bullying and physical abuse from peers and others in the community. In one study, 33 percent of children with special needs who attended mainstream schools were targets of bullying, compared to eight percent of their classmates.⁴⁰ Studies show that childhood isolation and resulting depression is also on the rise.⁴¹

Adults with mental illness may be victimized in other ways. They are at a much higher risk of being victims of violent crime than the general population.⁴² The research suggests that individuals with mental health challenges are more often the victim than the aggressor.⁴³

Stigma and discrimination may interfere with the ability of individuals living with mental health challenges to obtain housing and find or keep work, despite their ability to do the job. One in three mental health consumers reported being turned down for a job once their status became known. In some cases, job offers were rescinded when a history of mental health challenges was revealed.⁴⁴ These difficulties can increase the likelihood of becoming homeless. In 2000, an estimated 75,000 Californians with mental health challenges needed housing.⁴⁵

Additionally, stigma and discrimination may prevent individuals with mental health diagnoses from participating fully in civic life: 44 states, including California, have constitutional language taking away the voting rights of individuals if they are found to be “mentally incompetent.”⁴⁶ Under California’s Election Code, this applies to those who have a conservator, and to those been judged not competent to stand trial.

Self-Stigma

Experiencing the effects of stigma and discrimination can prompt feelings of low self-esteem, shame, anger, hopelessness and helplessness, and can fuel the cycle of self-stigma. Hopelessness and despair can often lead individuals to take their lives. Once again, while there are many anecdotes and first-person accounts of living with stigma and discrimination, available research to date has yet to calculate the numerical effects of these social and systemic pressures in terms of unemployment, homelessness, dropout rates, etc.

In order to avoid the stigma of being labeled with a mental illness, many individuals may refrain from seeking treatment for their mental health conditions, whether for themselves, their children, or for another family member. Fewer than 30 percent of people with mental health challenges seek treatment, according to a large-scale

epidemiological study.^{47,48} It should be noted, however, that stigma is not the sole reason individuals do not seek or continue treatment; affordable treatment may not be available or accessible in or around every community.

Stigma Impacts the Mental Health Field

According to the United States Surgeon General, another result of stigma is the public's reluctance to fund mental health programs and systems.⁴⁹ The public has generally ranked insurance coverage for mental health challenges below that for physical illnesses.⁵⁰ This picture may be changing for the better with California voters passing Proposition 63, the Mental Health Services Act, in 2004, and Congress's passage of the Mental Health Parity legislation requiring the equal treatment of mental health consumers by health insurance carriers and employers in September 2008.

Where Do Stigma and Discrimination Occur?

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

Housing

Landlords have been shown to be far less likely to consider renting to individuals who have revealed they had received hospital mental health treatment⁵¹ In addition, neighborhoods often organize to block housing projects that would accommodate individuals with mental health challenges or behavioral difficulties. Called NIMBYism (Not in My Back Yard), this practice increases the costs and difficulties of creating desperately needed affordable housing for individuals living with mental health challenges. If the individuals end up homeless as a result, they will likely experience increased, or multiple stigmas. They will also face an increased threat of violence. In one survey, two-thirds of homeless people reported being victimized in the previous year. Seventy-five percent of the crimes were assaults, and 23 percent were rapes.⁵²

Federal laws prohibit housing discrimination against individuals because of a disability which includes a mental illness. The Federal Fair Housing Act prohibits both individual and community discrimination. However, it may be difficult for individuals to establish evidence and find legal representation to seek redress. Funding to legal aid organizations has dwindled significantly, many people do not qualify for legal aid, and it can be a very arduous process to file a lawsuit against an employer or landlord.⁵³

Employment

The Americans with Disabilities Act (ADA) outlaws discrimination in employment, public services, transportation, and public accommodations. However, with regard to employment, a 1995 survey of U.S. employers showed that half would rarely employ someone with a psychiatric disability and almost one-quarter would dismiss someone

who had not disclosed a mental illness.⁵⁴ With the loss of work comes not only impoverishment, but the loss of a source of personal achievement, satisfaction, and participation in mainstream society which can be a key to recovery.

Educational Systems

Educational institutions are another system where the effects of stigma and discrimination are multiplied. This includes the pre-schools, K-12 schools, and higher education campuses. Yet, schools are in a unique position to dispel misconceptions about social, emotional, behavioral disorders and mental illness, and to encourage help-seeking behavior. It is recognized that schools address stigma and discrimination through a variety of programs and curricula addressing topics, ranging from general mental health education to bullying reduction campaigns. Yet, despite these efforts, many consumers, family members and advocates see the educational system as a setting that multiplies the effects of stigma. There is also growing concern about the ways in which students respond to and cope with the demands of growing up with a label.

Seriously Emotionally Disturbed (Sidebar)

In a qualitative survey conducted by Oregon Family Support Network (OFSN), findings indicated that “Seriously Emotionally Disturbed” (SED) is no longer the preferred term to use when describing symptoms of mental illness that children and their families experience. Instead, the most frequently recommended terms were;

- 1) Emotional and Behavioral Challenges
- 2) Emotional and Behavioral Disorders, or
- 3) A specific mental health diagnosis⁵⁵

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

At the university level, constricting budgets and the growing need to accomplish more with fewer resources have led many college counseling centers to become more evolutionary than revolutionary. College counseling centers were founded in the 1950s

to provide career counseling to veterans and other students. In the 1970s through the early 1980s, these centers expanded their services to include an array of clinical services such as personal counseling, assessment, diagnosis and treatment, psychoeducational testing, outreach, and prevention programs, and campus consultation.⁵⁶

Mental Health System

Studies have shown that stigma is prevalent among the mental health provider community, with many mental health care professionals harboring unconscious negative feelings about their clients.⁵⁷ When people encounter stigmatizing attitudes from mental health professionals, they may avoid seeking or continuing treatment. This may occur especially in critical initial contact when diagnosing a condition, a clinician may focus on problems and symptoms while appearing to ignore the strengths and resources of the individual and family.

One study of mental health professionals' attitudes toward integrating people with serious and persistent mental illness into the community found that members of mental health staff at outpatient psychiatric clinics held more exclusionary attitudes than staff in agencies providing residential services or advocating on behalf of people with severe and persistent mental illnesses.⁵⁸ Also, there may be institutional stigma and discrimination within the mental health system resulting in policies that can create inequities in access to and distribution of mental health resources for certain population groups.

Medical System

Individuals living with mental health challenges may face resistance when attempting to access basic and appropriate health care services. Studies suggest that individuals receive fewer medical services and are less likely to receive the same range of coverage under their insurance benefit plan.⁵⁹ Healthcare providers, including physicians, may not recognize the signs and symptoms of a mental illness or be knowledgeable about adequate and effective treatment. For example, according to the National Institute of Mental Health (NIMH), 20 percent of older adults who committed suicide had visited their primary care physician on the same day, 40 percent within one week, and 70 percent within one month prior to the suicide.⁶⁰ One study found that people with a serious mental illness die on average 25 years earlier than the general population.⁶¹

Criminal Justice System

With the closure of many public mental hospitals, jails and prisons have become the largest mental facilities in the U.S., fueled by the increasing tendency to house individuals experiencing mental health challenges in correctional facilities.⁶² The criminalization often begins when police, rather than mental health professionals, respond to mental health crises. Police and prison workers are often do not receive

adequate training needed to work effectively with individuals with mental health conditions, and jails are not designed to provide treatment and supportive services and may add to the individual's distress.⁶³

Sidebar:

Since 1955, 93.9 percent of the public psychiatric hospital beds in California have been eliminated.⁶⁴ At the same time, county jail systems and emergency rooms have seen large influxes of individuals suffering from mental health conditions. Of the nearly 20,000 inmates in the California County Jail System, roughly 60 percent suffer from a mental health challenge. The Los Angeles Police Department reports that at the Twin Towers jails, 1,000 beds are filled nearly every night by patients with psychiatric conditions, more than in any mental institution west of the Mississippi.⁶⁵ Similarly, over 60 percent of youth incarcerated in the juvenile justice system have a mental health diagnosis.⁶⁶

People exhibiting symptoms and signs of serious mental illness are more likely than others to be arrested by the police;⁶⁷ and people with mental illness tend to spend more time incarcerated than those without mental illness.⁶⁸ Of the 30,000 inmates in California jails and prisons who have a serious mental illness, the majority are thought to be nonviolent, low-level offenders who landed in the criminal justice system in part because they did not receive adequate community treatment.⁶⁹ Another important area for further inquiry is how law enforcement is affected by stigma when responding to mental health emergencies with little or no preparation or support.

Media

From the 1950s to the 1990s, the percentage of Americans who viewed individuals with mental health challenges as dangerous nearly doubled.⁷⁰ Observers, including the U.S. Surgeon General, have posited that such attitudes are influenced by portrayals in the media.⁷¹ Studies have found a clear connection between negative media portrayals of mental illness and public attitudes and stereotypes.⁷² Since many people may learn about mental illness from the media and entertainment industries,⁷³ inaccurate portrayals and information can inadvertently promote stigma and discrimination.

Despite the widespread view of dangerousness, the U.S. Surgeon General's 1999 report on mental health strongly emphasizes there is very little risk of violence or harm to a stranger from casual contact with a person who has mental health challenges.⁷⁴ However, the stigmatizing images of the dangerousness of the mentally ill abound in news and entertainment venues. A survey of more than 3,000 newspapers found 39 percent of the stories about mental illness focused on dangerousness and violence.⁷⁵

Other media venues also are the source of inaccurate and stigmatizing information and images. One study of 34 animated feature films produced by The Walt Disney Company, including *Dumbo* (1941), *Beauty and the Beast* (1991), and *The Lion King* (1994), found that 85 percent contained verbal references to mental illness. The verbal references were mainly used to set apart and degrade the characters.⁷⁶

Opportunities for the Future

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

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

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

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

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

Anti-stigma leaders drew from the experiences of successful efforts on many different fronts including disability, civil rights and other anti-discrimination and human rights efforts when they launched their first campaigns in the 1990s. These campaigns have been adapted since been adapted based on their successes and failures.

The first major anti-stigma campaign was international, launched in 1996 by the World Psychiatric Association with a pilot program in Canada that worked to increase positive mental health coverage in the media.⁷⁷ This *Open the Doors* stigma education campaign grew to include efforts in 19 countries and triggered other initiatives across the world in such countries as New Zealand, England and Scotland.

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

SAMSHA's Elimination of Barrier Initiative (Sidebar)

In January 2003, SAMHSA's Center for Mental Health Services (CMHS) launched the Elimination of Barrier Initiative (EBI). The purpose of the EBI was to identify effective approaches for addressing the stigma and discrimination faced by people with mental illness. The EBI was a 3-year demonstration designed to test approaches to addressing discrimination and stigma in eight pilot States: California, Florida, Massachusetts, North Carolina, Ohio, Pennsylvania, Texas, and Wisconsin.

In the case of the EBI, social marketing strategies and tactics encouraged target audiences to adopt favorable attitudes toward and be part of an accepting environment for people with mental illnesses.

The EBI employed three distinct social marketing strategies that have been shown by researchers to effectively reduce discrimination and stigma:

- Public education
- Direct contact with mental health consumers, and
- Reward for positive portrayals of people with mental health challenges.

The EBI focused on three target audiences:

- The general public (adults, age 25–54)
- The business community, and
- Secondary school educators

Over the years, anti-stigma campaigns have found that education is not enough. It produced a better informed public, but did not significantly reduce levels of discrimination. Campaigns have become multifaceted by incorporating various approaches, including efforts to change policies and laws, involving individuals with mental health challenges at all program levels and in contact programs where they can talk about their personal experiences. Many campaigns have been modeled on the work of Patrick Corrigan of the University of Chicago Center for Psychiatric Rehabilitation and the Chicago Consortium for Stigma Research, who has argued for approaches that identify particular discriminatory populations and discriminatory behaviors as targets for campaigns and protest actions.⁷⁸

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

New Zealand: Like Minds, Like Mine (Sidebar)

New Zealand's national *Like Minds, Like Mine* program has drawn attention and praise for its comprehensive, multilevel, long-term, social marketing-based approach to countering stigma and discrimination. It is widely regarded as the most successful mental health anti-discrimination program.⁷⁹ In place since 1997, it is also the longest national program.

In a 2006 campaign report, more than 50 percent of surveyed consumers reported reduced levels of stigma and discrimination from family, mental health services and the public, and about 50 percent reported a reduction in stigma and discrimination in the employment arena.⁸⁰ After 11 years, the percentage of the public viewing those with mental health challenges as more dangerous than others had decreased by 14 percent.⁸¹

The program has used a range of methods, including:

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

The program is a collaborative effort involving a broad spectrum of agencies such as mental health service providers, consumer-controlled organizations and networks, and non-governmental organizations.⁸² It includes national public relations efforts and regional promotional and training activities. Over time, it has been adapted; it now incorporates an outcomes-based planning framework and is working to strengthen the role that people with experience of mental challenges play in the program's leadership, management and operation. The program evaluates its efforts through national surveys and focus groups. During its first five years, it was funded at about \$1,457,000 (in American dollars) annually. For comparison purposes, New Zealand's population is about 12 percent of California.

www.likeminds.org.nz

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

The Hallmarks of a Successful Campaign

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

- Carefully planned and thought out approaches to targeting and influencing audiences, including both the general population and specific groups;
- Multifaceted, utilizing the full array of methods to achieve change;
- Multilevel, focused concurrently at the individual, family, schools, community, organizational, and system levels, both locally and statewide;
- Focused on changing both attitudes and behaviors;

- Long-term, as attitudes and behaviors do not change quickly and reinforcement is necessary;
- Adequately funded;
- Actively involving key stakeholders and program partners both within and outside the mental health community; and
- Incorporating benchmarks and evaluation, with the results used to inform future efforts.^{83, 84, 85}

Social Marketing (Sidebar)

Social marketing is similar to traditional marketing, but instead of encouraging the purchase of goods or services, social marketing encourages behavioral change. Social marketing can be an excellent tool for reframing behavior, reducing barriers to change, motivating individuals to explore behavioral alternatives, reaching unserved or underserved populations, and nudging social norms in the direction of positive change. Lessons learned from previous social marketing efforts stress the importance of strategically researching and identifying the intended audiences and the best strategies and methods to reach and influence them.

Overview of Strategic Methods

Anti-stigma campaigns have used five primary methods, or interventions, for creating change in attitudes and behaviors. These methods can be used alone or in conjunction with one another. A comprehensive campaign will carefully examine the merits of each method and combination of methods. Past and existing stigma and discrimination reduction programs are used as examples of the range of tools available.

The five methods are:

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

Education

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

Public Education

Public awareness campaigns have proved effective at influencing attitudes and behavioral change in the public health field such as with breast cancer, HIV/AIDS and

tobacco control in addition to the mental health stigma and discrimination reduction arena. A public education campaign can increase awareness and understanding as a means to reducing stigmatizing attitudes. Successful campaigns require an enormous collaborative effort between agencies, community organizations, community leaders, advertising agency partners, and the media.⁸⁶ Carefully crafted messages can be conveyed through advertisements or news being transmitted via television, radio, movies, CD-ROMs, newspapers, magazines, the Internet, brochures, or clothes and accessories. Television ads encompasses the more affordable public service announcements, or PSAs, which are unfortunately often be aired during times when few people are watching, as well as paid advertising, which is more effective but more costly, as it enables the campaign to target specific audiences by airing at specific times.

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

United Kingdom: Changing Minds (Sidebar)

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

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

Targeted Education

Social marketing and stigma reduction research have shown the benefits of tailoring content and materials to specific groups to increase a message's effectiveness.⁸⁷ Targeted campaigns can be focused on particular age groups such as children, adolescents, transition-age youth or older adults. Targeted campaigns for children are considered particularly important in order to influence stigmatizing attitudes and discriminatory behaviors before they are developed or become firmly established. Such

campaigns include Building Effective Schools Together (BEST), developed out of the University of Oregon by Hill Walker and Jeff Sprague. The *National Mental Health Awareness Campaign* was a nationwide nonpartisan public education campaign launched as part of the 1999 White House Conference on Mental Health organized by Tipper Gore, wife of then-Vice President Al Gore. The campaign aired public service announcements geared toward adolescents on MTV and other popular teen outlets. The result was overwhelming. More than 12 million hits to its associated website, www.whatadifference.samhsa.gov, were reported in the program's first five months.⁸⁸

Campaigns may also target racial, ethnic or immigrant groups, or other types of communities, such as faith-based organizations. For example, SAMHSA has developed anti-stigma educational materials in Spanish.⁸⁹ From 2004-2008, England conducted in its anti-stigma campaign *Shift*, specifically targeted to Blacks and other ethnic communities.⁹⁰ Mental Health Ministries in San Diego produces VHS and DVD media aimed at decreasing mental health-related stigma in faith-based communities.⁹¹

The Nhan Hoa Clinic (Sidebar)

Asian Pacific IslandersThe Nhan Hoa Clinic in Orange County, California, has been working in collaboration with Korean Community Services (KCS) and Orange County Asian Islander Community Alliance (OCAPICA) to establish the Asian Pacific Islander Outreach & Engagement Program. This collaborative partnership allowed them to provide a full scope of mental health services to the Asian Pacific Islander communities. Together, they have language capacities of Korean, Tagalog, Chinese, Samoan, Vietnamese, and other Asian Pacific Islander languages. These programs are funded by the Orange County Health Care Agency Mental Health Services Act, Proposition 63.⁹²

Some campaigns target friends, parents, family members, and others who would be in contact with individuals experiencing mental health challenges. SAMHSA's *What a Difference* media campaign targeted transition-age youth, encouraging them to maintain their social contact with friends who have mental health challenges.⁹³

Other campaigns target groups who may be in a particular position of power to stigmatize or discriminate, such as employers, school administrators, landlords, medical or mental health professionals, members of the media, and decision-makers. The People with Disabilities Foundation in San Francisco has produced an educational video aimed at employers. The *Open the Doors* program in Boulder County, Colorado, has launched efforts to educate and change attitudes within the criminal justice system. The *Open the Doors* program offers training programs for police, probation officers, correctional officers, attorneys and judges.⁹⁴

Trainings, educational curricula, and school learning programs are other examples of targeted educational efforts. An anti-stigma curriculum has been developed by the California Association of Social Rehabilitation Agencies for social work education programs. In Maryland, the Anti-Stigma Project's *On Our Own* targets stigma within

mental health services with workshops designed to help break down barriers between consumers, family members, providers and administrators.⁹⁵ Using consumer trainers, the workshops have enabled participants on all sides to see issues from a number of different viewpoints and have reduced polarizing interactions between consumers and staff.⁹⁶ Similarly, The National Alliance on Mental Illness (NAMI) sponsors a 10-week *Provider Education Course* taught by consumers and family members.

Direct Interpersonal Contact

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

Research, although limited, suggests that direct interpersonal contact is an effective tool for reducing stigma.^{97, 98} Studies show that the contact must be carefully crafted to be effective in helping to dispel stigmatizing attitudes.

Many anti-stigma contact efforts offer presentations in which consumers share personal stories. *The Heard*, a speakers' bureau organized by the National Mental Health Awareness Campaign, features young people who present their personal stories of recovery from mental illness at schools and other public venues. The speakers deepen public understanding of mental illness recovery, serve as reminders that consumers must be active participants in their own care, and provide hope and empowerment for others who may be experiencing mental health issues of their own.⁹⁹

In California, consumer-driven *Stamp Out Stigma* uses an interactive panel of four to six speakers sharing their personal stories. The organization has given more than 1,300 presentations to audiences including business people, policy makers, educators, doctors, and the general public through television and radio shows. In addition, the organization consults with law enforcement organizations, dentists, and others.^{100, 101} NAMI has also organized a speakers' bureau, called *In Our Own Voice*.¹⁰²

Advocacy, Public Policy and Legal Approaches

Researchers with Scotland's national health department have argued that any effort to tackle discrimination, stigma and social exclusion needs to acknowledge the substantial power differences that exist between people with mental health challenges and those who discriminate against them. Reducing discrimination requires reducing these imbalances in social, economic and political power.¹⁰³

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

Media Advocacy

Media advocacy programs have been a popular and effective means of influencing and altering mental health-related content in movies, television programming and print media. This is considered a particularly important area for action as sensationalist news coverage and film portrayals are believed to be one of the main factors contributing to distorted public attitudes about individuals with mental health challenges.^{104, 105}

The largest such effort in the United States is NAMI's *StigmaBusters*. StigmaBusters and its network of nearly 20,000 advocates monitor and protest inaccurate or stigmatizing representations of mental illness on TV, film, print or other media. StigmaBusters played a role in 2000 in removing from the air the ABC television show "Wonderland," which focused on a psychiatric hospital. StigmaBusters directed its advocates to complain not only to producers and ABC TV management, but also to CEOs of sponsors.^{106, 107} Other U.S. organizations engaged in stigma busting include the New York-based *National Stigma Clearinghouse*. Similar media-focus efforts have been used in England, Scotland and Australia.

Award programs are another means of influencing media. Several U.S. anti-stigma efforts have included award programs. The *Voice Awards*, sponsored by SAMHSA and a number of partners, is an annual ceremony held in Los Angeles to recognize entertainment writers and producers for their accurate, dignified and respectful portrayals of people with mental health challenges.¹⁰⁸ The DiDi Hirsch Community Mental Health Center holds an annual *Erasing the Stigma Leadership Award* to honor those in Hollywood working to reduce stigma.¹⁰⁹ Other media-related efforts include:

- The *Rosalynn Carter Fellowships for Mental Health Journalism*, a program at The Carter Center founded by former U.S. President Jimmy Carter and former first lady Rosalynn Carter;¹¹⁰
- The *Mental Health Media Partnership*, a program of the National Mental Health Awareness Campaign which serves as an information bridge between mental health experts and the entertainment industry.¹¹¹

Legal Advocacy

The United States has some powerful antidiscrimination laws, including the Fair Housing Act and the Americans with Disabilities Act (ADA), considered by some to be the most comprehensive disability discrimination law in the world covering psychiatric disability.¹¹² Yet, antidiscrimination efforts continue focus on improving public policy and regulations to further protect against discrimination, or to enforce or seek redress through the courts under existing legislation. Additional methods under this category would include the use of systemic approaches like investigations, assessment or reviews designed to determine if existing laws, policies or procedures are complied with and being enforced. Some observers have argued that laws and policies are essential components to successfully counter stigma and discrimination.

Quote from Liz Sayce (Sidebar)

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

A number of international anti-stigma efforts have incorporated new laws or policy changes. For example, the recently launched *Time to Change* anti-stigma campaign in England includes a component called Time to Challenge, which filed disability discrimination lawsuits on publicly important issues.¹¹³ Organizations such as the Bazelon Center for Mental Health Law and the Disability Rights Education and Defense Fund provide legal advocacy services in the interests of those with mental health challenges.

Partnering, Networking and Coalition Building

An important component of anti-stigma and discrimination campaigns is the coalition building of different individuals, organizations and sectors to work together towards a common goal. Several campaigns have been launched by a group of organizations, rather than one entity. For example, in Scotland, "see me..." was funded by the federal government, but run by an alliance of five Scottish mental health organizations. England's recently launched *Time to Change* effort is funded through a lottery fund and led by three non-governmental organizations: Mental Health Media, Mind, and Rethink.

Integrated Behavioral Health Care (Sidebar)

Community-based primary care is often the first line of defense for detection and treatment of mental health issues and is often the first point of contact for identifying and treating individuals who otherwise might face stigma, cultural or other barriers to accessing traditional mental health services. As trusted medical homes in the community, health centers can play a unique role in providing access to mental health services for individuals who may never seek out traditional mental health services. Whether or not people are physically ill and even how ill they are is not the primary determinant of whether they decide to visit a physician. Studies have suggested that only 12-25% of health care use can be accounted for by disability or morbidity alone. Nearly 70% of all health care visits have a psychosocial basis.¹¹⁴

Support, Guidance and Technical Assistance

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

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

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

One example of an empowerment approach is the *Mad Pride* parade sponsored by MindFreedom International in locations around the world, from Eugene, Oregon to Cape Town, South Africa. These parades seek to celebrate the culture and human rights of mental health consumers.¹¹⁶ Activists and artists using the term “mad” in these types of endeavors see this as an act of reclaiming power over historically negative stereotypes.¹¹⁷ Arts-based activities are also common and include *Nothing To Hide: Mental Illness in the Family*, an award-winning touring photo exhibit developed by the nonprofit Family Diversity Project, which tells poignant stories of courageous individuals and their families whose lives are affected by mental illness.^{118 119}

Research & Evaluation

More Research & Evaluation Is Needed to Know What Works Best

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

Mental health anti-stigma and discrimination programs have not received the kind of research and evaluation that more established, long term programs such as California's Tobacco Control Program have, or have not been able to show such dramatic achievements to date. For example, evaluators of Scotland's “see me....” program found reductions in stigmatizing attitudes toward those with mental health challenges, but they were unable to determine if the changes resulted from “see me....” or from a variety of other anti-stigma initiatives that occurred in Scotland at the same time.¹²² Scotland initially saw stigmatizing attitudes in surveys decline after its program launch, but later surveys showed those attitudes on the rise again.¹²³

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

Studies have shown promising findings from programs that provided for contact with individuals living with mental health challenges. One study found that the NAMI program

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

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

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

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

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

Other Research Findings:

Start Early: Include Prevention and Early Intervention Efforts

Some studies have shown that children's attitudes towards mental illness become firmly established between grades six and eight. While at the same time, the antecedents of stigma and discrimination manifest at very early ages in the form of peer exclusion and social isolation. This suggests that early education and prevention efforts could help prevent the development of stigmatizing attitudes.¹³³ Some researchers have urged the development and implementation of school-based anti-stigma educational programs.¹³⁴ Schools can reach a large number of children, and children are more likely to accept lessons related to accepting others, some argue.¹³⁵

Education Can be Effective under Certain Conditions

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

Some Approaches May Cause Rebound Reactions

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

Evaluation Should Be an Integral Component of Any Program

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

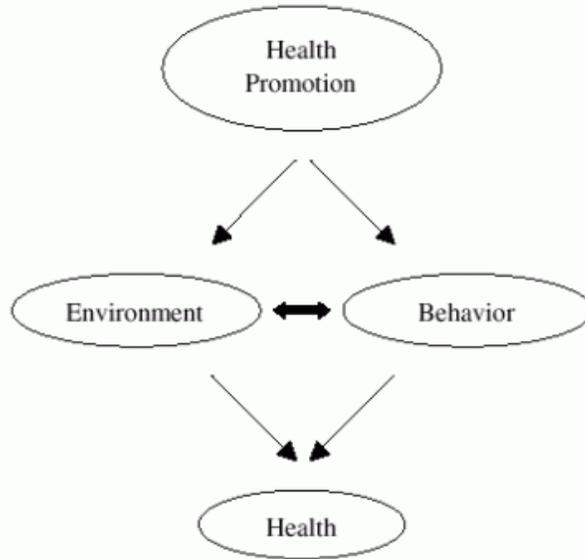
Creating the Future in California

The upcoming section of the Plan, focuses on what Californians can do to relegate mental health stigma and discrimination to the past. This section is a call to action for communities, government, the private sector, businesses and non-profit organizations as well as Californians from all walks of life. The strategies and steps discussed ahead will require creativity, thoughtful planning and determination at both the local and state levels to make a difference. Given that the evidence to date supports a multilevel, multifaceted approach, the Social Ecological Model appears to be a framework that would be appropriate and effective in structuring the work ahead. The social ecological model and social marketing have both played a critical role in numerous public health efforts promoting the use of seatbelts, tobacco control, suicide prevention and HIV prevention.

How the Social Ecological Model Can Help Frame the Interventions:

The Social Ecological Model (SEM) provides a framework for planning health promotion interventions that places a spotlight on the relationship between environmental and behavioral determinants of health. This relationship is reciprocal, the environment effects health-related behavior and people can through their actions affect the

environment. This approach assumes overall health is shaped by our web of societal relationships.



The underlying theme of the SEM perspectives is that the most effective interventions occur simultaneously at multiple levels. This particular model conceptualizes the social work in five spheres, or levels of influence.

The Social Ecological Model¹⁴⁰



PART 3: BLUEPRINT FOR REDUCING MENTAL HEALTH STIGMA AND DISCRIMINATION

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

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

About Core Principles, Strategic Directions, and Recommended Actions

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

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

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

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

Core Principle 2: Employ a life-span approach to effectively meet the needs of different age groups.

Core Principle 3: Involve a broad spectrum of the public, including mental health consumers, family members, friends, caregivers, mental health and allied professionals, advocates, and agencies that interact with children, youth, adults, and older adults.

Core Principle 4: Address all types of stigma and anti-discrimination laws.

Core Principle 5: Build upon promising practices and proven models.

Core Principle 6: Recognize that individuals experiencing mental health challenges are resilient and have the capacity for recovery, and that the best results in treatment for those experiencing mental health challenges often come from voluntary programs that offer choice and options.

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

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

- ❖ **All people at different points in their lives may experience different degrees of mental health from wellness to crisis; and**
- ❖ **Persons living with mental health challenges have resilience and the capacity for recovery.**

- 1.1.1 Form a local coalition of diverse representatives including those with mental health challenges to launch a community action plan to educate the public on mental health challenges and wellness and recovery models.
- 1.1.2 Develop messages and relevant materials for the public that explains mental health challenges and promotes social inclusion.
- 1.1.3 Change consumer information, current medical curricula, and the practice of mental health diagnoses and treatment to reflect and reinforce recovery, resilience, and wellness.
- 1.1.4 Assess existing print and electronic media on mental health challenges and emotional disturbances to be reflective of recovery, resilience, and wellness.
- 1.1.5 Simplify and promote available web resources for reliable information that promotes non-stigmatizing mental health information.
- 1.1.6 Rely on mental health consumers and family members to raise awareness of the importance of mental health.
- 1.1.7 Identify how everyday language is used to reinforce stigma and discrimination toward

those living with mental health challenges and substitute those words with non-stigmatizing and non-discriminatory language.

1.1.8 Confront stigmatizing messages from individuals, groups, organizations, and media.

1.2 Prevent the development of mental health stigma, stereotyping, and discrimination.

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

1.2.2 Utilize existing children and youth organizations to assess and enhance educational programs for parents, early childhood educators and caregivers on the social and emotional development of children.

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

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

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

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

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

1.4 Reduce self-stigma of individuals living with mental health challenges and stigma by association for their family members.

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

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

1.4.3 Encourage mental health providers to assess their procedures to identify and eliminate any contributory actions to consumer self-stigma.

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

1.5.1 Assess, develop, and disseminate information on peer-to-peer programs and social support models.

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

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

1.5.4 Promote education and skill-based training for consumer and family empowerment to address such topics as cultural competence, communication, and advocacy.

1.5.5 Utilize technology and other advancements to support groups or individuals who are geographically or emotionally isolated.

1.5.6 Enhance the skills of peers to be more effective trainers of mental health staff to better address client and family members' culture in their recovery and wellness services and other relevant topics.

1.6 Address the multiple stigmas of persons living with mental health challenges who are also faced with discrimination based on their race, ethnicity, age, sex, sexual orientation, gender identity, physical disability, or other societal biases.

1.6.1 Disseminate successful models that have been identified by different cultural communities.

1.6.2 Educate substance abuse providers and mental health providers to reduce the effects of stigma for individuals encountering co-occurring disorders.

1.6.3 Work with racial and ethnic community groups to ensure that models and programs are culturally and linguistically competent and eliminate stigmatizing barriers.

1.7 Provide increased support for those closely involved with the lives of individuals facing mental health challenges.

1.7.1 Apply innovative information technologies so that parents and caregivers may easily obtain accurate information, guidance and referrals to seek needed services.

1.7.2 Identify non-traditional community locations e.g., churches, youth programs, and community centers, to distribute information on available mental health resources.

1.8 Reduce the effects of stigma with a strength-based approach to assessment, diagnosis, treatment planning, and interventions.

1.8.1 Train providers to assess and develop individualized mental health plans that are strength-based.

1.8.2 Educate families, youth, peers, and adults in the concepts of resiliency, recovery, hope, and healing.

1.8.3 Provide training on the strength-based approach to child protective service systems, juvenile and adult justice systems, law enforcement, and education.

- 1.8.4 Promote opportunities for self expression through the arts and other outlets.
- 1.8.5 Address the stigma that comes from residing in a facility by providing increased support, education, training, and guidance to individuals residing in facilities, facility staff, county workers, family members, caregivers, and other closely associated and involved in the lives of individuals living in mental health facilities.

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

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

2.1.1 Explore, understand, and address how policies and procedures impact individuals living with mental health challenges.

2.1.2 Conduct a review of one or more of the following state or local systems and programs to identify behaviors, policies, and practices for areas of improvement: pre K- 12 education, local community college and university, medical system, mental health system, media, and law enforcement. The local community would disseminate its findings.

2.1.3 Support ethnic diversity and cultural competency training among mental health providers and advocacy groups.

2.1.4 Train mental health staff on stigma and discrimination reduction.

2.2 Establish developmentally appropriate prevention, recovery, and wellness programs.

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

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

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

- 2.3.2 Address the public resource distribution of mental health services to best meet the service needs of populations experiencing multiple stigmas.
- 2.3.3 Co-locate primary care and mental health services and staff to better meet the needs of people with mental health challenges through an integrated approach.
- 2.3.4 Implement Telemedicine technologies in rural communities and other areas.
- 2.3.5 Increase the use of non-traditional cultural approaches.
- 2.4 **Create a more holistic and integrated approach to physical health and mental wellness by:**
 - ❖ **Promoting integrative delivery models of mental health, primary health care, and social services;**
 - ❖ **Achieving parity between medical and mental health services in terms of coverage and financing; and**
 - ❖ **Utilize spirituality and faith-based practices as tools for wellness and recovery.**
- 2.4.1 Sponsor local and statewide programs to support medical practitioners to routinely screen for mental health risk factors and conditions as part of routine care and provide appropriate referrals.
- 2.4.2 Assist medical care practitioners in the detection and appropriate treatment of common problems such as depression, anxiety, alcohol and substance abuse, and childhood social emotional, and developmental problems.
- 2.4.3 Screen for and address both mental and medical needs of individuals entering a mental health facility.
- 2.4.4 Convene an expert panel to discuss financial strategies for reducing stigma associated with the mental health and medical health care systems. Topics of discussion could

include: The Mental Health Parity Act; same day visit reimbursement for community health centers and federally qualified health centers; the medical necessity criteria under Managed Care Mental Health for County Mental Health; preauthorization requirements for mental health services; MediCal reimbursement for medical practitioners who provide mental health screenings.

- 2.4.5 Train providers on the value of spirituality in the wellness and recovery process and the contributions made by faith-based and other non-traditional providers.
- 2.4.6 Establish and/or enhance regional inter-faith-based networks throughout California to serve as a resource to practitioners and consumers on faith-based approaches and methodologies.
- 2.4.7 Create a category on existing or future resource sites to address faith-based best practices and models covering prevention through recovery services.
- 2.4.8 Utilize the multi-faith-based network to provide insight on different beliefs/values that can inform treatment approaches and or methodologies.
- 2.5 Promote the dignity and safety of mental health consumers and their family members by training and educating law enforcement, first responders, other medical personnel, and the community at large to reduce stigmatizing attitudes and discriminating behavior by:**
 - ❖ **Educating the broader community about community alternatives available to assist with mental health-related crises;**
 - ❖ **Utilizing informed consent as a means to ensure voluntary choice;**
 - ❖ **Preparing and equipping law enforcement in responding to the needs of individuals in mental health-related crisis; and**

❖ **Reducing the need for the use of force and forced compliancy.**

- 2.5.1 Support the expansion of response programs at the local level to better meet the needs of individuals with mental health challenges, e.g., crisis residential programs, advanced directives, integrated community services teams.
- 2.5.2 Support and provide crisis intervention programs (Crisis Intervention Training) that provides information to first responders about alternative sites and transport methods for individuals experiencing a mental health crisis to minimize the use of 5150s and criminal incarceration.
- 2.5.3 Develop and widely disseminate information on de-escalation approaches and techniques (such as peer involvement) for emergency room personnel, law enforcement, homeless shelter staff, and mental health providers.
- 2.5.4 Provide increased support, education, training, and guidance to in-patient care staff to eliminate the use of seclusion and physical or pharmaceutical restraint.
- 2.5.5 Provide anti-stigma education and resources to individuals within a rural community who routinely come into contact with a wide range of people, for example clergy, pharmacists, postal carriers, fire and police, school teachers, those who deliver meals-on-wheels.
- 2.5.6 Work to enhance the partnerships between consumers, family members, and law enforcement.
- 2.5.7 Establish training requirements e.g., mandatory continuing education in mental health issues for criminal justice professions that may have close contact with children and adults with mental health challenges.
- 2.6 Educate employers on the importance of mental health wellness for all employees.**
- 2.6.1 Develop curriculum, training, Web sites, and guidebooks to educate employers on mental

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

2.6.2 Develop an educational campaign targeted to employers that emphasizes the financial benefits of a healthy workforce, both physically and mentally.

2.6.3 Provide a comprehensive list of community resources and referrals that employers can make available to employees under emotional stress.

2.6.4 Educate employers on their responsibilities to create work environments free of stigma and discrimination.

2.7 Expand opportunities for employment, professional development, retention, and success of mental health consumers in public, non-profit and private sector workplaces by enforcing current laws and challenging hiring biases.

2.7.1 Identify and disseminate strategies to promote the job seeking skills and employment of individuals with mental health challenges.

2.7.2 Create local opportunities for networking and relationship building among consumers, family members, regional business leaders, and other employers.

2.7.3 Implement successful strategies to increase the employment, retention, and advancement of consumers and family members within all levels of public and community mental health service delivery.

2.7.4 Encourage employers to select employee health plans that offer mental health coverage.

2.7.5 Encourage large employers to offer an Employee Assistance and Counseling Program as part of their benefit package.

2.7.6 Review existing employment practices to identify and address any gaps that may exist.

2.8 Eliminate discriminatory barriers in order to better meet the housing needs of mental health consumers by:

- ❖ **Educating the general public, landlords, and local officials on the rights and housing needs of mental health consumers and their families/caretakers;**
- ❖ **Ensuring that all private and subsidized housing meet the non-discrimination requirements of the Fair Housing Act and market, operate their admissions procedures, and manage their properties so as to ensure all applicants and tenants equal opportunities to benefit from the housing;**
- ❖ **Encouraging supportive housing and other housing for individuals with disabilities to be well integrated throughout the community and accommodating of all levels of care;**
- ❖ **Promoting the provision of housing first as one means to eliminating discriminatory barriers; and**
- ❖ **Promoting the accessibility of services in housing.**

2.8.1 Foster opportunities for consumers to meet, educate, interact with, and develop relationships with developers, neighborhood groups, planning commissions, and elected officials.

2.8.2 Promote affordable housing for people experiencing mental health challenges.

2.8.3 Promote the accessibility of supportive housing services for people with mental health challenges, e.g., case management, health, mental health, vocational, transportation.

2.8.4 Create reintegration models for the discharge of people who are at risk of becoming homeless when leaving institutional settings such as hospitals, juvenile halls/jails/prisons,

foster care, and detoxification facilities.

2.8.5 Identify and encourage the enforcement of current housing laws.

2.8.6 Convene local workgroups that reflect the diversity of the community and include housing developers, housing agencies, community organizations, mental health providers, and consumers and family members to develop strategies and recommendations to improve housing options for individuals living with mental health challenges.

2.9 Engage and educate the commercial, ethnic, public/community, and interactive media, as well as the entertainment industry on:

❖ **Standards and guidelines to promote balanced and informed portrayals of people living with mental health challenges; and**

❖ **Ways to serve as a resource for communicating accurate and non-stigmatizing information to the public on mental health issues and community resources.**

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

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

2.9.3 Develop strategies to reward the balanced portrayals.

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

2.9.5 Collaborate with higher education systems to provide information, resources and referrals regarding mental health concerns.

2.9.6 Work with the local and / or statewide media to develop mental health programming as

part of the “May is Mental Health Month.”

2.9.7 Train consumers and family members to serve as spokespeople for mental health issues.

2.10 Promote and enhance initiatives, programs, and curricula to change school cultures and increase social inclusion and social acceptance.

2.10.1 Integrate mental health within the required health education and wellness programs that school age children must complete.

2.10.2 Encourage local mental health units to work with educational institutions to develop prevention and early intervention techniques as alternatives to fail-first initiatives for children and youth experiencing a mental health challenge.

2.10.3 Develop support groups and systems for children and siblings of consumers experiencing mental health challenges.

2.10.4 Work with students, parents, teachers, administrators, school board members, and School Superintendents of Education to implement school programs and policies that promote social inclusion.

2.10.5 Establish training programs for teachers (pre-school to higher education) to work more effectively with student mental health.

2.10.6 Support greater special accommodations for individuals experiencing a mental health challenge that might not fall under educational guidelines for learning disabilities.

2.10.7 Determine successful approaches and methods for educating health profession students about stigma and discrimination, e.g., sensitivity training, stigma and discrimination awareness.

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

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

3.1.1 Develop and widely disseminate user-friendly fact sheets with contact information for education and training purposes on applicable state and federal laws, regulations for school personnel and students, the housing industry, public and private employers, as well as the medical and mental health systems.

3.1.2 Review federal and state regulations for consistency that support funding of mental health services in non-traditional settings to reduce stigma.

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

3.2.1 Establish periodic meetings with government and non-profit civil rights enforcement agencies to discuss the adoption of compliance and enforcement campaigns.

3.2.2 Develop local task forces, and/or build upon existing structures when available, including city and county legal counsels and diverse community members, to develop strategies for maximizing compliance with and enforcement of laws, regulations, and ordinances that protect individuals living with mental health challenges in the areas of employment, public accommodation, etc.

3.2.3 Create opportunities for local task forces to communicate and coordinate strategies for promoting the compliance and enforcement of current anti-discrimination laws and regulations.

- 3.2.4 Train staff at institutions of higher education, prisons, and public and private health facilities to ensure the understanding and proper implementation of existing privacy protections and confidentiality provisions.
- 3.2.5 Work with state agencies with appropriate jurisdictions to create joint statements offering legal opinions on specific areas of discrimination typically encountered by persons with mental health challenges in the areas of housing, employment, public accommodation, etc.
- 3.2.6 Create and disseminate anti-stigma education materials for treatment teams and discharge planning staff at mental health facilities and staff at public guardians' offices.
- 3.3 Work to enhance and/or amend current statutes and regulations to further protect individuals and their family members from discrimination.**
- 3.3.1 Develop a statewide committee with legal experts and diverse community members and build upon existing structures when available, to evaluate existing laws and regulations for any embedded discriminatory provisions and gaps, and develop corrective strategies to address these problems.
- 3.3.2 Disseminate widely the findings regarding legal gaps in current laws and regulations as well as the embedded discriminatory language in current laws and regulations, together with the recommended corrective strategies.
- 3.4 Develop policies and mechanisms within the criminal justice system to more appropriately meet the needs of individuals with mental health challenges, including those located in in-patient psychiatric facilities.**
- 3.4.1 Promote mental health courts and other alternatives to incarceration.

- 3.4.2 Disseminate any court policies and protocols developed by the Judicial Council of California and the Administrative Office of the Courts designed to improve outcomes for and reduce recidivism of persons with mental health challenges in the criminal justice system.
- 3.4.3 Develop training standards on anti-discrimination laws and regulations.
- 3.4.4 Train law enforcement and criminal justice officials to recognize and prosecute mental health discrimination.

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

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

- 4.1.1 Compile and report data on the community's strengths and how to best use this information in program design, development, and assessment.
- 4.1.2 Develop incentives to build partnerships between academic research and community-based research.
- 4.1.3 Provide assistance to counties in developing anti-stigma and anti-discrimination programs and the tools necessary to identify gaps and work collaboratively with the academic community.
- 4.1.4 Utilize multi-disciplinary research techniques from the anthropological, medical, and recovery and wellness fields to guide research on the various forms of mental health stigma and discrimination.
- 4.1.5 Identify research techniques on the evaluation of anti-stigma programs for local use.

4.2 Increase the skills and abilities of community participants to evaluate programs.

- 4.2.1 Identify funding streams for communities to enhance their research and evaluation skills.
- 4.2.2 Promote the community participatory methodology.

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

- 4.3.1 Research projects should be designed with input from the community to address data elements, methodology, sample size, over sampling of diverse populations, and other aspects as needed.
- 4.3.2 Ensure that communities are actively involved in research and that findings be shared with the community for review/input.
- 4.3.4 Utilize and disseminate existing research on social behavior campaigns targeted to ethnic groups and communities.
- 4.3.5 Develop cross-cultural research and evaluation resources and tools.
- 4.4 Disseminate the lessons learned, promising practices, and other outcome findings.**
- 4.4.1 Ensure findings, research and assessment tools, and market research are easily accessible and widely disseminated as they become available, and encourage community researchers and community leaders to contribute information.

REFERENCES

- ¹ Pescosolido, B.A., Martin, J.K., Link, B.G., et al. (2000). Americans' Views of Mental Health and Illness at Century's End: Continuity and Change. Public Report on the MacArthur Mental Health Module, 1996 General Social Survey. Bloomington: Indiana Consortium for Mental Health Services Research and Joseph P. Mailman School of Public Health, Columbia University.
- ² Rossen, Eric. Bullying: A Guide for Parents. Chesapeake ADHD Center of Maryland. Retrieved April 22, 2009 from: <http://www.chesapeakeadd.com/ChesapeakeADHDCenterofMaryland-Bullying-KathleenNadeauPh.D.Director.html>.
- ³ National Institute of Mental Health: *Statistics*. Retrieved January 12, 2009 from: www.nimh.nih.gov/health/statistics/index.shtml.
- ⁴ Cooper, A.E., Corrigan, P.W., & Watson, A.C. (2003). Mental Illness Stigma and Care Seeking. *Journal of Nervous and Mental Disease*, 191, 339-41.
- ⁵ Corrigan, P.W. (2004). How stigma interferes with mental health care. *American Psychologist*, 59, 614-625.
- Perlick, D., Rosenheck, R., Clarkin, J., et al. (2001). Adverse effects of perceived stigma on social adaptation of persons diagnosed with bipolar affective disorder. *Psychiatric Services*, 52, 1627-1632
- Sirey, J., Bruce, M., Alexopoulos, G., et al. (2001). Perceived stigma and patient-rated severity of illness as predictors of antidepressant drug adherence. *Psychiatric Services*, 52, 1615-1620.
- ⁶ National Institute of Mental Health. (2003). *In Harm's Way: Suicide in America*. NIH Publication No. 03-4594. Printed in January 2001; revised April 2003.
- Palmer, B.A., Pankratz, V.S. & Bostwick, J.M. (2005). The lifetime risk of suicide in schizophrenia: a re-examination. *Archives of General Psychiatry*, 62, 247-253.
- Raymont, V. (2001). Suicide in schizophrenia – how can research influence training and clinical practice? *Psychiatric Bulletin*, 25, 46-50.
- ⁷ National Institute of Mental Health. (2003). *In Harm's Way: Suicide in America*. NIH Publication No. 03-4594. Printed in January 2001; revised April 2003.
- Palmer, B.A., Pankratz, V.S. & Bostwick, J.M. (2005). The lifetime risk of suicide in schizophrenia: a re-examination. *Archives of General Psychiatry*, 62, 247-253.
- Raymont, V. (2001). Suicide in schizophrenia – how can research influence training and clinical practice? *Psychiatric Bulletin*, 25, 46-50.
- ⁸ Mildred, L. (2007). Eliminating the Stigma and Discrimination Against Persons with Mental Health Disabilities: A Project of the California Mental Health Services Act.
- ⁹ Hinshaw, Stephen P. (2007). *The Mark of Shame, Stigma of Mental Illness and an Agenda for Change*. New York, N.Y. Oxford University Press Inc.
- ¹⁰ Corrigan, P. (Ed.). (2001). *On the Stigma of Mental Illness. Practical Strategies for Research and Social Change*. Washington, D.C., American Psychological Association.
- ¹¹ Phelan, J., Link, B., Stueve, A., & Pescosolido, B. (1997). *Public conceptions of mental illness in 1950 in 1996: Has sophistication increased? Has stigma declined?* Paper presented at the meeting of the American Sociological Association, Toronto, Ontario.

- ¹² Corrigan, P.W. (2004). How stigma interferes with mental health care. *American Psychologist*, 59, 614-625.
- ¹³ State of California, Department of Finance. (2009). *California Current Population Survey Report: March 2007*. Sacramento, California. January 2009.
- ¹⁴ Sue, S. & Morishima, J.K. (1982). *The mental health of Asian Americans*. San Francisco, CA: Jossey-Bass.
- ¹⁵ Whaley, A. L. (1997). Ethnic and racial differences in perceptions of dangerousness of persons with mental illness. *Psychiatric Services*, 48, 1328–1330.
- ¹⁶ Angermeyer M.C., Schulze B., Dietrich S. (2003). Courtesy stigma--a focus group study of relatives of schizophrenia patients. *Social Psychiatry and Psychiatric Epidemiology*, 38, 593-602.
- ¹⁷ National Institute of Mental Health <http://www.nimh.nih.gov/science-news/2005/mental-illness-exacts-heavy-toll-beginning-in-youth.shtml>.
- ¹⁸ Whitt, S. (2007). *Student Mental Health Initiative Proposal*. California Mental Health Services Oversight and Accountability Commission.
- ¹⁹ *Student Mental Health Committee Final Report*. (2006). University of California, Office of the President.
- ²⁰ US Government Accountability Office. (2006). *Young Adults with Serious Mental Illness*. U.S. GAO Report GAO-08-678.
- ²¹ Little Hoover Commission. (1999). *Now in Our Hands: Caring for California's Abused & Neglected Children*. Sacramento, CA: Little Hoover Commission.
- ²² Little Hoover Commission. (2003). *Still in Our Hands: a Review of Efforts to Reform Foster Care in California*. Sacramento, California: Little Hoover Commission.
- ²³ New Freedom Commission on Mental Health. (2003). *Achieving the promise: Transforming mental health care in America, final report*. Rockville, MD: U.S. Department of Health and Human Services.
U.S. Department of Health and Human Services. (2001). *Mental Health: Culture, Race, and Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.
- ²⁴ U.S. Department of Health and Human Services. (2001). *Mental Health: Culture, Race, and Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.
- ²⁵ Snowden. L. R. & Cheung, F.K. (1990). Use of inpatient mental health services by members of ethnic minority groups. *American Psychologist*, 45, 347-355.
- U.S. Department of Health and Human Services. (1999). *Mental Health: a report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institute of Health, National Institute of Mental Health, 1999.
- ²⁶ Alegria M., Kessler R.C., Bijl R., Lin E., Heeringa S., Takeuchi D.T., et al. (2000). Comparing mental health service use data across countries. In G. Andrews (Ed.), *Unmet need in mental health service delivery* (pp. 97– 118). Cambridge, England: Cambridge University Press.

- ²⁷ National Council of La Raza, Institute for Hispanic Health. (2005). *Critical Disparities in Latino Mental Health: Transforming Research into Action*.
- ²⁸ Cahill, S., South, K., Spade, J. (2006). *Outing Age: Public Policy Issues Affecting Gay, Lesbian, Bisexual, and Transgender Elders*. National Gay and Lesbian Task Force Foundation.
- ²⁹ Rosenberg, S., Rosenberg, J., Huygen, C., & Klein, E. (2005). No Need to Hide: Out of the Closet and Mentally Ill. *Best Practices and Mental Health*, 1
- ³⁰ Cochran, S. (2001). Emerging Issues in Research on Lesbian's and Gay Men's Mental Health: Does Sexual Orientation Really Matter? *American Psychologist*. 56. 932-947.
- ³¹ Bahm A. & Forchuk C. (2009). Interlocking oppressions: the effect of a comorbid physical disability on perceived stigma and discrimination among mental health consumers in Canada. *Health & Social Care in the Community*, 17, 63-70.
- ³² Pescosolido, B.A., Martin, J.K., Link, B.G., et al. (2000). *Americans' Views of Mental Health and Illness at Century's End: Continuity and Change*. Public Report on the MacArthur Mental Health Module, 1996 General Social Survey. Bloomington: Indiana Consortium for Mental Health Services Research and Joseph P. Mailman School of Public Health, Columbia University, 2000.
- ³³ Substance Abuse and Mental Health Services Administration. (2002). *Report to Congress on the Prevention and Treatment of Co-occurring Substance Abuse Disorders and Mental Disorders*. Bethesda, MD: Substance Abuse and Mental Health Services Administration.
- ³⁴ U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2005). *Mentally Healthy Aging: A Report on Overcoming Stigma for Older Americans*. http://download.ncadi.samhsa.gov/ken/pdf/SMA05-3988/aging_stigma.pdf
- ³⁵ California Mental Health Planning Council. (2003). *California mental health master plan: A vision for California*. Sacramento, CA: California Mental Health Planning Council.
- ³⁶ U.S. Department of Health and Human Services. (1999). *Mental Health: a report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institute of Health, National Institute of Mental Health, 1999.
- ³⁷ New Freedom Commission on Mental Health. (2003). *Achieving the promise: Transforming mental health care in America, final report*. Rockville, MD: U.S. Department of Health and Human Services.
- ³⁸ Hoge, C.W., J.R. Carr, J. Gardner, Potter. (2004). Suicide Surveillance in the U.S. Military – Reporting and Classification Biases in Rate Calculations. *Suicide and Life-Threatening Behavior*, 34, 233-241.
- ³⁹ Retrieved from U.S. Department of Veterans Affairs Web site: <http://www1.va.gov/homeless/page.cfm?pg=1>
- ⁴⁰ Garrity, C. & Baris, M.A. (1996). Bullies and victims: a guide for pediatricians. *Contemporary Pediatrics*, 13, 90-114.
- ⁴¹ Rabin, Roni Caryn. (2009). *A.D.H.D. Treatment, Stroke Rehabilitation and Childhood Depression*. New York Times. March 30.
- ⁴² Hinshaw, Stephen P. (2007). *The Mark of Shame, Stigma of Mental Illness and an Agenda for Change*. New York, N.Y. Oxford University Press Inc.
- ⁴³ De Giere, G. (2004). *Protecting Californians from hate crimes: A progress report*. Sacramento, CA: California Senate Office of Research.

-
- ⁴⁴ Wahl, O.F. (1999a). Mental health consumers' experiences of stigma. *Schizophrenia Bulletin*, 25, 567-478.
- Wahl, O.F. (1999b). *Telling is risky business*. Piscataway, NJ: Rutgers University Press.
- ⁴⁵ Little Hoover Commission. (2000). Being there: Making a commitment to mental health. Sacramento, CA: Little Hoover Commission.
- ⁴⁶ Schriener, K., Ochs, L. (2000). *"No Right is More Precious": Voting Rights and People with Intellectual and Developmental Disabilities*. Policy Research Brief. Research and Training Center on Community Living, Institute on Community Integration (UCEDD). College of Education and Human Development, University of Minnesota.
- ⁴⁷ U.S. Department of Health and Human Services. (1999). Mental Health: a report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institute of Health, National Institute of Mental Health, 1999.
- ⁴⁸ Regier, D.A., Farmer, M.E., Rae, D.S., et al. (1993). One-month prevalence of mental disorders in the United States and sociodemographic characteristics: The epidemiologic catchment area study. *Acta Psychiatrica Scandinavica*, 88, 35-47.
- ⁴⁹ U.S. Department of Health and Human Services. (1999). Mental Health: a report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institute of Health, National Institute of Mental Health, 1999.
- ⁵⁰ Hanson, K. W. (1998). Public opinion and the mental health parity debate: Lessons from the survey literature. *Psychiatric Services*, 49, 1059–1066.
- ⁵¹ Page, S. (1995). Effects of the mental illness label in 1993: Acceptance and rejection in the community. *Journal of Health and Social Policy*, 7, 61-68.
- ⁵² Mallory, P. (2002). *Special report to the Legislature on Senate Resolution 18: Crimes committed against homeless persons*. Sacramento, CA: California Department of Justice.
- ⁵³ California Association of Social Rehabilitation Agencies. (2008). *Stigma and Discrimination: a Curriculum for the CalSWEC Mental Health Initiative*. Instructor's Manual.
- ⁵⁴ Manning, C., & White, P.D. (1995). Attitudes of employers to the mentally ill. *Psychiatry Bulletin*, 19, 541-543.
- ⁵⁵ Rice, Theresa. (2009) Parent/Professional Thoughts About the Use of the Term "Seriously Emotionally Disturbed. From *Focal Point*, 23:1. 7.
- ⁵⁶ Cooper, S., Resnick, J., Rodolfa, E., Douce, L. (2008). College Counseling and Mental Health Services: A 20 year perspective of Issues and Challenges. Biennial Review of Counseling Psychology. Taylor and Francis: New York.
- ⁵⁷ Tate, L. (1991). *California's mental health system: The history of neglect*. Sacramento, CA: California Senate Office of Research.
- ⁵⁸ Moldovan, V. (2007). Attitudes of mental health workers toward community integration of the persons with serious and persistent mental illness. *American Journal of Psychiatric Rehabilitation*, 10, 19-30.
- ⁵⁹ Corrigan, P. (Ed.). (2001). *On the Stigma of Mental Illness. Practical Strategies for Research and Social Change*. Washington, D.C., American Psychological Association.

- ⁶⁰ "Depression and Suicide Facts for Older Adults." <http://www.nimh.nih.gov>
- ⁶¹ Moran, Mark. (2007). Those With Serious Mental Illness Suffer From Lack of Integrated Care. *Psychiatric News*, 42:1, 5.
- ⁶² Hinshaw, Stephen P. (2007). *The Mark of Shame, Stigma of Mental Illness and an Agenda for Change*. New York, N.Y. Oxford University Press Inc.
- ⁶³ Council of State Governments. (2002). *Criminal Justice/Mental Health Consensus Project*. New York: Council of State Governments.
- ⁶⁴ California Association of Psychiatric Technicians.
<http://psychtechs.net/pages/indexes.cgi?idxcatid=60&idxid=9195>
- ⁶⁵ Abram, S. (2008). More mentally ill end up in jails. Justice Policy Institute.
- ⁶⁶ Youth Law Center.
- ⁶⁷ Teplin, L.A. (1984). Criminalizing mental disorder: The comparative arrest rate of the mentally ill. *American Psychologist*, 39, 794-803.
- ⁶⁸ Steadman, H.J., Vulvey, E., Monahan, J., et al. (1998). Violence by people discharged from acute psychiatric inpatient facilities and by others in the same neighborhoods. *Archives of General Psychiatry*, 55, 393-401.
- ⁶⁹ Little Hoover Commission. (2000). *Being there: Making a commitment to mental health*. Sacramento, CA: Little Hoover Commission.
- ⁷⁰ Pescosolido, B.A., Martin, J.K., Link, B.G., et al. (2000). *Americans' Views of Mental Health and Illness at Century's End: Continuity and Change*. Public Report on the MacArthur Mental Health Module, 1996 General Social Survey. Bloomington: Indiana Consortium for Mental Health Services Research and Joseph P. Mailman School of Public Health, Columbia University, 2000.
- ⁷¹ U.S. Department of Health and Human Services. (1999). *Mental Health: a report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institute of Health, National Institute of Mental Health, 1999.
- ⁷² Edney, D. (2004). *Mass Media and Mental Illness: a Literature Review*. Canadian Mental Health Association, Ontario.
- ⁷³ California Association of Social Rehabilitation Agencies. (2008). *Stigma and Discrimination: a Curriculum for the CalSWEC Mental Health Initiative*. Instructor's Manual.
- ⁷⁴ U.S. Department of Health and Human Services. (1999). *Mental Health: a report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institute of Health, National Institute of Mental Health, 1999.
- ⁷⁵ Corrigan, P.W., Watson, A.C., Gracia, G., Slopen, N., Rasinski, K., & Hall, L.L. (2005). Newspaper stories as measures of structural stigma. *Psychiatric Services*, 56, 551-6.
- ⁷⁶ Lawson, A. (2004). Mental illness in Disney animated films. *Canadian Journal of Psychiatry*, 49, 310-4.

- ⁷⁷ Sayce, L. (2003). Beyond good intentions. Making anti-discrimination strategies work. *Disability and Society*, 18, 625–642.
- ⁷⁸ Corrigan, P.W. (2004). Target-specific stigma change: a strategy for impacting mental illness stigma. *Psychiatric Rehabilitation Journal*. 28. 113-121.
- ⁷⁹ Myers, et al. (2009). *Evaluation of "see me" -- The National Scottish Campaign against Stigma and Discrimination Associated with Mental Ill-Health*. Scottish Government Social Research.
- ⁸⁰ Ministry of Health. (2007). *Like Minds, Like Mine National Plan 2007-2013: Programme to Counter Stigma and Discrimination Associated with Mental Illness*. Wellington Ministry of Health.
- ⁸¹ Wyllie, A., Cameron, A. & Howearth, J. (2008). *Impacts of National Media Campaign To Counter Stigma and Discrimination Associated with Mental Illness. Survey Nine Results for Campaign 4*. Phoenix Research. Research Report for Ministry of Health.
- ⁸² Like Minds, Like Mine website. Retrieved January 21, 2009 at: <http://www.likeminds.org.nz/page/24-About-Us>.
- ⁸³ Substance Abuse and Mental Health Services Administration. (2006). *Developing a Stigma Reduction Initiative*. SAMHSA Pub No. SMA-4176. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.
- ⁸⁴ National Institute for Mental Health in England (2004). *Scoping review on mental health anti stigma and discrimination: Current activities and what works*.
- ⁸⁵ Sartorius, N. (2006). Lessons from a 10-year global programme against stigma and discrimination because of an illness. *Psychology, Health & Medicine*, 11(3), 383-388.
- ⁸⁶ Mildred, L. (2007). Eliminating the stigma and discrimination against persons with mental health disabilities: A project of the Mental Health Services Act.
- ⁸⁷ Alcalay, R. & Bell, R.A. (2000). *Promoting Nutrition and Physical Activity through Social Marketing: Current Practices and Recommendations*. Center for Advanced Studies and Nutrition and Social Marketing, University of California, Davis.
- ⁸⁸ Corrigan, P.W. (2004). Target-specific stigma change: a strategy for impacting mental illness stigma. *Psychiatric Rehabilitation Journal*. 28. 113-121.
- ⁸⁹ Substance Abuse and Mental Health Services Administration. (2006). *Developing a Stigma Reduction Initiative*. SAMHSA Pub No. SMA-4176. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.
- ⁹⁰ About Shift. (2009). Retrieved January 24, 2009 from website: <http://www.shift.org.uk/aboutus/index.html>
- ⁹¹ Mental Health Ministries website. (2009). Retrieved on March 29, 2009 from website: www.MentalHealthMinistries.net.
- ⁹² Nhan Hòa Comprehensive Health Care Clinic. Retrieved May 11, 2009 from website: <http://nhanhoa.org/en/sec/psychology/index.do>.
- ⁹³ What a Difference. (2009). Retrieved March 29, 2009 from website: <http://www.whatadifference.samhsa.gov>
- ⁹⁴ Open the Doors. (2009). Retrieved March 29, 2009 from website: www.open-the-doors.com/english/01_05.html
- ⁹⁵ On Our Own. (2009). Retrieved January 23, 2009, from website: <http://www.onourownmd.org/asp.html>.

- ⁹⁶ Sayce, L. (2000). *From psychiatric patient to citizen: overcoming discrimination and social exclusion*. London: Palgrave Macmillan.
- ⁹⁷ Corrigan, P. (Ed.). (2001). *On the Stigma of Mental Illness. Practical Strategies for Research and Social Change*. Washington, D.C., American Psychological Association.
- ⁹⁸ Corrigan, P.W. (2004). Target-specific stigma change: a strategy for impacting mental illness stigma. *Psychiatric Rehabilitation Journal*. 28. 113-121.
- ⁹⁹ National Mental Health Awareness Campaign website. Retrieved January 25, 2009. <http://www.nostigma.org/speakers.php>
- ¹⁰⁰ Stamp Out Stigma. (2009). Retrieved March 29, 2009 from website: www.stampoutstigma.org
- ¹⁰¹ Hinshaw, Stephen P. (2007). *The Mark of Shame, Stigma of Mental Illness and an Agenda for Change*. New York, N.Y. Oxford University Press Inc.
- ¹⁰² In Our Own Voice. (2009). Retrieved January 26, 2009 from website: http://www.nami.org/Template.cfm?Section=In_Our_Own_Voice&Template=/ContentManagement/ContentDisplay.cfm&ContentID=48516
- ¹⁰³ Health Scotland. (2008). *Stigma: An international briefing paper: Tackling the discrimination, stigma and social exclusion experienced by people with mental health problems and those close to them*. Edinburgh. www.healthscotland.com
- ¹⁰⁴ Edney, D. (2004). Mass Media and Mental Illness: a Literature Review. *Canadian Mental Health Association, Ontario*.
- ¹⁰⁵ Hinshaw, Stephen P. (2007). *The Mark of Shame, Stigma of Mental Illness and an Agenda for Change*. New York, N.Y. Oxford University Press Inc.
- ¹⁰⁶ Corrigan, P.W. (2004). Target-specific stigma change: a strategy for impacting mental illness stigma. *Psychiatric Rehabilitation Journal*. 28. 113-121.
- ¹⁰⁷ National Alliance on Mental Illness (NAMI) website. (2009). Retrieved April 7, 2009 from website: http://www.nami.org/Template.cfm?Section=Press_Release_Archive&template=/contentmanagement/contentdisplay.cfm&ContentID=5770&title=Wonderland%20Premiere%20Brings%20Call%20On%20White%20House%20To%20Fight%20Stigma%20In%20Entertainment%20Industry
- ¹⁰⁸ The Voice Awards. (2009). Retrieved March 29, 2009 from website: <http://whatadifference.samhsa.gov/voiceawards/>
- ¹⁰⁹ Pillen, M., Colangelo, A. & Bell, J. (2005). *Final Evaluation Case Study Report of California's Implementation of the Elimination of Barriers Initiative*. Submitted to the U.S. Department Of Health And Human Services, Substance Abuse and Mental Health Services Administration. Arlington: James Bell Associates, Inc.
- ¹¹⁰ The Carter Center website. (2009). Retrieved March 29, 2009 from website: http://www.cartercenter.org/health/mental_health/fellowships/index.html
- ¹¹¹ National Mental Health Awareness Campaign website. (2009). Retrieved on March 30, 2009 from website: www.nostigma.org/programs.php
- ¹¹² Sayce, L. (2000). *From psychiatric patient to citizen: overcoming discrimination and social exclusion*. London: Palgrave Macmillan.

-
- ¹¹³ Time to Change website. Retrieved January 25, 2009. <http://www.time-to-change.org.uk/what-were-doing/time-challenge>
- ¹¹⁴ Strosahl, K. (2002). Identifying and capitalizing on the economic benefits of integrated primary behavioral health care. In Cummings, O'Donohoe & Ferguson (Eds.) *The impact of medical cost offset on practice and research: Making it work for you*. NV: Context Press.
- ¹¹⁵ "NAMI Connection," NAMI website. Retrieved January 26, 2009. http://www.nami.org/Content/NavigationMenu/Find_Support/Education_and_Training/Education_Training_and_Peer_Support_Center/NAMI_Connection/NAMI_Connection.htm
- ¹¹⁶ MindFreedom International website. Retrieved January 26, 2009. <http://www.mindfreedom.org>
- ¹¹⁷ Altered States of the Arts. Retrieved March 29, 2009 from website: <http://www.alteredstatesofthearts.com/>
- ¹¹⁸ Everett, B. (2006). "Stigma: The Hidden Killer." Mood Disorders Society of Canada.
- ¹¹⁹ Family Diversity Project website. (2009). Retrieved March 29, 2009 from website: www.familydiv.org
- ¹²⁰ Thornicroft, G. (2003). An evidence base for anti-discrimination actions. In *Reducing Stigma and Discrimination: What Works?* Conference Report from Rethink/Institute of Psychiatry conference on June 26, 2003 in England, 6.
- ¹²¹ Health Scotland, World Health Organization Collaborating Centre (2008), *Stigma: An International Briefing Paper*, p. 10.
- ¹²² Myers, et al. (2009). *Evaluation of "see me" -- The National Scottish Campaign against Stigma and Discrimination Associated with Mental Ill-Health*. Scottish Government Social Research.
- ¹²³ See me. (2009). Retrieved April 8, 2009 from website: <http://www.seemescotland.org.uk/howarewedoining/external-tools/>
- ¹²⁴ Rusch L., Kanter, J., Angelone, A., Ridley, R. (2008). The Impact of In Our Own Voice on Stigma. *American Journal of Psychiatric Rehabilitation*, 11: 373-389.
- ¹²⁵ Spagnolo, A.B., Murphy, A.A., Librera, L. (2008). Reducing stigma by meeting and learning from people with mental illnesses. *Psychiatric Rehabilitation Journal*, 31(3), 186-93.
- ¹²⁶ Couture, S.M. & Penn, D.L. (2003). Interpersonal contact and the stigma of mental illness: A review of the literature. *Journal of Mental Health*, 12, 291-305.
- ¹²⁷ Corrigan, P.W., Larson, J., Sells, M., Niessen, N., Watson, A.C. (2007). Will filmed presentations of education and contact diminish mental illness stigma? *Community Mental Health Journal*, 43(2), 171-81.
- ¹²⁸ Altindag A, Yanik M, Ucok A, Alptekin K, Ozkan M. (2006). Effects of an antistigma program on medical students' attitudes towards people with schizophrenia. *Psychiatry Clin Neurosci*, 60(3), 283-8.
- ¹²⁹ Brown, R. (1995). *Prejudice: its social psychology*. Oxford: Wiley-Blackwell.
- ¹³⁰ Case Consulting, Ltd. (2005). *The Power of Contact: Project to Counter Stigma and Discrimination Associated with Mental Illness*. Project to Counter Stigma and Discrimination Associated with Mental Illness.
- ¹³¹ Allport, G.W. (1954). *The Nature of Prejudice*. New York: Addison-Wesley.

-
- ¹³² Desforges, D.M., Lord, C.G., Ramsey, S.L., Mason, J.A., Van Leeuwen, M.D., West, S.C., & Lepper, M.R. (1991). Effects of structured cooperative contact on changing negative attitudes toward stigmatized social groups. *Journal of Personality and Social Psychology*, 60, 531-544.
- ¹³³ Pitre, N., Stewart, S., Adams, S., Bedard, T., Landry, S. (2007). The use of puppets with elementary school children in reducing stigmatizing attitudes towards mental illness. *Journal of Mental Health*. 16(3), 415-429.
- ¹³⁴ Hinshaw, Stephen P. (2007). *The Mark of Shame, Stigma of Mental Illness and an Agenda for Change*. New York, N.Y. Oxford University Press Inc.
- ¹³⁵ Levesque, P., Schachter, H. (2006). Sticks and Stones: Breaking the stigma of child and youth mental health difficulties through our schools. *The Provincial Centre of Excellence for Child and Youth Mental Health*.
- ¹³⁶ Corrigan, P. (Ed.). (2001). *On the Stigma of Mental Illness. Practical Strategies for Research and Social Change*. Washington, D.C., American Psychological Association.
- ¹³⁷ Hinshaw, Stephen P. (2007). *The Mark of Shame, Stigma of Mental Illness and an Agenda for Change*. New York, N.Y. Oxford University Press Inc.
- ¹³⁸ Hinshaw, Stephen P. (2007). *The Mark of Shame, Stigma of Mental Illness and an Agenda for Change*. New York, N.Y. Oxford University Press Inc.
- ¹³⁹ Hinshaw, Stephen P. (2007). *The Mark of Shame, Stigma of Mental Illness and an Agenda for Change*. New York, N.Y. Oxford University Press Inc.
- ¹⁴⁰ Dahlberg LL, Krug EG. Violence-a global public health problem. In: Krug E, Dahlberg LL, Mercy JA, Zwi AB, Lozano R, eds. *World Report on Violence and Health*. Geneva, Switzerland: World Health Organization; 2002:1-56.