Mental Illness Stigma Reduction Situational Analysis

FINAL REPORT
2013

PREPARED BY:
BEHAVIORAL ASSESSMENT INC.
Stigma is as disabling for people with mental illness as the illness itself. Advocates and researchers agree: erasing the stigma requires local and credible contact with people in recovery. This requires grounding public efforts in the perspectives of the area in which a stigma campaign is to be implemented. Paso del Norte Health Foundation and its partners are to be lauded for recognizing this priority and conducting an extensive situational analysis to inform the anti-stigma efforts in their area. This analysis was a labor intensive effort that included obtaining extensive information from all important stakeholder groups with consumers having an especially powerful voice. The analysis is not limited to a description of the problem. It yields concrete recommendations on how the community needs to organize to eradicate prejudice and discrimination against people with mental illness. The situational analysis is a beginning. Paso del Norte Health Foundation and partners need to now grab the wisdom of these findings to implement meaningful change.

Patrick W. Corrigan
Distinguished Professor of Psychology
Illinois Institute of Technology
and
Principal Investigator
National Consortium on Stigma and Empowerment

“We congratulate Paso del Norte Health Foundation and the people in the Paso del Norte region for taking the initiative to address stigma associated with mental illness using multi-level approaches. Building synergy through effective education programs and ongoing collaboration of organizations, consumers and families will lead to positive change in attitudes about mental illness and recovery.”

Linda Rosenberg, MSW, President and CEO
The National Council For Behavioral Health

“The Brain Trust, an open network of community members committed to changing minds and attitudes about mental illness, is dedicated to growing a collaborative movement for lasting impact. We applaud Paso del Norte Health Foundation’s Think.Change initiative. This Situational Analysis will foster the region’s strategic next steps to improve mental and emotional well-being for the health of children, youth, and adults.”

Sharon Butterworth,
Mental Health Advocate and Brain Trust Chair
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Behavioral Assessment, Inc. (BAI) was contracted by Paso del Norte Health Foundation (PdNHF), to conduct a comprehensive Stigma Reduction Situational Analysis for the region including Doña Ana, Luna and Otero Counties in New Mexico; El Paso and Hudspeth Counties in Texas; and Ciudad Juarez in the state of Chihuahua, Mexico.

- Purpose of the Situational Analysis: To determine prevailing regional attitudes regarding mental illness stigma, including demographics, media environment, barriers, and opportunities to address stigma and discrimination associated with mental illness.

Each Section of this Final Report on the Situational Analysis provides a summary of activities, findings, challenges and opportunities related to the specific components of the Situational Analysis along with recommended opportunities for stigma reduction and community action. While much of the information provided in this Final Report is detailed and in some cases technical, we believe this level of reporting captures the complexities of mental health and stigma. In some cases, additional details are included in the Appendices.

The Situational Analysis was designed to assess issues relevant to all population groups residing in the region with no singular focus on any specific age, nationality, ethnic or gender. Given the bi-national nature of the region and considerable presence of military facilities and personnel, recommendations include cultural information related to beliefs about mental illness, recovery, and stigma reduction messaging.

**Approach to the Situational Analysis**

In order to assess prevailing attitudes, challenges and opportunities in the region the following activities were undertaken by BAI:

1) Development of Mental Health Literature Review & Best Practices Compendium

2) Creation of County-level Mental Health Profiles

3) Coordination and collection of data from Key Informants

4) Coordination and collection of data from Consumers and non-Consumers via Focus Groups
5) Development of Recommendations for the Community and the Foundation related to stigma reduction for the region.

**Foundation Approach to Stigma Reduction**

Considerable background work has been completed by the Foundation, along with partners from the local universities, public health and mental health authorities and local stakeholders. Based on this work, the Foundation defines mental health and mental well-being as “Fundamental to the quality of life and productivity of individuals, families, communities and nations, enabling people to experience life as meaningful and to be creative and active citizens.”

This definition was central to the Situational Analysis and shaped many of the probative questions included in gathering key informant and focus group data.

In the May 2012 PdNHF Stigma Reduction Strategic Plan the preponderance of data on approaches to stigma reduction was summarized into three approaches:

- **Protest:** This approach is best described as a moral injustice. People are instructed not to act in this socially inappropriate way. For example, the National Alliance on Mental Illness [NAMI]’s Stigma Busters project challenges moviemakers, advertising groups, etc. when stigmatizing portrayals of mental illness are identified. Other efforts to protest might include public rallies and boycotts targeting business behaviors that are stigmatizing.

- **Education:** This approach is described as providing education with factual information about inaccurate mental illness stereotypes. Educational strategies aimed at reducing the stigma of mental illness may include public service announcements, books, flyers, lectures, movies, videos, and other audio-visual aids to dispel myths about mental illness and replace them with facts. A benefit of educational interventions is the relative ease and exportability of interventions that reach large audiences.

- **Contact:** This approach is described as interpersonal contact with members of the stigmatized group. For example, face-to-face, mutual interactions between a school group and a person with mental illness. Corrigan and Gelb (2006) explain that contact has long been considered an effective means for reducing intergroup prejudice. Several studies focused specifically on the effects of contact on the stigma associated with mental illness have produced promising findings.
Recent journal articles, including Corrigan and Gelb (2006), suggest that protest may be useful for changing behavior. However, it may also have negative impact on public attitudes about people with mental illness. Dr. Amanda Barczyk’s 2011 stigma reduction research, supported by Hogg Foundation for Mental Health, recommended an emphasis on education and contact approaches to for local stigma reduction.

**Paso Del Norte Health Foundation Framework for Stigma Reduction**

The PdNHF along with BAI developed a framework for stigma reduction. The framework relies on the original Corrigan model that includes Education, Protest and Contact strategies but also incorporates: a) Developmental Perspectives; and b) Cultural Factors. The following matrix is supported by findings from the Situational Analysis:

<table>
<thead>
<tr>
<th>PDNHF Stigma Reduction Framework</th>
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<tbody>
<tr>
<td>Education</td>
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<tr>
<td>Protest</td>
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<tr>
<td>Contact</td>
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Findings on prevailing attitudes point directly to the need to incorporate programs for developmental age groups, whether these are direct education programs for mental health promotion or messaging about mental health and stigma. Additionally, strong values toward family, personal relationships, religion and family support are mentioned as cultural influences in determining mental health and mental illness stigma. Cultural elements must be incorporated into both educational efforts and messaging to reduce stigma and improve help seeking behaviors for those with mental health issues.

**Orientation Meeting With Paso Del Norte Contract Officer and Other Staff Meetings**

An initial orientation meeting between BAI key staff and PdNHDF Senior Program Officer, Enrique Mata was held. Following the initial contract meeting, the BAI team utilized key unifying principles to conduct the Situational Analysis. Based on the PdNHF Stigma Reduction Strategic Plan written by Mr. Enrique Mata, consensus was achieved regarding the methods to be used for each aspect of the Situational Analysis. Subsequent meetings in person or by phone provided opportunities to continue to develop and articulate the Situational Analysis project.
Ciudad Juarez Situational Analysis

To complement the stigma reduction information from the 5-county U.S. border region in Ciudad Juarez, BAI partnered with the Alliance of Border Collaboratives (ABC) and Programa Compañeros (PC). Together, these organizations gathered data using the same methods and approaches utilized on the United States side of the border. ABC and Programa Compañeros worked with Dr. Richard Cervantes and Ms. Christina López-Gutiérrez of BAI to ensure that linguistic as well as cultural dimensions were reflected in all aspects of the study. A total of 3 consumer focus groups and 9 key informant interviews were coordinated and conducted by ABC and PC in Ciudad Juarez.
SECTION 1- KEY INFORMANT INTERVIEWS

Included in this Section of the report:

- Opportunities for Community Action Based on Prevailing Key Informant Data
- Purpose of the Key Informant Interviews
- Approach to Developing Key Informant Interview Questions and IRB Protocol
- Methods Used to Recruit Key Informants
- NVivo Data Analysis Findings Based on Key Informant Transcripts
Opportunities for Stigma Reduction Based on Key Informant Interviews

The following summary is based on a range of responses from key informant interviews. Specific recommendations, taken from 25 key informant interviews, help validate data gathered using various methods in conjunction with the Situational Analysis.

- **Increase and expand local and regional mental health training for health professionals and community leaders.**

  Key informants emphasized that training programs would increase knowledge about basic mental health and help dispel myths and misinformation in the region. Community leaders were identified as elected officials, school superintendents, chiefs of police, and other governmental leaders and administrators.

- **Increase and expand local and regional basic mental health education through training and workshops.**

  Key informants indicated that local and regional educational training and workshops conducted in schools, churches, libraries, town halls and other public venues would help provide programs like Mental Health First Aid for the general public.

- **Establish community dialogue through activities that encourage and promote the dissemination of accurate information about mental health and emotional well-being.**

  Key informant responses indicated that trained mental health providers should be involved in these dialogues to ensure that medically accurate information about mental illness and mental health care is disseminated. It is also suggested that reach and participation level in these activities be evaluated.

- **Increase and expand education programs for parents and children to raise awareness of available local and regional mental health services and promote mental health and emotional well-being.**
Results of the key informant interviews reflected a need to empower parents through education to better screen, identify and address early signs and symptoms of mental illness in their children and families. Evaluation of programs aimed at increasing parent education on children’s mental health is needed.

- **Increase public education about mental health through media.**

According to key informants, media that includes printed newspapers, magazines and brochures as well as electronic media such as the internet, social networking sites, television and radio can be useful in increasing positive messaging through public service announcements and special reports that emphasize the importance of early and available treatments for mental health problems.

- **Develop, implement and test media messaging models that address a paradigm shift away from the negative connotations associated with terms such as “mental,” “mental health care,” and “mental illness.”**

Key Informants stated that messaging should focus on terms that emphasize brain health, social emotional health, emotional well-being, wellness, and similar concepts rather than words with negative connotations.

- **Increase and expand training of Promotoras and other community lay health workers to assist with basic mental health screening and referral systems for children and families.**

Results from the key informant interviews suggest training and engaging health “navigators” such as Promotoras. This could be accomplished under the Affordable Care Act, using Mental Health First Aid or similar basic informational programs on mental illness, care and effectiveness of treatment. Implementation, testing and evaluation of these innovative educational models was also suggested to determine how these approaches increase use of mental health services.

- **Increase and expand campus-based mental health education to reduce stigma associated with mental illness.**
Educational programs should raise awareness about student depression, suicide and potential violence prevention through campus-based venues such as middle schools, high schools, colleges and universities. Reach and impact of increased education on mental and emotional health should be evaluated.

- **Explore innovative approaches to screening and treating military personnel with the goal of improving mental health outcomes.**

Recent behavioral health research (Becker, et. al., 2013) has shown that approaches such as internet-based interventions may improve mental health outcomes. Key informants suggested that these innovative, web-based or tele-health programs ought to be evaluated using media metrics to show how far the programs reach and to determine specific treatment outcomes.
PURPOSE OF THE KEY INFORMANT INTERVIEWS

As part of the Situational Analysis, the BAI team conducted key informant interviews with local health and mental health education providers, treatment providers, and some professionals within the legal sector (i.e. judges, attorneys). Using this qualitative method elicited a wide range of thoughts and ideas about mental health, mental illness stigma and opportunities for stigma reduction. These methods are widely accepted forms of reliable and valid approaches for gathering community-level data (Yin, 2013; Umaña-Taylor and Bámaca, 2007).

An understanding of complex community health and behavioral health issues often goes beyond the collection of survey based or epidemiological based data. The use of qualitative methods is one of the most powerful ways to fully understand the nature of stigma and mental health and to ascertain the basis of stigma, as well as how individuals and organizations view viable solutions to the issue of stigma reduction (Cervantes & Cordova, 2010; Yin, 2012).

Prior to beginning this task, BAI’s team first defined "key informant" as an individual who provides some form of health or human service to those with mental health issues. The term provider and key informant will be used interchangeably in this section. Those in any of the following professional roles were recruited for the study:

- Mental health and other related service providers (i.e. advocates, case managers, psychologists, psychiatrists, etc.).
- School administrators, officials, counselors, and teachers
- Healthcare professionals (i.e. nurses, doctors, etc.).
- Public officials and law enforcement officers (i.e. police officers, judges, probation officers, etc.).
- Military and veteran service representatives (i.e. counselors, military liaisons, etc.).
- Other community stakeholders (i.e. Promotoras, mental health advocates, etc.).

INSTITUTIONAL REVIEW BOARD (IRB) APPROVAL AND STAFF TRAINING

Upon approval of the stigma reduction interview protocol by the PdNHF staff, the study protocol was submitted to BAI’s Department of Health and Human Services (HHS) registered Institutional Review Board (IRB). The BAI IRB conducts reviews of all research and evaluation protocols and is led by Dr. Martha Cristo. With only minor modifications, the IRB approved BAI’s PdNHF interview protocol and consent forms. A participant incentive of $10 in the form of a gift card was included in the protocol.
The next step in the process included staff training in the use of the data collection protocol in both English and Spanish. Dr. Cervantes conducted the data collection training for all staff conducting interviews in both the United States and Mexico. The purpose of the training was to ensure that all of the staff was using a standardized method during the interviews, that all participant protection and IRB requirements were followed and that a clear process for distribution of participant incentives was in place. Other items covered during the training included; interview approaches, identification of participants, collection of demographic information, and the timetable for data collection.

**KEY INFORMANT PARTICIPANT RECRUITMENT**

BAI staff developed a list of potential contacts in each of the five U.S. counties: Doña Ana, Luna and Otero counties in New Mexico, El Paso and Hudspeth counties in Texas. The contacts were compiled using existing resource lists such as: a) BAI’s U.S. Counties along the Mexico Border contact list; b) PdNHF’s Brain Trust contact list; and c) New Mexico local collaboratives membership lists in Doña Ana, Luna and Otero counties in New Mexico. Additional referrals came from word-of-mouth by colleagues and other organizations and through searching local directories for mental health providers.

The BAI team contacted over 50 potential persons to address attrition and reach the target number of 25 key informants. Some of the factors that led to additional contacts included: 1) cancelled appointments; 2) scheduling conflicts; and 3) non responsive to scheduled appointments.

The BAI team contacted potential key informants by telephone and immediately thereafter sent a formal letter inviting each of them to participate in either a face-to-face or telephone interview. Informed consent and demographic information request forms were part of the formal invitation. Upon receipt of the signed and completed paperwork, the BAI team sent confirmation notices to each key informant confirming date and time of scheduled interview. (See appendices for consent and demographic forms and formal letters of invitation). Upon completion of the recorded interviews, the BAI team entered the demographic data into a database and transcribed the recordings. Interview staff used a tracking sheet to document the progress on the number of key informant interviews in each represented county. The tracking sheet also served as a tool to document and track transcription and translation as necessary.
Five face-to-face meetings facilitated by Rebeca Ramos (of ABC) with Programa Companeros staff. These meetings were held in Ciudad Juarez, Mexico. The purpose of the meetings was to discuss recruitment strategies and protocols for the key-informant interviews and the focus group interviews. The same protocols that were used in the U.S. were also used for the data collection in Ciudad Juarez, Mexico. Moreover, during the above mentioned meeting, some challenges emerged in the review of the protocol in Ciudad Juarez. Programa Companeros and ABC took the lead to review the epidemiological and other public health data from Mexico to document some proposed adaptation to the protocols. For the Situational Analysis, as an example, questions about the military as a sub-population were excluded and optional questions about children and youth mental health were substituted. No other modifications to the protocol were made.

QUALITATIVE ANALYSES OF INTERVIEW DATA

Once all the data had been collected and transcribed, the BAI team conducted the qualitative analyses using the software QSR NVivo. NVivo was selected as it is a widely used program for managing and analyzing qualitative interview and focus group data (Richards, 1999; Buchanan & Jones 2010). The BAI analytical team previously used QSR NVivo in earlier published studies on mental health for youth and adults (Cordova & Cervantes, 2010; Cervantes & Cordova, 2011). Our current data analysis team for this Situational Analysis included one Ph.D. research psychologist (Dr. Cervantes), one master’s level psychologist (T. Bui), and the project data coordinator (C. Lopez-Gutierrez). After the reading of a sample (50%) of all key informant interviews, Dr. Cervantes and the BAI analytical team developed a series of “core analytic” themes and research questions addressing issues related to the causes, consequences and solutions to stigma regarding mental illness as part of the quality assurance process (Richards, 1999).

Mexico-based data were analyzed by the BAI analytical team along with data from the 5 PdNHF counties. Team consensus and agreement was reached on key themes to create "nodes" as required when using QSR NVivo software. These nodes became themes to help guide and extract key ideas from the data transcripts.

KEY INFORMANT INTERVIEW FINDINGS

All of the frequency analyses provided in the Key Informant Sample Demographic Table (see the demographic table in appendices) are based on a sample of n=25 participants (5 from each U.S. county who completed the demographic form. These demographics include the following
information: The majority of the participants (84%) reported being mental health providers; nearly half (43.9%) of the participants were between the ages of 52-63; twenty one percent (21%) were ages 40-44; nearly 17 percent (16.8%) were ages 25-37; over ten percent (10.3%) were 65 years of age and older. Most of the participants (84%) were female; and (16%) were male. Nearly half (48%) of the participants reported living with their spouse; forty percent (40%) reported living with their children; twenty four percent (24%) reported living alone; twelve percent (12%) reported living with their mother; twelve percent (12%) lived with their father or siblings. For the marital status (52%) of the participants reported being married; twenty eight percent (28%) were single, and 16 percent (16%) were divorced. The majority of the participants (64%) reported having children, while 32 percent (32%) reported not having any children. Forty eight percent (48%) of the participants reported having between 1 and 3 children, and 16 percent (16%) reported having between 4 and 6 children. Seventy six percent (76%) lived in a household of 1 to 3 people. Sixteen percent (16. %) reported 4 to 6 people in their household. More than half of the participants (88%) said they were born in the United States. Twenty four percent (24%) of the participants reported being second generation immigrants, 12 percent (12%) were first generation immigrants, and 8 percent (8%) reported being third generation immigrants. The majority of participants stated their primary language as English (76%), while 20 percent (20%) stated their primary language as Spanish. Forty percent (40%) of participants reported being of Hispanic ethnicity. Over half (64%) of the participants identified themselves as being of White/Caucasian ethnicity, and 32 percent (32%) reported being of Mexican/Mexican American/Chicano ethnicity. For the highest level of education, 40 percent (40%) of participants completed college, and 40 percent (40%) of participants held master’s degrees. The majority of participants (92%) reported having full time employment; Fifty two percent (52%) reported total annual household income over $45,000, and 36 percent (36%) reported an annual household income between $20,000-$45,000. Nearly half (44%) of the participants reported being Catholic and 16 percent (16%) reported being Christian.

Note: All Spanish language quotes in the Findings are immediately followed by English translation in italics.

**CORE ANALYTIC QUESTION 1: What is Stigma?**

Summary - Respondents noted a variety of definitions for the term “stigma.” Most related stigma to social exclusion, discrimination and prejudice. For the PdNHF region, key informants
identified the lack of general education about mental illness and negative media portrayals about violence and mental illness as major contributors to stigma and stigmatizing behavior.

**NODES** - The following are selected quotes that support the interview themes. Nodes are themes based on individual responses to open ended questions.

- **DISCRIMINATION**

Key informants revealed that stigma is similar to the concept of discrimination. Some informants used the example of racial discrimination in defining the term. Others gave more precise definitions, including one participant from the non-consumer group who stated:

“The actual term stigma means that somebody is not seeing something or someone for whom and what they truly are.”

- **BASED ON LACK OF EDUCATION – UNEDUCATED**

“As time goes by, there’s a lot more children who appear to be affected with mental health issues, and the parents are afraid and don’t understand, you know, and aren’t getting their kids the help that they need. Even though there’s still a lot of work underway, there’s still a population out there that hasn’t been addressed.”

“Uno, que es el más poderoso, es la ignorancia, el hecho de que en la sociedad no estamos interesados en el tema, porque creemos que es algo incurable, que no se puede manejar, no se puede curar. Entonces, lo peor que hacemos en la sociedad es la ignorancia, no nos interesa el tema, porque inclusive hay gente que piensa que son cosas del diablo y cosas así, que no son normales, no son curables ni tratables.”

“One of the most powerful factors is ignorance and the fact that our society is not interested in this topic because we think that it is something incurable, that cannot be managed, cannot be cured. Therefore, the worst happens in society--ignorance. The topic does not interest us. As a result, there are folks that think that these are diabolic things and such, that these are not normal things, and that they are not curable nor treatable.”

- **PREJUDICE**
One counselor indicated that stigma often exists within organizations, resulting in a tendency to avoid hiring persons with mental illness.

“And I personally would just like to see more of the community organizations be tolerant of it, and being inclusive in trying to find a solution to the stigma rather than perpetrating the stigma by saying, ‘We don’t have people like that in our organization.’ when really they do. They just have their symptoms under control and can contribute to society without having to come out and say, “I have a mental illness.”

- **MEDIA SENSATIONALIZES OR USES DEROGATORY TERMS**

“I think the media is huge. I also think that people don’t understand mental illness or how people are treated. So when they hear someone is going to get treated, they automatically think back to when people were locked up and put in strait jackets, and not to mention, you have these horrendous news stories like the shooting in Newtown and the vigil in Colorado. Again, because they’re not educated enough, they’re saying, “Why don’t we just lock these people up.”

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**CORE ANALYTIC QUESTION 2: What are Public Perceptions about Mental Illness?**

Summary of Responses - Perceptions of mental illness in the PdNHF region typically are thought to involve concepts of weakness, lack of personal control and the perception of those with mental illness as being violent and dangerous.

**NODES**

- **REFLECTS WEAKNESS**

  “Este problema estés en el nivel que estés, es algo que la gente no entiende y te juzga como inseguro o flojo.”

  “This problem, no matter what the severity, is something that people do not understand, and they perceive it as insecurity or laziness.”

  “You don’t get help; you work through it.” I do think that hurts people. You are seen as weak. It’s not like something is affecting your liver.”
● **SOMETHING THAT PEOPLE SHOULD CONTROL**

“I think the way people act. I think that, unfortunately, there are a lot of people that have mental illness that people don’t even know about. Those are the people that are successful but feel they have to keep it hidden. The ones that are more out of control are the ones that get attention.”

● **PEOPLE WITH MENTAL ILLNESS SEEN AS VIOLENT**

“Exactly, but it seems that many tend to connect violence with mental illness right? And that’s part of the disservice the media is doing, you know. I mean yes, we can talk about them, but they should also be talking about what we are doing, strides being made, changes, etc., you know, but that doesn’t sell.”

“Well I think, as I said before, the emphasis is on people who are mentally ill who become violent. I am not sure it’s culture; I think it’s the general media and what they emphasize.”

**CORE ANALYTIC QUESTION 3: How has Stigma Affected You? Your Family/Community?**

Summary of Responses – Key informant data reflected that service providers also have negative or stigmatizing attitudes or actions (stigma associated with mental illness). Participants, who identified themselves as service providers, revealed situations where they witnessed the social exclusion and social isolation of patients within the treatment system. Examples included situations where stigmatizing behaviors stemmed from treatment system staff such as...

**NODES**

● **FORCES YOU TO CONTROL YOUR MENTAL ILLNESS - HIDE YOUR MENTAL ILLNESS**

“I think the way people act; I think that, um, unfortunately there are a lot of people that have mental illness that people don’t even know about. Those are the people that are successful but feel they have to keep it hidden. The ones that are more out of control are the ones that get attention.”

● **SOCIAL ISOLATION AND PERSECUTION**
“I think that people you know, like the neurotic housewife, would not be treated differently than somebody, let’s say, who has been diagnosed with schizophrenia okay, or somebody diagnosed with bipolar disease. I think that if they don’t keep their mental illness under control that the family does tend to shun them or they tend to not include them in family functions, uh hum, because of the possibilities that can occur.”

“Por la sociedad sí. Lo que yo he visto o vivido de cierta manera, es el rechazo el alejamiento, o el “no te quiero cerca” “no me arrimo” o la etiqueta de decir esa persona es de tal o cual manera sin si quiera saber si lo que están diciendo es lo que se vive en realidad.”

“With society yes. What I have seen or lived in one way or another is rejection or withdrawal, or the attitude of ‘I don’t want you near, Don’t get close’ or labeling that person one way or another without even realizing what (hurtful things) they are saying or not understanding what they actually go through.”

- **PEOPLE ARE FEARED**

“Well, um, I think probably, you know, that people need to be feared. People with mental illness, you need to be afraid of them because they could be violent or are violent, you know.”

- **LABELING AND MISTREATED**

“The teachers need to be educated and a lot of them already have preconceived ideas about mental illness. There are a bunch of crazies, and they shouldn’t be allowed on the streets of our city. That’s the main block of stigma that we run into, and being called ‘schizo,’ and “he’s got schizophrenia,” instead of his name is Charlie, and you know he’s got a mental illness. They refer to them as schizos, and they are a bunch of nuts, or they are crazy. That kind of stigma is going to always be with us. But, if we can change the perception that there’s a person in there, and a person of worth, then we would have accomplished something.”

- **OSTRACIZED BY FAMILY**

“I think that people, you know, like the neurotic housewife, would not be treated differently than somebody let’s say, who has been diagnosed with schizophrenia okay, or somebody diagnosed with bipolar disease. I think that if they don’t keep their mental illness under control then the family does tend to shun them or they tend to not include them in family functions, uh hum, because of the possibilities that can occur.”
CORE ANALYTIC QUESTION 4: Are there Stigma Related Factors Based on Culture (ethnic, military, etc.)?

Summary of Responses - Respondents gave a range of ideas about how culture may influence a person’s definition of mental health. We found distinct issues related to the Hispanic culture. Informant responses described examples where the Hispanic culture may encourage families to shelter members who have a mental health problem or deny that problems exist. Some of the English, Spanish language and educational factors may also be a barrier for Hispanics to seek out care. Distinct cultural issues present within the Military were also mentioned. In this regard, respondents noted a strict code against acknowledging mental health problems as it is a sign of weakness. Such an admission runs counter to the concepts of strength and self-control. Fear that the disclosure of mental health issues may impact one’s career advancement is a major factor that prevents soldiers from seeking mental health care within the military.

Informants identified cultural beliefs, based on family support concepts as potentially positive values. In this regard, cultures in the border region, including Native Americans, are said to support and nurture those with mental health issues. Hispanic families and extended families are seen as providing important social support networks.

NODES

- **CULTURE DENIES THERE IS A PROBLEM**

“I think that it’s something that a lot of folks do not want to talk about. As far as we have come, people still don’t want to talk about it and we tend to look at it as someone else’s problem. I think people that don’t know much about it, and sometimes, unfortunately, they feel that the person with a particular illness has the ability to do better and get themselves together. There are a lot of people that are in denial or maybe just ignorant. There comes a point when some people lose control and need support to get back on track, specifically with the Mexican culture, we don’t want to hear about it. There’s a lack of education within that area, even within my family.”

One provider from Mexico describes the interplay between cultural beliefs about mental illness and consequent lack of available services:
“En México es diferente, cuando las personas tienen que ir con el terapeuta piensa que ya está loco, pero no es así, todos tenemos cosas que resolver, y por eso se puede emplear ese servicio en México, pero no tenemos esa cultura. Por ejemplo yo no sé cuántos psiquiatras hay en Cdad. Juárez nunca he visto un consultorio de un psiquiatra como veo consultorios de pediatras porque estoy seguro que somos una ciudad con un índice significativo de enfermedad mental y no hay ni siquiera en los centros de salud, el IMSS mucho menos el ISSSTE.”

“It is different in Mexico when people have to go to the therapist, they think they are crazy already, but it is not like that. All of us have things we need to resolve and therefore we can use that resource in Mexico, but it is not part of our culture. For example, I don't know how many psychiatrists we have. I have not seen psychiatrists' offices like I see pediatricians’ offices. I am sure that we are a city that has a significant high number of mental illnesses, and we don't even have them (mental health services) in health centers.”

- SOME CULTURES ARE SUPPORTIVE OF THOSE WITH MENTAL ILLNESS

“I am not familiar with the military. I am from Silver City. I grew up here, and I would say the Hispanics view it (mental illness) differently than the Anglos. Not that either one is better, and I have lived in Gallup twice for a period of time, and the Native Americans, in particular the Navajo, have a different perception of mental illness too, in the way they handle it. I know that for the most part, the Navajos view it as a more spiritual problem or event or something like that, depending on how big of a problem it is., and, I think the Hispanic population here, uh, the younger ones, a lot of the younger ones see it with fewer stigmas than some of the older ones. Individuals, you know, the grandparents and I see it changing throughout the cultural populations, but, I know they treat it differently, you know, I have seen them treat people (those that have mental illness) differently.”

“You know what I discovered, living here most of my life and being in a significant majority Hispanic population, is that families tend to be very close here and people tend to stay in the home a lot longer. They tend to, um, have a certain hierarchy and respect towards their elders. That, you don't sometimes see in other cultures. Yeah, and so, so, so I definitely think that, um, typically when we deal with mentally ill people in the Hispanic culture, they tend to protect family members more, and try to ensure, you know, within their means, or what, they have access to, um, to get help for that individual, instead of, um, just kind of letting them be on their own.”
MILITARY SEES MENTAL ILLNESS AS A SIGN OF WEAKNESS

“Oh, I was going to say was that in the military, from what I have heard from people who have tried to talk about their problems while in the military, is that they are shut down, because they are branded as being weak. Right, and those in the military of course they don't want to tarnish their records so a lot of those in the military won't get help because of the fear of damaging their record.”

“Um, I think so. I mean, it’s hard for me to talk for any other culture but mine, but in our culture, it just seems like sometimes you don’t believe in some of these disorders. We have soldiers that come back with PTSD and you know, sometimes in our culture, it’s more like, you know, that has nothing to do with it. Um, maybe it’s just a lack of education on those topics and things that can really affect you.”

CORE ANALYTIC QUESTION 5: How are the Messages about Mental Health/Illness Communicated?

Summary of Responses – Based on key informant interviews, the media often perpetuates negative portrayals, presenting negative portrayals of mental illness. Respondents indicated that the media tends to only provide coverage about the mentally ill that is largely negative.

NODES

MEDICAL MESSAGES

Most provider interviewees commented about the negative or sensationalized portrayal that occurs when the media covers a story involving mental illness.

“I think that there’s probably, um, in these instances where people are violent and they shoot a bunch of people, that’s played up. I think that in television and movies, people with mental illness who are violent are focused on rather than those that are going about their business trying to lead their lives.”
“On television, they use derogatory language and portray someone ill as being violent. We see the recent situation with shootings, and people automatically associate it with someone who is mentally ill. They all act in that manner.”

**CORE ANALYTIC QUESTION 6: How Can We Reduce Stigma?**

Summary of Responses – There were commonalities in key informant responses in both the U.S. and Mexico regarding solutions and opportunities to reduce stigma. Themes included the importance of advocacy (protest) strategies, education at the community level, and provider and family levels. Some providers also gave particular recommendations for increasing contact strategies that involve the hosting of community events, community forums, and similar activities where consumers are included. Working to educate community leaders was an important strategy for changing social and organizational norms. In addition, one very important theme taken from the provider interviews was the recommendation that providers themselves become educators and community ombudsmen for other human services, faith-based and school-based personnel. The providers acknowledged that they have the experience and knowledge to help break down negative perceptions about mental illness and mental healthcare. Campus and school-based education were highly recommended by the provider respondents. Finally, specific educational approaches for military servicemen and military families were suggested.

While media messaging and negative media portrayals of those with mental illness were found to be key factors in shaping norms, few media based strategies or recommendations from providers were elicited.

**NODES**

- **TRAINING FOR HEALTH PROFESSIONALS AND LEADERS**

“I think it needs to begin with the leadership, and then the whole community (interviewee laughs) will benefit from it! I can’t think of any sector of the community that wouldn’t benefit from learning about it, and I think it begins with the leadership because they set the standard for the treatment and the behavior, um, uh, the way people are um, well, I think that’s where it begins! The leadership; they’re the ones in control and I think that makes a big difference, not
just for the financial resources, but also for the way that people behave and the information that’s disseminated, and how it’s um, perceived. Let’s start with the leadership, and then the whole community.”

- **POLICY ADVOCACY AND FUNDING FOR SERVICES**

  “Yeah, I think there needs to be more counseling available, uh, we’re in a economically depressed area, a lot of people don’t have the resources or finances, and uh, sometimes they just need somebody to sit down and talk to, you know, and uh, I think that’s one of the things that needs to be available as far as services, more than counseling. You know, Hudspeth County, many years ago, used to be able to take people to El Paso for psychological detention if they needed it, and I guess El Paso got to where they had so many, they didn’t have enough rooms to take them all in. We usually can find beds in Big Springs, but, I have been caught in a situation where they wanted us to transport to San Angelo or beyond you know, so, for Hudspeth County, you have to make a trip half way across the state just for mental illness confinement, and then when you get there they say, “Well, we don’t think this person fits our criteria.” Well, by that time, this person has had several hours (laughs), now you have a deputy that has a mental issue (laughs). Well, now there needs to be the availability of beds in closer proximity (laughs again).”

  “I’m talking about needs in the community, related to many different things. When government sits down and allocates money for education and law enforcement, mental illness is just one part of that. And clearly, I think, there has been a failure in this country to provide enough funding and resources to ensure people who want access, the ability to have it. Because I know, even here locally, that sometimes there are waiting lists to get in for treatment or medication. Um, and I don’t know what your next questions are, but we are actually working on some issues in the jail to help alleviate some of those issues of people, when they enter into the criminal justice system.”

- **EDUCATION FOR GENERAL PUBLIC/POPULATION TO CHANGE SOCIAL NORMS**

  “I think trying to get the message out every way you can, whether it’s in schools or churches. I think you need to use every gamete of your population, and I think that, um, have people who are trained, do some training with those who are interested.”
“I mean, if it’s a church, I expect, I think that they should be welcoming. I think health care providers, they need to go to the church and talk to the priest and say, “Hey, I am a mental health provider and I would like to talk with you about these problems in this community.” There are some people with mental health problems, I’ve done some evaluations, and there are some people that feel discriminated or feel unwelcomed at church. If that’s the case, maybe the priest can talk to them. It will be up to them how they address it or how they will say it.”

“Just things like ads in the paper and the posters at places, you know, I think would be helpful. You know, showing that you know people do get better. There is hope. You don’t have to live like, you know, this, for the rest of your life.”

Providers from Mexico highlight the importance of sending out messages about mental health as being part of one’s overall health. A more holistic approach to messaging about the importance of mental health is recommended:

“Darnos cuenta que la salud mental incluye no solo la salud física, si no la salud emocional, cuando estamos hablando del área espiritual, el ser humano es un ser muy complejo y tenemos que enfocarnos en estar satisfechos y satisfechas en cada uno de las áreas de nuestras vidas para poder tener esto, una buena salud mental y si yo me hago responsable de mi propia salud mental entonces creo que contribuyo en mucho poniendo ese granito de arena y si así lo hiciéramos la mayoría pues esto sería mejor, piensa positivo pues eso sería algo bueno, pensar constructivamente y hacerte responsable ti para mejorar tu yo creo que eso sería algo muy positivo algo muy bueno.”

“We need to realize that mental health does not only include physical health, but also emotional health. When we are talking about the spiritual area, the human is a very complete being, and we need to focus on being satisfied with ourselves in each area of our lives so that we can have this, a good mental health; and if I take responsibility for my own mental health, then I think I am able to contribute a lot by adding in my grain of salt, and if most of us would do that, then that would be better, being positive, that would be something good, thinking constructively and being responsible for yourself to improve ourselves. I think that would be something very positive, very good.”

“Pues para mí sería más que hablar del padecimiento hablar de qué cosas puedes hacer para estar bien. Si partimos por ejemplo de la definición de salud, que es estar bien, y más como lo dice la OMS es el estado de bienestar físico y social que puede tener un individuo para realizar y reforzar sus habilidades para enfrentar el estrés cotidiano de manera normal y particularmente para trabajar y ser productivo yo creo que para mí un mensaje positivo es más que hablar del
padecimiento hablar de lo que tú puedes hacer para mantenerte sano mentalmente y aquí hemos tenido una historia muy difícil en los últimos años en nuestra ciudad porque justamente hemos estado sometidos a un estrés social y entonces es cuando como seres humanos tenemos que estar preparados y buscar mecanismos para mantener esa salud mental.”

“Well for me, rather than talk about the burden, talk about the things that you can do to be well. If, for example, we split the definition of health, meaning the state of being well, and additionally like the OMS defines it, as the state of physical and social well-being that an individual has and reinforces his abilities to confront daily stress in a normal manner, particularly those related to work and being productive. I think that a positive message is more than just speaking about the burden. Talk about what you can do to maintain yourself mentally healthy. We have had a difficult story here in our city. These past few years, we have been forced into a social stress; therefore, that is when we as human beings need to be prepared and look for mechanisms that maintain our mental health.”

“Pues yo recomendaría que se hiciera un trabajo de difusión, de nivel eh pues tipo medios de comunicación, programas donde se informara la comunidad así como hay en el cambio y que vamos hablar de la depresión y te dicen todo sobre la depresión y los estudios que se han hecho, avances y todo y si realmente hubiera más de esos programas en televisión abierta porque es obviamente donde tiene acceso la mayoría de la gente esto sería mucho mejor y eso es a nivel medios de comunicación.“

“Well I would recommend that dissemination efforts be done at a level where media channels are used. Programs where the community can be informed such as what they use for the change (of life). If we talk about depression, then let everything about depression be said, and all the studies that have been done, any kind of (medical) advances and everything. If we really had more of these programs in open television, since obviously that is what most folks have access to, this would be much better. It could be done at a grand level using mass communication.”

● PARENT EDUCATION ABOUT CHILDREN’S MENTAL HEALTH

“First of all, you have to fund it, and second, I would start with younger people. Have some events for middle school kids, or even fifth and sixth graders. Starting with younger people, this would be where I would focus my input. They are the ones that will grow up to be our community leaders.”

“Lo primero sería esto que le estoy explicando, saber diagnosticar, atender y cuidar y así poder atender la enfermedad para poder avanzar.”
“The first thing would be what I just explained. Know how to diagnose, assist, and take care of the illness to be able to improve”

“Me ocurre por ejemplo que una persona cercana al enfermo, que esta viven la enfermedad, pudiera salir a dar su nombre soy fulano de tal y mi papa es esquizofrenia o mi mama tiene depresión etc., somos una familia como cualquier otra y los amo y son como cualquier y porque lo quiero lo trato y porque lo quiero lo cuido y porque lo quiero lo resuelvo así no más.”

“It occurs to me that perhaps someone close to the sick person, that lives with the illness could go out and give their name and say I am so and so, and my father is schizophrenic, or my mother has depression, etc. We are a family like any other family and because I love him, I regard him because I love him. I take care of him and because I love him, I figure it out, enough said.”

- **EDUCATION USING MEDIA –NEWSPAPERS AND NEWS MEDIA, PSA’S (INTERNET)**

“La salud mental es mucho más que estar bien física y emocionalmente, va más allá de eso, interéstate, infórmate no se o tal vez con imágenes, en sobre todo utilizaría las redes sociales más famosas, Facebook y Twitter o todo eso los jóvenes ahí fácilmente tienen mas acceso y yo creo que si se utilizara algo interactivo como un video o a lo mejor hasta una serie no, donde se fomente el conocimiento el respeto sobre la salud mental, eso sería muy padre, a lo mejor incluyendo jóvenes para que pudiera atraer este tipo de población y poder inducirlos en el tema.”

“Mental health is much more than being physically and emotionally well. It goes beyond that., Get interested, get informed. I don’t know, maybe with illustrations and most importantly use the most popular social media such as Facebook and Twitter or all that. Youth will have easy access. I think if something more interactive can be used, such as a video or a mini-series where knowledge can be fostered in regards to mental health, that would be neat. Maybe include youth so that they can recruit that (same) audience and include them (youth) in this topic.”

- **HOLD COMMUNITY DIALOGUES, FORUMS, AND CONVERSATIONS TO INCREASE CONTACT**

“Have the community hold open forums, talking, um, giving education. We got a lot done last year, we got to work on the newspaper and now we get to work on the school paper, and uh, trying to get the media involved in ways that are positive, and they have been. They gave complete publicity for us on this project, so you know, I think you need to use what resources there are out there, you know, instead of getting angry and putting up divisions, which I see is
happening in this community. Try to be inclusive and bring people together even if you disagree with what they are saying. Try to get people to talk, get a dialogue about it.”

“Well, I think, like they go around and do diabetic screenings and heart disease screenings. I think, having, you know, things like that regarding mental illness, you know, like having depression screenings or screenings for other, you know, sort of things, you know, like having a mental health training day, um, to provide some sort of free screening and awareness, um, for people. Um, just more community education in the form of classes, workshops, just like classes you know, in college, you know. I’m sure there’s somebody who is interested in a mental illness class, maybe having, you know, like, uh, more of the health articles, you know, addressing mental illness, too. Half of these articles, which usually talk about heart disease or diabetes or whatever, someone might want to read something on depression or anger, but there’s a lot of information being provided。“

● **PROVIDERS DOING OUTREACH AND EDUCATION**

“Well, if a pastor or clergy had information on mental illness, then it would be safer to approach the clergy and get some support. If the schools could teach the kids kindness and tolerance so they can interact with peers with mental illness, and if the counselor had information so that they can best communicate with the parent of an ill child, sometimes parents come to a (school) counselor first, and the counselor does not know where or how to direct them.”

“Perhaps get more, um, more of the community involved, and have more groups. I know we already have groups, but maybe have like a group, just like they have Bible studies. We could have like a group of people with disorders to talk about their problems and maybe even provide them with medical advice. Maybe have a doctor in here and work with them, or case managers. Because there are people out there that don’t get treated, and so, I think if they can have access to a doctor or case manager, I think, to provide that medical care, I think that would help them a lot.”

“Some of what I talked about is that I think education is always important. Um, I know that LC6 will take a lot of consumers to see legislators and have them meet with the legislators, so I think education and exposure to people who are different, in a situation where it doesn’t get volatile, and people don’t freak out, which requires support staff. That is what I think works best for me.”
“Tenemos un grupo donde manejando regularmente el tema de cáncer que es sinónimo de muerte, hemos cambiado el concepto ahora, CANCER ES EL PRINCIPIO DE VIDA. Se lleva a cabo con un grupo de personas que lo padecen y han modificando favorablemente su forma de pensar y su forma de vivir su vida.”

“We have a group where we regularly talk about the topic of cancer. This has been a synonym for death; however, it has changed, that concept is now cancer is the beginning of life! A group that has cancer meets, and they have favorably modified their way of thinking and their way of living their lives.”

● **TRAIN COMMUNITY HEALTH EDUCATORS (PROMOTORAS)**

“Okay, you know, um, like if people are having problems, like maybe adjustment disorders, or there’s been a divorce or what not, I think it is healthy to seek help, but it doesn’t have to be the rest of your life. I think for the general public, you know, I really like that Mental Health 101. The County was doing a lot of classes on mental health. It was very basic education for the lay community. I think that was very good, to get more grants like that to be able to educate the community.”

● **CAMPUS BASED EDUCATION**

“Well, for school there’s this song that Lady Gaga sings, “I Was Born This Way,” that I think is excellent. I think school kids, specifically teens, are really bad about ostracizing anybody who is different, and I think things that help to reduce bullying, and to talk about how our differences are what make us unique and more interesting. Those kinds of things that help.”

“Um, we do a program, a parenting program called the Security Ear and we started integrating it into the grad program in the high schools for kids who are expecting or are parents already. I think that's where my being able to go to the school and start at a younger age, begin to talk about what is going on at home and seeking help in a positive way, or encouraging or shifting the view of mental illness or mental health. One of the questions I ask them is: “What do you think of when you hear about mental health?” It is surprising to me what answers I get from them. But, I think educating and actually going out into the community and showing them it’s not just about talking, because other therapies are out there that can help, and also showing them that there are resources out there.”
“Um, we would like to start earlier in the elementary schools and get the message out that people with mental illnesses are people first, and they are not the mental illness. For example in SU3, we have a family member whose daughter has a mental illness and has been able to reach out to other family members whose children have been diagnosed with the same illness. And it’s been quite effective. So, for families that need one-on-one, we need to be able to get into the schools. Our biggest problem is that the schools have not let us in. Last year, we tried to have a poster contest there, um, on anti-stigma, and we were not even able to use all the certificates that we bought from Target to give out, because the turnout was so small.”

“A nivel de las escuelas no, que los maestros pudieran estar un poco más informados y poder a lo mejor traer ya alguna clase, o hacer unas reformas para que pudieran ver más contenidos al respecto, entonces y que los estudiantes pudieran ir aprendiendo, entonces eso sería maravilloso porque estamos actuando desde por los niveles básicos no, y entonces futuras generaciones crecerían con otro tipo de mentalidad.”

“At the school level no. Teachers could be a bit more informed and could perhaps bring someone to a classroom, or make some changes so that more content related to this topic could be included. Therefore, students can be learning (about mental health) and this would be marvelous because then we are implementing at early stages, and future generations would grow up with another type of mentality.”

● MILITARY-FOCUSED APPROACHES

“With the military, there’s a different um, way of approaching, because the children who are in families of parents who suffer from mental illness, um, are different from children that are not in families that suffer from mental illness. There’s a totally different set of needs there for those kids going through multiple separations, depression and all kinds of different things. It’s not just PTSD that they see their parents go through, but I think the family unit suffers a great deal and, uh, that’s a separate type of awareness or, um, needs to be tailored to that particular group of people.”

THEMES FROM CIUDAD JUAREZ

Summary of Responses from Mexico – Key informant interviews conducted in Ciudad Juarez shared some of the same themes as those conducted in the US. These responses were included in the nodes
and analysis above. At the same time, staff from ABC provided a secondary summary of the data specific to Mexico.

Key informants in Mexico indicated that the following reflects how some progress has been made to strengthen the mental health system:

- The legislative branch of government has initiated several legislative actions within a framework of human rights.

- There is an independent body (Comision de Derechos Humanos) that monitors violations of human rights. In addition, this Commission has the authority to conduct site visits of prisons, as well as other institutions that might house vulnerable populations, including psychiatric hospitals.

- There is semi-universal health coverage that includes principal mental illnesses to be covered under the insurance that is subsidized with federal funds.

- The Mexican Health Ministry is attempting to distribute psychiatric medications to all its medical clinics and currently estimates that about 70% have at least one medication per illness type.

At the same time, key informants’ responses reflected that much work is yet to be done to improve systems of care and reduce stigma:

- There are no special programs to meet the needs of populations based on their stage in life. Particularly vulnerable are children, adolescents, and older adults.

- There are little, if any, community mental health services, with psychiatric hospitals representing the main public investment in mental health.

- The larger the urban center the better the service, with smaller communities being totally neglected.

- There is ALMOST NO COORDINATION between mental health and other sectors, not even primary care. There is almost no contact with the schools, the churches, or other sectors of civil society.
What is Needed in Ciudad Juarez?

- More training and skill building. Professionals such as social workers and nurses to offer subspecialties or certificate programs in Mental Health Initiative of the Americas.

- The strengthening of health promotion, health education, and prevention of mental illness.

- Targeting vulnerable populations like youth at risk for suicide or women at risk for depression.

- Expand the role of the Comision de Derechos Humanos and its coordination with NGOs.

- Integrate programs like addiction services with mental health services.

- Strengthen programs that promote social inclusion, that help people find jobs or housing, and eliminate physical, social, environmental or contextual barriers to social inclusion.

- Consolidate strategies that provide social protection and eliminate stigma among various priority populations, including people in rehabilitation or recovery.

- Strengthen mechanisms like coalitions that provide families and consumers with the social and political platforms for social and legislative transformations.
SECTION 2- FOCUS GROUPS WITH CONSUMERS AND NON-CONSUMERS

Included in this Section of the report:

- Opportunities for Community Action Based on Prevailing Consumer and Non-Consumer Focus Group Data
- Purpose of the Consumer and Non-Consumer Focus Groups
- Approach to Developing Focus Group Interview Questions and IRB Protocol
- Methods Used to Recruit Focus Groups
- NVivo Data Analysis Findings Based on Focus Group Transcripts
Opportunities for Stigma Reduction Based on Focus Groups with Consumers and Non-Consumers

The following summary is based on a range of responses from consumer and non-consumer focus group interviews. These summaries represent specific recommendations taken from 10 focus groups conducted in the U.S. and 3 focus groups conducted in Mexico. These focus groups help validate information and data gathered from other methods in the Situational Analysis.

- **Advocate for school system changes.**

  Respondents indicated that school system and curricula changes are needed to better promote emotional well-being and discourage bullying. This includes development of stronger school policies and enforcement as well as increased teacher and parent education on children’s mental health.

- **Increase and expand programs that emphasize early detection and treatment of emotional and behavioral problems as well as addressing issues associated with overmedicating children or medicating them prematurely or unnecessarily.**

  Based on the focus group responses, advocacy programs and educational campaigns can be useful in informing parents about the benefits of early screening and detection of behavioral and emotional problems in youth and can provide information with regard to care.

- **Increase implementation of new and innovative teaching techniques aimed at helping children cope with their mental health issues.**

  Based on the focus group responses, Mental Health First Aid, stress management and cultural supports can be integrated into traditional health-focused curricula. This includes increased teacher training programs designed to improve sensitivity to children’s emotional and behavioral health.

- **Expand and increase advocacy and education for families of consumers toward improving integration into mainstream society.**
Focus group responses indicated that NAMI-based organizations and NM Behavioral Health Collaboratives are good models for increasing community advocacy and education for families and consumers.

- **Increase and expand general education among those who provide information related to mental and emotional health: doctors, community health education and teachers.**

  Focus group data also indicated that Mental Health First AID and similar orientation training programs need to be implemented in general health care settings to include training for health professionals on mental and emotional health services, early screening and detection.

- **Increase and expand school-based and community-based parent education programming to better screen, identify and address early signs and symptoms of mental illness in their children and families.**

  Results from the focus groups reinforced the idea that early screening, identification and treatment of emotional and behavioral problems in young children can help avoid more pronounced problems in later childhood and adolescence. Parent training can also help dispel culturally-based myths about mental illness.

- **Increase and expand school-based educational programs that provide age-appropriate information to children about emotional and behavioral health.**

  Focus group participants recommended that programs to increase youth knowledge about mental health can help youth develop sensitivity for those with emotional problems and can reduce bullying based on mental health/mental illness.

- **Increase the production and dissemination of educational media through campaigns and programs aimed at raising the general public’s awareness about mental and emotional health.**

  Focus group respondents indicated that positive media messaging can play a significant role in changing negative perceptions and overcoming perceived norms in the larger community.
PURPOSE OF THE FOCUS GROUPS

As part of the PdNHF Stigma Reduction Situational Analysis, focus groups were chosen to augment data collected from the key informant provider sample. We were particularly interested in hearing from both consumers and non-consumers regarding their perceptions, experiences and feelings about mental health and stigma, as well as obtain input from the 2 distinct groups about solutions for overcoming stigma in the El Paso region.

Focus groups have been shown to be a powerful investigative tool to facilitate collection of rich data, particularly for disenfranchised populations (Denzin & Lincoln, 2005; Patton, 2001). For example, given the low literacy and high school completion rates in the Hispanic population residing in border communities, focus groups facilitate the expression of ideas and experiences that may otherwise be overlooked or may require higher literacy capabilities (Morgan, 1997; Stewart et al., 2007). All focus group facilitators conducting the interviews were bilingual and of Hispanic origin as suggested by Umaña-Taylor and Bámaca (2004). Secondly, the focus groups consisted of mixed-gender participants. Mixed-groups allow for the potential to generate diverse insights (Stewart et al., 2007; Umaña-Taylor and Bámaca, 2007). Lastly, participants were given a choice to participate in either a Spanish or English language focus group interview. All protocols for the focus groups, consent forms and recruitment flyers were approved by the BAI IRB as described in the previous section of this report.

FOCUS GROUP PARTICIPANT RECRUITMENT

Two focus groups were carried out in each of the five target U.S. counties. One of the focus groups was conducted with consumer participants and a second group was comprised of non-consumers. The BAI team targeted the following participants for the Consumer Focus Groups:

- Persons receiving counseling for a mental health issue.
- Parents or caregivers of a person receiving counseling for mental health issue.
- Persons receiving other mental health intervention services (i.e. parenting services, case management).

The primary recruitment venues for consumer focus group participants were: 1) mental health agencies; and 2) consumer advocacy groups. For instance, one of the ways that the BAI team reached out to mental health agencies was targeting their existing programs, specifically those implementing psycho-social rehabilitation (PSR) programs at their sites. These programs are
generally run during the day and include several educational and psychotherapeutic services in a group setting to consumers. BAI was able to be part of the daily agenda and conduct focus groups with clientele.

Another way that the BAI team worked with mental health agencies was with existing support groups. For example, in Luna County, New Mexico, BAI learned that PSR programs were not available. However, one of the local mental health agencies provided counseling services for parents of youth who were part of the probation system and receiving counseling. One more way that the BAI team coordinated with mental health agencies, especially those in rural, underserved counties, was by inviting existing individual consumers to participate in a focus group. Due to confidentiality issues, the BAI team worked closely with agency staff to coordinate recruitment of participating consumers.

One last approach was working with other active groups. For example, in NM, BAI targeted the Behavioral Health Local Collaboratives. The purpose of these local groups is to plan and coordinate local health services in their participating regions. Mental health consumers are part of the membership and leadership of the Local Collaboratives.

In reference to the non-consumer focus groups, the BAI team targeted community groups that had little to no relationship with behavioral health services. These community groups included:

- ESL (English as a Second Language) adult classes
- Religious groups (i.e. church choir)
- Community exercise groups (i.e. Zumba classes)
- Parent groups (i.e. parent-teacher organizations)

After the BAI team identified groups in the targeted county, the recruitment approaches included visiting existing meetings, word of mouth, and handing out recruitment flyers at community and religious organizations (A table listing all focus group participants, including individuals and organizations is included in the Appendices).

**METHODOLOGY**

Once the BAI team solidified dates, times and locations of focus groups, facilitators began the process by reviewing protocol, collecting demographic information, collecting consent forms,
and explaining the audio recording process to participants. This process added an average of 15-20 minutes to the actual question and answer session, depending on group size. After the question and answer session came to an end, the BAI team provided group participants with information about incentives. BAI awarded gift cards upon finalizing the question and answer session.

As focus groups and key informant interviews were being carried out, the BAI team began to identify individuals and groups with identification numbers on a tracking document. This document also served as a way to track the transcription progress of each of the interviews and groups. Interviews and transcriptions were done in tandem throughout this process.

Once all the data had been collected and transcribed, the BAI team made the qualitative analyses using QSR NVivo qualitative software. The BAI data analysis team included one Ph.D. research psychologist (Dr. Cervantes), one master’s level psychologist (T. Bui), and the project data coordinator (C. Lopez-Gutierrez). All the Mexico based data were analyzed along with data from the 5 PdNHF counties. Team consensus and agreement was reached on key themes to create "Nodes" as required for QSR NVivo qualitative software. These nodes were themes that would help guide and extract key ideas from the transcripts, including community-based solutions to mental health stigma.

CONSUMER FOCUS GROUP FINDINGS

**CORE ANALYTIC QUESTION 1: What is Stigma?**

Summary of Responses – The consumer groups’ responses covered a wide range related to defining stigma. Respondents indicated that stigma is a negative stereotype that often results in discrimination and barriers to personal achievement. Stigma is also based on the misconception that all individuals with mental illness are schizophrenic or drug addicted.

NODES  -The following are selected quotes that support the interview themes. Nodes are themes based on individual or group responses to open-ended questions.

- **DISCRIMINATION**

  “So, simply put, it’s to discriminate someone.”
“To reject someone.”

“It is more to discriminate instead, I think a person feels more isolated when they are discriminated instead of rejected.”

● **BASED ON LACK OF EDUCATION - UNEDUCATED**

“A negative opinion based on ignorance.”

“We can call it a generalized perception, lacking specific knowledge.”

● **UNCLEAR ABOUT STIGMA DEFINITION**

“A misperception of reality.”

● **PREJUDICE**

“Um, it causes people to be prejudiced against, um, that individual. Not enabling them to have the same opportunities as other people socially.”

“So, a level of pre-judging.”

● **MEDIA (SENSATIONALIZE) OR USES DEROGATORY TERMS**

“The public tends to think we are mentally incompetent or something, a serial killer. They don’t think we are smart, or you don’t have the right mind set to make your own decisions, and being called a psycho. In my life, my family said that I’m crazy.”

● **MENTAL OR EMOTIONAL DISORDERS TERMINOLOGY**

“I think just the word “mental,” it's in our heads, you are mental, you’re all in your head. It’s like when you’re sick; you’re not sicker. You have a problem, so when they say mental it’s like something is wrong with your head. It’s just the word mental, if they say behavioral they think, oh, because you don’t know how to behave and that’s not what it is.”

● **FAMILIAL, GENERATIONAL OR CULTURAL BELIEF OR VALUE**
“At the least, stigma is beliefs and values that an individual holds and has passed down through the family into the communities. They can be based on biasness or their own personal experience.”

- **BARRIERS**

“When I think of stigma, I think of barrier. That is the first thing that pops into my mind, barrier.”

“Stigma is usually a negative behavior. When I think of stigma, I think of barrier.”

“But again, the stigma attached, there’s a barrier there that keeps you from finding out the reality, the whole truth. It can stop something right then and there.”

“When I see people discuss mental illness, there’s two separate issues. There’s people with schizophrenia and there’s people with substance abuse, addiction, and it seems that people understand that if you’ve got schizophrenia it’s not your fault and we will do anything we can to help you, but, if you are an addict, you brought that on yourself. Again, this is not my feelings, but your low down, you brought this on yourself by doing the drugs that you did, and you don’t say that when people have diabetes brought on by overeating, or lung cancer brought on by smoking. You never say, well you shouldn’t get treatment because you smoke cigarettes. But, with addicts, it’s like, you are no good, so we don’t have the money or the resources to provide help for you because quite frankly you don’t deserve it. This is a great barrier of stigma.”

- **NEGATIVE BELIEF SYSTEM**

“It’s a negative label or connotation that defines somebody, and that there is quality of life. Because they will hide it, they will minimize it, and not get help and they need to make a better reality for themselves.”

**CORE ANALYTIC QUESTION 2: What are Public Perceptions about Mental Illness?**

Summary of Responses – Respondents felt that overall public perceptions about mental illness are negative. The prevailing attitudes are that people with mental illness should be able to
control their condition, that stigma forces people to avoid or deny mental illnesses, and that numerous derogatory and negative stereotypes are perpetuated in the community.

**NODES**

- **REFLECTS WEAKNESS**

  “Um, for me it’s just mainly weakness, neediness, yeah, takers.”

- **SOMETHING THAT PEOPLE SHOULD CONTROL**

  “My family, um, had a philosophy, of pulling yourself up by your bootstraps. If you can’t, it’s because you are not disciplined, you lack self-control; you lack will. Um, it’s all negative, all the things you don’t have, and never emphasizing what you do have; that is a stigma that is definitely attached to mental illness. Um, pick yourself up and get going. No, um, no room to allow for an illness.”

- **SOMETHING TO AVOID OR DENY**

  “I felt that I didn’t want to talk about it, but I didn’t really discriminate there. I just didn’t know how to deal with it.”

  “I think some are different; some will try to hide it because they don’t want anybody to know they need the help. Some will, like, go to that person that needs the help, and will be different with them, only it causes that person to be worn out. They feel like they shun away, because they shelter them.”

  “It’s a way to disguise. I know a lot of other families that I see that do that because they try not to speak out loud, because they want to keep it quiet. They don’t want anybody to know they need that.”

  “I guess with the majority of families, they don’t say that somebody in their family needs help because they are too embarrassed to.”
“Many times we don’t accept something that is happening to us and that may be a similar situation, we never see our own errors; we are looking at someone else's errors but can't seem to ask the same of ourselves.”

- **SEEN AS DEROGATORY**

“Um, I might think, that they think we are crazy.”

“A bumbling idiot.”

“Um, like when I’m totally depressed, people think I’m being lazy.”

“Now that I’ve been trying to treat my mental disorder, you know, it’s not just because I’m psycho, or dangerous, or anything like that, I mean, we all have those capabilities, but it was more along the lines of there was something wrong with me. I was defective in some way.”

“They say the Mexican heritage, well, we are poor, and we suffer from being poor, and we are always worried about that. The Indians and the Nopacos, that they are higher than us., Stereotypes.”

“You know with the Indians back in the day when they had their so called mental illness, if we did the same thing they did we wouldn’t have this problem.”

“For people that have mental disabilities, people think you are crazy or dangerous, a negative opinion.”

“We all notice the changes, we say "something is wrong" or "they have something," they are crazy, and we can't even say that because we don't really know what is going on.”

“Sometimes we say "she is crazy” but then, we don't even pay attention to our behaviors; ours may be just the same as well.”

“They confuse the illnesses. They think they are one in the same, such as schizophrenia and bi-polar, they think that because they are bi-polar they are crazy. We have people who come here to the center, and they have schizophrenia or are bi-polar and they get referred to a mental health agency. But, they get bothered by that referral because they say "those places are for
people who are crazy and I am not crazy,” but that is the general reaction. They get upset at the fact they are told they have a mental illness.”

- **SHOULD BE INSTITUTIONALIZED**

  “Sometimes they think that we should be locked up.”

- **AS A CRY FOR HELP OR SUPPORT**

  “I don’t see it as going to see the crazy doctor. I see it as just needing to speak with someone else regarding their problems. I don’t see it as them being crazy; it’s just that some people need to communicate with other people in different ways. Goes to see a family member, or maybe they can communicate with someone else, so they are not judged in a certain way.”

  “Yah, but sometimes they are not getting the help that they need either.”

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<th>CORE ANALYTIC QUESTION 3: How has Stigma Affected You, Your Family/Community?</th>
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Summary of Responses – The consumers, in particular, gave very detailed accounts of their experiences of being stigmatized. Consistent with much of the literature on stigma, the focus group participants shared experiences of being called derogatory names, being excluded by friends and family, being feared in the community and being discriminated against. These experiences reflect prevailing negative attitudes and behaviors in the region towards persons with a mental health issue or problems.

**NODES**

- **SOCIAL ISOLATION**

  “They don’t want to spend time with me.”

  “Um, I don’t get invited to things. Um, like my niece had a baby and I wasn’t informed. I wasn’t even invited to the baby shower. Um, they go places, and I’m not invited.”

  “Yeah, I’m bipolar, OCD. I don’t like people punishing me just because I have a hard time with my OCD. Some people, I know, understand the problem. I can’t take care of myself, but, people say, “You stop that or I’m not bringing you back to this restaurant.” It’s hard.”
“They don’t go places with their family. Basically, they just stay at home because of that. Everybody is just looking at them, and they look at you differently too. They ask you why you’re there, why you’re helping them; they can’t help themselves.”

“People are isolated, there are some people, children that provoke pity, and others feel pity for them. I take care of a child that is 6 years of age, and others look at his mom with pity. They feel sorry for her, and she has been part of the community for some time now. But, even though they are invited to parties or other social events, people still whisper and talk amongst themselves about ‘Poor her’. That is most of what people say.”

“Rejection. People will say she is going to come with her child; let’s see how it goes, how they will act here at our event.”

● PERSECUTION/DISCRIMINATION

“They wanted to fire me because of my mental illness. At the time, I was coming in doing what I was supposed to do, but my boss didn’t think I was able to do the job, and I felt like, hey, I’m trying my best. But they just didn’t want to deal with me anymore, you know, and I quit, because I didn’t want to be fired.”

“Yeah, I don’t know how statistically true this is, but crime rates seem to be higher near the border towns, and a lot of people, especially law enforcement, automatically associate people that are mentally ill as somebody who is more prone to criminal activity. As much as I hate to say this, there is a truth that it’s racially biased as well. According to law enforcement, and I’m not Hispanic, but I do know there are a lot of Hispanics in the prison system, and a lot of what law enforcement does, is they um, um, profile people, and in profiling, they also create more, or, perpetuate the stigma.”

“I had cancer and then towards the end of the my treatment, I realized that I needed to get support for what I went through. I didn’t realize it then, but now I know that I was depressed. I would cry often and didn’t know why. For example, when my family would say ‘I am going to Wal-mart’”, and they would walk to the car, I would stare out the window crying because they didn’t invite me, I felt those emotions inside me but I didn’t know what was going on.”
“They take advantage of me, like that. They are frightened of me, you know, it’s kind of sad.”

“I think there is still that fear, of um, mental illness, and people know it’s not contagious, but I think, and that goes back to the barriers. People shy away from it because they don’t know how to deal with it. Whether it’s in their families, or in their work place, community, even in this century, those barriers have not been broken and there is a tremendous amount of fear.”

“I was pretty much going to say what they were saying, that there’s a lot of fear and a lot of misconceptions regarding illnesses that are more symptomatic. I mean a lot of people assume that everybody who has schizophrenia is violent. Where, you know, normally the gentleman who has schizophrenia never comes out of his house because of his stigma, you know, associated with his illness. You know, a lot of people assume that there is no hope; they are always going to be crazy. They are always doing those things, you know they see a gentleman you know, by the bus stop talking to himself, everybody kind of walks the other way, pretends that it’s not there, and it’s just that people are scared of what they don’t know and what they don’t understand.”

“Um, not too long ago, I walked into my probation office for my first time, and, um, I had to give him the list of all the medications I’m on, in case they doing a urine analysis. My first probation officer, she looked at the list of medications, and instantly said, “Are you schizophrenic?” And, with that kind of tone, and I said, “No, I’m actually bipolar, and I use the medications for them.” So, there was obviously a prejudice against me, because I was on medication to begin with.”

“Yeah, we were treated differently.”

“At first they treated me like a baby.”

“I find sometimes that I’m treated differently because of the way I am towards other people.”
“Like when I was growing up, I have um, PTSD, and it was hard growing up. My family couldn’t understand what I was going through, and I felt discriminated from them. Like teachers and stuff, they were just trying to get me to pass classes, but I needed the help.”

“Ok, um, I um, I also, I’ve been in jail, and, ah, you know having a mental illness, and anxiety and stuff like that. It was like my second time in jail and I was panicking and stuff, so, I got a really bad anxiety attack, and one of the officers came to the window, and they started telling me that I needed some medication or something. She just said she didn’t plainly like what I was doing with my hands, so she pepper sprayed me, (gasp) and took me down with some other officers and I guess about when I was going down, I must of kicked her with my foot, and now I have a, a record of assault with a police officer.”

● OSTRACIZED BY FAMILY

“But, the problem also lies in the fact that my family hasn’t always gotten along, cause of these disorders. It’s only been recently now that we’ve been getting treatment, that my family has started to pull together. Cause if one person starts, in our family, that’s dysfunctional like that. If one person starts to get better and go through treatment, sometimes it domino effects and helps everybody else in our family. Fortunately that is what is happening with me, with the treatment here that I’m getting.”

“I do better away from them, because I try and I have faith in myself, and you know, support from other people. But, they have no idea who I am you know, and that is kind of sad. It would make them feel guilty about all the years that they, um, ostracized me, you know.”

● SELF MEDICATION OR ADVERSE COPING

“Um, before I knew I had a mental illness, I knew it was depression, but I would self-medicate. Because of the way I felt, it felt better. So, now my family just thinks that because of what I’ve done, this is the way I am.”

“They are in denial. They feel like they don’t need the help.”

● PERSONAL OR PROFESSIONAL LOSSES
“Um, my brother in law was schizophrenic, and, um, they discharged him from… what is it called? The National Guard.”

“A lot of the men and women get out of the service because of their mental illness. It’s like they have it, and they can’t get the help they need after they are out, because they don’t want to claim that they have it, because of what they’ve been through, and it was their fault. They won’t help a lot of these people. And that is sad.”

● PERSONAL TRIUMPH

“If it weren’t for a lot of people sitting in this room right now, at the very bottom point in my life, I don’t think I’d be where I am today. I had no support from my family whatsoever. None, zero. The people sitting around me were a big, big part of keeping me where I am today, of taking me where I am today, because they supported me and they encouraged me a lot. That encouragement doesn’t come from everybody, just because you are worthless, you are never going to amount to anything, and those are the types of things I hear from my family.

“The community wrapped their loving arms around me and loved me back to life. That is exactly what happened.”

CORE ANALYTIC QUESTION 4: Are there Stigma Related Factors Based on Culture (ethnic, military, etc.)?

Summary of Responses – Focus group respondents gave many examples of how military culture stigmatizes against those with a mental health problem. They expressed the fact that self-disclosure of mental illness could have a negative impact on career advancement.

NODES

● SOME CULTURES ARE SUPPORTIVE OF MENTAL ILLNESS

“Yeah, it was honor. A lot of it was built around family honor. You know, one of the first things I had to learn, when working with somebody was don’t look them right in the eye, (laughs). I had one girl I was working with, and she kept looking down at the floor right in front of her, and,
that didn’t work, (laughs), you know. There are enormous cultural influences on what’s wrong, and how to deal with it.”

● MILITARY SEES MENTAL ILLNESS AS SIGN OF WEAKNESS

“Mental illness is not accepted or acknowledged in a military family. It affects your rank, it affects your choice assignment. Case in point, we were going to England. I got a call from my friend at the hospital. He said, “I hope you don’t have anything in your records because they came and got your records, to check for any mental health background, because if you have any, you won’t get that assignment.”

“I think about when we were at a meeting several months ago with the military psychologist that basically told us in this meeting that the military now have a no tolerance for mental illness. That was news to me. I don’t think they ever did, I was a military child, and that just wasn’t so, it causes a tremendous amount of pressure on families and military children, and the expectations are so much higher, and it’s all hidden. You are talking lives, loss of career and livelihood, so it’s this whole culture of denial that the military has.”

● LACK OF EDUCATION ABOUT POST TRAUMATIC STRESS DISORDER (PTSD)

“Um, yeah, my dad is well, um, Mexican, and he has PTSD. He’s 93, but they didn’t used to call it PTSD. They used to call it shell shock. His brothers and even his dad would say, “Oh, you’re just weak,” but, you know, he was a medic, and he saw a lot of stuff, and yeah, they didn’t treat him really well because he had the waking nightmares and things like that. They’d say, “Well you just need to get over it.” Well, you can’t get over what you see, and so then, he was over-medicated, because back then they used Librium. I remember him taking 100 mgs of Librium three times a day. He was a zombie, you know, so now, you know. Now they see that he wasn’t weak, that, you know, from everything that he saw, that is what affected him.”

● AFTER EFFECTS OF MILITARY INVOLVEMENT

“They just came out of the army, and they have problems.”

CORE ANALYTIC QUESTION 5: How are the Messages about Mental Health/illness Communicated?
Summary of Responses – Focus group respondents shared their views about how stigma is communicated in the region. They indicated that negative messages about mental illness are seen or heard in the media. They talked about the wide reach and power of the negative media messages and that most negative messaging is the result of lack of education about mental and emotional health.

**NODES**

- **NEGATIVE MEDIA MESSAGES**

“The media tend to sensationalize the mentally ill, but they do it in a bad way.”

“The media can reach a lot of people at one time, and you know, when they abuse that power, and they go and say the wrong things about a group of people. It can get to a lot of other people, you know what I mean, faster, not that they didn’t have their own idea to begin with, but they make it into something that it’s not. The media tends to do that.”

“Religious Communities, they kind of impose their views on the majority of the people, and it is usually negative. It’s usually someone who thought they were demon possessed. You can have a mental illness, and it’s very, very bad, especially the so called religious, you know. Yeah, it’s hard.”

“Yeah, I was thinking that, um, sometimes, when you are under the media, you’ll be judged very hard. And many people that you know somewhat, may not have a good impression of you. People discriminate against each other all the time anyways.”

“Keep away from mentally retarded people.”

“Yeah, because a lot of people don’t know, and they judge, they say something that’s not true then later on try to correct it, but it’s too late.”

“Like these guys that go bomb and kill people, what’s the first thing they say, Mental!!! Really, you know, sometimes that’s their way of life, their culture”

“In all reality, now days it doesn’t as much, because now we stop and we look at it, and we hear it, and we’re like, well, no that’s just a copout. There’s nothing wrong with them, that’s just
something they wanted to do. But still, as soon as they say that word, though, I mean, then everybody is like, oh, it’s not their fault, they’re sick. You know what, it is their fault, and some of them aren’t sick, they just say they are to get away with it.”

"I think a lot of the problems associating mental health illness and criminals is the media, because they never put on the media, this person suffered from schizophrenia for twenty years, or has gone to college, has a degree, has a family, is doing well. No, this person is schizophrenic; gone and done killed his neighbor’s dog in the steam room, and so, it’s almost combined with criminology. It has nothing to do with criminology.”

● POSITIVE MEDIA MESSAGES

“People with mental illnesses, are just as human as anybody else, they are people too. They need to be treated with just as much respect as somebody would treat somebody who doesn’t have mental illness. So, I don’t know what can be derived from that.”

“You know, they should change the assumption that if you’re mentally ill, that you are stupid. You know, they should kind of let that go, because people from all walks of life can become mentally ill.”

“Because it is not a low income disease, or relevant to a certain class of people or race of people. It can touch anybody.”

● FAMILY OR PERSONAL MESSAGES

“Don’t let reality slow your dreams, that’s my family motto.”

“So, to box everybody into mental illness, it is unjust, and it is a societal pressure that people buy into, cause it’s easier to say, ‘Yeah that’s right,’ than it is to address it.”

● MESSAGES IN SOCIETY OR COMMUNITY

“Um, one of the things I’ve discovered is that they are making a real effort to either employ or redirect people’s lives. Um, some of the people that even work here were, at one time, clients themselves. That is one of the things that is very positive in this area is that there are people
fighting within the mental health community; to be able to function in a way that is constructive and productive for the rest of our society here in this town.”

“Yeah, I have, I’m working with the stigmas like, mental illness. People say, ‘Your mentally ill people need to stop doing that’ I get offended by that. They don’t want to deal with you.”

“The same goes for treatment and probably the biggest negative social community messages, just throw good money after bad. Nobody changes, nobody gets better. The crazies stay crazy; the druggies stay druggies; drunks stay drunks; the problem isn’t the community, it’s not the providers, it’s not our mental health clients, it’s not our addicted clients, it’s the system that funds us less, expecting greater outcomes, and as long as they do that, we will fail.”

“I think that a lot of what shapes the community’s view is the demographics. Like you know, this is an older retirement community, you know, so, um, different generations have different opinions. Like PTSD, for the older generation, is not a real mental illness. But, I know some classmates of mine that say they got PTSD from a counselor or therapist, just so they can skip a semester of school. So, you know, it really is generational.”

- **LACK OF EDUCATION**

“People aren’t educated right on the mental illness part, you know, they just don’t know or don’t realize.”

“I don’t think I’ve ever really seen any negative messages, I don’t know if there’s really a positive or negative way to say about it.”

“There’s nothing really out there, not that I’ve seen anyway. It goes back to the definition of mental. It’s already embedded in us what the definition of mental is, that’s why we think of it as an issue that people are having problems or are crazy.”

“Well, then you run into the ignorance, of course, even if you have a family with someone with mental illness you run into the ignorance of what’s wrong. I mean, you know, yeah, I deal with that all the time. It’s my business, been doing it for a long, long time, and, you know, when you can’t make any progress, you get, um; it’s frustration that occurs, you know, that’s internal. But, mostly the family, you know, is knowledgeable about it, so that’s different. I think it all comes back to how much you know about it. Ignorance and, um, education is extremely important. I
think that the new mental health first aide is just, hopefully, going to do a tremendous amount of good, in terms of this issue.”

**CORE ANALYTIC QUESTION 6: How Can We Reduce Stigma?**

Summary of Responses - Many recommendations were given by focus group respondents. The consumer focus group participants believed that having more qualified professionals that understood mental illness and important issues such as confidentiality would be a significant benefit. Consumers felt that more support around funding, in terms of prevention, as well as maintenance for mental health issues, would help individuals get better. One area of great interest was improvement in the school system to decrease mental health stigma in education. Consumers felt that children with mental health diagnoses should be mainstreamed and not alienated from their social environment, and at the same time there should be general psycho educational meetings. Consumers also believed that law enforcement should receive better protocol for interacting with people with mental illness as a requirement for their training. They also felt that there were many negative media messages that need to be addressed. Finally, Consumers felt a need for acceptance for their mental illness and reduction of stigma includes embracing that mental illness can affect people of all class or racial ethnicity. They felt that the support from churches and the community, in general, was very effective in helping them cope.

**NODES**

- **TRAINING FOR HEALTH PROFESSIONALS**

  “On the same note, the advocates, their training needs to be updated somewhat because of, according to some statistics I heard yesterday, or read yesterday, um, some of the training that both advocates and other, um, staff members of certain agencies, it’s old, it’s twenty years old. So, if the training is updated, they’ll be a lot more accurate as far as being able to help people in their recovery process, and to reintegrate them into society. Um, both within the society, and also those that is coming out of institutions and penitentiaries.”

- **UPDATED TRAINING, WHICH WOULD REQUIRE MORE TRAINING.**

  “More qualified people. There are not enough of them. But, some of the ones that are working there, I mean some we know personally, when you go in there, your counseling somebody, you
don’t go in there so that they can tell you their problems, but, so they can listen to yours. So actually who’s getting the help?”

“Everybody knows everybody and it makes it hard.”

“You need some help sometimes, I’m afraid to get help because I know those people and I don’t want those people telling other people my business.”

**POLICY ADVOCACY AND FUNDING FOR SERVICES**

“I was just going to say, I think that what the community agencies do here is very important, because dealing with mental health issues, dealing with people who are experiencing anxieties, depression, um, can be very time consuming and very exhausting for families, and they don’t know how to deal with it. So, they don’t. Ignore it and it will go away, and fortunately we have people here at the table who are very important to that process of, don’t let that happen.”

“I mean, you have to make successes, and what we have to do is not measure each individual. We don’t know, you can’t put it on one guy or one group, so we tend to measure, just to say, if I can start this, we can succeed in 90 days or 60 days, but, if you get that one individual and it take six times, then it takes six times.”

“The funding you (coughing) you know, it’s because, um, if you got diabetes, for the most part, for most people, once they have it, let’s say you have type 1, which would equate to a mental illness, you have it for life, and nobody argues that you keep having treatment. But, if you are mentally ill, and you keep having treatment, well, it’s not working; you are not getting any better. That’s not the point, the point is that you are maintaining. You are not getting any worse, because sometimes you can’t get better. That equation, you know, we try to make that, somehow it just kind of flies over people’s heads. There’s a connection there, but that comes back to also, it’s so important, to separate mental illness from the behavioral and the biological, because, they are very different things.”

“They don’t pay for maintaining, they want to see progress ongoing, you know what I mean, as a whole, and we are taxed with having to show a measure of a program, to show that we are making progress. These people are getting better while they are here.”

“Well they don’t want to pay for prevention either.”
• **TRAINING LAW ENFORCEMENT**

“Um, I would like to see the protocol for law enforcement to be, not necessarily changed, but alternate in such a way, that is more tolerant or conducive toward people who just get thrown in jail, getting slammed in jail because they don’t understand what the person is going through. Now, that might require an addition to their training. The training that they have is obviously archaic in reference to the way that they deal with people with mental illnesses. Just because somebody goes maniacal and tears his shirt off in the middle of the street, doesn’t mean that they need to be locked up.”

• **INTEGRATING THOSE WITH MENTAL ILLNESS INTO JOBS AND SOCIETY**

“There could be, this is just an idea, there could be a way of testing people with mental illness, or some kind of process to find out, what you might say their skills are, or their talents are, and to implement that into certain factions of society, within any given community. So that way, any organization that actually attempts to do this, would be able to have project funding, to implement that. The reason why is because people everywhere, all humans have talents or some kind of skills. Some positive purposes, and sometimes, it is just a matter of drawing it out of that person. When it comes to people with mental illness, people with mental illness are not socially defective, or alienated from society just because a mental illness, they just need to find out, figure out ways to fit people into society, and of course, they have to be willing themselves, in order to function holistically in society as well.”

• **PARENT EDUCATION ABOUT CHILDREN’S MENTAL HEALTH**

“Um, one of the things I came to understand about the school systems, um, all the way through, from preschool on up, is that, instead of, and this might contribute to stigma, instead of actually trying to reintegrate a student into society, or not society, but into the curriculum, or classrooms, based on their skills and talents, what a lot of people have done, across the nation, is they pulled them out, and stigmatized them by doing so. Like, for example, for a child who has ADD or ADHD, instead of trying to integrate them back in to the classroom, what they do is they take them out and put them into an alternative school, or special education, which can be useful or helpful to a certain extent. But, all it does is create bigger stigma amongst the other students as well.”
“Stigma exists in the school level. There are a lot of kids getting bullied at school; they tell them if you have a problem go to the teachers, really? My stepson has been bullied at school and no one has helped him. He comes home he is crying and says he doesn’t want to live anymore. The only thing I can think of is sending him back to Tucson, letting him finish school over there, because no one is going to help him here. What good is counseling when they don’t want to help.”

“And it’s true, a lot of the kids need counseling, they want to talk to someone, but no one is there to listen to them. They don’t want to, they turn around, and they have an open door policy, but do they really?”

“But honestly, too, I know some kids who are just embarrassed to be pulled out of the class because they have to go and counsel, and they, like you know, they don’t want it to be known that they are being pulled out for counseling.”

“Maybe have little events that really get kids engaged, activities or something.”

“Schools system needs seminars. Teachers and anybody at the school with the kids needs to do the seminars. Seminars would be good for the parents too.”

“I’d change our school system. I would change our school system that would fit someone like me. That can’t sit at a desk for eight hours. That needs to be in other people’s business, mentoring other people, moving around. I’d start with the education system, and make it ok not to be, you know, this. I think we streamline, everybody has to fit. Our box needs to expand and fit the person that is in it. So, I think it’s a whole redesign of our society, and embrace creativity, and start in our education.”

“Right, so then, they are labeled for life, and then if it’s really bad, we are going to put you in the classroom with the other emotionally disturbed kids and try and educate you. So you know that kind of system is a top, a problem system.”

- EDUCATION USING MEDIA –NEWSPAPERS AND NEW MEDIA PSAS (INTERNET)

“I just think that’s there’s got to be more awareness.”
“I think over all, we’ve heard negative things today. This is a caring, giving, community, and I think that message needs to get out and stay out. Because, even with the military stuff, I’m here because of the military, retired in ’92 and I’ve been back for the last twenty years as a retiree, and you know, that is because this community accepted me as a military person back in the ‘70’s. You know, in a lot of places I was at, in that era, we were not accepted. So again, this is a caring, you know, this is a caring community.”

*HOLD COMMUNITY DIALOGUES, FORUMS, AND CONVERSATIONS*

“But right now, privacy is killing us. We need to come out publically, as a group, and say we are functioning. We are not completely healed, but we are functioning, look at us. Don’t hide any more. I don’t think we will get over the stigma until the people themselves, me included, come out and say, “look what I can do, in spite of that.” I think all mental health professionals need to be in a position of supporting that coming out. That public announcement of saying “In spite of that, I’m ok.” Without that, we are not going to get anywhere. “

*CAMPUSS BASED EDUCATION*

“They used to take people like from the Southwest, and take them to the high schools and talk to them in the gym, and tell them about the stigma and about mental illness, because there’s a lot of kids who have mental illness in high schools and middle schools, but I don’t know about elementary schools. I think it’s a good idea, just to go and have, like, a meeting, talking.”

“Yeah, um, they could teach in elementary schools, ok, famous historical figures had mental illnesses. It’s been around for a while, and people can still do things. For example, Lincoln’s wife, she suffered from depression, and he had it too. He went on to be president.”

“I was going to say, from a school perspective, we’ve been dealing with suicide, you know, threats and type issues. So, you know, we had to develop a whole protocol because, you know, teachers are not always comfortable when the kids come up and say, you know, they just want to end it all. I’m not going to ask them, you know, if they are serious or if they have a plan, what if they didn’t and then they think of one while I’m asking, you know, they are tired of this, and so, there is a lot of education needed. You know, we are still in the process of educating in that area, and starting with the counselors and the nurses. A complete protocol of what to do, because some of the times they will say, “I think they were just joking, or just looking for
attention,” that kind of thing. So, I think that there is definitely a stigma along that line, and not wanting to make it worse, not understanding mental health. You know,“

● **NEEDS FOR IMPROVEMENT THROUGH ADVOCACY**

“Well, it depends on what they are being bothered about. I would advise someone to be an advocate, and I don’t know if we have too many advocates here for the mental disabilities.”

“Yeah, we need more advocates.”

“If there was more emphasis on research, when it came to students learning more about mental health, maybe not just in the mental health, ah, careers, or fields, but, maybe perhaps within the school systems themselves, especially in college, where a person can have access to both help and treatment, and also somebody within a school system advocating, helping treatment for people to run parallel with their curriculum.”

“A church that has a big sign the reads: “All Welcome,” and you walk in, and you are welcome.”

“Um, people just accepting you, just the way you are.”
CORE ANALYTIC QUESTION 1: What is Stigma?

The major themes in the non-consumer groups seemed to center around the absence of knowledge and resources. One of the groups, for example, asked for a definition of stigma and/or a clarification of the meaning of stigma early on in the process. This inability to provide a definition of stigma, as it relates to mental health, aligns with the other themes, such as a lack of knowledge, a lack of awareness, and a lack of resources. Focus group facilitators provided some general definitions to help stimulate discussion related to Question 1. Following are the themes that then emerged.

NODES

● DISCRIMINATION

“Discrimination, fear, for all the factors that were mentioned earlier. We are afraid to go to the doctor because of lack of money. They know that something is happening to them, but they don’t have money. Will they feed their kids, or will the go get treated? Here in the community, I know a few people that need help, they need for their kids, for everything, and they don’t go. We know they are not ok and that they need that help.”

“The fear of not knowing how to treat the individual, or how they are going to react.”

“Lastly, I need to say that there is a lot of discrimination towards those people.”

● PREJUDICE

“En lo personal en el tema de salud mental les comparto que mi hijo fue mal diagnosticado y mal medicado, no supimos que hacer, ni los profesionales sabían que hacer y mi vida cambio. Mi hijo tenía hiperactividad y déficit de atención y sí, yo tenía prejuicios con algunas personas que padecían salud mental y cuando viví esto, cambio totalmente mi perspectiva y me di cuenta de que las personas con un problema mental pueden tener éxito en la vida igual que uno y ¿quién estable lo normal y lo no es normal?, nuestro hijo supero la hiperactividad, más
no el déficit de atención y eso es terrible, pero bueno termino su profesión y poco a poco ahí va avanzando y me siento orgulloso de esos avances.”

“On a personal note, I will share with you that my son was mis-diagnosed and medicated improperly. We did not know what to do. The professionals didn't know what to do and my life changed. My son had hyperactivity and attention deficit disorder; I had prejudices with some people who had a mental illness and when I went thru this myself, my perspective changed completely and I learned that people with a mental problem can have success in their lives just like one can; who establishes what is normal and what is not normal? Our son got over his hyperactivity, but not his attention deficit disorder and that is terrible, but either way he finished his profession and little by little he is moving forward and I feel very proud of his successes.”

“El estigma es como una calle de dos sentidos, es lo que uno favorece, percibe y prejuzga y la forma de cómo la otra persona lo toma cuando uno lo está tratando con esas características. Es un freno de mano para que haya un desenvolvimiento personal y en las relaciones humanas.”

“Stigma is a two way street, one way favors, perceives and prejudices and the (other) way in which the other person takes this kind of behavior. It is a barrier and limits the personal development in our human relationships.”

“Es cuando encasillas o clasificas a determinadas personas con ciertas características en una descripción que muchas veces no es la precisa pero por prejuzgo o mala información se utiliza.”

“It is when you label or classify certain people with certain characteristics using a description that many times is not accurate because of a prejudice or the misinformation that is used.”

“I'll give you an example of how we judge. It was winter, and I work at the hotel, and we always have hot coffee and they come over and drink it, and I always saw this individual with a coat, a long coat, but this time he didn't have it, and it was probably about 20 degrees outside. I talked to him for the first time. ‘Aren't you cold?’ He held a normal conversation and I learned that he was very intelligent and he just has a re-occurring illness. I called home for extra clothes and gave it to him; I don't think he realized he didn't have a coat until I gave him one. I learned a lot from him that day and not to judge.”

“Yo vengo de una familia que ha vivido violencia familiar y trabajo desde esa perspectiva, me ha costado mucho porque he sido una persona que si ha estigmatizado, soy una persona con prejuicios que me cuesta manejarlos.”
“I come from a family that has lived violence and that is my perspective. It has been very difficult for me because I have been a person who has been stigmatized. I am a person that has many prejudices and I struggle with that.”

- **BASED ON LACK OF EDUCATION – UNEDUCATED**

“I think it is lack of education; people aren’t aware of what it is, they don’t know how to respond, people aren’t educated.”

“But, he doesn’t have the support that he needs. We aren’t prepared to face these situations. My cousin is a person, who is ok, but, sometimes you have him do things that he can’t do. His mind isn’t all there, and even then, day by day, they would have him do those things. But, they would always send him to me, because I interacted a lot with him. Sometimes, I wouldn’t complain anymore because he wouldn’t know how to do things, I would ask my uncles, why do you keep making him do these things? Sometimes I’d be mad, no, they are wrong, because he wasn’t all there, and still they would send him day after day. It was an everyday ordeal. It was really sad, but we weren’t really prepared to care for him.”

“I think that education has a lot to do as well. Because I have a friend who has a child with Down Syndrome, the dad is a doctor with a college degree, and the little girl is really well treated. Other people also interact well with her (because of how she interacts with others).”

“Muchas veces no entienden que son las enfermedades. O que ay diferentes tipos de enfermedades. O so, en el pasado pensaban que les entro el diablo. So no entienden que es lo que les esta pasando a esa persona. O porque le esta pasando eso.”

“Many times they don’t understand what the illnesses are. Or they don’t understand the different types of illnesses. In the past, they thought the devil got into them. So they did not understand what was happening to that person or why that was happening to them.”

“When the father washed his hands, he left it (ring) in the bathroom, and since the boy’s illness was too advanced, he swallowed it. He began to lose his voice, but they didn’t know why. Also, the dad used to cut his nails a lot, and so the nail clippers, the boy swallowed too. So, because of the lack of knowledge as to how to treat the boy with this problem, the boy’s illness continued to grow, and they didn’t seek adequate help. They were only watching him, but
obviously you can’t watch someone twenty four hours a day. The boy committed suicide by swallowing those things. I think there was a huge lack of information from the parents as to how to treat that specific illness.”

- **UNCLEAR ABOUT STIGMA DEFINITION**

“Qué es eso? (Riéndose)” *What is that? (Laughing)*

“Stigma is a problem, there is a problem.”

“Something that hurts.”

“Something that we think, that we need to do what is necessary.”

- **LACK OF /FALTA DE**

“Nos falta mucha sensibilización, falta de información en la salud mental y trastornos. En lo personal cuando yo tuve una visita la primera vez al Hospital Civil (hospital psiquiátrico) me dio temor, es un ambiente diferente, típico el lenguaje que utilizamos “el loquito que va en la calle.”

“We lack alot of awareness, lack of information in mental health and illnesses. Personally, when I had my first visit to the Civil Hospital (psychiatric hospital), I was fearful. It is a different environment, it lends itself to the language we use “the crazy person that roams the street.”

“Muchas de las personas caen y es muy difícil levantarse y tienen cuadros terribles, muchos están en la maquiladora por falta de educación, por las condiciones del trabajo, por la presión social, por prejuicios, por ignorancia o por lo que ustedes quieran.”

“Many people fall (to mental illness) and it is very difficult to pick themselves up, they have terrible incidents; many of them are in the maquiladoras because they lack education, due to the labor conditions, social pressures, prejudices, because of ignorance or for whatever reason.”

“I have something completely different to say about lack of funds. These people that I know, have more than enough money, they are very rich, and the son, since he is the only one, has everything, is spoiled, doesn’t need for anything, didn’t want to go to school anymore. He didn’t worry, because he had everything. So now the problem that they have with him is that
he has a mental illness. He’s sick, because they already took him to specialists out of the country; they even did surgery, and a lot of things. But, with all the money they have they couldn’t do anything, because he already has that fear, which sometimes is too much. Even with all that money, its better sometimes, to keep them leveled, that way, they can value life.

“Maybe it has to do with a lack of resources, and then sometimes the family may get fed up and the problem ends up getting bigger, they don't know what to do with that family member.”

• MEDIA (SENSATIONALIZE) OR USES DEROGATORY TERMS

“Pues en las noticias que nos dicen, este hombre mato a tanta gente porque volvió loco. Entonces pensamos eso porque nos dicen las noticias.”
“*Well the news tells us, this man killed so many people because he went crazy. Therefore we think that because the news tells us.*”

“Another thing is that, I think, to me the television would not change my way of thinking. I mean, I already have a positive opinion, and if I know that my neighbor has Alzheimer’s, I try to be considerate of her. I know that the television, channel 26 or 45 or whatever, saying treat her better, is not going to do anything. I already have my opinion; I am going to treat her like this.”

“Well, yes, the news. I think someone will be disturbed, not to the point of going crazy, but having that fear that something will happen.”

“The images that they show.”

“Yeah, the newspapers, and some of the ones we have here in the area, they are sensationalized, and that sells.”

“Media tends to focus on marketing. The media puts stories out not to help out the community, but because they want to sell.”

“Because they just want to advertise.”

“Well the main media is television, and TV has everything and broadcasts to everyone so the main problem is programming, and many of it is violent and usually the young children or youth is exposed to this and they are having an erroneous perspective, they (TV) don't display values,
so even if the kids don’t have a psychic problem, then this helps shape their behaviors, because no one is attending to them.”

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<th>CORE ANALYTIC QUESTION 2: What are Public Perceptions about Mental Illness?</th>
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Summary of Responses - The viewpoints shared by the non-consumers, as they relate to public perceptions focus primarily on offensive themes. As seen in Core Analytic Question 1 much of the information that the participants stated for this question also relates to misinformation, and prevailing attitudes around the perceptions of people being violent, being labeled by others or simply described as being "crazy".

NODES

- **SEEN AS VIOLENT**

“Desgraciadamente en nuestra ciudad la ola de violencia y el tráfico de drogas nos va dejar mínimo diez generaciones con un trastorno mental, porque muchos de esos niños que vieron y vivieron esta situación lo van a tomar como una forma de vida y van a quedar marcados por toda su vida y esta situación de salud mental va ser difícil de contener y sobre todo si no sabemos diagnosticarlo a tiempo va dejar estragos.”

“Unfortunately in our city, the wave of violence and drug trafficking will leave us with at minimum 10 years of mental ailments; many of those kids that saw and lived the situation will apply that to their way of life and that will be pronounced in their lives, this situation regarding mental health will be very difficult to contain, especially if we do not know how to diagnose early on, it will leave scars.”

“I lived with my grandparents a while before they died, both were old. Both had problems with their memories too. They would tell me, oh I really like this juice, and then they would tell my aunt, throw this away it is gross. Things like that, but, my grandfather had it much worse. He would run through the streets, we’d ask the police for help; we couldn’t control him, and the next minute he’d be at home like nothing. But, I think similar things happen to most of the older people.”

- **USE OF “CRAZY” AS A DEROGATORY TERM**
“I feel that mental health doesn’t have a set age. Older people, of course, will start to lose their lucidity with time. But, I feel that nowadays so many other things are affecting it. Drugs, alcohol, problems, stress, so much violence, of course, if someone is on drugs, they will get to a point where they will lose their minds. Someone who drinks too, maybe, a housewife can suffer from a mental illness. Not necessarily go crazy, but also not be in her senses, because of problems with kids, husband, economical problems. So then one will get sick slowly.”

“When we go to classes, other kids make comments about my child "He is crazy." He is not crazy, and other parents need to be considerate of what the kids say to others?”

“That they are treated like they are crazy.”

“Probably their families too, because they are associated with that family member, and the others think that they kind of did that to themselves, at least that is what I see.”

“You have to treat them differently; sometimes you have to take care of yourself. I used to be a caregiver for someone who had Alzheimer's and they showed us how to take care of ourselves, you don't know what they are thinking and how they are going to react.”

“People are afraid to talk to them; they don't know what happened to them, why they are like that, a car accident or something else. I tell my kids ‘that could be you’. We need to be in a society where we don't judge people, and as we always say crazy, so I think it’s the fear of not knowing.”

“The families too, they try to hide and it shouldn't be that way, we need to motivate that person to get help, it’s just humanity to be, um, be able to do that, and we don’t. We hear "mental" and we hear "crazy" but we need to realize there are different levels of illnesses, and I think there needs to be support rather than the criticism.”

“What the gentleman said, that it’s hereditary.”

“Or they use excuses and justifications like "she used drugs when she was pregnant" and that is why that (illness) is caused. They try to justify why he is crazy.”

● “MENTAL” AS A DEROGATORY TERM
“I think that when you hear "mental illness" we sadly think it’s a bad person and we ourselves need to realize and know that we need to support them as a community, but, we hear "mental" and we right away think they are crazy and don't help, we reject them, it shouldn't be that way.”

“Yo he reflexionado en el tema de salud mental porque en un momento u otro puedo estar ahí, yo no estoy ajena. Soy una persona que si he estigmatizado y si he sido prejuicioso, me cuesta mucho a veces. No estamos totalmente sanos ni totalmente enfermos.”

“I have reflected on the topic of mental health because I may suddenly be there, I am not immune. I am a person that has stigmatized and I have been prejudice, I struggle with that sometimes. We are not totally healthy nor totally ill.”

● LABELING / ETIQUETAS

“Esta "chiflado." “Off the rocker.”

“He is a dummy.”

“That he is unable to orient himself, he is not well adjusted.”

“I think it’s like a label.”

“Well, insecurity or low self-esteem.”

“Que pobrecitos. Pobrecitas personas.” “Poor them. Poor people.”

“Es cuando encasillamos a cierto tipo de personas y les asignamos características que para mí pueden ser negativas las cambiamos de un rol y no les permitimos salir de ahí o también hay una serie de mecanismos a nivel social, cultural y familiar que no permite que la persona pueda desarrollarse en otros ámbitos o pueda salir de ese medio donde están.”

“When we label certain types of people and we assign them characteristics that for me are usually negative, we change their role and we do not allow them to leave (that situation); also there is a series of systems, social, cultural and familial ones that do not allow for that person to develop in other environments; they cannot leave the situation they are in.”
“La etiqueta que se pone a la persona y las señales, las encasillan en algo, y logramos influir en otras personas con ciertas conductas y actitudes para que ponga sus límites y llega influir negativamente a la persona.”
“The labeling that is used on a person and behaviors classify them with something and we tend to influence others to do so as well, therefore others behaviors and attitudes limit the person and affect them in a negative manner.”

“Mira como corre y entonces vamos formando clasificaciones y lo único que hacen es que nos limitan en cuanto a los alcances que podemos tener socialmente y el desenvolvimiento.”
“Look how he runs, and then we start forming labels and the only thing that it does is limits us in relation to how much we can be socially and how much we can accomplish.”

**CORE ANALYTIC QUESTION 3: How has Stigma Affected You, Your Family/Community?**

Summary of Responses - A range of thoughts were shared about how stigma has affected the individual, family and community. Much of the emphasis was on family impact. The notion that people are feared, ostracized and even abused was often articulated in this particular set of responses. It appears as though the isolation and lack of acceptance and even harm are based on fear; specifically, fear of how the individual with a mental illness may react (i.e., violent) or fear of being near the individual with a mental illness. Often, this is because they are unaware of the disease, and the person interacting with someone with a mental illness does not know how to react. This kind of seclusion was pronounced in two major settings, in the social setting and family setting.

**NODES**

- **SOCIAL ISOLATION**

“El estigma es una construcción social y es limitante lo vemos desde la familia, la escuela, la iglesia y desde la sociedad todos hemos sido estigmatizados de una manera u otra, el tener ciertos comportamientos el vestirte de una forma etc. Por ejemplo si tú eres abogado esperan que tengas cierto comportamiento y pautas a seguir y si no lo haces te estigmatiza tú mismo grupo, los maestros, tu propia familia.”
“Stigma is a social construct and it is debilitating; we see it in the family, in school, in church and from a social point of view, we have all been stigmatized in one way or another, like having certain behaviors or dressing a certain way, etc. For example, if you are a lawyer, it is expected that you have certain behaviors and norms to follow, and if you don’t do it, then you are stigmatized by your peers, your instructors, your own family.”

“Creo que hay cosas que no se pueden cambiar, la palabra estigma ya tiene la carga negativa, todo sabemos que es algo malo y con este fin lo utilizamos y la propuesta es cambiar la definición que no tuviera esa carga negativa. Para mí me oprime y es algo que no permite ser yo, me limita y me genera dolor.”

“I think there are things that you cannot change, the word stigma has a negative connotation, we all know it is something bad and we use it with that purpose; the suggestion is to change the definition, so that it doesn’t have that negative meaning. For me it is something that oppressed me and something that doesn’t allow me to be myself, it limits me and it generates pain.”

● OSTRACIZED BY FAMILY

“O que, la persona que tiene esa enfermedad, ya la aíslan en su casa. Ya no lo dejan, o no la dejan salir porque dicen que ya no pueden, ya se quiere encerrar a esa persona.”

“Or the person that has that illness, they isolate them at home. They don’t let them, they don’t let them go out because they say that they are unable to, they want to lock up that person.”

“But a lot of times their own families, they say, no I don’t want him to go because he is ill. For example, I have a cousin who has a child with Down Syndrome, and they isolate him.”

“I also knew someone who also had a daughter, older, but she was very aggressive. At a party, all of the people there rejected her. Only the parents would have any interaction with her, and because I never really knew her or hung out with her, she wanted to walk around and go everywhere, and all the people felt uncomfortable.”

“Well, yes, they are treated differently, because their family always ends up responsible for them and they always end up putting them in a home. They isolate them and they are left there, they are lonely, no one likes to be lonely, that is what they end up doing to the elderly.”

● PEOPLE ARE FEARED

“Here you see a lot of people walking around and talking to themselves.”
“We have one that likes to scare kids.”

“They isolate themselves; they don't want to be around anyone.”

“Like the ones who get angry, display anger to others to their families.”

“El sentimiento que me ha generado el trabajar con salud mental es el miedo, tristeza, también dolor, además la sociedad asocia la enfermedad mental con cargas negativas, ir con el psicólogo es estar loca, tomar tratamiento también es estar loca, la enfermedad se ve mayormente con una connotación negativa y no vemos que los seres humanos no somos totalmente buenos ni malos, ni totalmente sanos ni enfermos.”

“The feeling that has been generated for me as a result of working with mental-health is fear and also pain, plus society associates mental illness with a negative connotation; if you go to a psychiatrist, you are crazy, if you take medication, you are crazy, the illness is mainly associated with negativity and we do not see that human beings are nor totally good, nor totally bad, nor totally healthy, nor ill.”

“I used to take care of a lady, and sometimes she didn’t say anything, and I never gave my back to her, even when I cleaned the house, you don’t know how you are going to react.”

● **PEOPLE HAVE FEAR TO GET HELP**

“Fear, first of all, because some are illegal. Some think, if they tell you they are crazy, they are going to take their kids away, the ones with kids. There are so many factors. For example, one of my acquaintances, a few weeks ago she was telling me that she doesn’t remember, but she had an argument with her significant other. She says she remembers parts of it, but she doesn’t remember what she did. She remembers throwing and tearing a lot of things. When she finally came to, she didn’t know that she had done. But her kids told her that she did it. So, it’s been over a year that I told her, and she doesn’t want to accept it. So, I asked her what her reasons were, why she was scared, first of all, money, because she didn’t have any, and didn’t know where to go.”

● **MISTREATED**
“Some time ago, I heard of a case of a child that they had locked up, they had him with a chain from his little foot, he was swollen, he was hurt really bad, and what he ate was mixed up with his waste, and they removed him from that abuse, because of all the harm.”

“It’s been known that they get locked up, in chains, in cages, because, I think we need to know how to treat those people, because if we treat them bad, then they will be aggressive, just like anyone else, if you treat me bad, then I will react, and they do the same. But, those people (caregivers) are misinformed, of course we need to be careful on how they are with the necessary treatments, but not be aggressive with them, or be, like, they are crazy, or they are ill, no cannot be like that.”

**CORE ANALYTIC QUESTION 4: Are there Stigma Related Factors Based on Culture (ethnic, military, etc.)?**

Summary of Responses - The viewpoints shared by the non-consumers as they relate to public perceptions focus primarily on cultural norms. The cultural customs of the region put an emphasis on being discrete. With this said, other ideas such as embarrassment and overprotection are strong themes as well.

**NODES**

- **SUPPORTIVE OF ILLNESS**

“Like the kids that the lady is talking about, they go around town, greet others, he likes to shop, he asks the community for money to eat, he is not needy, but that is how interacts with the community.”

“If you greet them, they answer back very well mannered.”

“They want to be around town, be free.”

“He is like that because he was on drugs, but does no malice.”

“Everyone knows him he is not a bad person.”

“Like the helper we have here in the church, he tries to do things and we all accept him like he is, we don't see him differently.”
FEELING WITHOUT SUPPORT

“I have a cousin, who also has a son with Down Syndrome. He’s an adult now. She says she wouldn’t like to die first, she would prefer him go first, because she doesn’t know what her son would do without her. He isn’t aggressive, but he is difficult and only she can control him. Sometimes, he’ll be asking for soda and she will say no, and we say give him some, poor thing, and she will not give in. And he will listen to her, not us. So she worries what he will do. She also worries what she will do when he gets older and older, but she does get sad. To say that if she is gone, who will take care of her son?”

“Creo que es un problema muy complejo la salud mental no ha sido prioridad para nuestro sistema de salud y las organizaciones hacemos más en salud mental que el propio gobierno que no tiene políticas públicas y teniendo recursos no los etiqueta en esta problemática, que si hacen trabajo, pero no el que se necesita, así como que nada más estamos tapando hoyitos, ejemplo bueno tenemos esto y vamos abrirle un programa de terapia psicológica a estas personas, pero que a veces no es tanto la salud mental individual sino familiar o comunitaria también.”

“I think mental health is a complex problem and it has not been a priority for our health system; we as organizations provide more services on mental health than our own government; they don’t have public agendas and having the resources, they don’t label them; the agencies do the work but it doesn’t address the need. It is as if you are bandaging problems only; a good example is that we have this and we are going to start a psychological therapy program for these people; sometimes individual mental health services are not enough nor family and community services.”

“En mi familia tengo un primo que tiene 20 años ya está con diálisis, de un mes a tres ya no le funcionaron los riñones, etc. y entendí el caso que compartiste porque lo estamos viviendo de cercas y en bien doloroso, si se le atiende a él, está enojado, resistente y le das terapia a él, pero ves que toda la familia está en un problema de salud y los servicios te dicen: yo le doy terapia a él porque él es el que la necesita, pero la mamá está en depresión, no puede dormir, el hermano también, la hermana se casó por salirse de la casa, tienen problemas económicos, esto es un problema del sistema, tenemos que cambiar de paradigmas y si trabajar con estas personas que están dando los diagnósticos para que los hagan precisos y den tratamiento individuales y familiares para que se tenga éxito.”
“In my family, I have a cousin who is 20 years old and he is already on dialysis, his kidneys stopped working in a matter of one to three months, and I related to that case study you shared because we are living a similar situation and it is hurtful. He does get services, he is angry and resistant and he is the one that gets therapy, however you know that the entire family has health problems and the resources indicate that only he gets therapy because he needs it. On the other hand his mom has depression, she cannot sleep, his brother as well, his sister married to get out of the house and has economic problems; there is a problem with the system, there needs to be a paradigm shift and work with these folks who are providing the diagnosis so that they make precise diagnoses and provide treatment for individuals and families so they can be successful.”

- **CULTURE**

“I don’t think culture has anything to do with that, we all act the same way towards persons (with mental illness), don’t matter what you are, we all call them crazy just the same. It’s not being racist we all just stay away.”

“Es el machismo. Yo digo que eso es, porque ha sí la conocemos a esa persona. Y, como le digo que estábamos platicando, no le da, no tiene esa paciencia, usted ya está enferma, usted. Yo digo que eso tiene mucho que ver. Como de donde viene.”

“It’s the machismo. I think that is what that is because that is how we know that person. And like I told you, we were talking, he doesn’t have that patience (for her) he says you are ill already. I think that has alot to do with it. Like where you come from.”

“Vemos que muchas mujeres por la cuestión cultural que nos enseñan asumir todos los problemas de la familia y encima de esos sentirnos culpables por lo que paso y lo que no pasa, las mujeres somos responsables de ser el soporte emocional de la pareja, los hijos, la vecina y luego, además, tenemos que ser el soporte de nosotras misma, esto es una carga muy pesada para las mujeres. En cuestión de los varones ellos tienen otras maneras de externar sus problemas, a través del alcohol mucha de las veces o utilizan drogas y es necesario reconocer esta diferencia para dar una atención más adecuada.”

“Many times for cultural reasons, we see women learn to take on all the family problems and in spite of all this, then they feel guilty for what has happened or what has not happened to them; women are responsible for being the emotional support of their partners, their children, neighbors and in addition, support for themselves; this is a very heavy load for women. In relation to the men, they have other ways to externalize their problems. Many times this
includes alcohol or the use of drugs. It is necessary to recognize these differences so that more accurate services are provided.”

“We think everyone tends to their own business, problems in their own world, like they say "the one who gets out of the way, is the one who helps the most" we usually don't have the know-how to help nor the means, and especially us Latinos, we say "poor them, it’s their bad."

“We put this dividing line; we don't even want to think about being in that situation.”

“A los profesionales de la salud nos tomó de sorpresa los graves problemas que se generaron por la evolución del ser humano, de todas las complicaciones que nos trae, la problemática social que se genero por ser una ciudad fronteriza con problemas sociales muy diferentes a los del interior de la Republica. Somos una ciudad de tráfico y consumo de drogas, una ciudad cosmopolita que se ha vuelto, una ciudad que alberga a mucha gente que viene del sur y del centro país a un contexto diferente que genera cambios hasta en la forma de vivir y de alimentación y eso les genera trastorno de ansiedad y depresión entonces si nosotros y las instituciones estamos mejor formadas en los procesos de salud mental creo que no vamos a necesitar de construir hospitales que no tienen la verdadera capacidad y la gente especializada y desgraciadamente en México somos muy dados a improvisar y eso nunca es bueno.”

“The professionals were taken by surprise by all the serious problems that were generated by the evolution of the human being. In the face of all this, the social problems that were generated due to being part of a border city with social problems that are very different from those in the hub of the Republic. We are a city of drug trafficking and drug use, a cosmopolitan city that has transformed into a city that houses many of the folks that come from the south and the central part of the country to a different context that generates lifestyle changes even in the way we eat, and that produces anxiety and depression; if we and the institutions have better capacity in regards to mental health, I think we will not need to build hospitals that do not have the capacity nor the specialized folks; unfortunately in Mexico, we are known to improvise and that is never a good thing.”

● CULTURE HIDES THOSE WHO ARE MENTALLY ILL, EMBARRASSED

“I think it has more to do with embarrassment. Let’s say I have a brother, and I don’t want anyone to find out, I won’t go to the hospital, because I don’t want them to find out that he has “X”.”
“Simplemente que miramos y no se quiere arrimar y todo, porque si, muncas veces trata uno de no arrimarse a esa persona porque tiene una enfermedad. Ósea, pero yo pienso que no debe uno porque todos somos humanos.”

“We simply look and we don’t want them to get near and everything, because sometimes we try not to get near that person who has an illness. I think that one should not be like that because we are all humans.”

“O no sabemos de qué platicar, porque no queremos hacer una pregunta que los familiares van a decir, pos no es tu negocio, verdad? O no queremos hablar de la enfermedad. Solo sabemos que decir cuando no sabemos que uno tiene una enfermedad mental. So, es mas difícil hacer platica con la gente, verdad.”

“Or we don’t know what to talk about, we don’t want to ask our family members a question and have them respond ‘Well, its none of your business, right?’ Or we don’t want to talk about the illness. We only know what to say when we don’t know that someone has a mental illness. It is much more difficult to talk to people, right.”

“Si tiene muncho que ver. Porque, así como eso, de que no le dan esa importancia ya a esa persona. No le dan oportunidad de hablar. No, este, para empezar ya les prohíben ciertas cosas. Y ya con esta enfermedad que entran, ya se les limitan mas sus derechos de hablar, de expresarse, de que, porque ya va a batallar para comunicarse. Y las personas estas no tienen paciencia. O muchas veces ellos pueden decir, no tienes nada, no es nada. Y esa enfermedad, va creciendo mas y mas porque ellos no quieren ni ir al doctor porque, no este nomas llora por que quiere llorar. No la entienden ellos a la mujer, o, yo digo que eso tiene muncho que ver. Pero a la misma vez, no todos son así. No quiero decir que todos los Mexicanos, todos los hombres, porque hay algunos, que gracias a Dios entienden mas. Pero porque ya están más desenvueltos en los Estados Unidos. Y es muy dificil para un mujer cuando el hombre, pues no le cree. No le cree que este en la depresión, porque va a estar deprimida? Y cuando llora, que le pasa, no entienden que la depresión va creciendo.”

“Yes, that has alot to do with it. Because just like that, they don't acknowledge that person. They don't give that person the opportunity to speak. No, then to begin with they prohibit certain things. And once the illness sets in, then they limit their rights to speak, to express themselves, supposedly because they struggle to communicate. And these people don't have patience. Or many times, they say nothing is wrong, its nothing. And that illness is growing more and more because they don't want to go to the doctor because they say she only cries because she wants to cry. They don't understand women, or I say that has alot to do with it. But at the same time, not everyone is like that. I don't want to say that all Mexicans, all men, because
there are some that, thank God, understand more. But this is because they are more acculturated in the United States. It is very difficult for a women when the man doesn't believe her. He doesn't believe her that it’s depression, why she is depressed? And when she cries, what is happening (to her), he doesn't understand that the depression is growing.”

“So sometimes the family member is not agreeing that they are ill, I know someone who is not well and the family always hides them, they don't recognize or think that they are ill.”

- OVERPROTECT

“Sometimes we overprotect our children. Don’t go by yourself and other cases like that. I had my daughter, who is twenty one years old; there was a time when she was scared about things, because we were overprotecting her. We would say, no, this is dangerous. But, my daughter started to get sick, so we started to worry. This is not right, we are overprotecting her and it is affecting her. The good thing was that my daughter went back to normal, and we have to be careful with the way we talk and everything, because sometimes we overprotect them and then they are scared to go out into the world on their own. That is very important, there have been a few cases with young people, and that is what young people pick up on, those disorders.”

“I see that my mother protects my brother instead of punishing him as she does the others, or he will say himself, no it’s because I’m dumb, and I tell him, dumb when it works for you. (laughing). So, he wants to get away with breaking some rules, because he himself says that. But he does other things, really smart things. That’s why I tell him he’s dumb when it benefits him, if I didn’t tell you he had a problem, you wouldn’t be able to tell.”

“Yes because we always want to cover up, and overprotect.”

“We do it because we are embarrassed, or because of what others will say or because of rejection, many times we don’t want others to find out because of those reasons.”

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CORE ANALYTIC QUESTION 5: How are the Messages about Mental Health/Illness Communicated?

Summary of Responses - Several thoughts about the way that messages are communicated about mental health and mental illness were shared by non-consumer focus groups. The major
themes include: 1) media messages; 2) family messages; and the unique messages that are present in this region.

**NODES**

- **MEDIA MESSAGES**

“Well yes, the news. I think someone will be disturbed, not to the point of going crazy, but having that fear that something will happen.”

“Por el miedo Por lo que se oye en la televisión, lo que se oye lo que les pasan a los que, gracias a Dios, están bien de salud, verdad? Y los papas dicen, si a mi hijo le falla, que va a pasar con él, que me le van a hacer a él? Mucho es miedo también de los papas. De lo que se oye que pasa en las escuelas.”

“Because of fear. Because of what is heard on television, what you hear, what happens to those that thank God, are in good health, right? And the parents say, if my son has a screw loose, then what will happen to him, what are they going to do to him? The parents also have alot of fear. Of what you hear, what is said in the schools.”

“Well the main media is television, and TV has everything and broadcasts to everyone so the main problem is programming, and many of it is violent and usually the young children or youth is exposed to this and they are having an erroneous perspective, they (TV) don't display values, so even if the kids don't have a psychic problem, then this helps shape their behavior, because no one is attending to them (kids watching TV).”

“I think the television is exhibiting programming that is affecting young children and families. TV is like schooling, but it is not a positive message, it is a negative, strong message that is hurting children and families with messaging and programming.”

“Pues en las noticias que nos dicen, este hombre mato a tanta gente porque volvió loco. Entonces pensamos eso porque nos dicen las noticias.”

“Well on the news, what they tell us, that man killed so many people because he went crazy. Therefore we think that because the news tells you.”

- **QUÉ DIRÁN / DICEN**
“Con la experiencia en el trabajo con las mujeres que son atendidas por violencia en el área de psicología, ellas siempre mienten, porque si informan a sus familiares que van con el psicólogo les dicen que están locas y eso les afecta también en su salud mental.”

“We have experience working with women who are in psychological treatment for violence, they always lie. If they inform their family members that they are going to a psychologist, then they tell them they are crazy and that also affects their mental health.”

“Me dicen que hay un nuevo centro que es por Tierra Nueva que al parecer es particular y que reciben a personas con problemas de salud mental que tiene muchos años San Juan de Dios.”

“They say that there is a new center that is around Tierra Nueva. Supposedly it is a private (center) and they receive persons with problems with mental health that have many years in San Juan de Dios.”

“O que, la persona que tiene esa enfermedad, ya la aíslan en su casa. Ya no lo dejan, o no la dejan salir porque dicen que ya no pueden, ya se quiere encerrar a esa persona.”

“Porque, es como dicen verdad, que si mencionamos un enfermedad muy seguido, ellos también van a sentirse más enfermos. So trata uno de, no sabe uno como platicar con ellos, sin hacerlos sentirse mal. Munchas veces nosotros mismos los hacemos sentirse mal porque mencionamos esa enfermedad. Y no pues ya tiene dos anos, o pobrecita, ya tiene... No, es de ayudarlos. Tratar de llevar la vida lo más normal que se pueda. Sin estar ahí nomas pensando y hablando de esa enfermedad de esa persona. Que eso no está bien.”

“Or that the person who has that illness, they isolate her at home. They don’t let them go out because they say that they are not able to, they want that person confined. Its like they say, that if you mention a mental illness frequently, then they also feel even more ill. So then we try to, we don’t know how to talk to them without making them feel bad. Many times we make them feel bad because we mention that illness. Like, well, it’s been already two years and poor them and it’s been... that is not helping. Its trying to live life as normal as possible without just thinking and talking about the illness of that person. That is not right.”

“Muchas veces no entienden que son las enfermedades. O que ay diferentes tipos de enfermedades. O so, en el pasado pensaban que les entro el diablo. Por eso habla ha sí, o por esto están haciendo esto. Y ahora también dicen eso. So no entienden que es lo que les está pasando a esa persona. O porque le está pasando eso.”

“Many times they don’t understand what the illnesses are. Or they don’t understand the different types of illnesses. In the past, they thought the devil got into them. So they did not understand what was happening to that person or why that was happening to them.”
“I think people like that (with illness) they are very easy to get along with, they talk, they greet everyone.”

“I say rumors, they start talking, it starts as a rumor here in the community and what the community thinks about that person is damaging.”

“They think they are dumb.”

● FAMILY MESSAGES

“But, a lot of times their own families, they say, no I don’t want him to go because he is ill.”

“And the family would want to treat her like someone special; we always look at the family and think they are all crazy.”

“I think their own family treats them differently, how they express themselves about them and how they treat them. They begin to treat them the way they want, they marginalize them, because they don't have enough information for the family.”

“Sometimes people just group everyone together, they don't see it as an isolated case, if they see someone behaving a certain way, then they think the whole family acts the same way as well.”

“Yes, it happens, we have a lot of people here who are not mentally healthy and they are discriminated by their own family, we see them walking around the streets by themselves during winter time, and when it is hot. They are human like we are but nobody helps them, and that is bad for our communities.”

● MENTAL ILLNESS IS NOT REAL

“So sometimes I think, she is just pretending (laugh), no, it’s because that is the way she is. I just don’t understand why she says things backwards. So, I have my doubts, but she does things that one says that’s wrong, for example, one time in the food that we took her, it was potatoes
and meat, and she said she didn’t want the food because the potatoes looked like faces of children. She does things like this that make me think, is she or isn’t she.”

**Core Analytic Question 6: How Can We Reduce Stigma?**

Summary of Responses - Several recommendations were given by non-consumers, but two areas stood out; 1) The need to provide everyone with information about the illness with an emphasis on parents and teachers. It seems as though the venues for much of the education in these communities are schools. As a result, comments put emphasis on teacher training. 2) The second area concerned the lack of access to services and qualified professionals to tend to the needs of the community. It appears as though non-consumer participants felt that the lack of trained professionals or even retention of professionals is a gap in their communities. As a result, individuals who need services are not able to obtain services in a timely manner.

**NODES**

- **DISSEMINATE POSITIVE MEDIA MESSAGES AND BROCHURES**

“I think there should be an association for mental illness, like there is for autism, cancer, and all of that. We see them a lot on the television, about the help they need, and where you can get more information to learn more about it, and what you can do, where to go, all of that. There needs to be an association for mental illness.”

“Very few times, I like to learn from the television, from other people, so I would like to see more information on TV, so I can learn about this problem.”

“I think they should give information from the root of the problem, the symptoms, for example I have an acquaintance that says I need to get a divorce immediately, then he starts to tell me about his situation and then I asked him, "Based on your story, and what you are telling me, have you considered that maybe your wife maybe bi-polar?" And he doesn't know what it is, something like diabetes prevention; they present certain symptoms and if you have them, then you are more likely to go to the doctor quickly, so something like that, more information on how to diagnose your illness.”

“Use the media, more information.”
“More information given at school.”

“The government has to implement recommendations so that the media can disseminate messages that are positive.”

“Messages should be given everywhere, sometimes until you are looking for something (resource) you don't even know it is there. Just need to know I am going to that place and I know that they will help me, but sometimes until it affects you, people don't get informed until it affects them.”

“The important thing is recognizing problems in ourselves, but nowadays, we tend to have a quick fix with pills, but, that is not the solution, because those medications may lead to mental illnesses, I want to address the previous question again, we need to have prevention programs and not an all cure with a pill.”

"The problems don't just belong to one person, they belong to everyone" - this would prevent the isolation of the problems, because that is the problem, we isolate with stigma, how about: “It’s a community problem, let's resolve it together.”

“Something like, "a mentally healthy society has a positive future" or something along those lines, like he says, we are a society, we are like one organism and if we start with our mental health, then it (society) will be successful with projects or whatever is planned in the community.”

“It would have to be something more creative. But maybe not have "mental health" since people may hear "mental" and then they will think that it doesn't pertain to them, so, I agree with a health message, but something like a healthy society, somehow to take away the blinders that we have that it will not happen to my child or you are not talking to me about my child; if we say "mental" we will automatically discard it, but we need self-awareness and that is mental too, I don't have an exact idea.”

● **INCREASE ACCESS TO SERVICE AND/OR ADDRESS ISSUES OF LACK OF SERVICE AND LACK OF TRAINED PROFESSIONALS IN THE AREA**
“I think the first visit should be free (laughs) yes, the help should be there, and then assess what is wrong, sometimes people do not access services because they cannot pay, they don’t have insurance and their legal status; they shouldn't discriminate.”

“No discrimination based on race, nor legal status. If they don't have papers, they should be treated the same, they don't have the economic means if they don't have papers, they should be treated all the same.”

“Yes all the same.”

“To not (discriminate) services based on sex, nor nationality.”

“Nationality or medical problems, so that we can learn to be around certain people or certain groups.”

“Yes, very beneficial, but some people are there teaching that shouldn't be there.”

“Parents don't come with a manual, so parent training or orientation for parents as well.”

“They (parents) can go to therapies, they can learn about how to deal with persons like that.”

“We need that a lot here in this community, a counselor.”

“Therapists and psychologists.”

“I have grandkids they used to live with me and now their dad has his trailer, they were abandoned by their mom, she chose drugs over my grandkids and they have that trauma and need to go to services but no one is here in town.”

“Well those of you that have the resources, just know that we need services here, others (communities) don't notice because they have the services.”

“The traditions, as far as in the county, how many people are there that can do that, are able to provide services, do you know?”
“I think it should be brought up to the health councils and then take it to the community to see what kind, I guess.”

“Support, yeah support, how many agencies are here in the county and how much support is needed and where and what kind of level of resources can be offered, because sometimes resources aren't there, waiting lists are long.”

“Outreach.”

“Yeah, outreach, because half of these people don't even know it’s available to them.”

“I know that Border area, you go and you walk in and no help is given at the front, they don't do that.”

“Yeah I used to go there and they changed therapists, and by the time the person gets an appointment and a second appointment, they already changed to another provider or they make people wait.”

“I used to work there and the case loads are heavy and the turnover is very high because of the high caseload and people just don’t have the resources to go somewhere else. It’s very much to keep up with all the clients, it wasn't fair for clients and they were not adequately provided services, it made me sad.”

“Like the NA meetings, no one here in Deming is qualified to do those, they only have AA meetings, and the court has mandated, but they don’t have a group to go, they need open up these services, all of us here, our kids have to go to AA and they don't drink, they need NA, so those kind of services are needed. They are into the Meth and marijuana, they are not into alcohol.”

“Well, recommend that they need help, to go to a psychologist.”

“In my town, where I am from in Mexico, many kids are like that because of drugs and they take them to a center, and when they are back from rehabilitation they are better, and when they see they are acting up again, they take them to rehab again.”
“People with depression here need a worker sent to their house, especially because they have other illness like diabetes, high cholesterol.”

“We need to learn to listen to them and not leave them alone, so that person feels important.”

“So they have a sense of importance, not leave them alone, unattended.”

“We need a lot of help with our elderly here.”

“Here in our town, it’s pretty big, and even though we visit the elderly, we need resources to make a big center for them and provide services for them, some of them have depression, some of them have other illnesses like diabetes or they can't move because their legs don't help them, they are invisible to the community and they need services for them, take them the services, not expect them to go to places.”

“Have persons that are capable of handling such programs, have resources.”

- **TEACHER TRAINING; BE SENSITIVE TO CHILDREN ON MEDICATION**

“Information for kids, to help them interact with kids that are ill.”

“Let me tell you, I have a child that is on medication and another child that is also on medication, and I would like to educate the teachers, because sometimes the teacher singles them out "you have to take your medication." They need to be aware that they should not be saying and calling them out. I think that affects the child.

“That has a lot of effect on how the other kids act toward him, sometimes if children have more energy, the teachers who know they are on medication tend to say that they need more medication just because they are more active. They may not integrate them in kids' activities. When we go to classes for this then other kids make comments about my child "He is crazy."

“The responsibility is also ours (parents), we need to help our teachers understand our children who are on medication, we are the first teachers, you cannot expect the teacher to focus all of their efforts in one child.”

- **INCREASE FUNDING TO EXPAND RESOURCES**
“One of the best things they can do is have a shelter for those people with mental problems that are homeless, like in Juarez, they have that, and they are part of the community. They smell bad and they don't have a place for hot soup, of course because they are homeless.”

- PROVIDE EDUCATION FOR ALL AND PROGRAMS DESIGNED TO INTEGRATE OUR FAMILIES INTO SOCIETY

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“More training for parents.”

“Yes, parents so they know how to educate their kids around others.”

“Sometimes some kids are stronger that others, but some are not. My daughter told me that the teacher was telling her some things, and she is the kind of student that turns in her work, and she kept telling me that he told her things until one day, I went to talk to the teacher and they think that sometimes parents are present and they disrespect kids. Thereafter, she has not said anything else.”

“I think we go back to the same thing, because of our culture, we need to talk to our kids about children with special needs, with certain problems and we need to make them sensitive to the needs of the other children, again it falls on the parents to speak to our kids.”

“I would add that we need to look at those kids as blessings, and we don't know what, but something is waiting for us.”

“So we need to attack it from all angles, the parents, the media, schools, especially with soap operas (laughter).”
“There is no one to teach us how to treat these people with these problems. The families, they should teach us, because a lot of times, we also make mistakes with the individual, and we don’t know how to treat them. So, then all we do is back them onto the streets, I say it from experience. I have a brother who has Schizophrenia. He is going on his twelfth year in jail, and I don’t know why. So then, I know.”

“People like you need to come to community centers like this and talk about this.”

“In other words, you need to multiply and go and inform people.”

“Kids need a foundation, this is not going to change over time, we need various programs without having to burden the teachers.”

“But we have something complex here, if we have programs in the schools, the kids get it there, but parents don’t get the information nor do they have any desire to obtain information and then it’s not fruitful what the child hears at school, because at the home, the message is not supported, the success is not going to be there, not just include something at the schools is not enough.”

“It’s a process, parents must be included they need orientation too.”

**EDUCATE ALL SECTORS OF THE COMMUNITY: DOCTORS, COMMUNITY HEALTH EDUCATORS, TEACHERS**

“Well the most important point here in these schools is that they (teachers) don’t have the skills to be here in our schools, they have ex-military or people from other professions are teaching.”

“Well schools have their counselors but sometimes they are not that useful. I saw a child once that was isolated in physical education class, the teacher isolated him and he even wet his bed because of the teacher yelling at him and the other teachers isolating, I went to the principal's office and talked to parents, and after I talked to the principal and the teacher got reprimanded, then the child who was not well in his head did better.”

“I recommend small groups in certain areas, small community groups in different communities, some areas may need the groups now, but with some kind of orientation in this group, so that I can build the capacity in myself and then I can see the growth in myself and other too, we are
learning and that helps out much. It’s a way of orientation to the community, groups or sessions, and somehow some kind of mandate, incentives to attend this orientation.”

“Don't wait until something bad happens, something needs to be done ahead of time. For example DWI, then the messages seem to come after the fact, but don't wait until something bad happens here, information needs to be given out in the community, at schools, and in some way disseminate so that others see the need to come and learn or sessions about what I should do just in case (of mental illness).”

“Sometimes give incentives or credits for the classes that you are going to offer, this way people can gain something else in return.”

“I like the way the child support dept. did it, they offered classes to people if they wanted to take care of children and they would learn at the same time as gain their check too.”

Summary of Qualitative Findings

Consumer Summary: A range of thoughts was shared about reducing stigma from the viewpoint of local consumers, which included updated training for health care professions and “advocates” for mental health. The consumers believed that having more qualified professionals that understand mental illness and important issues, such as confidentiality, would be a significant benefit. Consumers felt that more support around funding in terms of prevention as well as maintenance for mental health issues would help individuals improve. One area of great interest was improvement in the school system to decrease mental health stigma in education. Consumers felt that children with mental health diagnoses should be mainstreamed and not alienated from their social environment and, at the same time, there should be general psycho-educational meetings. Consumers also believed that required training protocols should be improved to enable law enforcement to better interact with people with mental illness. They also felt that there were many negative media messages that need to be addressed. Finally, consumers felt the need for acceptance for their mental illness and reduction of stigma should include embracing the concept that mental illness can affect people of all classes and racial ethnicities. They felt that the support from churches and the community in general can be very effective in helping them cope.

Non-Consumer Summary: Several recommendations were given, but two particular themes stood out. The first was the need to provide everyone one with information about the illness
with an emphasize on parents and teachers. It appears that the venues for much of the education in these communities are schools. As a result, comments emphasized teacher training. The second area that came across was the lack of access to services and qualified professionals to meet community needs. Non-consumer participants seemed to feel that the lack of trained professionals or even retention of professionals has created a gap in their communities. As a result, individuals who need services are not able to obtain services in a timely manner. In summary, this group perceived the lack of information as a key recommendation to reduce stigma.

Provider Summary: Important information from providers in the U.S. and Mexico about strategies for reducing stigma in the region was elicited. Themes included the importance of advocacy (protest) strategies, education at the community, provider and family levels. Some providers also gave particular recommendations for increasing contact strategies that involve the hosting of community events, community forums and similar activities where consumers are included in this type of educational dialogue. Working to educate community leaders was an important strategy for changing social and organizational norms. In addition, one very important theme in the provider interviews is the recommendation that providers themselves become educators and community ombudsmen for other human services, faith-based and school-based personnel. The providers suggested that they have the experience and knowledge to help break down negative perceptions about mental illness and mental health care. Campus and school-based education are highly recommended by the provider respondents. Finally, some providers suggested that specific educational approaches for military and military families ought to be explored. While media messaging and negative media portrayals about those with mental illness were identified as key factors in shaping norms, few media-based strategies or recommendations from providers were elicited.

Group Similarities: Overall a comparative of the different groups illustrates that all three groups were interested in reducing stigma through training professionals, changing the school system, providing more public education and forums for discussion, increasing funding for services, and encouraging a more holistic view of mental illness in the media messages. The results of educational strategies, contact strategies, advocacy strategies and relevant cultural strategies are shown in Table 1 below.

The following table (Table 1) highlights the various recommendations about stigma reduction strategies that were generated from the qualitative interview data.

Table 1. Comparative Summary of Interview and Focus Group Strategies for Stigma Reduction
<table>
<thead>
<tr>
<th>CONSUMER GROUP</th>
<th>NON-CONSUMER GROUP</th>
<th>PROVIDER GROUP</th>
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</table>
| **EDUCATIONAL STRATEGIES** | • Training for Health Professionals  
• Parent education  
• School based educational programs for children  
• Educational media programs to educate about mental illness | • Change in the school system  
• Avoid overmedicating children prematurely or unnecessarily  
• Implement new, different teaching techniques to help children cope with their mental health issues  
• Teacher training to increase sensitivity to children on medication  
• Education to integrate families to society  
• Education to all sectors of the community: doctors, community health education and teachers | • Training for health professionals and leaders  
• Providers need to be included as community educators  
• Education for the general public in schools or churches  
• Provide parent education and education for children regarding mental health  
• Education about mental health using media  
• Train Promotoras  
• Provide campus based education |
| **CONTACT STRATEGIES** | • Public educational forums for discussing mental health issues  
• Community center for dialogue with professionals for education and positive messaging | • Community based dialogue, programs that offer opportunities for community dialogue, consumer based programs, including the military population  
• More open community forums | • Hold community open forums  
• Encourage providers to do outreach and education  
• Community education in the form of classes and workshops |
SECTION 3 - LITERATURE REVIEW OF MENTAL HEALTH AND STIGMA REDUCTION

This section of the report includes:

• Opportunities for Community Action Based on Existing Literature

• Purpose of the Stigma Reduction Literature Review

• Methods Used to Gather and Synthesize Existing Literature

• Summary of Education, Protest and Contact-based Programs that Appear in the Literature
Opportunities for Stigma Reduction Based on the Literature Review of Mental Health and Stigma

The following summary is based on information gathered in the review of literature on mental health and stigma reduction. It is important to note that the literature review had to be expanded to include national and international data sources given that the published research on mental health and stigma in the PdNHF region are very limited. At the same time, studies are relevant for developing a community action plan to reduce stigma in this region.

- **Increase and expand evaluation studies, research studies and other publishable anti-stigma data that highlight local and regional stigma reduction efforts.**

  The literature review indicates that there are few local and regional studies on approaches to stigma reduction. Efforts between local programming and research-based organizations should be fostered to help determine what approaches to stigma reduction are effective. New stigma reduction studies specific to the PdNHF region are sorely needed.

- **Increase collaborations between local organizations, universities and other private research and evaluation groups to study and report data on stigma-related projects.**

  Based on the literature review, new research on stigma reduction needs to be stimulated for the border region, rural and hard to reach communities, including those that are non-English speaking.

- **Expand the original Corrigan model of Stigma Reduction.**

  The literature review suggests that new models for stigma reduction are needed for the region. These models should include key cultural variables such as acculturation as well as lifespan concepts and developmental theories focused on children and adolescents.
PURPOSE OF THE LITERATURE REVIEW

As part of the Situational Analysis, a comprehensive literature review on issues related to mental health and stigma was conducted by the BAI technical team, including Dr. Cervantes, Mr. Fred Sandoval and Ms. Rose Nava. The literature review provided a glimpse into some of the most recent key national and international research findings to date on the topic of mental health and stigma. The literature review was framed in the Corrigan model to gather key information on literature related to Contact, Education and Protest as well as cultural and regional studies of importance to the U.S.-Mexico border region. The purpose of the literature was to:

- Determine what the scientific literature says about stigma related to mental illness
- Specify studies related to Education, Contact and Protest strategies to reduce stigma
- Identify studies specific to special populations including children and military personnel
- Determine existing evidence-based programs and practices for stigma reduction, including strategies being tested in other countries

The literature review provided a quick historical perspective on the treatment of people with mental illness and examined some of the unique challenges faced by rural communities (i.e., shortage of services, denial of mental health issues, and financial concerns) as well as those of children in schools, military and veterans, and senior adults. Common themes about stigma emerged from the literature indicating that fear, misconceptions, and discrimination could successfully be applied through targeted outreach educational programs. Many of the programs proved to be promising in changing societal beliefs into becoming more accepting of and empathetic toward people with mental illness. The literature focused on ways to integrate and accept persons with mental illness by direct contact and by asking people in recovery to speak out and share their stories. This, researchers argued, would help people realize that mental illness is common and, thereby, help reduce stigmatization.

METHOD USED TO GATHER DATA/LITERATURE

The majority of studies, papers and web-based documents were peer reviewed and gathered through searches of twenty-two databases and three on-line libraries. Combined, they provided access to an estimated 40,000 academic and professional journals, books and articles dating from the early 1900s to present day. The article search specifications included dates
within the past 11 years (2002-2013) and full access to the article. An extensive combination of Boolean terms was used and included phrases such as mental health, stigma, access to care, rural populations, military, social exclusion, social inclusion, self-stigma, border health, mental wellness, Latinos, Hispanics, Mexico-United States border, clinical bias, inadequate clinical services, prejudice, discrimination, mental disorders, stigma reduction, public policy, mental disorders, health beliefs, mental health care barriers, mental health stigma, etc. In addition to these sources, key materials were suggested by PdNHF Senior Program Officer Enrique Mata and were also incorporated into the literature review.

**FINDINGS OF LITERATURE REVIEW**

The literature revealed that educational programs in schools reduced discrimination toward school-aged children and fear of mental illness and increased beliefs that people with mental illness can recover. Discrimination, misunderstanding were decreased and acceptance and support were increased on community levels through the use of strategic media health campaigns targeting misconceptions about mental illness and promoting the ability to live long and productive lives. The literature also suggested going beyond education of traditional mental health practitioners, citing studies that reported success in utilizing skills of peer educators, Promotores, and spiritual leaders. The literature revealed there is promise in utilizing other professionals in reducing mental health stigma, but it may mean increasing their knowledge base by teaching practitioners how to identify signs and symptoms of mental illness, when to refer a community member who is in crisis, and to whom. Efforts to reduce stigma, promote overall health, and provide culturally appropriate interventions must take into account multiple and complex challenges continually faced by individuals with mental illness, including the stigma unique to the border culture.

**RECOMMENDATIONS FOR FUTURE REGIONAL STIGMA REDUCTION EFFORTS**

Based on findings from the literature review, successful strategies to combat and reduce stigma have included calling attention to inaccuracy and misguided representations of people with mental illness in mainstream culture such as movies, music and journalism and through efforts such as letter-writing campaigns.

- Protest and advocacy efforts in the region among the Foundation and its community partners is an essential component of any anti-stigma effort
Legislative reform, including the Affordable Care Act, will improve access to care for people with a mental illness and will also present opportunities for outreach in communities most likely to benefit from access. Advocacy strategies may include combating the stigmatization of mental health professionals; requiring culturally appropriate care; and promoting mental health agendas on policymakers desks that address inequality in matters such as funding, services, and social justice. The use of mental health “navigators” may be an area to be considered for further development by the Foundation. This last strategy, which might include stigma self-management, campaigns that promote empowerment, and acceptance, have also proven to be effective in promoting overall wellness and recovery.

Educational strategies, including mental health literacy for individuals, families and communities, have also shown promising results. Research also has shown that contact with people with mental illness can decrease discrimination, fear and social exclusion while increasing the belief that people can recover.

- Increased educational strategies to assist community stakeholders in obtaining basic and accurate knowledge about mental health and mental illness are a core component of any successful stigma reduction effort and should be included in any regional effort.

Due to the lack of health care professionals and treatment options for rural communities, community-based solutions to stigma for this region may lay in the use of non-traditional mental health professionals, including peer educators, Promotores and clergy members. The spirituality that many people use instead of seeking mental health treatment is a strength that could be incorporated into anti-stigma efforts. Trainings such as Mental Health First Aid can assist communities in conducting outreach and help individuals who are needlessly suffering when proven treatments are available.

- Efforts to reduce stigma, promote the overall health, provide culturally appropriate interventions, must take into account multiple and complex world views, cultural beliefs and challenges. Increase the use of CLAS cultural standards in all stigma reduction strategies.

Finally, the literature review clearly highlights the need for continued use of research and evaluation studies to document successful stigma reduction efforts. Evaluations, such as the recent efforts in the U.K. to assess effective stigma reduction, point to strategies that are effective and that can be replicated with local adaptations.
New and innovative programming that includes contact, education and advocacy along the U.S.-Mexico border region shows promise as long as strong evaluation components are included.
SECTION 4 - COMPRENDIUM OF RESOURCES AND STIGMA REDUCTION PROGRAMS

The full Compendium of Stigma Reduction Programs is included in the Appendix to this report. Found in this Section of the report are:

- Opportunities for Community Action Based on the Compendium of Programs and Practices

- Purpose of Developing the Compendium

- Methods Used to Create the Compendium

- Summary and Example of Programs, Practices and Strategies included in the Compendium
Opportunities for Stigma Reduction Based on the Compendium

The following summary is based on a compilation of stigma reduction programs, practices and strategies that were found in the published literature. Included are programs developed in the U.S. as well as programs that have been tested and implemented in other countries.

- **Increase and expand the implementation of stigma reduction programs and practices identified in the Compendium.**

  Based on findings in compiling the Compendium, the implementation and testing of a wide spectrum of programs have been found to be effective in other regions and other countries and offer a basis for long-range stigma reduction in the PdNHF region.

- **Develop and test adaptations of existing evidence-based practices to include programming that addresses children’s mental health, family and culturally-based programming toward stigma reduction.**

  Based on Compendium findings, while a variety of education, protest and contact programs are available, these will need to be adapted in consideration of the local languages, cultures and age groups present in the PdNHF region.

- **Establish and expand evaluation requirements for organizations in determining the outcomes of implementing and replicating existing or adapted strategies included in the Compendium.**

  Findings from Compendium suggest that organizations that have stigma reduction programming would benefit through participation in training that involves evaluation technical assistance. Developing evaluation skills that lead to rigorous outcome evaluations of stigma reduction needed in the region. Provide training on fidelity monitoring and adaptation processes.

- **Establish and increase training and technical assistance in capacity building efforts for local organizations in the region.**
Findings from the Compendium also suggest that assistance for organizations is needed on matching and assessing their capacity to adopt, adapt and implement anti-stigma reduction programs and practices included in the Compendium. This technical assistance may include mentoring, coaching or assistance that is culturally appropriate to the nature, size and unique profile of organizations. Optimize the training and technical assistance support available from anti-stigma program developers, especially if local adaptations are necessary.

- **Increase the level of organizational knowledge of the cultural considerations of language, beliefs, values, customs, practices and social norms found in the region.**

Findings from the Compendium point to the need for cultural competence that goes beyond providing a demographic description of the region but that teaches stakeholders and organization about cultural brokers, cultural leaders and community representatives. Also suggested is an increase in the use of programs that implement new CLAS standards as part of anti-stigma strategies. Findings from the Compendium also suggest the need to consider culturally relevant messaging or taglines that cross cultural lines applicable to the region.

- **Increase overall implementation of anti-stigma programs, practices and strategies among smaller community-based, grassroots, neighborhood, consumer-operated, family-operated, school-based and coalition-based entities.**

Consumers and family members must have active, meaningful engagement by leaders, facilitators, partners and cohorts in implementation of anti-stigma programs.
PURPOSE OF DEVELOPING THE COMPENDIUM OF PROGRAMS AND PRACTICES

As part of the Situational Analysis, it was important to conduct a survey of current programs, practices, strategies and activities in the field for the purpose of stigma reduction. There is a growing body of such programs and practices, and these have been compiled into a Compendium. The information included in the Compendium may be helpful to the Foundation and its partners as a comprehensive stigma reduction effort is developed for the PdNHF region. While there were no specific stigma reduction programs found specifically for the U.S. - Mexico border region, certain programming included in the Compendium may be adapted, implemented and evaluated for the region. The Paso Del Norte Health Foundation's Stigma Reduction Initiative Strategic Plan focuses on two primary approaches to stigma reduction: Contact and Education. A third approach - Protest - is acknowledged as an important component but is not a primary Foundation focus area in the first phase of the initiative. However, these strategies were included in the compilation of the Compendium.

METHOD USED TO GATHER DATA/INFORMATION

For purposes of identifying and producing a compendium of approaches to stigma reduction, advocacy, information, contact, education, contact-based education, legislative reform, stigma self-management, and protest approaches were searched. This helped to garner a comprehensive set of programs, practices and activities used in various settings and even in other countries.

The overall approach to identifying anti-stigma efforts was to examine multiple sources found in the literature both in the United States and abroad. The primary sources included the Department of Health and Human Services Substance Abuse and Mental Health Administration, the World Health Organization, and the National Mental Health Authorities in Australia, Great Britain and Canada. Additional sources came from the literature review, PdNHF identification of anti-stigma programs, and the consumer programs which have led the fight to combat stigma head on. Further, the search methodology for the Compendium component consisted of examining many of the same peer-reviewed journals, books, articles, and research reports used in the literature review. In addition, materials gathered from state, national, and international conferences including presentations that explored and discussed various areas of mental and emotional well-being, behavioral health, substance use and abuse, and stigma-
associated health issues were also used. Finally, a broad web-based search that included online libraries was conducted. Non-governmental organizations such as the National Alliance on Mental Health and the HOGG Foundation for Mental Health, were searched for program curricula, books and meta-analysis reports with compilations of research.

Key word searches included the following range of terms: stigma, stigma reduction, social inclusion, anti-stigma, social exclusion, stigma reduction training, mental illness discrimination, education or curriculum, and mental health promotion training. The individual links to more than 200 websites were reviewed to identify the description of anti-stigma programs, practices, initiatives, strategies, or activities that were education-based. Of the 200 websites visited, 13 were identified from Paso Del Norte Health Foundation Anti-stigma plan, 54 were identified from resource pages on the SAMHSA website, 12 were identified and found in Great Britain’s mental health authority, 10 from Australia mental health authority, five from Canada’s mental health authority, four from the World Health Organization, five from the literature review in this Situational Analysis, 10 from the National Latino Behavioral Health Association, five from the National Alliance on Mental Illness, and 72 from individual title-based searches.

Web links include information uniquely organized by each organization. They include or describe additional web pages about activities, programs, practices, initiatives, services or training activities that identify or provide a stigma reduction description. Most websites provide sections on what the organization does, mission or vision, resources, education or campaigns which can augment descriptions about their anti-stigma efforts.

Because organizations may have multiple programs, initiatives or strategies addressing stigma, content analysis was used with each program or practice to review, separate and identify educational strategies that contained identifiable curricula, manualized descriptions or training component. The majority of educational stigma reduction strategies did not describe or use a curriculum or manualized approach and thus were not included in the final Compendium.

**SUMMARY OF THE COMPENDIUM (The full Compendium document is included as an appendix item)**

The full Compendium includes a total of 84 anti-stigma reduction programs and 98 practices from across the United States and four other countries as well as the following types of stigma reduction programs and practices: Education, Contact, Advocacy and Protest. A brief summary of each area is included below to identify and describe the key characteristics of each category.

**EDUCATIONAL ANTI-STIGMA PROGRAMS**
The definition for education used in the Situational Analysis Compendium for education based program to combat stigma is as follows:

Education refers to public outreach efforts to replace misconceptions and myths with accurate information. The goal is to improve mental health literacy, reduce the fear often associated with mental illness, and promote early help-seeking (Corrigan, 2004). Studies have shown educational programs reduce stigmatizing views towards people with mental illness (Spagnolo, Murphy & Librera, 2008; Reavley & Jorm 2011; Kirkwood & Stamm, 2006) and have been successful in increasing mental health literacy and help-seeking behaviors using tools created from pop culture (López et al., 2009). Trainings, such as Mental Health First Aid, have been shown to improve trainees’ knowledge, attitudes and helping behaviors within the community (Kitchener & Jorm, 2006). Appropriate language training for individuals with mental illness reduces linguistic obstacles to receiving proper treatment and empowers individuals to express themselves and actively participate in society (European Union, 2010).

Educational approaches in the general sense show a diversity of approaches across the nation and around the globe used to combat stigma from a singular approach to a multi-faceted approach. As a result, and informed by the Situational Analysis, a targeted focus on educational approaches to stigma reduction was used in identifying which educational approaches to consider. The selection of curricula, trainings and/or manualized instruction aimed and effective at reducing and combating stigma were then selected for this Compendium. The ability to import and replicate the educational programs or practices identified in the Compendium weighed favorably because they could be applied broadly to diverse audiences from across community that had an impact on reducing stigma.

The Compendium includes information from 16 organizations with a total of 21 distinct stigma reduction educational programs or practices. Two organizations have more than one stigma reduction educational program included in this Compendium that are curriculum-based or manualized approaches. The educational stigma reduction programs included in the final Compendium are primarily targeted for adult populations. Several are aimed at youth or young adult populations.

Each entry in the Compendium is organized with the following sections: Name of the Project, Name of the Organization, Contact Information/Person/Developer, Links, Description of the program, Target Population, Goals, Costs Involved, Cultural Appropriateness, and Location
(Local, State, Regional, National or International). The Compendium is alphabetized by project name to help the reader quickly identify the educational anti-stigma program by its title.

Of the 21 distinct anti-stigma education programs or practices found in the Compendium, two are evidence-based: NAMI Family to Family and Mental Health First Aid USA. NAMI Family to Family can be found in the National Registry of Evidence Based Programs and Practices (NREPP) and Mental Health First Aid USA is under review by NREPP for inclusion. For instance, five published studies in Australia show that Mental Health First Aid saves lives, improves the mental health of the individual administering care and the one receiving it, expands knowledge of mental illnesses and their treatments, increases the services provided, and reduces overall stigma by improving mental health literacy. One trial of 301 randomized participants found that those who trained in Mental Health First Aid have greater confidence in providing help to others, greater likelihood of advising people to seek professional help, improved concordance with health professionals about treatments, and decreased stigmatizing attitudes. Unexpectedly, the study also found that Mental Health First Aid improved the mental health of the participants themselves. For further evidence supporting the implementation of Mental Health First Aid, please see the Evaluation section of the Australian Mental Health First Aid website: http://www.mhfa.com.au/evaluation.shtml.

NAMI Family to Family, which is a psycho-educational program for families, helps to inform parents, caregivers and family members about mental illness, resources for families, facts and myths about mental illness, and how to combat stigma. In one study, family members participating who were assessed in a pretest and 6 months posttest for knowledge about mental illness scored higher than assessments conducted at 3 months and at pretest. Another study of FtF showed that participants had greater improvement than the control group in knowledge about mental illness.

CONTACT BASED ANTI-STIGMA PROGRAMS

The value of anti-stigma contact approaches, for instance, can help augment educational strategies thus using multiple approaches to combat an entrenched and institutionalized set of patterns and behaviors. Community groups with little or no experience in using curriculum or manualized training approaches may find contact approaches to be effective at community engagement and mobilization that is critical to involving grassroots, community members or families reluctant to participate in more formal or structured processes. Consumer and family guided or driven contact approaches allow individuals to be a part of the development and implementation of anti-stigma messages and become meaningfully involved with communities.
in a face to face fashion. This allows for a powerful messaging about the lived experience and how stigma has affected individuals personally. This approach has the benefit of an immediate impact on listening audiences who learn about mental illness, its impact, the barriers, the hope of recovery and presentation conducted in an organized. This type of planned approach can culminate in a setting open to the public or focused on specific groups such as schools, community organizations or providers.

ADVOCACY BASED ANTI-STIGMA PROGRAMS

Anti-stigma initiatives, campaigns or media focused approaches not included in the Compendium can also be effective at bringing awareness, visibility, public dialogue and public voice to community stigma that supports innovative or broader venues, vehicles and approaches. The limited number of veterans’ anti-stigma programs or the limited number of public school-based anti-stigma programs speaks to the culture where stigma can thrive in a silent environment or settings that can incubate stigmatized views, beliefs or norms. Advocacy approaches allow individuals and families to gravitate toward their personal strengths to "voice and articulate needs" of persons impacted by mental illness. Many advocates, who are compelled to express the negative effects of stigma and other barriers confronting persons with mental illness and impact on families, can shed light on existing conditions and support the need to develop services and policies that improve access and availability of mental health services.

PROTEST ANTI-STIGMA PROGRAMS

While the fewest anti-stigma programs in the Compendium are characterized as protest practices, their significance is important because of how communities are mobilized to express dissatisfaction. The public outcry of protest approaches can bring to light circumstances that may not otherwise receive public attention. The inertia behind protest approaches reflect a pent-up frustration with policies and practices that may contribute to institutionalized perceptions or attitudes towards persons with mental illness. Protest approaches are a very direct attempt to combat stigma in a strong and activist fashion.

The White House Conference on Mental Health in Washington, D.C. in June 2013 is encouraging communities to open the dialogue on mental illness and to bring light to social and health conditions that can be plagued by stigma. This open discourse and highly public discussion
underscores the need to break down barriers to social inclusion and health equity. The opportunity to educate our communities may best be served by using more than one approach to fighting and reducing stigma. President Obama was quoted on June 3, 2013 that:

"There should be no shame in discussing or seeking help for treatable illnesses that affect too many people that we love. We've got to get rid of that embarrassment; we've got to get rid of that stigma."

RECOMMENDATIONS FOR FUTURE REGIONAL STIGMA REDUCTION

The educational stigma reduction programs and practices identified in this Compendium will readily help interested parties, stakeholders, community groups, organizations, agencies, schools, and other entities find information in a centralized document. The Compendium is written so that the reader can read the key description of the program or practice and is organized to easily identify contact information, target audiences and project goals. The cultural appropriateness description helps identify those programs and practices describing how the program serves diverse populations. This is particularly important given that the PdNHF serves a culturally and linguistically rich and diverse region. The sheer size of the Hispanic population, particularly of Mexican origin, in the PdNHF region significantly influences the social, economic and educational environments. The Compendium can serve as a tool and resource for identifying, selecting, promoting or implementing anti-stigma programs or practices in communities, schools, organizations or agencies.

Based on the findings from the Situational Analysis and the production of this Compendium, the following recommendations can help inform the policy-, decision- and grant makers of PdNHF to consider on how to best use and distribute the Compendium of educational stigma reduction programs and practices.

**Recommendation 1:** Increase implementation of stigma reduction programs and practices identified in the Compendium. This can include operating support to help eligible organizations integrate anti-stigma programs into the organization including their outreach and engagement strategies or that reduce the costs of implementing anti-stigma programs.

**Recommendation 2:** Establish an evaluation requirement to assist organizations in evaluating the outcomes of implementing and replicating adapted strategies included in the Compendium.
Support organizations that participate in an evaluation technical assistance training. Develop practices that lead to rigorous evaluations of stigma reduction outcomes in the region.

**Recommendation 3:** Increase and expand required training and technical assistance in the region to help organizations match and assess their capacity to adopt, adapt and implement stigma reduction programs and practices identified in the Compendium. This may include mentoring, coaching or assistance that is culturally appropriate to the nature, size and unique profile of eligible organizations. Optimize the training and technical assistance support available from anti-stigma program developers.

**Recommendation 4:** Improve organizations’ working knowledge of the cultural considerations of language, beliefs, values, customs, practices and social norms found in the region. This goes beyond a demographic description but shows evidence of cultural brokers, cultural leaders and community representatives having been historically involved in the eligible organizations’ planning, programs or leadership or commitment to do so.

**Recommendation 5:** Increase local organizations use of the new CLAS standards that will ensure cultural adaptations or infusion of cultural considerations, including translation and bilingual language access for those that participate in anti-stigma programs and practices.

**Recommendation 6:** Develop and communicate a new branding to replace the traditional label of stigma reduction to promote or market social inclusion and health equity. Consider culturally relevant messaging or tag lines that cross cultural lines applicable to the region.

**Recommendation 7:** Increase the number of community-based, grassroots, neighborhood, consumer-operated, family-operated, school-based or coalition-based entities that engage in stigma reduction efforts. These groups already demonstrate active and meaningful engagement of families and youths in their programs as participants, planners, leaders, facilitators and partners and cohorts in other human services programs.
SECTION 5 - COUNTY PROFILES

Included in this Section of the report:

- Opportunities for Community Action Based on Existing Demographic and Other Relevant Data
- Purpose of the Stigma Reduction County Profiles
- Methods Used to Gather Existing County Profile Data
- Summary of County Profiles
Opportunities for Stigma Reduction Based on 5 County Profiles of Existing Data

The following summary is based on existing data on PdNHF regional demographics as well as mental health issues and related mental health risk factors. The data have been used to help determine prevailing attitudes about stigma in the region as well as develop conclusions about next steps for community action.

- **Increase efforts to collect and analyze data that is specific to the PdNHF region.**

  Findings from the County Profiles show that gaps in data exist in the areas of children’s mental health, military mental health, school-based mental health issues.

- **Increase parent, teacher and other child caretaker education on mental health such as Mental Health First Aid programs.**

  Findings from the County Profiles suggest increasing specific education for parents, school officials, and community leaders on the value of early intervention and prevention programs with regard to suicide. Consider mental health check-ups or screenings among youth in schools and at community health events.

- **Increase the number of stigma reduction projects that have established logic models and clear education, contact and protest evaluation outcomes.**

  Findings from the County profiles emphasize the need for clearly articulated program goals and objectives that can measure improvements in prevailing community attitudes about stigma.

- **Increase and expand the use of data in communities to raise awareness about stigma associated with mental illness and suicide among youth.**
The findings from the County Profiles also suggest that media campaigns and public awareness should be based on valid and reliable data on teen depression, other mental illnesses, and treatment success.

- **Increase and expand services for co-occurring mental health and substance use in rural areas and other hidden populations throughout the region.**

Based on findings from the County Profiles, co-occurring drug use and mental health problems appear to be prevalent in the region. Tailored dual diagnosis treatments are needed.

- **Increase and expand public employee education for personnel in county and city jails, law enforcement, EMTs and emergency rooms on issues surrounding mental illness to lessen stigma and increase early identification and treatment of mental illness.**

Based on the findings from the County Profiles, mental health needs are also present in non-traditional settings. Expansion of innovative mental and emotional health training in these non-traditional work settings is needed.

- **Develop comprehensive local and regional mental health workforce plans complete with recruitment, retention, and training initiatives.**

Given recent demographic trends and increases in military populations, diversity workforce development in the area of behavioral health would help meet needs for mental health service delivery in rural, frontier and tribal areas of the region.

- **Given the large military population in the PdNHF region, increase military mental health services.**

Based on findings from the County Profiles discrete services, including web-based treatments, are needed for the region that address PTSD, traumatic brain injury, co-occurring problems and suicide prevention.
Increase cultural and linguistically appropriate mental health services in small community settings that are distinguished by large Hispanic populations, close proximity to Mexico, and rural communities (colonias).

Based on findings from the County Profiles, colonias are a unique feature of the border region. These colonias may have high mental health needs as a result of stress associated with poverty, migration and cultural differences. There is a call for increased and culturally appropriate services in these small, rural community settings.

PURPOSE OF DEVELOPING THE COUNTY PROFILES

To augment the scientific literature on existing stigma related studies, the Situational Analysis included the development of a series of county-level profiles. County-level data on a variety of community mental health issues, risk factors, cultural factors and other related information was included in 5 county profiles. Each county borders Mexico and is part of the Foundation’s service area. Profiles are key to understanding community-level mental health issues that may influence or be influenced by stigma factors. Unmet mental health needs, for example, may be in part the result of stigma that affects one community more than another. BAI’s approach to developing county profiles includes presentation of county-level data in comparison to state and national data where available.

The county profiles will help to identify who lives in the communities within this 5-county region and will help to identify gaps and barriers relevant to mental health and mental illness that may aid in anti-stigma efforts associated with this Situational Analysis and future initiatives.

The county profiles presented here are also provided in a more detailed PowerPoint slide presentation format found in the Appendix. The county profiles include the counties of El Paso and Hudspeth counties in South Texas and Dona Ana, Luna and Otero Counties in Southern New Mexico. Key data includes demographic information for each county, accessibility to mental health services, local perceptions about mental health and treatment, information on rural or remote areas and hidden populations within this region, and includes state and national data where appropriate. The following specific data elements are included in the county profiles:
• Community profile information that includes number of households in each county and average household size, race, median age, educational attainment, median income and primary language spoken at home.
• Health Behaviors (smoking, drug poisoning, substance abuse)
• Attitudes Toward Mental Illness
• Health Related Quality of Life (mentally unhealthy days)
• Mental Health Providers in the 5-County Region
• Social and Economic Factors
• Youth Suicide
• National Alliance on Mental Illness Networks Available in Texas and New Mexico
• Remote Populations or “Colonías” in Region
• Family Separations due to Immigration Policy in Border Region
• Prevalence of Mental Illness among Children and Adults in Region
• Stigma Associated Issues among Military Personnel and Families

METHOD USED TO GATHER DATA/INFORMATION

Several methods were used for gathering information and data presented in the county profiles including literature and website searches of local, state, and national level area reports and publications and databases from the following resources:

Federal Resources:
• U.S. Census 2010 Bureau
• U.S. Department of Health and Human Services, Department of Health Resources and Services Administration (bhpr.hrsa.gov 2013)
• Department of Health and Human Services, CDC’s National Center for Health Statistics
• Centers for Disease Control and Prevention. [http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5920a3.htm](http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5920a3.htm)
• Data Source: National Center for Health Statistics (NCHS), National Vital Statistics System (2010)

State of New Mexico Health Status Resources:
• 2011 State of Health Report
• NM IBIS (Indicator Based Information System) – [http://ibis.health.state.nm.us](http://ibis.health.state.nm.us)
• NM Environmental Public Health Tracking System – [https://nmtracking.unm.edu](https://nmtracking.unm.edu)
• NM Department of Health

State of Texas Health Status Resources:
• State of Texas Behavioral Health Data Book 2009.[http://www.dshs.state.tx.us/](http://www.dshs.state.tx.us/)
• State of Texas, Department of State Health Services online at: http://www.dshs.state.tx.us/
• Texas School Survey of Substance Use 2012
• Texas Department of State Health Services, Professional Licensing and Certification Unit - September 13, 2011

Other Resources
• National Association for Mental Illness (NAMI). The State of Mental Health across the Nation (2009). http://www.nami.org/gtsTemplate09.cfm?Section=Findings&Template=/ContentManagement/ContentDisplay.cfm&ContentID=75255

SUMMARY OF COUNTY PROFILE FINDINGS

The combined number of households in the PdNHF region is 367,320 with a total population of 1,102,248. There are 2.75 people per each household, and the median age is 35.2. Nearly 76% of the total population in the PdNHF region is Hispanic. In the state of Texas, 38.1% of the population is Hispanic, and 46.7% of the state of New Mexico is Hispanic. Nationally, 16.7% of the population is Hispanic. The total population in the U.S. grew 10% over the decade according to the 2010 Census, while the Hispanic population grew by 43%. Nearly 44% are under the age of 18 in the PdNHF region, and the national percentage under the age of 18 is 23.7%. In 2010, there were fewer high school graduates in this region (69.3%) than the national average of 85%. New Mexico’s high school graduates numbered 83.1% in 2010, and Texas high school graduates were at 80%. Median incomes were $32,802 in 5-county region compared to $52,752 nationally; $50,920 in state of Texas; and $44,631 in state of New Mexico. Primary language spoken in the 5-county region is Spanish (52.9%). To summarize, the majority of the population in the PdNHF region is primarily Hispanic, relatively younger, has an educational attainment level at high school or less, earned less money (high poverty rates) than the general
population, and primarily speaks Spanish. In addition, there is a larger percentage of children under the age of 18 with mental illness in those counties with significant military populations.

**ATTITUDES TOWARD MENTAL ILLNESS IN NEW MEXICO AND TEXAS**

Negative attitudes about mental illness often underlie stigma, which can interfere with recovery (CDC, 2010) and can cause affected persons to deny symptoms, delay treatment, and/or be excluded from employment. Understanding attitudes toward mental illness at the state level could help create initiatives to reduce stigma, but state-level data is limited and county-level data is not available. To study such attitudes, the CDC analyzed data from the 2007 Behavioral Risk Factor Surveillance System (BRFSS), the first state-specific study of attitudes toward mental illness treatment and empathy toward persons with mental illness. New Mexico and Texas were among the 35 participating states in the study, which showed that most adults in Texas and New Mexico believed in the effectiveness of mental illness treatment, but fewer agreed that people are caring and sympathetic toward persons with mental illness. No border specific data was reported.

**TABLE 1.** Level of agreement* with the statement that treatment can help persons with mental illness lead normal lives, by state and territory --- Behavioral Risk Factor Surveillance System, 2007

<table>
<thead>
<tr>
<th></th>
<th>Sample size</th>
<th>Disagree strongly</th>
<th>Disagree slightly</th>
<th>Neither agree nor disagree</th>
<th>Agree slightly</th>
<th>Agree strongly</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Mexico</td>
<td>5,961</td>
<td>1.8 (1.2--2.6)</td>
<td>3.8 (3.1--4.6)</td>
<td>2.4 (1.9--3.0)</td>
<td>24.4 (22.8--26.2)</td>
<td>63.3 (61.5--65.2)</td>
</tr>
<tr>
<td>Texas</td>
<td>7,386</td>
<td>2.2 (1.8--2.8)</td>
<td>4.9 (4.1--5.8)</td>
<td>4.4 (3.7--5.2)</td>
<td>24.9 (23.2--26.6)</td>
<td>57.9 (56.1--59.7)</td>
</tr>
<tr>
<td>All States</td>
<td>202,065</td>
<td>1.8 (1.6--2.0)</td>
<td>3.9 (3.6--4.1)</td>
<td>2.1 (1.9--2.3)</td>
<td>25.8 (25.3--26.3)</td>
<td>62.8 (62.3--63.4)</td>
</tr>
</tbody>
</table>

* Adjusted for sex, age group, racial/ethnic group, education and household income level. Estimates are weighted; sample size is unweighted.

**TABLE 2.** Level of agreement* with the statement that people are caring and sympathetic to persons with mental illness, New Mexico and Texas --- Behavioral Risk Factor Surveillance System, 2007

<table>
<thead>
<tr>
<th></th>
<th>Sample size</th>
<th>Disagree strongly</th>
<th>Disagree slightly</th>
<th>Neither agree nor disagree</th>
<th>Agree slightly</th>
<th>Agree strongly</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Mexico</td>
<td>5,961</td>
<td>10.5 (9.5--11.7)</td>
<td>26.1 (24.5--27.7)</td>
<td>2.3 (1.8--3.0)</td>
<td>31.7 (29.9--33.5)</td>
<td>25.7 (24.0--27.4)</td>
</tr>
<tr>
<td>Texas</td>
<td>7,386</td>
<td>10.6 (9.5--10.9)</td>
<td>19.1 (18.4--20.1)</td>
<td>5.2 (4.5--6.1)</td>
<td>32.1 (30.4--32.7)</td>
<td>26.3 (24.6--26.9)</td>
</tr>
</tbody>
</table>
MENTAL HEALTH RELATED QUALITY OF LIFE IN THE 5-COUNTY REGION

Mentally unhealthy days are an estimate of the overall number of days during the previous 30 days when respondents felt that his/her physical or mental health was not good. To obtain this estimate, responses to 4 questions were combined to calculate a summary index of overall mentally unhealthy days, with a maximum of 30 unhealthy days. The Healthy Days surveillance data are particularly useful for finding unmet health needs, identifying disparities among demographic and socioeconomic subpopulations, characterizing the symptom burden of disabilities and chronic diseases, including stigma, and tracking population patterns and trends. The brief standard CDC HRQOL-4 is used in surveys, surveillance systems, prevention research, and population health report cards. **Questions asked when calculating summary index of unhealthy days include:**

- **Would you say that in general your health is excellent, very good, good, fair or poor?**

- **Now thinking about your physical health, which includes physical illness and injury, how many days during the past 30 days was your physical health not good?**

- **Now thinking about your mental health, which includes stress, depression, and problems with emotions, how many days during the past 30 days was your mental health not good?**

- **During the past 30 days, approximately how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?**

The number of mentally unhealthy days in the PdNHF Region reported by respondents was higher than the average number of mentally unhealthy days statewide in New Mexico and Texas (3.48-3.77 days out of every 30) (Centers of Disease Control & BRFSS, 2009). Luna County, NM had the highest number of mentally unhealthy days with 8 days per every 30 days. Respondents in Dona Ana County reported 6.7 days out of every 30 days, and Otero County reported 5.8 days out of every 30 days as mentally unhealthy. El Paso County, TX, reported 6.5
days out of every 30 days as mentally unhealthy, and Hudspeth had no data available. In comparison to national data, according to the CDC (2009), the national number of mentally unhealthy days is 3.638 out of every 30 days, and much lower that found for the PdNHF region.
Table 3. Number of Mentally Unhealthy Days per Month (over 18 years old)

<table>
<thead>
<tr>
<th>Location</th>
<th>Days per Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>El Paso County, TX</td>
<td>6.5 days</td>
</tr>
<tr>
<td>Luna County, TX</td>
<td>8 days</td>
</tr>
<tr>
<td>Otero County, TX</td>
<td>5.8 or 6 days</td>
</tr>
<tr>
<td>Dona Ana County, NM</td>
<td>6.7 or 7 days</td>
</tr>
<tr>
<td>Hudspeth County, NM</td>
<td>No data</td>
</tr>
<tr>
<td>State of Texas</td>
<td>3.48-3.77 days</td>
</tr>
<tr>
<td>State of New Mexico</td>
<td>3.48-3.77 days</td>
</tr>
<tr>
<td>Nationally</td>
<td>3.638 days</td>
</tr>
</tbody>
</table>

SADNESS AND SUICIDAL THOUGHTS AMONG YOUTH IN NEW MEXICO AND TEXAS

Youth Risk Behavior Surveys (2012) in Texas and New Mexico show that percentages of high school students (grades 9 – 12) with sad and suicidal thoughts and who had attempted suicide during the 12 months before the surveys (2011) were higher in the region than U.S. averages. Texas had highest percentage of youth reporting sadness and suicide attempts, while New Mexico had slightly higher numbers of youth that considered suicide as well as those with a plan for committing suicide. See Table 4.

Table 4. Percentages of high school students (grades 9-12) with sad and suicidal thoughts and who had attempted suicide during the 12 months before the Youth Risk Behavior Surveillance Survey (2011)

<table>
<thead>
<tr>
<th>Location</th>
<th>Sadness Everyday for 2+ Weeks</th>
<th>Seriously Considered Suicide</th>
<th>Had a Plan for Committing Suicide</th>
<th>Attempted Suicide</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Average</td>
<td>28.5%</td>
<td>15.8</td>
<td>12.8</td>
<td>7.8%</td>
</tr>
<tr>
<td>State of New Mexico</td>
<td>29.1</td>
<td>16.7</td>
<td>13.4</td>
<td>8.6%</td>
</tr>
<tr>
<td>State of Texas</td>
<td>29.2</td>
<td>15.8</td>
<td>13.2</td>
<td>10.8%</td>
</tr>
</tbody>
</table>

PREVALENCE OF MENTAL ILLNESS AMONG CHILDREN

Mental health is a key component in a child’s development. Children need to be healthy in order to learn, grow, and lead productive lives. **Children and youth in military families tend to have higher rates of mental health problems than those in the general population**, and those mental health problems are especially pronounced during a parent’s deployment (The National Center for Children in Poverty, 2010).
Figure 1. Rates of mental illness among children under 18 in the 5 counties are shown above. 

The highest rate of mental illness among children under the age of 18 is in El Paso, Dona Ana and Otero Counties, where there are large military populations. High rates of mental illness among children in military populations could be due to stigma, as military personnel tend to not seek help for mental illness. **There is more need for parent awareness. Need to educate parents about recognizing mental health problems in their children.**

**MILITARY VETERANS IN EL PASO REGION**

An estimated 13 percent of the 2 million troops who have served in Afghanistan and Iraq since 9/11 are from El Paso, TX. Texas is home to the second-highest female veteran population in the nation, just behind California. More than 152,000 Texas veterans are women (Cervantes & Texas Tribune, 2011). **A major reason many service members do not seek treatment is the stigma associated with receiving mental health care.** Many service members are worried that disclosing psychological difficulties or seeking out mental health treatment will negatively affect their military careers (American Psychological Association’s Monitor on Psychology, 2011).

**SUICIDE AMONG MILITARY PERSONNEL AT FT. BLISS MILITARY BASE, EL PASO, TEXAS**

In 2012, there were 350 suicides among U.S. military personnel. Five were Army soldiers stationed in Ft. Bliss Military Base in El Paso, TX. There were more suicides in the U.S. military (350) in 2012 than combat deaths in Afghanistan (310). The rate of suicide in Ft. Bliss has
decreased to 3 to date in 2013. While the suicide rate is rising in the military, it's declining for troops stationed at Fort Bliss Military Base in El Paso, Texas. According to Commanding General Dana Pittard, of Ft. Bliss, the focus now is on seeking help and getting soldiers the mental health help they need. **General Pittard has led efforts to overcome the stigma and military's macho culture that considers reaching for help a sign of weakness.** Pittard mandated that all troops arriving at Ft. Bliss take a two-day suicide awareness and prevention course that is different from the training used by the rest of the Army. The program, which uses a more interactive approach, including role-playing, stresses action and intervention by peers to help troubled soldiers. In addition, Ft. Bliss has mental health counselors now stationed near brigade headquarters. As of July 2010, Ft. Bliss officials reported that more than 1300 soldiers had taken advantage of suicide prevention training programs (Hunt, 2013).

**PREVALENCE OF MENTAL ILLNESS IN EL PASO COUNTY JAILS AND EMERGENCY ROOMS**

According to the CEO of El Paso Mental Health and Mental Retardation (MHMR), jails and emergency rooms are increasingly becoming El Paso County's mental-health providers by default. Almost half of El Paso residents who need mental health services receive them (46%). On any given day, 30 percent to 35 percent of the county's 2,200 inmates are on medication to treat mental illness (Ramirez & El Paso Times, 2013). According to Jesus Guiroga, intake and crisis services at El Paso Mental Health and Mental Retardation, 41 percent of those in El Paso's jails receive some kind of mental health care. That is about 811 inmates every day. Of those, 132 are diagnosed with the most severe mental health issues, like being bipolar, schizophrenic or substance abusers. MHMR has one full-time case worker at the jail. **There is a need to educate employees in county and city jails, law enforcement, EMTs and emergency room personnel on mental illness to lessen stigma associated with mental illness among employees and inmates/patients.**

**HIDDEN POPULATIONS (LINGUISTICALLY ISOLATED & REMOTE/RURAL AREAS)**

The word ‘colonia’ means neighborhood in Spanish. Colonias are small communities located within 150 miles of the U.S./Mexico Border. While every colonia is unique in size, demographics, and level of development, four characteristics distinguish these communities in Arizona, California, New Mexico, and Texas. They include: (1) exceedingly high rates of poverty; (2) high numbers of immigrants or descendants of immigrants, regardless of proximity to the border; (3) a largely rural nature; and (4) lack of infrastructure and essential services. There are 397 colonias total in the 5-county region including 332 in El Paso, TX; 5 in Luna County, TX; 17 in
Otero County, TX; 37 in Dona Ana, NM; and 6 in Hudspeth County, NM. Cultural and spiritual beliefs and the stigma associated with mental illness may keep a majority of people in these remote areas from seeking mental health care in addition to access and language barriers.
CHILDREN AND FAMILIES AFFECTED BY IMMIGRATION POLICY & STIGMA

Since 2010, Immigration and Customs Enforcement (ICE) has removed more than 200,000 immigrants from the U.S. who are parents of at least one child who is a U.S. citizen. The number of immigrants removed has steadily risen from approximately 190,000 deportations in 2001 to close to 400,000 per year in the past four years. In the first six months of 2011 alone, more than 46,000 parents of U.S. citizen children were deported (Center for American Progress, 2012).

In El Paso County, TX alone, 5,191 parents had been deported in 2011. One of the biggest current mental health needs across the nation is treatment and psychological education in Spanish. Many new immigrants to the U.S. who have the means and desire to seek treatment can’t find a provider to competently help them (Meek, 2006). Many immigrant families avoid mental health programs and health care programs due to a fear of deportation. U.S.-born children suffer from mental stress and fear for their parents, and may suffer from the effects of stigma in relation to immigrant status or mental illness, preventing them from obtaining mental health care services.

HEALTH BEHAVIORS

The regional substance use including binge drinking and prescription drug use in the 5-county region is lower than the national average. Binge drinking was highest in Dona Ana County, New Mexico at 22.5% for adults over 18. A total of 41% of children in grades 9-12 in the 5-county region drank alcohol within past 30-days. Binge drinking in El Paso County (at 17%) was just under the national average (national average 17.1%). (see Table 4 below). The Centers for Disease Control (CDC) found New Mexico to have the highest overall overdose death rate of any state. New Mexico suffered 27 overdose deaths per 100,000 people. Since 1991, the unintentional overdose death rate in New Mexico has increased 242%.

INDIVIDUALS IN 5-COUNTY REGION ARE MOST AT RISK

According to the Centers for Disease Control those most at risk for substance abuse and overdose are low-income people, those living in rural areas, people on Medicaid, people with mental illness, and those with a history of substance abuse. Individuals who have both a mental health and substance use problem often must cope with the stigma of overlapping
negative attitudes associated with mental illness and substance use, which keeps them from seeking help.
Table 5. Health Behaviors in PdNHF 5 - County Region

<table>
<thead>
<tr>
<th>BINGE DRINKING (5+ drinks 1 or more times)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>El Paso County, TX</td>
<td>17%</td>
</tr>
<tr>
<td>Luna County, NM</td>
<td>17.6%</td>
</tr>
<tr>
<td>Otero County, NM</td>
<td>18.2%</td>
</tr>
<tr>
<td>Dona Ana County, NM</td>
<td>22.5%</td>
</tr>
<tr>
<td>Hudspeth County, TX</td>
<td>No data available</td>
</tr>
<tr>
<td>Binge Drinking state of Texas</td>
<td>14% to 19%</td>
</tr>
<tr>
<td>Binge Drinking state of New Mexico</td>
<td>14% - 19%</td>
</tr>
<tr>
<td>Alcohol Use in past 30 days among grades 9-12 in Southwest Region</td>
<td>41%</td>
</tr>
<tr>
<td>National Average of Binge Drinkers</td>
<td>17.1%</td>
</tr>
</tbody>
</table>


UNINTENTIONAL DRUG POISONING (Prescription Drug Overdose) rates per 100,000

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>El Paso County, TX</td>
<td>9.4</td>
</tr>
<tr>
<td>Luna County, NM</td>
<td>No data available</td>
</tr>
<tr>
<td>Otero County, NM</td>
<td>21.3</td>
</tr>
<tr>
<td>Dona Ana County, NM</td>
<td>17.4</td>
</tr>
<tr>
<td>Hudspeth County, TX</td>
<td>No data available</td>
</tr>
<tr>
<td>Drug Overdose in Southwest Region (2010)</td>
<td>20.8</td>
</tr>
<tr>
<td>Drug Overdose in New Mexico State</td>
<td>27</td>
</tr>
<tr>
<td>Drug Overdose in Texas state</td>
<td>11.9</td>
</tr>
<tr>
<td>National Average Prescription Drug Overdose / poisoning (per 100,000 deaths)</td>
<td>27.3</td>
</tr>
</tbody>
</table>


NUMBER OF MENTAL HEALTH CARE PROVIDERS

A high-quality mental health system supports a carefully balanced and adequate supply of care across a continuum of services. When a full spectrum of community-based services is not available, people are sent to emergency rooms, hospital beds, jails, and nursing homes, and those facilities become overcrowded. According to the Grading the State Report, conducted by NAMI (2009), there is a critical shortage of qualified mental health personnel, and states show an extremely limited capacity to provide data on their service delivery. Only a few states have comprehensive mental health workforce plans complete with recruitment, retention, and training initiatives.
The number of mental health providers currently available for the entire PdNF Region is less than 120, with the majority located in El Paso County, TX (96). There is 1 in Otero County, and there are 15 in Dona Ana county, NM, with no data on providers available in Hudspeth or Luna counties. It is noted that persons needing mental health treatment or counseling travel to El Paso, TX or Dona Ana County, NM.

Note: There was no specific data found on national averages of mental health care providers needed by county or state. The U.S. Department of Labor reported 661,400 mental health providers nationally in 2011.

NATIONAL ALLIANCE FOR MENTAL ILLNESS (NAMI) NETWORKS IN THE REGION
Founded in 1979, NAMI is a nationwide American advocacy group, representing families and people affected by mental illness. NAMI claims to be a grass roots organization and has affiliates in every American state and in thousands of local communities in the country. NAMI's mission is to provide support and research for people and their families living with mental illness through various public education and awareness activities. The total number of active NAMI networks in the 5-county region is 2. The state of Texas has 30 active NAMI networks with 1 in Region 3 (El Paso County NAMI). New Mexico has 7 active NAMI networks with 1 in Dona Ana County. Increasing the number of NAMI networks in PdNHF region would aid in education and advocacy regarding mental illness and stigma.

OPPORTUNITIES FOR FUTURE REGIONAL STIGMA REDUCTION EFFORTS

Recommendation 1: Increase education on mental health, emotional well-being, mental illness and treatments. The data shows that for the PdNHF region, stigma and negative opinions about mental illness exist. At the same time, people in the region do believe that treatment works. Stigma reduction strategies are clearly needed for the region to reduce negative perceptions toward mental illness by providing education and information.

Recommendation 2: Increase education efforts for parents, teachers and other childcare providers. Mental health problems among children in the region appear to be more prevalent in those areas with high military populations (El Paso, Dona Ana and Otero Counties), and in hidden populations (colonias) among U.S. children of immigrant parents. Therefore, mental health education programs such as Mental Health First Aid need to be considered for parents, teachers and other child caretakers.
Recommendation 3: Educate parents, school officials, and community leaders on the value of early intervention and suicide prevention programs and consider mental health check-ups or screenings among youth in schools and at community health events. Sadness and suicidal thoughts among youth (grades 9-12) in New Mexico and Texas were higher in the region than U.S. averages. Texas had highest percentage of young people reporting sadness lasting 2+ weeks (29.1) and suicide attempts (10.8%), while New Mexico had higher rates of suicide consideration (16.7) and higher number of youths who had developed a plan for committing suicide (13.4%). U.S. national rate of attempted suicide among youth (7.8%); sadness (28.5%); suicide consideration (15.8%) and suicide plan developed (12.8%). This data suggests that New Mexico and Texas, including the PdNHF region need to raise awareness in communities about the stigma associated with mental illness and suicide among youth.

Recommendation 4: Increase and expand services for co-occurring mental health and substance use. This appears to be a significant problem in the region, especially in rural areas and among other hidden populations throughout the region.

According to the Centers for Disease Control those most at risk for substance abuse and overdose are low-income people, those living in rural areas, and people with mental illness - with a history of substance abuse. Otero County, New Mexico reported 23.5% compared to the national average (13%). Prescription drug overdose in New Mexico has the highest overall overdose death rate of any state in the nation. Since 1991, the unintentional overdose death rate in New Mexico has increased 242%. The data show that the overdose rate in the PdNHF region is at 20.8%, just under the national rate of 27%. Binge drinking among adults in the region is barely under the national average, but the rate is highest among youth in grades 9-12 with 41% use in past 30 days. It appears that people in the PdNHF region may be experiencing stigma associated with mental illness which may be leading to substance abuse problems. Treatments for co-occurring disorders need to be expanded.

Recommendation 5: Increase and expand mental health related education among personnel in county and city jails, law enforcement, EMTs and in emergency rooms on issues surrounding mental illness to lessen stigma.

Data shows that in El Paso County, jails and emergency rooms have experienced an increase in the number of jail prisoners and hospital ER patients suffering from mental illness.

Recommendation 6: Increase and advocate for development of comprehensive mental health workforce plans complete with recruitment, retention, and training initiatives to meet the
increasing needs for mental health service delivery in rural, frontier and tribal areas of the region.

New Mexico and Texas show limited capacity to provide data on their mental health service delivery, and according to NAMI, there is a critical shortage of qualified mental health personnel across the country as well as in the region.

**Recommendation 7:** Given the large military population in the PdNHF region, increase off-base and other innovative treatment approaches, including web-based, for active duty and military veterans. There is a need for military mental health services that can be provided discretely and that address PTSD and traumatic brain injury in addition to suicide prevention.

There were more suicides in U.S. military (350) in 2012 than combat deaths in Afghanistan (310). Efforts to overcome the stigma within the military's culture, that considers reaching for help as a sign of weakness, has yielded positive results in El Paso. However, there are 14 other military bases in Texas and 4 military bases in New Mexico, including 2 in the PdNHF Region. The White Sands Missile Base located in Otero County is the largest and widest military base in the U.S. It spreads over 5 counties.

**Recommendation 8:** Increase outreach, screening and treatment services in rural, non-English speaking communities. One successful method of providing culturally and linguistically appropriate health education in these remote areas has been through the use of Promotores (Community Health Workers).

There are 390 colonias in the 5 county region, including 332 colonias in El Paso, TX; 5 in Luna county, TX; 17 in Otero county, TX; 37 in Dona Ana county, NM; and 6 in Hudspeth county, NM. Due to the large Hispanic populations and the proximity to Mexico, these remote communities need cultural and linguistically appropriate mental health services.

Promotores are lay Hispanic/Latino community members who receive specialized training to provide basic health education in the community. They have gained significant importance in the way that care is delivered for Latinos. Since Promotores are often leaders and well-respected in their communities, they are able to deliver interventions in a culturally sensitive manner, be perceived as someone with similar values and experiences, and create a more immediate rapport with program participants.
SECTION 6- FINAL CONCLUSIONS & RECOMMENDATIONS FROM THE SITUATIONAL ANALYSIS

The Situational Analysis provides varying perspectives and data driven answers about mental illness and stigma, its causes, consequences and potential solutions. El Paso and the surrounding border region is unique in many ways and has a diversity of cultures, lifestyles and connections with both sides of the international border. The complexity of mental illness and stigma calls for multi-level approaches and strategies that include mental health promotion efforts, education, policy change and cultural group engagement, all aimed toward reducing the stigma associated with receiving mental health care. Based on the information and data collected in the Situational Analysis, we find that the Corrigan model of stigma reduction is very applicable. Yet current practices and stigma reduction strategies such as those used in the U.K., must include cultural information and must be tailored to meet the needs of Hispanics and military personnel. Similarly, strategies used in Mexico may need further tailoring as systems of care in Mexico for those with mental illness seem to lag well behind the service systems that are available in the U.S.

Information from the Situational Analysis clearly points to the following prevailing attitudes, challenges and opportunities related to reducing stigma in the region:

- The rates of mental health problems among individuals and children in the region are just as high or higher than those found in the general population. Untreated mental health problems may drive these rates upward and are likely influenced by stigma associated with obtaining help for mental illness.
- Stigma associated with mental illness is prevalent in the region. Focus group data shows that adults in the region hold negative perceptions about mental illness, and these continue to drive the negative social norms surrounding mental illness.
- Data from the key informants and focus groups suggest a variety of underlying causes for stigma, with social norms being influenced heavily by mass media and portrayal of individuals with mental illness as violent. Stigma reduction messaging must combat such negative portrayals.

**Opportunities for Stigma Reduction**

A regional media campaign, regional educational programming, advocacy efforts to institute policies aimed at improving emotional health and reducing stigma should be part of a
comprehensive strategy. A new framework for approaching stigma reduction has been supported by the Situational Analysis and suggests that developmental perspectives and culture must be included in existing models (e.g. Corrigan). Solutions for overcoming stigma have been identified within the Corrigan model of Education, Protest and Contact; however, the findings from the region also show that culture has a large influence on stigma AND that culturally based approaches to stigma reduction need to be developed. This includes strategies for reaching out to military personnel who may suffer from trauma-related mental health issues. The following general recommendations are based upon specific opportunities for community action in each section of this report:

- Educational approaches should be increased in the region. These approaches are more preferred by community members and consumers over Protest (advocacy) and Contact strategies based on the qualitative interviews and focus groups.
- Evaluation of any stigma reduction strategy is very important for the region. Clearly articulated personal, familial, and community-level outcomes are critical to further development of stigma reduction efforts for the region.
- A regional messaging campaign to reduce stigma is needed. Such a campaign would help shape more positive attitudes about mental and emotional health, making help-seeking more acceptable and provide hope for recovery. Such messages should include voices from community leaders. Leader involvement was mentioned throughout the qualitative interviews.
- Parent education and family educational approaches should be increased in the region and are highly recommended by community members, providers, and consumers as a way to help individuals and youth receive more timely mental health services without fear of stigma and social exclusion.
- Increase training on mental health and stigma for community health workers, promotores and health navigators. These community workers can help “translate” positive messages about mental and emotional health and treatment as well as assist those with early mental health symptoms in accessing available services.
- Close family ties and strong family values are an important cultural strength in this region based on focus group findings. Increase programs that incorporate cultural messages about family and extended families as natural support systems.
- Increase the development and evaluation of innovative online treatment service models and tele-health models for military personnel and families. Improve mental health education for military leaders, officers and administrators throughout the region.
Limitations of the Situational Analysis

One final mention should be made of the limitations of this project. First, we recognize that not all the data collected for the Situational Analysis was gathered in a scientific or controlled experimental fashion. Primary method used to engage key informants and focus group members was word-of-mouth recruitment. As such, qualitative data, while reflective of current community norms and prevailing attitudes, was not based on random community sampling. Other limitations may be present. These include lack of current or real-time data on mental health prevalence among certain subpopulations in the region, including data from military sources.
GLOSSARY OF TERMS

Advocacy - The act of pleading for, supporting, or recommending.

Advocacy Strategy - A combination of approaches, techniques and messages by which the planner seeks to achieve the advocacy goals and objectives.

Affordable Care Act - Passed in March 2010, the Affordable Care Act is a series of reforms to health insurance designed to increase availability of health insurance policies to individuals.

Boolean Search Terms - Boolean search terms are the logical terms AND, OR, and NOT, which are used in making database searches more specific. They make searches more precise by allowing one to specify the words and letters to be included in or excluded from the search.

Colonias - Rural, unincorporated settlements which often lack basic infrastructure and which are marked by poverty, located along the U.S.-Mexican border.

Compendium - A short, complete summary; an abstract.

Corrigan Model - A progressive model of self-stigma yields four stages leading to diminished self-esteem and hope: being aware of associated stereotypes, agreeing with them, applying the stereotypes to one's self, and suffering lower self-esteem.

Culturally Appropriate Care - Knowledge and understanding about the culture of the people being served, including their traditions, history, values, language, and family systems.

Disenfranchised Populations - A group of persons without a home or political voice, who live at the whims of a host. Examples include homeless, refugees of war and natural disasters, felons, prison inmates, etc.

Emotional Well-Being - Mental health and mental well-being are fundamental to the quality of life and productivity of individuals, families, communities and nations, enabling people to experience life as meaningful and to be creative and active citizens.

Empowerment - For the purpose of this report, the definition of empowerment is when one feels that he/she is or is about to become more in control of their destinies.
Epidemiological Transition: is a phase of development witnessed by a sudden and stark increase in population growth rates brought about by medical innovation in disease or sickness therapy and treatment.

Evaluation- Evaluation of performance by assigning a grade or score.

Focus Group- A small group selected from a wider population and sampled, as by open discussion, for its members' opinions about or emotional response to a particular subject or area.

Health Outcome- A measurable change in the health of an individual, or group of people or population, which is attributable to interventions or services.

Health-related quality of life" (HRQL) - An individual's satisfaction or happiness with domains of life as they affect or are affected by "health"

Hidden Populations- Groups of people like undocumented immigrants “living under the radar;” and people who do not speak English well or even at all. Each of these and more are populations that are “hidden” by mainstream research.

Interventions- The act of intervening in a situation so as to alter or hinder an action or development.

Key Informant Interviews- Conducted with key individuals within the community, schools, etc. Key Informant Interviews provide project staff with detailed, qualitative information about impressions, experiences and opinions. Conducted in person or by telephone.

Mental Health- A state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.

Mental Health First Aid- Mental Health First Aid is a groundbreaking public education program that helps the public identify, understand, and respond to signs of mental illnesses and substance use disorders. Mental Health First Aid USA is managed, operated, and disseminated by three national authorities

Mental Health Problem- A disruption in the interaction between the individual, the group and the environment, producing a diminished state of mental health.
Mental Illness - A clinically diagnosable disorder that significantly interferes with an individual’s cognitive, emotional or social abilities.

Node - An Nvivo qualitative software term. Themes are based on individual or group responses to open ended questions.


Psycho-Social Rehabilitation - The process of restoration of community functioning and well-being of an individual who has a psychiatric disability.

Preponderance - Superiority in numbers or amount; Superiority in weight, force, importance, or influence

Proactive - defined as taking action; such as seeking treatment before serious problems develop.

Probative - Serving to test or designed for testing

Promotores - Lay Hispanic/Latino community members who receive specialized training to provide basic health education in the community.

Protest - The act of objecting or a gesture of disapproval <resigned in protest>; especially: a usually organized public demonstration of disapproval; a complaint, objection, or display of unwillingness usually to an idea or a course of action

Public Stigma - Stereotype Negative belief about a group (e.g., dangerousness, incompetence, character weakness), prejudice agreement with belief and/or negative emotional reaction (e.g., anger, fear), discrimination behavior response to prejudice (e.g., avoidance, withhold employment and housing opportunities, withhold help)

QSR NVivo Software - Analytical software that allows you to collect, organize, and analyze content from interviews, focus group discussions, surveys, audio and social media.

Qualitative Data - Data that can be arranged into categories that are not numerical. These categories can be physical traits, gender, colors or anything that does not have a number associated to it.
Sample- a subset of a population

Self-stigma- Stereotype Negative belief about the self (e.g., character weakness, incompetence); Prejudice Agreement with belief, negative emotional reaction (e.g., low self-esteem, low self-efficacy), Discrimination Behavior response to prejudice (e.g., fails to pursue work and housing opportunities).

Situational Analysis- Refers to a collection of methods that are used to analyze an organization's internal and external environment to understand the organization's capabilities, customers, and business environment.

Social Inclusion- With regard to relationships and human behavior, social inclusion means accepting someone into interpersonal interactions and social networks.

Standard CDC HRQOL-4- Center for Disease Control’s Health Related Quality of Life standard assessment tool used in surveys, surveillance systems, prevention research, and population health report cards to calculate a summary index of unhealthy days.

Themes- A subject or topic of discourse or of artistic representation; a specific and distinctive quality, characteristic, or concern.
Compendium of Stigma Reduction
Practices, Initiatives, Campaigns and Programs

Prepared by BAI
and
the National Latino Behavioral Health Association

February 28, 2013
### Category or Approach: Advocacy

<table>
<thead>
<tr>
<th>Name of Program</th>
<th>The Bazelon Center For Mental Health Law</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Organization</td>
<td>The Bazelon Center For Mental Health Law</td>
</tr>
<tr>
<td>Contact Information/Person/Developer</td>
<td>General Inquiries and Website: <a href="mailto:communications@bazelon.org">communications@bazelon.org</a></td>
</tr>
<tr>
<td>Links</td>
<td><a href="http://www.bazelon.org">http://www.bazelon.org</a> Links on Facebook, and Twitter</td>
</tr>
<tr>
<td>Description of Program</td>
<td>The Bazelon Center for Mental Health Law is devoted to legal advocacy for adults and children with mental illness. The Attorneys at the Center work on issues and cases to guarantee rights, consumer choice, access to services, and autonomy to people with mental illness in Federal legislation and regulation, policy analysis and research and technical assistance.</td>
</tr>
<tr>
<td>Target Population/Audience</td>
<td>Congress, Court, State and Local Advocates</td>
</tr>
<tr>
<td>Goals</td>
<td>An America where people who have mental illnesses or developmental disabilities exercise their own life choices and have access to the resources which allows them to participate fully in their communities.</td>
</tr>
<tr>
<td>Costs Involved</td>
<td>N/A Accepts donations</td>
</tr>
<tr>
<td>Cultural Appropriateness</td>
<td>The Center works to eliminate stigma in the areas of housing and employment, areas where discrimination occurs.</td>
</tr>
<tr>
<td>Location (Local, national, etc.)</td>
<td>National; Federal Level</td>
</tr>
</tbody>
</table>
### Category or Approach: Advocacy

<table>
<thead>
<tr>
<th>Name of Program</th>
<th>Chicago Consortium for Stigma Research</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Organization</td>
<td>Illinois Institute of Technology</td>
</tr>
<tr>
<td></td>
<td>College of Psychology</td>
</tr>
<tr>
<td>Contact Information</td>
<td>M. Ellen Mitchell, PhD; Dean</td>
</tr>
<tr>
<td></td>
<td>312-567-3500</td>
</tr>
<tr>
<td></td>
<td><a href="mailto:mitchelle@iit.edu">mitchelle@iit.edu</a></td>
</tr>
<tr>
<td>Links</td>
<td><a href="http://www.iit.edu/psych/people/profiles/ccsr.shtml">http://www.iit.edu/psych/people/profiles/ccsr.shtml</a></td>
</tr>
<tr>
<td>Description of Program</td>
<td>The Chicago Consortium for Stigma Research (CCSR) studies stigma especially the stigma of mental illness through its grounding in basic principles of field research. Experts in the fields of psychology, psychiatry, social work, survey research, law, sociology, human development and the humanities aim to bridge the goals of research on mental illness stigma. The stigma surrounding mental illness can compound problems experienced by sufferers, causing discrimination and limiting the opportunities of those in recovery.</td>
</tr>
<tr>
<td>Target Population/Audience</td>
<td>The Consortium is comprised of faculty from eight Chicago-area universities—experts in the fields of psychology, psychiatry, social work, survey research, law, sociology, human development and the humanities— with IIT College of Psychology Professor Patrick Corrigan as principle investigator.</td>
</tr>
<tr>
<td>Goals</td>
<td>Eliminate Stigma for individuals with mental illness. The CCSR aims to bridge the goals of research on mental illness stigma with the strength of theories and methods developed by social psychology, enhancing the external validity of these studies through its grounding in basic principles of field research.</td>
</tr>
<tr>
<td>Costs Involved</td>
<td>No information available</td>
</tr>
<tr>
<td>Cultural Appropriateness</td>
<td>No information available</td>
</tr>
<tr>
<td>--------------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>Location (Local, national, etc.)</td>
<td>National, Illinois</td>
</tr>
</tbody>
</table>

**Category or Approach:** Advocacy

<table>
<thead>
<tr>
<th>Name of Program</th>
<th>&quot;Taking Our Place&quot;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Organization</td>
<td>Community of Mental Health of Australia (CMHA)</td>
</tr>
</tbody>
</table>
| Contact Information/Person/Developer | Ground Floor Broughton Hall (Bldg 125)  
Corner Church and Glover Sts  
Lilyfield NSW 2040  
Ph: 02 9555 8388  
Fax: 02: 9810 8145  
email: info@mhcc.org.au |
| Description of Program | "Taking Our Place" White Paper details Australia's active mental health programs and their direction. Appropriate learning and training based on research evidence of what has been shown to be effective in improving the quality of life of consumers and careers is a major step towards improving community mental health in NSW. Training is conducted broadly across the state in response to identified need, particularly in rural and regional NSW. MHCC provides other educational opportunities and initiatives through: conferences; seminars; Mental Health Month themes such as talking about stigma, forums; workshops; the quarterly ‘View from the Peak’ newsletter; publications; submissions and sector information freely available to the community via this website. |
| Target Audience | Whole spectrum of individuals receiving mental health services in addition to the public |
| Goals | Recovery oriented services and culture change to counter stigma |
Category or Approach: Advancing

Name of Program | Silver Ribbon Campaign  
CAMPAIGN FOR THE BRAIN

Name of Organization  | NARSAD Artworks

Contact Information/Person/Developer  
Jean Liechty  
PO Box 941  
La Habra, California 90633  
1-800-607-2599  
714-529-5571

Links  
www.SilverRibbon.org  
http://www.narsadartworks.org/

Description of Program  
The Silver Ribbon Campaign for the Brain promotes public awareness of the need for emotional, social, governmental, and research support of these individuals. The Silver Ribbon Coalition represents the combined interests of all those who are affected by a brain disorder or disability. To date, the Coalition is represented by advocates for and individuals with a wide variety of brain disorders and disabilities.

Target Population/Audience  
General Public
### Goals

Increasing public awareness will decrease stigma and increase support to result in improved treatment and eventual cures for those affected.

### Costs Involved

Silver Ribbons can be purchased starting at $3.00 each at www.narsad.com

### Cultural Appropriateness

Covers all populations regardless of race, ethnic, religion, creed or religious beliefs

### Location (Local, national, etc.)

Local, State, National and International campaign

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**Category or Approach: Education**

<table>
<thead>
<tr>
<th>Name of Project</th>
<th>Resource Center to Promote Acceptance, Dignity and Social Inclusion associated with Mental Illness (The ADS Center)</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>National Anti-Stigma Campaign</td>
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<tr>
<td></td>
<td>Social Inclusion Campaign</td>
</tr>
<tr>
<td></td>
<td>Caring for Every Child’s Mental Health Campaign</td>
</tr>
<tr>
<td></td>
<td>Elimination of Barriers Initiatives</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of Organization</th>
<th>Substance Abuse and Mental Health Services Administration (SAMHSA)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Contact Information/Person/Developer</th>
<th>SAMHSA Pub No. SMA-4176. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2006. 1-800-540-0320; <a href="mailto:promoteacceptance@samhsa.hhs.gov">promoteacceptance@samhsa.hhs.gov</a>; <a href="http://www.stopstigma.samhsa.gov">www.stopstigma.samhsa.gov</a> Phone: 800-789-2647 <a href="http://store.samhsa.gov/shin/content/SMA06-4176/SMA06-4176.pdf">http://store.samhsa.gov/shin/content/SMA06-4176/SMA06-4176.pdf</a></th>
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<tr>
<th>Links</th>
<th><a href="http://www.samhsa.gov">www.samhsa.gov</a></th>
</tr>
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<tbody>
<tr>
<td></td>
<td><a href="http://promoteacceptance.samhsa.gov/">http://promoteacceptance.samhsa.gov/</a></td>
</tr>
<tr>
<td></td>
<td><a href="mailto:nmhic-info@samhsa.hhs.gov">nmhic-info@samhsa.hhs.gov</a></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Description of Program</th>
<th>As a resource center ADS provides materials and Technical Assistance to individuals, states, and public &amp; private organizations in the design of programs. The center launched The Campaign for Social Inclusion in 2006 and provides Public Service Announcement (PSA) by way of a Campaign</th>
</tr>
</thead>
</table>
Website Brochure (PDF) in addition to encouragement of social media and grassroots communities.

National Anti Stigma Campaign: SAMHSA and the Ad Council developed an anti-stigma campaign known as the “What a difference a friend makes campaign.” Messages are targeted to men and women 18-24 years old and focused on friends as a key component of mental health recovery.

SAMHSA developed a step by step guide to development of a stigma reduction campaign. This 2006 document was the starting point for many of the existing programs in the United States. The document emphasizes the importance of completing a situational analysis as the first step to development of an approach to stigma reduction. The authors explain that a well done situational analysis will: provide key data to address the issue of stigma, identify potential program partners, stakeholders, and target audiences, identify opportunities to increase social inclusion, investigate similar efforts nationally and internationally, identify options for technical assistance in the various regions, establish message characteristics, communications strategies.

The Campaign for Social Inclusion, formerly the Campaign for Mental Health Recovery (CMHR), is a multiyear, national, public education campaign launched in December 2006 to educate the general public about social inclusion. People with mental health and substance use problems are more likely to fully recover and rebuild their lives when they have access not only to care and services, but also to social, economic, educational, recreational, and cultural opportunities that most citizens take for granted. A socially inclusive society promotes the necessary supports and opportunities for people in recovery to contribute to their communities as peers, parents, employees, residents, students, volunteers, teachers, and active citizens.

The Campaign uses proven social marketing strategies and public education methods to disseminate TV, radio, and print public service advertisements (PSAs) along with many supporting materials including a Campaign Web site, brochure [PDF format - 785 Kb], community site kit, and Web-based advertising. In 2010, the Campaign was expanded with the launch of four multicultural campaigns aimed at African-American, Hispanic/Latino, American Indian, and Chinese-American communities. The Campaign also encourages online social networking strategies as a way to reach a wider audience. The Campaign also has an extensive community-based grassroots network that includes State and local partners who are working to expand the reach of the Campaign.
| **Caring for Every Child’s Mental Health Campaign** | The SAMHSA National Mental Health Information Center campaign helps families, educators, health care providers, and young people recognize mental health problems and to seek or recommend appropriate services. It also strives to reduce the stigma associated with mental health problems. |

**Elimination of Barriers Initiative (EBI).** Based in eight pilot States, the EBI aimed to build awareness of and counter the discrimination and stigma associated with mental illnesses. The EBI laid much of the groundwork for SAMHSA’s National Anti Stigma Campaign (NASC). It also laid the groundwork for developing the contents of this Resource Kit called **Developing a Stigma Reduction Initiative.** This resource Kit is intended to raise awareness of mental health and help counter the stigma and discrimination faced by people with mental illnesses. You are invited to use it in the fight against stigma and discrimination. |

| **Target Population/Audience** | Consumers, Older Adults, Family Members, State and Local Entities and the General Public |

| **Goals** | Educate the Public about Social Inclusion which works to improve the lives of individuals who have a mental health diagnosis and to raise awareness of mental health and help counter the stigma and discrimination faced by people with mental illnesses. |

| **Costs Involved** | No Cost; publications are available on the SAMHSA bookstore. |

| **Cultural Appropriateness** | The Campaign for Social Inclusion launched four multi-cultural campaigns to include African-American, Hispanic/Latino, American Indian, and Chinese-American communities. The Developing a Stigma Reduction Initiative toolkit has extensive information on multi-cultural approaches to stigma activities and outreach to diverse communities. |

| **Location (Local, national, etc.)** | National |
**Category or Approach:**  **Education**

<table>
<thead>
<tr>
<th>Name of Program</th>
<th>Center for Psychiatric Rehabilitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Organization</td>
<td>Sargent College of Health and Rehabilitation Boston University</td>
</tr>
<tr>
<td>Contact Information/Person/Developer</td>
<td>Kim Mueser; Executive Director Email: <a href="mailto:psyrehab@bu.edu">psyrehab@bu.edu</a> Phone: (617) 353-3549 Fax: (617) 353-7700</td>
</tr>
<tr>
<td>Links</td>
<td>Located on Facebook <a href="http://cpr.bu.edu/">http://cpr.bu.edu/</a></td>
</tr>
</tbody>
</table>
**Description of Program**
dedicated to improving the lives of persons who have psychiatric disabilities. It publishes the Psychiatric Rehabilitation Journal and includes on its website information about the use of appropriate language to refer to individuals with psychiatric disabilities in addition to e-guides on anti-stigma practices. The Center uses the 4E Framework (exposure, experience, expertise and embedding).

<table>
<thead>
<tr>
<th><strong>Target Population/Audience</strong></th>
<th>General Public; Individuals with Mental Health Diagnoses and their Family Members; Providers and Front-Line Staff Members</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Goals</strong></td>
<td>To improve effectiveness of people, programs and service systems.</td>
</tr>
<tr>
<td><strong>Costs Involved</strong></td>
<td>Not indicated.</td>
</tr>
<tr>
<td><strong>Cultural Appropriateness</strong></td>
<td>The develop section of the website has services and resources for anyone looking to develop services supports and systems.</td>
</tr>
<tr>
<td><strong>Location (Local, national, etc.)</strong></td>
<td>National, International</td>
</tr>
</tbody>
</table>

**Category or Approach:** _Education_

<table>
<thead>
<tr>
<th><strong>Name of Program</strong></th>
<th>Mental Health First Aid (MHFA) USA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Name of Organization</strong></td>
<td>Managed, operated, and disseminated by three national authorities — the National Council for Community Behavioral Healthcare, the Maryland Department of Health and Mental Hygiene, and the Missouri Department of Mental Health.</td>
</tr>
</tbody>
</table>
| **Contact Information/Person/Developer** | Susan Partain  
202-684-7457 X232  
Australia Mental Health First Aid was created by Professor Anthony Jorm and Betty Kitchener |
**Description of Program**

MHFA is an interactive 12-hour course that helps the public identify, understand, and respond to signs of mental illness and substance use disorders. Provides information and an intensive training over a two day period for people to better understand mental illness and its effects on individuals. A practical training which can be used anywhere. Those who are trained in Mental Health First Aid have greater confidence in providing help to others, greater likelihood of advising people to seek professional help, improved concordance with health professionals about treatments, and decreased stigmatizing attitudes.

**Target Population/Audience**

General Public, Consumers and Family Members

**Goals**

To eliminate disparities and stigma about mental illness and substance use disorders.

**Costs Involved**

Trainers are required to do three free trainings to the public in exchange for the training.

**Cultural Appropriateness**

Licensed by Original Creator. Spanish translations pending.

**Location (Local, national, etc.)**

Local, National, International (originated in Australia)

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**Category or Approach:** **Education**

<table>
<thead>
<tr>
<th>Name of Program</th>
<th>Media campaigns and education</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Organization</td>
<td>Entertainment Industries Council, Inc.</td>
</tr>
<tr>
<td>Contact Information/Person/Developer</td>
<td>Larry Deutchman, EVP <a href="mailto:deutch@eiconline.org">deutch@eiconline.org</a></td>
</tr>
<tr>
<td>Links</td>
<td><a href="http://www.eiconline.org">www.eiconline.org</a></td>
</tr>
<tr>
<td>-----------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td><strong>Description of Program</strong></td>
<td>Collaboration between individuals in the entertainment industry and the medical field that is oriented towards those in the entertainment industry and offers information about mental illness and suggestions for ways to depict mental illnesses in order to help combat stigma. Development of media campaigns and educational materials.</td>
</tr>
<tr>
<td><strong>Target Population/Audience</strong></td>
<td>Greater Public</td>
</tr>
<tr>
<td><strong>Goals</strong></td>
<td>Recognition and reduction of stigma using multiple markets and media campaigns.</td>
</tr>
<tr>
<td><strong>Costs Involved</strong></td>
<td>Not indicated.</td>
</tr>
<tr>
<td><strong>Cultural Appropriateness</strong></td>
<td>Publications and media are formatted for local areas. There is cultural sensitivity in the materials keeping in mind specific cultures and their stigma towards mental illness.</td>
</tr>
<tr>
<td><strong>Location (Local, national, etc.)</strong></td>
<td>National and Local</td>
</tr>
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</table>

**Category or Approach:** Education

<table>
<thead>
<tr>
<th>Name of Program</th>
<th>Alternatives Conference</th>
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<tbody>
<tr>
<td>Name of Organization</td>
<td>National Empowerment Center</td>
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</tbody>
</table>
### Contact Information/Person/Developer

<table>
<thead>
<tr>
<th>Details</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>599 Canal Street</td>
<td>Lawrence, MA 01840</td>
</tr>
<tr>
<td>1-800power2u</td>
<td>1-800-769-3728</td>
</tr>
</tbody>
</table>

### Links

- [http://power2u.org/](http://power2u.org/) on Face book and Twitter

### Description of Program

This program provides educational resources online to educate and support. It is run by consumers of behavioral health issues. Every other year the NEC runs the Alternatives Conference which provides an opportunity for individuals with mental health issues and others to network and learn more about mental health and stigma in their community and others.

### Target Population/Audience

Individuals with mental health and those experiencing stigma.

### Goals

To carry a message of recovery, empowerment and of hope and healing to individuals with mental health issues.

### Costs Involved

Not indicated.

### Cultural Appropriateness

Provides some information in English, Spanish, Japanese, and Icelandic

### Location (Local, national, etc.)

National, International

---

**Category or Approach:** **Education**

<table>
<thead>
<tr>
<th>Name of Program</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fine Line</td>
<td></td>
</tr>
<tr>
<td>Fine Line</td>
<td></td>
</tr>
</tbody>
</table>
## Name of Organization

| Contact Information/Person/Developer | Michael Nye  
806 South Main Avenue  
San Antonio, Texas 78204  
studio p: 210-476-0497  
michaelnye@aol.com |

## Links

| Links | http://www.michaelnye.org/fineline/index.html |

## Description of Program

Fine Line is a documentary of voices, stories, and portraits that confront stereotypes and reveal the courage and fragility of those living with mental illnesses. The traveling multimedia exhibition, created by photographer Michael Nye, was completed in 2004 and had its debut opening at the Witte Museum in San Antonio, Texas. Fine Line asks each person viewing the exhibit to listen carefully, throw away their old definitions of mental illness, and start over. The exhibit addresses schizophrenia, depression, obsessive-compulsive disorder, anxiety, bipolar disorders, and many other illnesses while exploring topics such as family, confusion, pain, abuse, treatment, and healing. The exhibit has traveled to over 40 cities. Many sites have used this exhibit as the centerpiece for lectures, school field trips, panel discussions, educational material, fundraising, radio programs and other community activities.

## Target Population/Audience

| Target Population/Audience | Public at large, community members who visit the traveling exhibit. |

## Goals

| Goals | To promote greater understanding and insight into the lives of persons who have been affected by mental illness and to develop greater empathy and awareness to the plight and conditions surrounding mental illness. |

## Costs Involved

| Costs Involved | Promotional packet including video, DVD, digital photographs and reviews available upon request. For rental prices contact the program. |

## Cultural Appropriateness

| Cultural Appropriateness | Photographed subjects are from diverse backgrounds and racial groups. |

## Location (Local, national, etc.)

| Location (Local, national, etc.) | Statewide in Texas and 120 cities across the U.S. |

## Category or Approach: **Education**
<table>
<thead>
<tr>
<th>Name of Program</th>
<th>Telling Our Stories</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Organization</td>
<td>National Alliance of Multi-Ethnic Behavioral Health Associations</td>
</tr>
</tbody>
</table>
| Contact Information/Person/Developer | 3 Bethesda Metro Center  
Bethesda, MD 20814  
Office Phone: (301) 941-1834  
Fax: (301) 657-9776 |
| Links                | www.nambha.com                           |
| Description of Program | Telling our stories is an educational program designed to engage consumers from diverse communities to tell their story about mental illness, stigma, seeking help, recovery and hope. The stories are recorded on a DVD series which has multiple vignettes of real life persons telling their story. The total run time is about 5 minutes per vignette. The DVD can be used as part of a stigma reduction and education program. |
| Target Population/Audience | General population                       |
| Goals                | To educate communities about the experiences of diverse communities whose members have mental illness or other behavioral health conditions. To fight stigma, educate the public about mental illness, and to demonstrate how hope and recovery is possible. |
| Costs Involved       | No costs.                                 |
| Cultural Appropriateness | The content is specifically intended to address the cultural considerations of diverse communities experiencing mental illness. The DVD produced include African Americans, Asian Americans and one is being produced on Latinos and Native Americans. |
| Location (Local, national, etc.) | This can be shown in any location across the nation, in schools, community agencies, public events and faith communities. |
**Category or Approach:**  Education

<table>
<thead>
<tr>
<th>Name of Program</th>
<th>Project Relate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Organization</td>
<td>Collaboration of Nine Organizations in Nebraska</td>
</tr>
</tbody>
</table>
| Contact Information/Person/Developer | E-mail: info@projectrelate.org  
info@thekimfoundation.org |
[http://www.projectrelate.org/view_campaign.html](http://www.projectrelate.org/view_campaign.html) |
| Description of Program  | Project Relate, an anti-stigma advertising and public service campaign serving Nebraska, was launched on April 7, 2004. Developed through the cooperative efforts of Nebraska mental health service providers, advocacy groups, and nonprofit organizations, the campaign aims to increase awareness and improve public perceptions of people with mental illnesses. In addition to addressing stigma and providing mental health education, Project Relate operates a clearinghouse of mental health resources for the entire State. Uses print ads, television and radio ads, brochures and billboards. |
| Target Population/Audience | Public and community at-large. |
| Goals                   | To break down the stigma and stereotypes associated with mental illness and help the public relate to those who cope with these issues. |
| Costs Involved          | Not indicated. |
| Cultural Appropriateness | Radio in Spanish. |
| Location (Local, national, etc.) | Statewide across Nebraska. |
**Category or Approach:** Education

<table>
<thead>
<tr>
<th>Name of Program</th>
<th>Nothing To Hide: Mental Illness in the Family Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Organization</td>
<td>Family Diversity Projects</td>
</tr>
</tbody>
</table>
| Contact Information/Person/Developer | P.O. Box 1246  
Amherst, MA 01004  
Phone: 413-256-0502  
E-mail: info@familydiv.org |
| Links                           | http://familydiv.org/contact-us/                     |
| Description of Program          | Nothing To Hide: Mental Illness in the Family is a touring photo exhibit that was developed by the Family Diversity Project, a nonprofit educational organization based in Amherst, MA. The exhibit presents a collection of 20 museum-quality photographs and the text of interviews that tell poignant stories of courageous individuals and their families whose lives are affected by mental illness. The exhibit also is available in book form, featuring portraits and stories of 44 families who defy the stigma of mental illness by speaking candidly about their lives. |
| Target Population/Audience      | Public and community at large                       |
| Goals                           | By bringing visibility to these individuals and their families, Nothing to Hide helps dispel harmful stereotypes, myths, and misconceptions about mental illness. |
| Costs Involved                  | Not indicated, receives donations.                  |
| Cultural Appropriateness        | Exhibits done at universities, place of worship, schools, workplaces, corporations, mental health organizations. Photographic images of diverse communities. Has multiracial, LGBT, youth and persons with disabilities. |
| Location (Local, national,      | National                                             |
Category or Approach: **Education**

<table>
<thead>
<tr>
<th>Name of Program</th>
<th>&quot;You KNOW Me&quot; Alaska Anti-Stigma Campaign</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Organization</td>
<td>Alaska Mental Health Trust Authority</td>
</tr>
<tr>
<td>Contact Information/Person/Developer</td>
<td>Delisa Culpepper, Chief Operating Officer</td>
</tr>
<tr>
<td></td>
<td>3745 Community Park Loop, Suite 200</td>
</tr>
<tr>
<td></td>
<td>Anchorage, AK 99508</td>
</tr>
<tr>
<td></td>
<td>Phone: 907-269-7960</td>
</tr>
<tr>
<td></td>
<td>E-mail: <a href="mailto:delisa_culpepper@revenue.state.ak.us">delisa_culpepper@revenue.state.ak.us</a></td>
</tr>
<tr>
<td>Links</td>
<td><a href="http://www.mhtrust.org/index.cfm/Communications/Media-Campaigns">http://www.mhtrust.org/index.cfm/Communications/Media-Campaigns</a></td>
</tr>
<tr>
<td>Description of Program</td>
<td>The You KNOW Me Alaska anti-stigma campaign was developed in 2005 by the Alaska Mental Health Trust and Alaskan consumer advocacy boards. Two Television promotions included: You Know Me -- Winter 2009 - Mental Health Parity TV (4,450 KB) TV spot regarding mental health parity. You Know Me - Winter 2009 - Mental Health Parity (747 KB) The Trust and its partner board, the Alaska Mental Health Board, are raising awareness about new federal legislation that requires certain employer-provided health insurance with mental health benefits to begin providing matching coverage for mental health. This is a significant step toward reducing the stigma of mental illness and other disabilities while helping people get the treatment or services they need.</td>
</tr>
<tr>
<td>Target Population/Audience</td>
<td>Public and Community at large</td>
</tr>
<tr>
<td>Goals</td>
<td>It is aimed at reducing stigma and discrimination, promoting support for treatment and services, and increasing public awareness of the issues and challenges faced by individuals, families, and communities who experience mental illnesses and other disabilities.</td>
</tr>
<tr>
<td>Costs Involved</td>
<td>Not indicated.</td>
</tr>
</tbody>
</table>
### Cultural Appropriateness
Not indicated.

### Location (Local, national, etc.)
A statewide initiative in Alaska

## Category or Approach: **Education**

<table>
<thead>
<tr>
<th>Name of Program</th>
<th><strong>Minding the Gap: Improving Mental Health Access - Eliminating Stigma Initiative</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Organization</td>
<td>National Black Nurses Foundation</td>
</tr>
</tbody>
</table>
| Contact Information/Person/Developer | The 1Joshua Group, LLC  
1513 East Cleveland Avenue  
Bldg., 100-B, Suite 110  
Atlanta, GA 30344-6947  
V: 404.559.6191  
F: 404.559.6198  
info@nbnfoundation.us |
| Links | For more information, visit [www.nbnfoundation.us](http://www.nbnfoundation.us). |
| Description of Program | Minding the Gap is an initiative developed by the National Black Nurses Foundation to increase public awareness of and promote collaboration around behavioral health services and policies. The initiative promotes recovery and aims to reduce negative perceptions. It brings together communities, individuals, policy makers, and other mental health stakeholders to improve access to equitable behavioral health services for all people. |
| Target Population/Audience | The Minding the Gap: Improving Mental Health Access - Eliminating Stigma Initiative was developed as a result of the 2009 Mental Health Colloquium Series, sponsored by the National Black Nurses Foundation. Discrepancy in treatment is due in part to the stigma that surrounds mental illness. |
| Goals | To educate communities on the importance of care, while seeking to eliminate the public's hesitation to acknowledge mental illness. |
This national initiative is designed to increase awareness, enhance information, and improve education about success to mental health services and treatment.

<table>
<thead>
<tr>
<th>Costs Involved</th>
<th>Not indicated.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cultural Appropriateness</td>
<td>Focused on underserved populations.</td>
</tr>
<tr>
<td>Location (Local, national, etc.)</td>
<td>National</td>
</tr>
</tbody>
</table>

**Category or Approach: Education**

<table>
<thead>
<tr>
<th>Name of Program</th>
<th>One in Five: Overcoming the Stigma of Mental Illness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Organization</td>
<td>Saginaw County Community Mental Health Authority</td>
</tr>
<tr>
<td>Contact Information/Person/Developer</td>
<td>Mark Leffler</td>
</tr>
<tr>
<td></td>
<td>500 Hancock</td>
</tr>
<tr>
<td></td>
<td>Saginaw, MI 48602-4224</td>
</tr>
<tr>
<td></td>
<td>Phone: 1-800-258-8678</td>
</tr>
<tr>
<td></td>
<td>E-mail: <a href="mailto:mleffler@sccmha.org">mleffler@sccmha.org</a></td>
</tr>
<tr>
<td></td>
<td><a href="mailto:cservice@sccmha.org">cservice@sccmha.org</a></td>
</tr>
<tr>
<td>Links</td>
<td><a href="http://www.sccmha.org/contact-us.html">http://www.sccmha.org/contact-us.html</a></td>
</tr>
<tr>
<td>Description of Program</td>
<td>1 in 5: Overcoming the Stigma of Mental Illness is an educational anti-stigma activity which includes a documentary produced in 2006 by the Saginaw County Community Mental Health Authority in Michigan.</td>
</tr>
<tr>
<td>Target Population/Audience</td>
<td>The documentary, featuring mental health consumers, provides an opportunity for the general public.</td>
</tr>
<tr>
<td>Goals</td>
<td>To learn about the lives of these individuals and to learn about the misconceptions, myths, and stigma associated with mental illnesses.</td>
</tr>
<tr>
<td>Costs Involved</td>
<td>Not indicated.</td>
</tr>
<tr>
<td>Cultural Appropriateness</td>
<td>Not indicated.</td>
</tr>
<tr>
<td>Location (Local, national, etc.)</td>
<td>Local (Michigan)</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>-----------------</td>
</tr>
</tbody>
</table>

**Category or Approach:** **Education**

<table>
<thead>
<tr>
<th>Name of Program</th>
<th>Beyond the Label</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Name of Organization</th>
<th>Centre for Addiction and Mental Health</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Contact Information/Person/Developer</th>
<th>Website: <a href="http://www.camh.net">www.camh.net</a></th>
</tr>
</thead>
<tbody>
<tr>
<td>33 Russell Street</td>
<td></td>
</tr>
<tr>
<td>Toronto, ON M5S 2S1</td>
<td></td>
</tr>
<tr>
<td>Canada</td>
<td></td>
</tr>
<tr>
<td>Tel.: 1 800 661-1111 or 416 595-6059 in Toronto</td>
<td></td>
</tr>
<tr>
<td>E-mail: <a href="mailto:marketing@camh.net">marketing@camh.net</a></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Description of Program</th>
<th>Beyond the Label has been designed to: 1. help service providers ensure that their services are accessible and supportive to people with concurrent mental health and substance use problems by examining stigma and the barrier it presents. 2. provide mental health and addiction workers with concrete tools to use in their agencies and in the community, to raise awareness about the stigma associated with concurrent disorders. Beyond the Label is not an information resource on concurrent disorders. This educational kit focuses on the stigma associated with concurrent mental health and substance use problems, and includes activities that:  • emphasize the impact of attitudes and beliefs on people with concurrent mental health and substance use problems</th>
</tr>
</thead>
</table>

• emphasize the impact of attitudes and beliefs on people with concurrent mental health and substance use problems
<table>
<thead>
<tr>
<th><strong>Target Population/Audience</strong></th>
<th>People working in the fields of mental health and/or addiction treatment including practitioners, volunteers, managers, board members, and community agencies or coalitions.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Goals</strong></td>
<td>To Promote Awareness and Understanding of the Impact of Stigma on People Living with Concurrent Mental Health and Substance Use Problems</td>
</tr>
<tr>
<td><strong>Costs Involved</strong></td>
<td>Toolkits can be purchased from CAMH</td>
</tr>
<tr>
<td><strong>Cultural Appropriateness</strong></td>
<td>Suggests that information is used across cultural lines.</td>
</tr>
<tr>
<td><strong>Location</strong> (Local, national, etc.)</td>
<td>Nationally and internationally.</td>
</tr>
<tr>
<td>Category or Approach: <strong>Education</strong></td>
<td></td>
</tr>
<tr>
<td>----------------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>Name of Program</strong></td>
<td><strong>Open Minds, Open Doors</strong></td>
</tr>
<tr>
<td><strong>Name of Organization</strong></td>
<td>Wisconsin United for Mental Health (WUMH) statewide coalition</td>
</tr>
</tbody>
</table>
| **Contact Information/Person/Developer** | c/o Wisconsin Women’s Health Foundation  
2503 Todd Drive  
Madison, WI 53713  
800-448-5148  
Email: [info@wimentalhealth.org](mailto:info@wimentalhealth.org)  
Toll-free Phone Number: 866-WIUUNITED (948-6483) |
| **Links** | [http://www.wimentalhealth.org/about/contact.php](http://www.wimentalhealth.org/about/contact.php)  
<p>| <strong>Description of Program</strong> | Open Minds, Open Doors is the latest anti-stigma/anti-discrimination campaign of the Wisconsin United for Mental Health (WUMH) statewide coalition. Launched in May 2007, the campaign consists of a series of radio public service announcements (PSAs) that asks listeners to support the anti-stigma statements on the WUMH Web site. Listeners are asked to sign up in support of the belief that stigma and |</p>
<table>
<thead>
<tr>
<th>Target Population/Audience</th>
<th>Community and Public at large</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goals</td>
<td>Education and awareness about mental illnesses to reduce stigma and promote recovery.</td>
</tr>
<tr>
<td>Costs Involved</td>
<td>Not indicated</td>
</tr>
<tr>
<td>Cultural Appropriateness</td>
<td>Not indicated</td>
</tr>
<tr>
<td>Location (Local, national, etc.)</td>
<td>Wisconsin</td>
</tr>
</tbody>
</table>

**Category or Approach: Education**

<table>
<thead>
<tr>
<th>Name of Program</th>
<th>Northern Lakes Community Mental Health Stigma Busters</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NLCMH Movies on Recovery, Hope and Acceptance</td>
</tr>
<tr>
<td>Name of Organization</td>
<td>Northern Lakes Community Mental Health agency</td>
</tr>
</tbody>
</table>
| Contact Information/Person/ Developer | Cynthia Petersen  
105 Hall Street  
Traverse City, Michigan 49684  
Phone: 231-935-3099  
E-mail: cindy.petersen@nlcmh.org |
| Links | http://www.northernlakescmh.org/ |
| Description of Program | The Stigma Busters program of Northern Lakes Community Mental Health agency is a five-part project to counter the stigma associated with mental illnesses and normalize help-seeking behaviors and, unfortunately, many will not receive treatment because of stigma. |
To help change this and to make a difference in our local communities, people served by Northern Lakes CMH are sharing their personal experiences, challenges and recovery tools. **Look Closer: See Me For Who I Am** is just over 13 minutes long.

"Stigma Busters," called, **To See What I See: The Stigma of Mental Illness**. This 20-minute movie chronicles the creation of the first photobiographies at Northern Lakes.(Photobiographies are personal recovery stories created by people with experience with mental illness, illustrated with photography by the individuals.) In the movie, individuals share their experiences and opinions on prejudice, stereotypes, and discrimination associated with having a mental illness.

<table>
<thead>
<tr>
<th>Target Population/Audience</th>
<th>Public and Community at large</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goals</td>
<td>To eliminate the prejudice, stereotypes and discrimination associated with mental illness and share their message of hope: recovery is possible.</td>
</tr>
<tr>
<td>Costs Involved</td>
<td>CDs of movies can purchased on line. Funded by a Michigan Department of Community Health Federal block grant</td>
</tr>
<tr>
<td>Cultural Appropriateness</td>
<td>Not indicated.</td>
</tr>
<tr>
<td>Location (Local, national, etc.)</td>
<td>Michigan, National Distribution</td>
</tr>
</tbody>
</table>

**Category or Approach:** **Education**

<table>
<thead>
<tr>
<th>Name of Program</th>
<th>Real Warriors, Real Battles, Real Strength</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Organization</td>
<td>Department of Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE)</td>
</tr>
</tbody>
</table>
Link to Contact Us requires email inquiry and information request.  
DCoE Outreach Center  
For Psychological Health and Traumatic Brain Injury Information and Resources  
866-966-1020 |
| Links                      | http://www.realwarriors.net/search/node |
**Description of Program**
The Real Warriors Campaign is a multimedia public awareness campaign and initiative launched by the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE) designed to encourage help-seeking behavior among service members, veterans and military families coping with invisible wounds. The campaign is an integral part of the Defense Department's overall effort to encourage warriors and families to seek appropriate care and support for psychological health concerns. To reach the broadest audience possible, the campaign features a variety of strategies including outreach and partnerships, print materials, media outreach, an interactive website, mobile website and social media. Includes a Resource link to stigma reduction for military, active duty, reserves, National guard, veterans, families and health professionals.

**Target Population/Audience**
Returning service members; and other members of the military, active duty, reserves, National guard, veterans, families and health professionals.

**Goals**
To promote the processes of building resilience, facilitating recovery and supporting reintegration of returning service members, veterans and their families.

**Costs Involved**
Not indicated.

**Cultural Appropriateness**
Serves all returning service members.

**Location (Local, national, etc.)**
National.

**Category or Approach:** **Education.**

<table>
<thead>
<tr>
<th>Name of Program</th>
<th>Time to Change - &quot;Lets end mental health discrimination&quot; Campaign</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Organization</td>
<td>Time To Change</td>
</tr>
</tbody>
</table>
| Contact Information/Person/Developer | Email: [info@time-to-change.org.uk](mailto:info@time-to-change.org.uk)  
Tel: 020 8215 2356  
15-19 Broadway  
LONDON  
E15 4BQ |
Time to Change is England's biggest stigma education campaign. Talking about mental health can strengthen friendships, aid recovery, break down stereotypes and take the taboo out of something that affects us all. Sign our pledge wall and start your conversation today. Time to Change also provides resources on Open Up launch their Speak Out resource with handy tips on how to challenge stigma and discrimination, using examples from community based projects.

Target Population/Audience
Open to the public and community at large.

Goals
To challenge mental health stigma and discrimination.

Costs Involved
Not indicated.

Cultural Appropriateness
Diverse photographic images are used, but not other information indicated.

Location (Local, national, etc.)
National throughout England.

Category or Approach: **Education**

<table>
<thead>
<tr>
<th>Name of Program</th>
<th>No Kidding, Me too! Anti-Stigma Campaign</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Organization</td>
<td>No Kidding? Me 2!</td>
</tr>
<tr>
<td>Contact Information/Person/</td>
<td>Joe Pantoliano</td>
</tr>
<tr>
<td></td>
<td>Founder &amp; President</td>
</tr>
<tr>
<td></td>
<td>NKM2</td>
</tr>
<tr>
<td></td>
<td>210 West Hamilton Ave.</td>
</tr>
</tbody>
</table>
**Developer**
Suite 229  
State College, PA 16801

**Links**
http://www.nkm2.org/  
Facebook, Twitter ([Follow @nkmtoo](http://www.nkm2.org/)) and YouTube

**Description of Program**
This campaign Anti-stigma organization started by actor Joe Pantoliano uses a wide range of tools to help educate the community about stigma including: Vlogs, short films, Organize the creative talents of our industry professionals to generate messages for various media and use our celebrity status to ensure these messages are heard. The messages will be of empowerment and acceptance and can include topics as basic as giving job opportunities to those with a brain disease. Documentaries, PSAs, and Movie clips and trailers. Organize the creative talents of our industry professionals to generate messages for various media and use our celebrity status to ensure these messages are heard. The messages will be of empowerment and acceptance and can include topics as basic as giving job opportunities to those with a brain dis-ease.

No Kidding, Me Too! is a 501(c)(3) public charity, whose purpose is to remove the stigma attached to brain dis-ease (BD) through education and the breaking down of societal barriers.

**Target Population/Audience**
Create strategic partnerships with members of industry, academia, organizations and government to ensure a broad-based spectrum of support and input. Public and the community at large.

**Goals**
To educate souls everywhere to stomp the stigma out of mental illness. To empower those with Brain Dis-ease to admit their illness, seek treatment, and become even greater members of society.

**Costs Involved**
Not indicated.

**Cultural Appropriateness**
Videos and other materials included diverse demographic characteristics.

**Location (Local, national, etc.)**
Regional and National in scope.

**Category or Approach:** **Education**

<table>
<thead>
<tr>
<th><strong>Name of Program</strong></th>
<th><strong>Texans Working Together</strong> - A business initiative to eliminate barriers.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Name of Organization</strong></td>
<td>Texas Department of State Health Services</td>
</tr>
<tr>
<td><strong>Contact</strong></td>
<td></td>
</tr>
<tr>
<td>Information/Person/Developer</td>
<td><a href="http://www.texansworkingtogether.org/default.htm">http://www.texansworkingtogether.org/default.htm</a></td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-------------------------------------------------</td>
</tr>
<tr>
<td>Links</td>
<td><a href="http://www.texansworkingtogether.org/default.htm">http://www.texansworkingtogether.org/default.htm</a></td>
</tr>
<tr>
<td>Description of Program</td>
<td>The Texas Department of State Health Services (DSHS) is providing information via this website as a public service. Business executives and other Texas leaders have made three discoveries about mental illness that have changed their lives and changed how they run their businesses. Company executives share their stories with viewers. Focuses on mental health business friendly companies to illustrate how companies accommodate and address barriers for employees in their companies and policies &amp; practices to ensure that the workplace is eliminating challenges and stigma for their employees. The site has links to additional resources.</td>
</tr>
<tr>
<td>Target Population/Audience</td>
<td>Employers and worksites.</td>
</tr>
<tr>
<td>Goals</td>
<td>A Web site dedicated to the elimination of the stigma of mental illness in every Texas workplace.</td>
</tr>
<tr>
<td>Costs Involved</td>
<td>Not indicated.</td>
</tr>
<tr>
<td>Cultural Appropriateness</td>
<td>Not indicated.</td>
</tr>
<tr>
<td>Location (Local, national, etc.)</td>
<td>Statewide across Texas.</td>
</tr>
</tbody>
</table>

**Category or Approach:** **Education, Advocacy**

<table>
<thead>
<tr>
<th>Name of Program</th>
<th><strong>OpenMindsOpenDoors (OMOD)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Organization</td>
<td>Mental Health Association in Pennsylvania</td>
</tr>
</tbody>
</table>
**Contact Information/Person/Developer**

Phone: 717-346-0549  
E-mail: info@openmindsopendoors.com  
866-578-3659.

**Links**

http://www.openmindsopendoors.com/about.htm

**Description of Program**

OpenMindsOpenDoors (OMOD) is a Pennsylvania campaign focused on creating awareness and reducing stigma and discrimination for all Pennsylvanians. Each year the campaign focuses on a key audience; develops strategies, goals and materials for that audience. Work with each audience with crucial support from our local partners. Currently, the campaign is working with employers, providers, and legislators.

**Target Population/Audience**

Employers, providers and legislators.

**Goals**

Aimed at ending discrimination against people who have mental illnesses. This campaign is centered around five messages to educate the public about mental illnesses, and the legal rights of people living with a mental illness.

**Costs Involved**

Not indicated.

**Cultural Appropriateness**

Website photographic images of diverse communities, not information indicated.

**Location (Local, national, etc.)**

Statewide Pennsylvania

---

**Category or Approach:**  **Education, Advocacy**

<table>
<thead>
<tr>
<th>Name of Program</th>
<th>National Facing Us Campaign</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Name of Organization</td>
<td>Depression, Bipolar Support Alliance</td>
</tr>
<tr>
<td>----------------------</td>
<td>-------------------------------------</td>
</tr>
</tbody>
</table>
| **Contact Information/Person /Developer** | Board Chair: Lucinda Jewell  
730 N. Franklin Street, Suite 501  
Chicago, Ill 60654  
1-800-826-3632 |
| **Links** | [www.DBSAlliance.org](http://www.DBSAlliance.org)  
On Facebook and Youtube |
| **Description of Program** | DBSA provides hope, help, support and education so that the lives of people with mood disorders are improved. On the website are several links to developing wellness guides and tracker, journaling, and education about mental illness. National Facing Us Campaign and letters to Congress and the media to help eliminate stigma. |
| **Target Population/Audience** | General Public; Individuals with Mental Illness; Peers, Providers |
| **Goals** | Improve the lives for people with mood disorders, provide education to the public especially Providers about Recovery and the impact stigma has on recovery. |
| **Costs Involved** | Not available |
| **Cultural Appropriateness** | Materials and Web Pages in Spanish |
| **Location (Local, national, etc.)** | Local and National |

**Category or Approach:** Education, Advocacy

<p>| Name of Program | The Rosalynn Carter Fellowships in Mental Health Journalism |</p>
<table>
<thead>
<tr>
<th><strong>Name of Organization</strong></th>
<th>The Carter Center Mental Health Program</th>
</tr>
</thead>
</table>
| **Contact Information/Person/Developer** | Thomas Borneman, ED Director  
One Copenhill;  
453 Freedom Parkway; Atlanta, GA 30307  
404-420-5100  
1-800-550-3560  
carterweb@emory.edu |
On all Social Networking Sites |
| **Description of Program** | This program promotes awareness, initiates educational messages and symposia, and addresses public policy issues related to mental health on a State, National, and International Levels. The Rosalynn Carter Fellowships in Mental Health Journalism selects, supports, and mentors journalists as they complete projects related to mental health. Carter Center's Mental Health Program works to promote awareness about mental health issues, inform public policy, achieve equity for mental health care comparable to other health care, and reduce stigma and discrimination against those with mental illnesses. |
| **Target Population/Audience** | General Public and Individuals with Mental Health Issues and their family members |
| **Goals** | Educate the public that Mental Illnesses can be diagnosed and treated |
| **Costs Involved** | N/A |
| **Cultural Appropriateness** | The Carter Center has worked in many countries and with the International Committee of Women Leaders on Mental Health to end disparities in Mental Health Worldwide. |
| **Location (Local, national, etc.)** | National; International |

**Category or Approach:** Education, Advocacy
<table>
<thead>
<tr>
<th>Name of Program</th>
<th>Informes de Esperanza (Radio Public Health Updates)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Organization</td>
<td>De Sol a Sol</td>
</tr>
</tbody>
</table>
| Contact Information/Person/Developer | Gilberto Romero  
505-753-8906 |
| Description of Program | Over a Five day period this local radio program has daily 3 minute spots regarding various health issues; predominately dealing with Mental Health and Mental Illness. Resources are identified for the listener who will know where to find information, services and supports. The radio is broadcast through 810AM KSWV. |
| Target Population/Audience | Community, Media, General Public, Consumers and Family Members, Various Government Entity |
| Goals | Public Health Updates radio programs include lifestyle changes which are grounded in the principles of recovery and resiliency. |
| Costs Involved | Approximately $20K per year  
Project was discontinued in 2010  
Funding of Project was through State Agencies |
<p>| Cultural Appropriateness | Informes de Esperanza is conducted both in English and Spanish. |
| Location (Local, national, etc.) | Local – New Mexico |</p>
<table>
<thead>
<tr>
<th>Category or Approach: <strong>Education, Advocacy</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Name of Program</strong></td>
</tr>
<tr>
<td><strong>Name of Organization</strong></td>
</tr>
</tbody>
</table>
| **Contact Information/Person/Developer** | Phyliss Vine  
editor@miwatch.org  
168 Warburton Ave  
Hastings-Hudson, NY 10707 |
| **Links** | www.MIWatch.org  
Links to all Social Media Websites |
| **Description of Program** | It includes new items related to current issues in mental health and columns and will include a bulletin board for exchange of views from interested participants from the mental illness community. |
| **Target Population/Audience** | General Public, Advocates, Clinicians, Consumers and their family members |
| **Goals** | To improve treatment and knowledge about mental illness and its effects on individuals with a diagnosis.  
The stated goal of Mental Illness Watch is improvement in legal, medical, judicial, scientific, government, programmatic, political, and human rights for individuals living with mental illnesses. |
| **Costs Involved** | Relies on the Public providing donations |
| **Cultural Appropriateness** | There are some stories about how the Latino community copes as caretakers of individuals with mental illness. |
| **Location (Local, national, etc.)** | National |
Category or Approach: **Education, Advocacy**

<table>
<thead>
<tr>
<th>Name of Program</th>
<th>Daily Stigma Campaign</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Organization</td>
<td>MIND (Wales)</td>
</tr>
</tbody>
</table>
| Contact Information/Person/Developer | Call info line at 0300 123 3393  
15-19 Broadway, Stratford, London E15 4BQ   
T: 020 8519 2122, F: 020 8522 1725   
e: contact@mind.org.uk |
| Links                         | Mind.org.UK  
Links to Face book and Twitter  
Sign up for Mind’s campaigner bulletin so you can be involved in future campaigns  
Link to On-line blog at mind.org.UK |
| Description of Program        | MIND provides education, funding for programs, including training on anti-stigma. Training includes mental health awareness, working with personality disorders, understanding self-harm, how to deal with people at work are over worked and stressed. Provides printed materials for distribution. Has facilities located all over the UK.  
Daily Stigma campaign fights back against benefits stigma and an unfair and ineffective welfare system for people with mental health problems.  
Read the Daily Stigma online using the reader at the bottom of this page and watch our film about distributing the paper in London |
| Target Population/Audience    | Anyone experiencing a mental health problem. |
| Goals                         | To empower and support anyone experiencing a mental health problem. |
| Costs Involved                | N/A |
| Cultural Appropriateness      | Black, minority ethnic mental health and migrant mental health.  
Training programs include: Cultural perspectives on mental health (Many landscapes) and the Needs of Refugees and asylum seekers, The needs of; Diversity; and LGBT. |
| **Location (Local, national, etc.)** | Local and national (throughout Wales) |
### Category or Approach: Education, Advocacy

<table>
<thead>
<tr>
<th>Name of Program</th>
<th>Digital Stories</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Time to Change (Wales)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of Organization</th>
<th>MIND (England and Wales) (National Association for Mental Health)</th>
</tr>
</thead>
</table>

| Contact Information/Person/Developer | 3rd Floor  
|                                      | Quebec House  
|                                      | Castle bridge  
|                                      | Cow bridge Road East  
|                                      | Cardiff CF11 9AB |

| Links | http://timetochangewales.org.uk/home  
|       | On Face book and Twitter  
|       | Leadership@Timetochangewales.org.uk |

| Description of Program | Mind (National Association for Mental Health) provides information on a national level for England and Wales. Their activities promote the values of autonomy, equality, knowledge, and participation in the community for all people, especially those with mental illnesses. Digital stories are used to challenge stigma and breaking down barriers. Everyone has a story to tell that are a powerful way of challenging myths and stigma and ‘humanising’ mental health. Watching a film about it in their own voice, help us connect with them. Digital stories can show how people overcome their issues, prove that they can recover from mental health problems and help us to realise that we are not alone in our experiences. Making a digital story can be a cathartic process, helping people on their journey to recovery and also to develop self expression, confidence and self esteem. The people who feature in these digital stories had the opportunity to tell their story.  
|                       | Time to Change Wales - Website provides talking tips, stories, information on myths and facts to assist individuals in receiving help for their mental illness.  
|                       | Adult consumers, legislative bodies and the general public in Wales and England  
|                       | To end mental health discrimination thru education and stories by using |
powerful and inspirations films to move to a more positive perception of mental health and to help people on their journey to recovery and to develop self expression, confidence and self esteem. To improve the policy and attitudes of governing bodies in the United Kingdom, and has developed highly successful local-level initiatives for consumers of mental health.

<table>
<thead>
<tr>
<th>Costs Involved</th>
<th>Funded for three years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cultural Appropriateness</td>
<td>Web pages are written in Welsh and English</td>
</tr>
<tr>
<td>Location (Local, national, etc.)</td>
<td>Local and national (England and Wales)</td>
</tr>
</tbody>
</table>
## Category or Approach: Education, Advocacy

<table>
<thead>
<tr>
<th>Name of Program</th>
<th>News and Alerts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Organization</td>
<td>National Mental Health Consumers’ Self-Help Clearinghouse</td>
</tr>
<tr>
<td>Contact Information/Person/Developer</td>
<td>1211 Chestnut Street, Suite 1207 Philadelphia, PA 19107 1-800-553-4539 <a href="mailto:info@mhselfhelp.org">info@mhselfhelp.org</a></td>
</tr>
<tr>
<td>Links</td>
<td><a href="http://mhselfhelp.org/">http://mhselfhelp.org/</a></td>
</tr>
<tr>
<td>Description of Program</td>
<td>A consumer-run national technical assistance center serving the mental health consumer movement. The Clearinghouse helps connect and provide expertise to self-help and advocacy resources to self-help groups and other peer-run services for mental health consumers. Partners with Mental Health Association and University of Pennsylvania Collaborative on Community Integration and provides a directory of consumer driven services. The News and Alerts includes 40 major news articles on Stigma covering a forty year period. Other services include: training, technical assistance, and resources.</td>
</tr>
<tr>
<td>Target Population/Audience</td>
<td>Consumers of behavioral health services</td>
</tr>
<tr>
<td>Goals</td>
<td>To assist consumers achieve dignity, respect opportunity and empowerment</td>
</tr>
<tr>
<td>Costs Involved</td>
<td>Not available</td>
</tr>
<tr>
<td>Cultural Appropriateness</td>
<td>Encourages traditional providers to accept people with psychiatric disabilities as equals and partners in society and treatment</td>
</tr>
<tr>
<td>Location (Local, national, etc.)</td>
<td>National</td>
</tr>
</tbody>
</table>
**Category or Approach: Education, Advocacy**

| Name of Programs          | World Mental Health Day  
|                          | Breaking through Barriers |
| Name of Organization      | World Federation for Mental Health (WFMH) |
| Contact Information/Person/Developer | info@wfmh.com  
|                          | eberger@wfmh.com |
| Links                     | http://www.wfmh.org/  
|                          | On Face Book and Twitter |
| Description of Program    | The WFMH is an international, non-profit organization that works to advance, among all peoples and nations, the prevention of mental and emotional problems, proper treatment and care of those with such disorders, and promotion of mental health. The organization’s focus is on global mental health, and it sponsors World Mental Health Day each year.  
<p>|                          | One of the WFMH’s other initiatives is the Breaking Through Barriers education campaign about depression, with information provided in several languages. |
| Target Population/Audience| General Public |
| Goals                     | To increase public awareness about the importance of mental health. To gain understanding and improve attitudes about mental illness |
| Costs Involved            | N/A |
| Cultural Appropriateness  | World Mental Day 2013 to include older adults |</p>
<table>
<thead>
<tr>
<th>Location (Local, national, etc.)</th>
<th>National, International</th>
</tr>
</thead>
</table>

**Category or Approach:** **Education, Advocacy**

<table>
<thead>
<tr>
<th>Name of Program</th>
<th>Stigma Alarm Network (SANE)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Organization</td>
<td>SANE</td>
</tr>
</tbody>
</table>
| Contact Information/Person/Developer | First Floor Cityside House  
40 Adler Street  
London E1 1EE  
Info@sane.org.uk |
Links to Face Book, Twitter and You Tube |
| Description of Program | Provides practical help to improve the quality of life for people who are affected by mental illness by initiating research into causes and treatments of mental illness, education, and by providing emotional support and education. Works to address stigma. |
| Target Population/Audience | Geared towards United Kingdom population. |
| Goals | To raise Mental Health awareness, combat stigma and increase understanding. |
| Costs Involved | Accepts Donations |
| Cultural Appropriateness | Seeks to improve the quality of life for anyone affected by mental illness. |
| Location (Local, national, etc.) | Australia and International |
### Category or Approach:  **Education, Advocacy**

| Name of Programs       | Defeat Depression Campaign  
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>“Every Family in the Land: Understanding prejudice and discrimination against people with mental illness”</td>
</tr>
<tr>
<td>Name of Organization</td>
<td>Stigma.org</td>
</tr>
</tbody>
</table>
| Contact Information/Person/Developer | John Crook, Administrator  
|                        | 0845-638-2200  
|                        | Run by Stigma Trust |
| Links                  | www.stigma.org.uk  
|                        | On Face Book and Yahoo |
| Description of Program | This is an International organization that is dedicated to fighting stigma and preventing discrimination and exclusion of those who experience mental illnesses. Its efforts include the Defeat Depression Campaign and a published and on-line book, “Every Family in the Land: Understanding prejudice and discrimination against people with mental illness”. |
| Target Population/Audience | Adult Population |
| Goals                  | To provide a better understanding of stigma and its effects on individuals with mental illness |
| Costs Involved         | N/A |
| Cultural Appropriateness | Has Age-Related area on site |
| Location (Local, national, etc.) | National in UK only |
**Category or Approach:**  Education, Advocacy

<table>
<thead>
<tr>
<th>Name of Program</th>
<th>Open the Doors Programme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Organization</td>
<td>World Psychiatric Association (WPA)</td>
</tr>
<tr>
<td>Contact Information/Person/Developer</td>
<td><a href="mailto:wpasecretariat@wpanet.org">wpasecretariat@wpanet.org</a></td>
</tr>
<tr>
<td>Links</td>
<td><a href="http://www.wpanet.org/">http://www.wpanet.org/</a></td>
</tr>
<tr>
<td>Description of Program</td>
<td>The Open the Doors Programme provides a model for establishing anti-discrimination. A summary of the Programme and its results in many different countries is contained in a book by Sartorius and Schulze, “Reducing the stigma of mental illness”. This organization is concerned with the scientific and ethical advancement of psychiatry and mental health around the world. In 1996, the WPA began an International Programme to Fight the Stigma and Discrimination because of Schizophrenia. The Programme is intended to dispel the myths and misunderstandings surrounding schizophrenia and mental illnesses in general.</td>
</tr>
<tr>
<td>Target Population/Audience</td>
<td>General Public, Practitioners</td>
</tr>
<tr>
<td>Goals</td>
<td>To ensure scientific and ethical advancement of psychiatry and mental health around the world.</td>
</tr>
<tr>
<td>Costs Involved</td>
<td>N/A</td>
</tr>
<tr>
<td>Cultural Appropriateness</td>
<td>The Open the Doors Programme has been used in many countries.</td>
</tr>
<tr>
<td>Location (Local, national, International)</td>
<td>International</td>
</tr>
</tbody>
</table>
Category or Approach: **Education, Advocacy**

<table>
<thead>
<tr>
<th>Name of Program</th>
<th>Governor’s Council on Mental Health Stigma</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Organization</td>
<td>State of New Jersey</td>
</tr>
</tbody>
</table>
| Contact Information/Person/Developer | Executive Director  
NJ Governor’s Council on Mental Health Stigma  
Department of Human Services  
Division of Mental Health and Addiction Services  
50 East State Street; PO Box 727  
Trenton, NJ 08625 |
| Links | http://www.state.nj.us/mhstigmacouncil/index.shtml |
| Description of Program | The council was begun in 2004 to investigate NJ’s mental health system and develop solutions for individuals facing mental illness. The site offers information and news in addition to information about awards and happenings throughout the state. Community efforts are applauded by the Council and have their own place on the site. |
| Target Population/Audience | General Public; Consumers and Family Members; Advocates; Providers |
| Goals | To defeat mental health stigma and to create a better mental health system. |
| Costs Involved | Not indicated. |
| Cultural Appropriateness | The site offers a Culture Competence section within the Community heading |
| Location (Local, national, etc.) | Local; Statewide in New Jersey |
Category or Approach: **Education, Advocacy**

<table>
<thead>
<tr>
<th>Name of Program</th>
<th>White Papers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Organization</td>
<td>Mental Health Coordinating Council (MHCC)</td>
</tr>
<tr>
<td>Contact Information/Person/Developer</td>
<td>PO Box 668&lt;br&gt;Rozelle, NSW 2039&lt;br&gt;Email: <a href="mailto:info@mhcc.org.au">info@mhcc.org.au</a></td>
</tr>
<tr>
<td>Description of Program</td>
<td>MHCC is the main body for community mental health organizations in New South Wales. They advocate for policy development and legislative reform; build capacity through partnerships, collaboration, and workforce development; research and report on new developments; and provide training in recovery oriented practices.</td>
</tr>
<tr>
<td>Target Population/Audience</td>
<td>Whole spectrum of recipients of mental health services</td>
</tr>
<tr>
<td>Goals</td>
<td>Improved mental health care, recovery oriented, culture change to counter stigma</td>
</tr>
<tr>
<td>Costs Involved</td>
<td>N/A</td>
</tr>
<tr>
<td>Cultural Appropriateness</td>
<td>There are various materials on Cultural Competence on the site to include: transcultural mental health, workforce culture, and women</td>
</tr>
<tr>
<td>Location (Local, national, etc.)</td>
<td>National</td>
</tr>
</tbody>
</table>
**Category or Approach: Education, Advocacy**

<table>
<thead>
<tr>
<th>Name of Program</th>
<th>&quot;Unlocking the Mind&quot; TV Show - Anti-Stigma Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Organization</td>
<td>Community Network Services of Michigan (CNS)</td>
</tr>
</tbody>
</table>
| Contact Information/Person/Developer | Waterford, Michigan  
  Toll Free: 1-800-273-0258  
  Farmington Hills, Michigan  
  Toll Free: 1-800-615-0411 |
| Links                            | http://www.cnsmi.org/  
  http://www.cnsantistigmaprogram.org/  
  Links to Face book and Twitter |
| Description of Program           | Located in two places in Michigan this anti-stigma program is a part of the CNS who works with individuals, family, members and the general community to teach about mental health and stigma including Mental Health First Aid and advocacy work at the legislature-both state and federal, and a monthly TV show known as “Unlocking the mind”. |
| Target Population/Audience       | Community, State and National Legislature, rallies |
| Goals                            | To educate people about mental health and stigma |
| Costs Involved                   | Not indicated |
| Cultural Appropriateness         | Works to train the community about mental illness crossing cultural lines. |
| Location (Local, national, etc.) | Local in Michigan |
**Category or Approach:**  **Education, Advocacy**

<table>
<thead>
<tr>
<th>Name of Program</th>
<th>Disability Rights of New Mexico (DRRNM)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Organization</td>
<td>Disability Rights of New Mexico (DRRNM)</td>
</tr>
<tr>
<td>Contact Information/Person/Developer</td>
<td><a href="mailto:Info@drnm.org">Info@drnm.org</a></td>
</tr>
<tr>
<td>Links</td>
<td><a href="http://www.drnm.org">www.drnm.org</a></td>
</tr>
<tr>
<td></td>
<td>Links to Face book</td>
</tr>
<tr>
<td>Description of Program</td>
<td>DRNM strives to promote and support legal rights of individuals with disabilities by education to the community and legislature. In addition, they advocate on behalf of individuals who are disabled in the event their rights have been violated.</td>
</tr>
<tr>
<td>Target Population/Audience</td>
<td>People who are disabled, legislature, public, government agencies</td>
</tr>
<tr>
<td>Goals</td>
<td>To strive to enforce existing laws supporting disability rights</td>
</tr>
<tr>
<td>Costs Involved</td>
<td>N/A</td>
</tr>
<tr>
<td>Cultural Appropriateness</td>
<td>Services geared toward the culture of disabled persons</td>
</tr>
<tr>
<td>Location (Local, national, etc.)</td>
<td>Statewide in New Mexico</td>
</tr>
</tbody>
</table>
Category or Approach: **Education, Advocacy**

<table>
<thead>
<tr>
<th>Name of Program</th>
<th>2008 Campaign for Mental Health Recovery: Mad Cool Advocacy Course Recovery University</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Organization</td>
<td>Advocacy Unlimited, Inc.</td>
</tr>
</tbody>
</table>
| Contact Information/Person/Developer | 300 Russell Rd. Wethersfield, CT 06109  
Local: (860) 667-0460  
Toll free in CT: 1-800-573-6929  
Fax: (860) 667-2240 |
<p>| Links | <a href="http://www.mindlink.org/about_who.html">http://www.mindlink.org/about_who.html</a> |
| Description of Program | This project was developed by Advocacy Unlimited, Incorporated. It was funded through the 2008 Campaign for Mental Health Recovery state implementation awards. An interactive board game was developed called Mad Cool. The purpose is to educate its players about recovery and mental illness. The young adults on the design team were involved with all aspects of the project from development of the concept through field testing at 10 locations. Test sites included mental health centers, peer-run organizations and homeless shelters. The project used pre- and post- game evaluations to assess the increase in knowledge provided by the game. Mad Cool’s young adult design team has expressed a great deal of satisfaction with their experience. Advocacy Unlimited is operated and controlled by persons in recovery from mental health or co-occurring disorders. Two programs are: Advocacy Course and Recovery University, both on-line training programs. |
| Target Population/Audience | Provide education and advocacy for the community and for consumers. |
| Goals | To achieve total integration for these individuals into the community. To accomplish this goal, AU educates consumer leaders in recovery and advocacy skills that will empower them to play a central role in shaping the policies and services that affect their lives. The vision is to educate enough people to build a “strong, vocal, and united” grassroots movement in Connecticut. |
| Costs Involved | Not indicated. |
| Cultural Appropriateness | No information stated. |</p>
<table>
<thead>
<tr>
<th>Location (Local, national, etc.)</th>
<th>State of Connecticut</th>
</tr>
</thead>
</table>

## Category or Approach: Education, Advocacy

<table>
<thead>
<tr>
<th>Name of Program</th>
<th>California Wellness and Dignity Collaborative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Organization</td>
<td>California Wellness and Dignity Collaborative</td>
</tr>
<tr>
<td>Contact Information/Person/Developer</td>
<td>Established by charter with six collaborative partner organizations.</td>
</tr>
<tr>
<td>Links</td>
<td>None available</td>
</tr>
<tr>
<td>Description of Program</td>
<td>The California Wellness and Dignity Collaborative is a non-exclusive working group of consumer-run and consumer advocacy organizations with significant experience in programs and policy related to reduction of stigma and discrimination which has committed to coordinating efforts, sharing resources and enlarging opportunities jointly.</td>
</tr>
<tr>
<td>Target Population/Audience</td>
<td>Consumer-run and consumer advocacy organizations</td>
</tr>
<tr>
<td>Goals</td>
<td>To accomplish the best possible impacts for promoting dignity, hope, self-determination and justice for all those affected by mental health stigma in California. <a href="#">Click here</a> to view the charter for the collaborative.</td>
</tr>
<tr>
<td>Costs Involved</td>
<td>Not indicated.</td>
</tr>
<tr>
<td>Cultural Appropriateness</td>
<td>Collaborative partners are culturally and ethnically diverse.</td>
</tr>
<tr>
<td>Location (Local, national, etc.)</td>
<td>State of California</td>
</tr>
</tbody>
</table>
Category or Approach: **Education, Advocacy**

<table>
<thead>
<tr>
<th>Name of Program</th>
<th>National Day Without Stigma</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Organization</td>
<td><strong>Active Minds On Campus</strong></td>
</tr>
<tr>
<td>Contact Information/Person/Developer</td>
<td>2001 S Street, NW Suite 450</td>
</tr>
<tr>
<td></td>
<td>Washington, DC 20009</td>
</tr>
<tr>
<td></td>
<td>(202) 332-9595</td>
</tr>
<tr>
<td>Links</td>
<td><a href="http://www.activeminds.org/our-programming/awareness-campaigns">http://www.activeminds.org/our-programming/awareness-campaigns</a></td>
</tr>
<tr>
<td></td>
<td>Facebook, Twitter</td>
</tr>
<tr>
<td>Description of Program</td>
<td>Active Minds is a student-run program that addresses the stigma surrounding mental illness among college students. Active Minds empowers students to change the perception about mental health on college campuses. Started in 2001 at the University of Pennsylvania. The objective of National Day Without Stigma is to eliminate the shame and discrimination surrounding mental health disorders by creating communities of understanding, support, and help-seeking. Community and Chapter Action Kits are available for taking action in your community.</td>
</tr>
<tr>
<td>Target Population/Audience</td>
<td>College campuses.</td>
</tr>
<tr>
<td>Goals</td>
<td>Active Minds has worked to expose and reduce stigma associated with mental illness within college environments.</td>
</tr>
<tr>
<td>Costs Involved</td>
<td>Not indicated. Accepts donations.</td>
</tr>
<tr>
<td>Cultural Appropriateness</td>
<td>Visual materials reflect diversity communities; Veterans are addressed</td>
</tr>
<tr>
<td>Location (Local, national, etc.)</td>
<td>Campuses nationally.</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>Category or Approach: <strong>Education, Advocacy</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Name of Program</strong></td>
<td>Friendship Counts and Open Minds Open Doors</td>
</tr>
<tr>
<td><strong>Name of Organization</strong></td>
<td>Tarrant County and Community Solutions</td>
</tr>
<tr>
<td><strong>Contact Information/Person/Developer</strong></td>
<td>No physical address provided. Submit a contact us to reach the program. Ft. Worth Texas</td>
</tr>
</tbody>
</table>
| **Links** | [www.friendshipscount.com](http://www.friendshipscount.com)  
Watch the video: [www.youtube.com/friendshipscount2](http://www.youtube.com/friendshipscount2)  
Local resources, check out links offered by the Mental Heath Connection of Tarrant County: [www.mentalhealthconnection.org/local_resources.php](http://www.mentalhealthconnection.org/local_resources.php) |
<p>| <strong>Description of Program</strong> | Friendship Counts is an anti-stigma campaign launched in late 2008 by the Mental Health Connection of Tarrant County and Community Solutions of Fort Worth. The campaign aims to communicate with 6th through 12th graders, through the use of a campaign Web site (<a href="http://www.friendshipscount.com">www.friendshipscount.com</a>), YouTube video &quot;Dear Friend of Mine,&quot; posters, and bookmarks. The Friendship Counts campaign focuses on attention-deficit hyperactivity disorder (ADHD), bipolar disorder, anxiety disorder, and depression because each is different from the others in symptoms and treatments. Youth were involved in the development of this campaign and adolescents with and without the specific disorders reviewed the messages on the posters and bookmarks, giving invaluable feedback as the campaign developed. The YouTube video was written by a high school senior who has a sister with a mood disorder. She is the female singer on the video. The young man who sings with her has a sister with bipolar disorder. All of the models are local high school students who volunteered their time and images. The Friendships Counts campaign builds on a previous campaign—Open Minds Open Doors—which kicked off in 2005. |</p>
<table>
<thead>
<tr>
<th><strong>Target Population/Audience</strong></th>
<th>Adolescents 6th to 12th grade.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Goals</strong></td>
<td>To improve the mental health delivery system in Tarrant County. Community Solutions and to help families and children find the best mental health care and reduce stigma.</td>
</tr>
<tr>
<td><strong>Costs Involved</strong></td>
<td>No costs indicated.</td>
</tr>
<tr>
<td><strong>Cultural Appropriateness</strong></td>
<td>Students from all backgrounds who are affected by mental health issues are included.</td>
</tr>
<tr>
<td><strong>Location (Local, national, etc.)</strong></td>
<td>Tarrant County, Texas</td>
</tr>
</tbody>
</table>
**Category or Approach:** **Education, Advocacy**

<table>
<thead>
<tr>
<th>Name of Program</th>
<th>Helping Veterans Overcome Mental Health Stigma</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Organization</td>
<td>U.S. Department of Veterans Affairs</td>
</tr>
<tr>
<td>Contact Information/Person/Developer</td>
<td>Reingold, Communications and Marketing 433 E Monroe Avenue Alexandria, VA 22301 202.333.0400</td>
</tr>
<tr>
<td>Links</td>
<td><a href="http://www.reingold.com">www.reingold.com</a></td>
</tr>
</tbody>
</table>
| Description of Program    | Reingold is creating a strategic, integrated communications campaign to help Veterans and their families and. The project aims to help Veterans overcome the stigma associated with getting mental health treatment. Veterans who fear and avoid the stigmatizing labels they associate with people who have mental health challenges are a key audience for the campaign. Because of this label avoidance, these Veterans do not seek help—and may not even recognize that they have mental health issues that could be treated.

Stigma research and best practices in reducing stigma is fundamental to the campaign’s messaging framework. The campaign aims to create awareness among Veterans and their families that a more fulfilling life is possible. To encourage Veterans to seek the support and mental health services they need, the campaign will leverage a contact approach, involving personal interactions with and exposure to persons who have dealt with mental health challenges.

As much as possible, campaign elements will be targeted, local, credible, and continuous—and rely on trusted intermediaries and key influencers to deliver carefully tailored messages to Veterans and their families. |
<p>| Target Population/Audience | Veterans, their families and friends. |
| Goals                      | To overcome the stigma associated with seeking mental health services, and to increase the number of Veterans who obtain support |</p>
<table>
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<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td><strong>Costs Involved</strong></td>
<td>Not costs indicated.</td>
</tr>
<tr>
<td><strong>Cultural Appropriateness</strong></td>
<td>Veterans of all backgrounds.</td>
</tr>
<tr>
<td><strong>Location (Local, national, etc.)</strong></td>
<td>National</td>
</tr>
</tbody>
</table>
Category or Approach: **Education, Advocacy**

<table>
<thead>
<tr>
<th><strong>Name of Program</strong></th>
<th>&quot;It Takes a Friend&quot; Campaign</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Name of Organization</strong></td>
<td>NAMI Missouri</td>
</tr>
<tr>
<td><strong>Contact Information/Person/Developer</strong></td>
<td>Mr. Tim Harlan, President (800) 374-2138 Jefferson, Missouri</td>
</tr>
<tr>
<td><strong>Links</strong></td>
<td><a href="http://www.nami.org/sites/MO">www.nami.org/sites/MO</a> <a href="mailto:namimosb@yahoo.com">namimosb@yahoo.com</a></td>
</tr>
<tr>
<td><strong>Description of Program</strong></td>
<td>This project was developed by NAMI Missouri through funding by the 2007 Campaign for Mental Health Recovery state implementation awards. The campaign intends to train and support a minimum of 22 young adult mental health consumers to deliver presentations aimed at educating communities throughout the State on mental illness and the effects of social exclusion. The mental health consumers involved with the campaign will also participate in panel presentations at large conferences in the state, as well as &quot;In Our Own Voice&quot; presentations through NAMI. Individuals also will participate in media trainings in preparation for their participation in the developed media campaign.</td>
</tr>
<tr>
<td><strong>Target Population/Audience</strong></td>
<td>Public at large</td>
</tr>
<tr>
<td><strong>Goals</strong></td>
<td>To educate communities on mental illness and the effects of social exclusion including stigma.</td>
</tr>
<tr>
<td><strong>Costs Involved</strong></td>
<td>No costs indicated.</td>
</tr>
<tr>
<td><strong>Cultural Appropriateness</strong></td>
<td>Open to participants of all diverse backgrounds.</td>
</tr>
<tr>
<td><strong>Location (Local, national, Statewide)</strong></td>
<td>Statewide through Missouri</td>
</tr>
</tbody>
</table>
**Category or Approach:**  Education, Advocacy

<table>
<thead>
<tr>
<th>Name of Program</th>
<th>The Dignity and Recovery Center</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Organization</td>
<td>Mental Health Association of San Francisco (MHASF)</td>
</tr>
</tbody>
</table>
| Contact Information/Person/Developer | Eduardo Vega, Director and Center Principal Investigator  
And Dr. Patrick Corrigan, Director and Co-Principal Investigator, the National Consortium on Stigma and Empowerment, and Dr. Larry Yang, Columbia University Mailman School of Public Health |
| Links                            | thecenter@mentalhealthsf.org  
www. |
| Description of Program           | The Center for Dignity, Recovery and Stigma Elimination (The Dignity and Recovery Center) works to advance the effectiveness of community driven stigma change programs as informed by the world's foremost researchers, and to understand how California's diverse communities address stigma and discrimination using the Technical Assistance, Research and Training Center model.  
The mission of the Dignity and Recovery Center is to advance human dignity and wellness on a sustained basis by changing behavior and bias associated with mental health conditions through development, evaluation, and dissemination of best practices in stigma reduction that are effective in the context of diverse communities, and to advance the field of stigma change research and practice for sustained global benefit.  
The Dignity and Recovery Center is the first consumer-run Technical Assistance, Research, and Training Center focused on knowledge transfer in the area of stigma change practice.  
The CalMHSA "Resource Development" program, identifies stigma reduction programs, and provides research and evaluation of the most effective strategies for reducing stigma. This project partners community leaders in stigma reduction across California with the National Consortium on Stigma and Empowerment, led by Director, Dr. |
<table>
<thead>
<tr>
<th><strong>Target Population/Audience</strong></th>
<th>Statewide stakeholder advocacy organizations and prominent consumer-run community programs (Program Partners)</th>
</tr>
</thead>
</table>
| **Goals**                     | - Develop culturally relevant tools for fighting stigma within California's diverse communities  
- Inform dialogue on how community-based programs address stigma around mental health conditions  
- Promote statewide initiatives that support community-led practices  
- Empower communities through input and action  
- Increase visibility and exposure of community-based programs  
- Share expertise with similar programs statewide |
| **Costs Involved**             | The California Mental Health Services Authority (CalMHSA) provides funding through Proposition 63 for the Center's two principle statewide projects: Resource Development and Promising Practices. |
| **Cultural Appropriateness**  | The CalMHSA "Promising Practices" engages directly with California communities to identify culturally specific attitudes towards mental health; examine cultural strengths and resources; and support approaches that reduce stigma within culturally, ethnically and racially diverse communities. Dr. Larry Yang, of Columbia University's Mailman School of Public Health, leads this research. With a focus on rapid knowledge transfer, the Center's professional teams work together to build a knowledge base for evidence-based community-driven stigma change. The teams integrate cutting edge instruments for evaluation, strategies, and resources that community organizations can utilize to strengthen their programs. |
| **Location (Local, national, etc.)** | Regionally across California |
## Category or Approach: **Education, Contact**

<table>
<thead>
<tr>
<th>Name of Program</th>
<th>Dare to Dream</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Organization</td>
<td>Provincial Centre of Excellence for Child and Youth Mental Health at CHEO (the Centre)</td>
</tr>
<tr>
<td>Contact Information/Person/Developer</td>
<td>Jane Tallim 695 Industrial Ave, Ottawa, Ontario, K1G 0Z1 Tel.: 613-737-2297 Fax: 613-738-4894 Email: <a href="mailto:D2D@cheo.on.ca">D2D@cheo.on.ca</a> Phone: 613-737-7600, ext. 3324</td>
</tr>
<tr>
<td>Links</td>
<td><a href="http://www.daretodreamprogram.ca/">http://www.daretodreamprogram.ca/</a> Facebook, Twitter and YouTube links</td>
</tr>
<tr>
<td>Description of Program</td>
<td>Dare to Dream is an initiative started in Canada in 2005 by the Provincial Centre of Excellence for Child and Youth Mental Health at CHEO (the Centre). This program helps Ontario youth (18 years of age and under) become more aware of mental health. Dare to Dream is a unique youth-led funding program that helps young people create and implement project ideas that promote mental health and well-being. Promotes youth engagement, crafting written proposals for $5,000 and teaming up with an adult mentor from a youth organization.</td>
</tr>
<tr>
<td>Target Population/Audience</td>
<td>Primarily youths and adolescents, who work with adult mentors.</td>
</tr>
<tr>
<td>Goals</td>
<td>Increase awareness of mental health issues in school or community.</td>
</tr>
<tr>
<td>Costs Involved</td>
<td>Not indicated.</td>
</tr>
<tr>
<td>Cultural Appropriateness</td>
<td>Not indicated.</td>
</tr>
<tr>
<td>--------------------------</td>
<td>----------------</td>
</tr>
<tr>
<td>Location (Local, national, etc.)</td>
<td>Ontario, Canada</td>
</tr>
</tbody>
</table>

**Category or Approach:** **Education, Contact**

<table>
<thead>
<tr>
<th>Name of Program</th>
<th>Natural Helpers Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Organization</td>
<td>Pojoaque Valley School</td>
</tr>
<tr>
<td>Contact Information/Person/Developer</td>
<td>1574 State Road 502 West Pojoaque, New Mexico 87506 (P) 505-455-2282</td>
</tr>
<tr>
<td>Links</td>
<td><a href="http://pvs.k12.nm.us/">http://pvs.k12.nm.us/</a></td>
</tr>
<tr>
<td>Description of Program</td>
<td>Natural Helpers Program is a youth guided and youth driven peer support program for high school age students to help provide support, outreach and education about emotional and physical stressors that contribute to teen suicide attempts and completions. This program opens the dialogue among students and school officials about provide support to peers experiencing difficulties with personal, familial and educational conditions. The approach takes the approach that peers helping peers is critical to student wellbeing and that reaching out for help can be experienced without stigma.</td>
</tr>
<tr>
<td>Target Population/Audience</td>
<td>High School age students.</td>
</tr>
<tr>
<td>Goals</td>
<td>To help support students at risk or in crisis that are thinking or considering on suicide and getting students help to address the</td>
</tr>
</tbody>
</table>
challenges and overwhelming stressors experienced by students.

To develop a peer support network on the school campus to create a helping community among students.

<table>
<thead>
<tr>
<th>Costs Involved</th>
<th>Programs are supported through school resources and outside grants when possible.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cultural Appropriateness</td>
<td>The peers are representative of the students in the school, the peer group uses a facilitated and inclusive set of principles that allow for student leadership and opportunities to aid their peers.</td>
</tr>
<tr>
<td>Location (Local, national, etc.)</td>
<td>This program is operated at the school district level in Pojoaque, New Mexico.</td>
</tr>
</tbody>
</table>

**Category or Approach:** Education, Contact

<table>
<thead>
<tr>
<th>Name of Program</th>
<th>Reducing Stigma by Meeting and Learning From People with Serious Mental Illness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Organization</td>
<td>University of Medicine and Dentistry of New Jersey Department of Psychiatric Rehabilitation</td>
</tr>
<tr>
<td>Contact Information/Person/Developer</td>
<td>Amy B. Spagnolo, M.S., CRPR, Assistant Professor 1776 Raritan Road Scotch Plains, NJ 07076 Phone: 908-889-2544 E-mail: <a href="mailto:Spagnoam@umdnj.edu">Spagnoam@umdnj.edu</a></td>
</tr>
</tbody>
</table>

**Links**

**Description of Program**

Explores how engaging in contact with consumers with mental illness can change perceptions, bias, misconceptions or assumptions about persons with mental illness. This model has been published in several journals outlining the outcomes of person to person contact approaches to reducing stigma.

**Target Population/Audience**

Public and community at large

This stigma reduction project aims to promote public awareness and
Goals | education about mental illness, expose people to information on recovery, dispel myths and inaccuracies associated with mental illnesses, and highlight mental health consumer strengths and resiliency.

Costs Involved | Not indicated.

Cultural Appropriateness | Not indicated.

Location (Local, national, etc.) | National.

**Category or Approach:** Education, Contact

<table>
<thead>
<tr>
<th>Name of Program</th>
<th>Minds Interrupted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Organization</td>
<td>NAMI Dona Ana County</td>
</tr>
</tbody>
</table>
| Contact Information/Person/Developer | Rosemary Zibart  
Michele Herling  
In Las Cruces contact NAMI DAC 575-386-6890 |
| Links | www.nami-dac.org |
| Description of Program | A structured series of autobiographical monologues by persons grappling with mental illness or that have been affected by mental illness in a loved one through theatre style presentations to audiences and groups. Involves written and edited scripts about real life experiences by consumers and family members who write the originating narratives. |
| Target Population/Audience | Community and public at large |
### Goals
Aimed at removing the stigma of mental illness.

### Costs Involved
$10 tickets, scholarships are available.

### Cultural Appropriateness
Open to the public.

### Location (Local, national, etc.)
Statewide in New Mexico and National

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**Category or Approach:** **Education, Contact**

<table>
<thead>
<tr>
<th>Name of Program</th>
<th>Stand Up for Mental Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Organization</td>
<td>Stand up for Mental Health</td>
</tr>
</tbody>
</table>
| **Contact Information/Person/Developer** | David Granirer  
3633 Triumph Street Vancouver  
British Columbia V5K 1V4 Canada  
Tel. 604.205-9242 |
| Links                 | http://www.standupformentalhealth.com/about.shtml  
Facebook and Twitter |
| **Description of Program** | David teaches standup comedy to people with mental illness as a way of building their confidence and fighting public stigma, prejudice, and discrimination.  
Shows look at the lighter side of taking medications, seeing counselors, getting diagnosed, and surviving the mental health system. Performances are held at conferences, treatment centers and psychic |
<table>
<thead>
<tr>
<th>Target Population/Audience</th>
<th>Prisons, on Military Bases and University and College Campuses, at Government, Corporate and Community fundraisers and Forums, and Most Importantly, for the General Public</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goals</td>
<td>A campaign to eliminate stigma. To help audiences to re-evaluate their perceptions of and prejudices against people who have a mental illness.</td>
</tr>
<tr>
<td>Costs Involved</td>
<td>Contact SUMH to book for performances.</td>
</tr>
<tr>
<td>Cultural Appropriateness</td>
<td>Not indicated.</td>
</tr>
<tr>
<td>Location (Local, national, etc.)</td>
<td>Across Canada and the US.</td>
</tr>
</tbody>
</table>

**Category or Approach: Education, Contact**

<table>
<thead>
<tr>
<th>Name of Program</th>
<th><strong>Bring Change 2 Mind</strong> - Anti-Stigma campaign</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Organization</td>
<td>Bring Change 2 Mind</td>
</tr>
</tbody>
</table>
| Contact Information/Person/Developer | 1265 Battery Street, Fifth Floor  
San Francisco, California 94111  
415-814-8846  
information@bringchange2mind.org |
| Links | http://bringchange2mind.org/  
Facebook, Twitter, and YouTube |
| Description of Program | Bring Change 2 Mind is a national anti-stigma campaign founded by Glenn Close, The Balanced Mind Foundation, Fountain House, and Garen & Shari Staglin of the International Mental Health Research Organization (IMHRO), through widely distributed Public Education |
materials based on the latest scientific insights and measured for effectiveness. Bring Change 2 Mind acts as a portal to a broad coalition of organizations that provide service, screening, information, support and treatment of mental illness. Also includes NAMI Walk sponsorship, PSAs, consumer and family videos. Celebrity actress, Glenn Close, volunteered at Fountain House, where both her sister, Jessie Close, and nephew, Calen Pick, live. Take the Bring Change 2 Mind Pledge to help end stigma.

<table>
<thead>
<tr>
<th>Target Population/Audience</th>
<th>Community and Public At-large.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goals</td>
<td>Working together to erase the stigma and discrimination of mental illness and aimed at removing misconceptions about mental illness. To emerge as the world's most effective organization working to eradicate the stigma and discrimination surrounding mental illness.</td>
</tr>
<tr>
<td>Costs Involved</td>
<td>Not indicated.</td>
</tr>
<tr>
<td>Cultural Appropriateness</td>
<td>Videos included diverse families. No other information indicated.</td>
</tr>
<tr>
<td>Location (Local, national, etc.)</td>
<td>National</td>
</tr>
</tbody>
</table>

**Category or Approach: Education, Contact**

<table>
<thead>
<tr>
<th>Name of Program</th>
<th>Firewalkers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Organization</td>
<td>VOCAL Network</td>
</tr>
<tr>
<td>Contact Information/Person/Developer</td>
<td>1904 Byrd Avenue, Suite 111 Richmond, VA 23230 (804) 343-1777 toll free: (877) 862-5638 (VOCLNET)</td>
</tr>
<tr>
<td>Links</td>
<td><a href="mailto:network@vocalvirginia.org">network@vocalvirginia.org</a> <a href="mailto:firewalk@vocalvirginia.org">firewalk@vocalvirginia.org</a></td>
</tr>
</tbody>
</table>
| Description of Program | Firewalkers is an arts, media and social justice project that redefines "mental illness" as a journey of altered states, emotional turbulence, ecstatic visions, crazy blessings, and mad gifts. We are engaged in community events and campus outreach. Through storytelling, photography, media engagement, book publishing, community art groups, trainings, and grassroots outreach, Firewalkers is changing the story of mental health.

VOCAL speakers are available to facilitate workshops or present on Firewalkers themes. Workshops are designed to shed positive light on the ways each of us overcomes mental illness. We have spoken to social work, psychology, and nursing students with great success. |
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<tbody>
<tr>
<td>Firewalkers: Stories of People Transformed by Mental Illness</td>
<td>This project was developed by the Virginia Organization of Consumers Asserting Leadership, Inc. through funding by the 2007 Campaign for Mental Health Recovery state implementation awards and is due to be completed by May 2009. A book with personal stories of 7 people who have experienced a mental illness was developed. The book includes information on mental illness and social inclusion strategies, as well as an appendix on recovery resources. Photographs of the individuals also will be taken for use on their book, web site, and poster. An educational &quot;how to&quot; manual also will be created for use in classrooms, medical schools, college orientation programs, and mental health programs.</td>
</tr>
<tr>
<td>Target Population/Audience</td>
<td>Consumer operated program and provides services to the broader community.</td>
</tr>
</tbody>
</table>
| Goals | VOCAL focuses on creating broad-scale social change, as well as change in the lives of individuals. VOCAL works to transform the mental health system -- and create alternatives to the system -- by promoting mental health recovery, self-determination and peer leadership. 

As people who have personally experienced mental health crisis, we work to create programs that respect the inherent worth and dignity of all people, regardless of their current or past mental state, diagnosis, or use of medications. 

We value the worth and dignity of each individual, the right to self-determination, and the important contributions of peer support and self-help. |
| Costs Involved | $8.00 for the book 
Other services not cost indicated. |
### Cultural Appropriateness

No information indicated.

### Location (Local, national, etc.)

Regional and statewide program throughout Virginia

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**Category or Approach:** Education, Contact

<table>
<thead>
<tr>
<th>Name of Program</th>
<th>Time to Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Organization</td>
<td>Mind and Rethink Mental Illness.</td>
</tr>
</tbody>
</table>
| Contact Information/Person/Developer | Email: [info@time-to-change.org.uk](mailto:info@time-to-change.org.uk)  
Tel: 020 8215 2356  
Time To Change  
15-19 Broadway |
**Description of Program**

Time to Change is England's most ambitious program to challenge mental health stigma and discrimination. With 35 projects led by Mind and Rethink, the program is backed by international evidence on what works and has at its heart people with direct experience with mental health problems. The approach is based on: What is social contact? A conversation where someone with experience of mental health problems shares this with someone without. **Why does it work?** Meeting someone who is open about their experiences and having the chance to ask questions, can make people think twice about commonly held stereotypes.

**Target Population/Audience**

Public and community at large.

**Goals**

To end discrimination faced by people who experience mental health problems.

**Costs Involved**

Not indicated.

**Cultural Appropriateness**

No indication

**Location (Local, national, etc.)**

England

**Category or Approach:** Education, Contact

<table>
<thead>
<tr>
<th>Name of Program</th>
<th>Resilient Places micro-grants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Organization</td>
<td>Queensland Alliance</td>
</tr>
</tbody>
</table>
| **Contact Information/Person/Developer** | admin@qldalliance.org.au  
Level 2, 266 Brunswick Street  
Fortitude Valley Q 4006  
07 3252 9411 |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Links</strong></td>
<td><a href="http://qldalliance.org.au/home/">http://qldalliance.org.au/home/</a></td>
</tr>
<tr>
<td><strong>Description of Program</strong></td>
<td>The Queensland Alliance, a Non Government Organization (NGO) which supports over 240 community organizations working in mental health in Queensland, Australia advocates for community services that promote mental health and well being. The Queensland Alliance recently launched an $8.5M four-year initiative to reduce negative stereotypes about mental illness and negative perceptions of people with mental health problems. Micro-grants support local activities that promote positive mental health, improve wellbeing and build community resilience.</td>
</tr>
<tr>
<td><strong>Target Population/Audience</strong></td>
<td>Community based agencies</td>
</tr>
<tr>
<td><strong>Goals</strong></td>
<td>Their goals are social inclusion and community well-being; a mental health system focused on people's recovery in their own homes and communities; and easy access to information and strategies that promote mental health.</td>
</tr>
<tr>
<td><strong>Costs Involved</strong></td>
<td>Not indicated.</td>
</tr>
<tr>
<td><strong>Cultural Appropriateness</strong></td>
<td>Works extensively with diverse communities including the indigenous communities in Australia.</td>
</tr>
<tr>
<td><strong>Location (Local, national, etc.)</strong></td>
<td>Australia</td>
</tr>
</tbody>
</table>

**Category or Approach:** **Education, Contact**
<table>
<thead>
<tr>
<th><strong>Name of Program</strong></th>
<th>“Asian-Americans, Mental Health and Community Engagement”</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Name of Organization</strong></td>
<td><strong>Erasing the Distance</strong></td>
</tr>
<tr>
<td><strong>Contact Information/Person/Developer</strong></td>
<td>6504 N. Winchester ~ Chicago, IL 60626 ~ Contact us to learn more! 773.856.3455 or <a href="mailto:info@erasingthedistance.org">info@erasingthedistance.org</a>.</td>
</tr>
<tr>
<td><strong>Links</strong></td>
<td><a href="http://www.erasingthedistance.org/what/education/">http://www.erasingthedistance.org/what/education/</a></td>
</tr>
<tr>
<td><strong>Description of Program</strong></td>
<td>Erasing the Distance is a Chicago-based theater company dedicated to shedding light on mental illness. The company tours its original productions, as well as facilitated audience dialogues, mental health trainings, and high quality mental health resource, to junior high and high schools, colleges and universities, places of worship, hospitals, community groups, and workplaces. Erasing the Distance also creates customized productions to help communities give voice to their own mental health stories and leads long term artistic residencies in schools. ETD leads presentations, workshops, trainings, and longer-term programs to teach artists, mental health advocates, and current/future health professionals our specific methodology.</td>
</tr>
<tr>
<td><strong>Target Population/Audience</strong></td>
<td>Community at large, professionals, advocates and artists</td>
</tr>
<tr>
<td><strong>Goals</strong></td>
<td>To generate compassion and understanding for all those impacted by mental health issues.</td>
</tr>
<tr>
<td><strong>Costs Involved</strong></td>
<td>Contact agency for costs.</td>
</tr>
<tr>
<td><strong>Cultural Appropriateness</strong></td>
<td>Has specifically developed monologues for Asian Americans and can customize workshops and dialogues for diverse groups.</td>
</tr>
<tr>
<td><strong>Location (Local, national, etc.)</strong></td>
<td>Chicago, Illinois</td>
</tr>
</tbody>
</table>

**Category or Approach:** Education, Contact
<table>
<thead>
<tr>
<th>Name of Program</th>
<th>Erase Stigma Arts Festival - Behind the Mask</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Organization</td>
<td>Orange County Orange County Stigma Elimination Task Force</td>
</tr>
</tbody>
</table>
| Contact Information/Person/Developer | Richard O. Krzyzanowski  
Consumer Employment Support Specialist  
Orange County Health Care Agency  
600 W. Santa Ana Blvd., suite 550  
Santa Ana, California  92701  
714-667-5607  
Fax 714-667-5612  
rkrzyanowski@ocha.com |
| Links                                | [http://occommunityresources.blogspot.com/search/label/stigma](http://occommunityresources.blogspot.com/search/label/stigma) |
| Description of Program              | A multi-medium, community event developed in partnership by several organizations including consumers and family artists to display, perform, present and utilize art, music, poetry, films, plays and artistic mediums to present anti-stigma messages including: three galleries including the "Stigma Room", Film Series, Exhibits, Workshops (e.g., Mental Illness, Creativity and Stigma), Play and consumer and family produced, directed, supported performances. |
| Target Population/Audience           | General Public, community at large |
| Goals                                | To use a creative alternative to addressing stigma to help consumers and families present new, visible, artistic, and emotional experiences to help understand mental illness and ways to "see, hear, feel and touch" intuitive and sensory learning experiences of the effects of stigma and the benefits of social inclusion. |
| Costs Involved                       | Not indicated. |
| Cultural Appropriateness             | Not indicated. |
| Location (Local, national, etc.)     | California |
Category or Approach: **Education, Contact**

<table>
<thead>
<tr>
<th>Name of Program</th>
<th>Social Exclusion Simulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Organization</td>
<td>Alder School of Psychology  [Adler Institute on Social Exclusion]</td>
</tr>
<tr>
<td>Contact Information/Person/Developer</td>
<td>17 North Dearborn Street  [Chicago, IL 60602]  [Phone: 312-662-4000]  [Fax: 312-662-4099]</td>
</tr>
<tr>
<td>Links</td>
<td><a href="http://www.adler.edu/page/institutes/institute-on-social-exclusion/projects/social-exclusion-simulation">http://www.adler.edu/page/institutes/institute-on-social-exclusion/projects/social-exclusion-simulation</a></td>
</tr>
<tr>
<td>Description of Program</td>
<td>The Adler Institute on Social Exclusion works to identify the most effective ways of addressing social exclusion through prevention and intervention. The institute supports these goals through research, outreach, and awareness programs. The ISE developed an experiential role play exercise called the Social Exclusion Simulation. The purpose of the exercise is to illustrate what social structures are, how they operate, and how they can systematically block access for some groups to rights, opportunities, and resources required for social integration. The Simulation uses re-entry experiences of formerly incarcerated women to illustrate content. The Simulation has been an effective tool for helping people change their outlooks and behaviors on important social issues, question the prevailing perceptions and assumptions, and appreciate the limits on personal responsibility that sometimes result from a context of constraining social structures and systems</td>
</tr>
<tr>
<td>Target Population/Audience</td>
<td>All workshops, conferences, presentations, and events seek to engage the Adler School community and the general public</td>
</tr>
<tr>
<td>Goals</td>
<td>To promote the academic and public understanding of the concept of 'social exclusion' and the factors that create and increase the severity of this condition</td>
</tr>
<tr>
<td>Costs Involved</td>
<td>Not indicated</td>
</tr>
<tr>
<td>Cultural Appropriateness</td>
<td>Not indicated</td>
</tr>
<tr>
<td><strong>Location (Local, national, etc.)</strong></td>
<td>Illinois and Vancouver, British Columbia, Canada</td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>--------------------------------------------------</td>
</tr>
</tbody>
</table>

**Category or Approach:**  **Education, Contact**

<table>
<thead>
<tr>
<th><strong>Name of Program</strong></th>
<th>COLLAGED REALITIES: Photography and Mixed Media</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Photography and Mixed Media Exhibit</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Name of Organization</strong></th>
<th><strong>The Fountain Gallery</strong></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>Contact Information/Person/Developer</strong></th>
<th>Gallery 702 Ninth Avenue @ 48th St. New York, NY 10019 212.262.2756</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>Links</strong></th>
<th><a href="http://www.fountaingallernyc.com/Artist.cfm">http://www.fountaingallernyc.com/Artist.cfm</a></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>Description of Program</strong></th>
<th>The Fountain Gallery is a nonprofit cooperative run by and for artists living with mental illnesses. Fountain Gallery is the premier venue in New York City representing artists with mental illness. The gallery sells original artworks and collaborates with a wide network of artists, curators, and cultural institutions. Embracing artists who are emerging or established, trained or self-taught, Fountain Gallery cultivates artistic growth and makes a vital contribution to the New York arts community.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>Target Population/Audience</strong></th>
<th>Public and community at large, art community of artists and galleries.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>Goals</strong></th>
<th>It works to change common misconceptions about people living with mental illnesses by publicly exhibiting the works of their talented artists and by providing a safe and secure place for self-expression.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>Costs Involved</strong></th>
<th>Artwork is for sale.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>Cultural Appropriateness</strong></th>
<th>Over 40 artists from diverse communities.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location (Local, national, etc.)</td>
<td>Local: New York City, New York</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>---------------------------------</td>
</tr>
</tbody>
</table>

**Category or Approach:**  **Education, Contact**

<table>
<thead>
<tr>
<th>Name of Program</th>
<th>Anti-Stigma Project</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The Anti The Transitional Age Youth Outreach (TAY) Project</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of Organization</th>
<th>On Our Own of Maryland, Inc.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Contact Information/Person/Developer | Jennifer K. Brown, Director of Training and Communications  
1521 South Edgewood Street, Suite C  
Baltimore, MD 21227  
Phone: 410-646-0262  
E-mail: anti-stigma@usa.net |
|-------------------------------------|------------------------------------------------------------------|

<table>
<thead>
<tr>
<th>Links</th>
<th><a href="http://www.onourownmd.org/about-us/local-wellness-recovery-centers">http://www.onourownmd.org/about-us/local-wellness-recovery-centers</a></th>
</tr>
</thead>
</table>

| Description of Program               | The Anti-Stigma Project is part of On Our Own of Maryland, Inc., Maryland's Statewide consumer/survivor organization. The project reduces stigma by raising awareness, facilitating discussion, searching for creative solutions, and educating the public.  
The Transitional Age Youth Outreach (TAY) Project seeks to create a space within On Our Own of Maryland's peer network of Wellness & Recovery Centers for the activities and conversations of young adults between the ages of 18 and 30. Their mission is to empower youth with mental health struggles to share their experiences and speak out about the kind of help and services they'd like to see within the mental health system where they receive care. Foster a sense that the life experiences of young adults are full of unique insight and that they are able to reach out and touch the lives of other young adults through peer support and to advocate for a mental health system which |
|--------------------------------------|-------------------------------------------------------------------|
adequately addresses their needs and honors their voices.

<table>
<thead>
<tr>
<th><strong>Target Population/Audience</strong></th>
<th>Consumer operated organizations, public &amp; community at large.</th>
</tr>
</thead>
</table>
| **Goals**                      | • To support, advise and provide technical assistance to our affiliated consumer-operated organizations, to foster self-help programs.  
• To promote improvements in & alternatives to the current mental health system.  
• To educate the public regarding the problems and needs of persons involved in the mental health system.  
• To educate the public regarding the need for the enforcement or extension of civil and human rights for current and former recipients of mental health services. |
| **Costs Involved**             | Not indicated.                                                 |
| **Cultural Appropriateness**   | Not indicated.                                                 |
| **Location (Local, national, etc.)** | Baltimore, Maryland                                            |
### Category or Approach: **Education, Contact**

<table>
<thead>
<tr>
<th>Name of Program</th>
<th>Anti-Stigma Campaign</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Organization</td>
<td>Rethink</td>
</tr>
</tbody>
</table>
| Contact Information/Person/Developer | Alexandra Burner, Senior Campaigns Officer  
E-mail: alex.burner@rethink.org  
Head Office  
15th Floor  
89 Albert Embankment  
London  
SE1 7TP  
Tel: 0300 5000 927  
email: info@rethink.org |
| Links                   |  
http://www.rethink.org/about_us/index.html  
Facebook, Twitter links, On-Line Discussion forum |
| Description of Program   | The anti-stigma campaign was developed and launched by Rethink, a national mental health membership charity in England. It was a month-long campaign aimed at raising public awareness of the stigma associated with mental illnesses and the discrimination that people with mental illnesses face in their daily lives. The campaign also aimed to increase awareness of Rethink. |
| Target Population/Audience | Rethink Mental Illness is the largest national voluntary sector provider of mental health services, with about 250 services and over 150 support |
Groups and almost 60,000 people every year across England.

<table>
<thead>
<tr>
<th><strong>Goals</strong></th>
<th>Rethink Mental Illness is a charity that believes a better life is possible for millions of people affected by mental illness. 'Leading the way to a better quality of life for everyone affected by severe mental illness'</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Costs Involved</strong></td>
<td>Not indicated.</td>
</tr>
<tr>
<td><strong>Cultural Appropriateness</strong></td>
<td>Not indicated.</td>
</tr>
<tr>
<td><strong>Location (Local, national, etc.)</strong></td>
<td>Throughout England.</td>
</tr>
</tbody>
</table>

**Category or Approach:** Education, Contact

<table>
<thead>
<tr>
<th><strong>Name of Program</strong></th>
<th>Families of Kids with Mood and Anxiety Disorders, Inc.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Name of Organization</strong></td>
<td>Families of Kids with Mood and Anxiety Disorders, Inc.</td>
</tr>
</tbody>
</table>
| **Contact Information/Person/Developer** | Tampa Bay, FL  
Email: [FKMAD@fkmad.org](mailto:FKMAD@fkmad.org) |
<p>| <strong>Links</strong> |  |
| <strong>Description of Program</strong> | Families of Kids with Mood and Anxiety Disorders, Inc. supports child and teen mental health by empowering Florida families through increased community awareness and stigma reduction programs. They strive to involve the whole community in education, care and support programs. |
| <strong>Target</strong> | For upper elementary, middle school, high school |</p>
<table>
<thead>
<tr>
<th>Population/Audience</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Goals</strong></td>
<td>To reduce stigma and increase self-confidence so all youth may openly be accepted and understood for who they are.</td>
</tr>
<tr>
<td><strong>Costs Involved</strong></td>
<td>Not indicated.</td>
</tr>
<tr>
<td><strong>Cultural Appropriateness</strong></td>
<td>Not indicated.</td>
</tr>
<tr>
<td><strong>Location (Local, national, etc.)</strong></td>
<td>Florida</td>
</tr>
</tbody>
</table>

**Category or Approach:** **Education, Contact**

<table>
<thead>
<tr>
<th>Name of Program</th>
<th>Palmetto Media Watch</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Organization</td>
<td>South Carolina Department of Mental Health</td>
</tr>
</tbody>
</table>
| **Contact Information/Person/Developer** | Sue Perry  
Palmetto Media Watch Coordinator  
Office of Communications  
SCDMH  
P.O. Box 485, Columbia, SC, 29202  
Phone: 803-898-8582 |
| **Links** | [www.state.sc.us/dmh/mediawatchmanual.htm](http://www.state.sc.us/dmh/mediawatchmanual.htm) |
| **Description of Program** | The Palmetto Media Watch Program is a public education initiative of the South Carolina Department of Mental Health to help the media accurately and fairly represent people with mental illnesses. 70 people from all across South Carolina are trained to watch media articles, stories and advertisements and take action to provide factual |
information to media outlets by writing letters and training media sources. A training guide is on the SCDMH website,

<table>
<thead>
<tr>
<th>Target Population/Audience</th>
<th>Media outlets: radio, television, newspapers, and other public broadcasting vehicles.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goals</td>
<td>1. Promote the use of personal stories by consumers and family members that identify barriers created by stigma for use in mental health educational material and by the media; 2. Increase accurate, positive media portrayals of people with mental illnesses and issues around mental illnesses; 3. Strengthen alliances with advocacy groups to develop anti-stigma strategies.</td>
</tr>
<tr>
<td>Costs Involved</td>
<td>Not indicated.</td>
</tr>
<tr>
<td>Cultural Appropriateness</td>
<td>Not indicated.</td>
</tr>
<tr>
<td>Location (Local, national, etc.)</td>
<td>Statewide throughout South Carolina</td>
</tr>
</tbody>
</table>

**Category or Approach:** **Education, Contact**

<table>
<thead>
<tr>
<th>Name of Program</th>
<th>Bell’s Let’s Talk Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Organization</td>
<td>Canadian Mental Health Association</td>
</tr>
</tbody>
</table>
| Contact Information/Person/Developer | National Phoenix Professional Building  
595 Montreal Road, Suite 303  
Ottawa ON K1K 4L2  
Fax: 613-745-5522 |
| Links | http://www.cmha.ca/about-cmha/contact-us/ Facebook, Twitter, LinkedIn |
| Description of Program | Bell’s campaign encourages people to “start the conversation” about mental health with friends, family and co-workers, recognizing that |
simply talking makes a significant impact in breaking down the stigma attached to mental health. The campaign is framed around what three things all Canadians can do in their daily lives to increase awareness about mental health and decrease stigma:

1. Remove the fear. Start talking with kids.
2. Invite people with mental health problems into your life.
3. Challenge stereotypes and help dispel the myths of mental illness.

And to STOP behaviors that lead to stigma to include:

- S – Stereotyping?
- T – Trivializing or belittling their health challenges?
- O – Offending someone with your attitude?
- P – Patronizing people with mental health challenges because you unconsciously believe you are “better” than them?

<table>
<thead>
<tr>
<th>Target Population/Audience</th>
<th>Public and community at large</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goals</td>
<td>To break down the stigma attached to mental health.</td>
</tr>
<tr>
<td>Costs Involved</td>
<td>Not indicated.</td>
</tr>
<tr>
<td>Cultural Appropriateness</td>
<td>Open to the entire community, but no description about diverse community groups.</td>
</tr>
<tr>
<td>Location (Local, national, etc.)</td>
<td>Nationwide in Canada</td>
</tr>
</tbody>
</table>

**Category or Approach:** Education, Contact

| Name of Programs          | Mental Illness is Real  
|                          | SANE StigmaWatch |
| Name of Organization      | SANE Australia |
| Contact Information/Person/Developer | Jack Heath BA (Hons), LLB  
|                            | SANE’s Australian Business Number (ABN) is 92 006 533 606. |
| Links                     | http://www.sane.org/information/about-sane  
<p>|                            | Visit the Join StigmaWatch page. |
|                           | Mental Illness Is Real is a national media campaign that was launched in |</p>
<table>
<thead>
<tr>
<th>Description of Program</th>
<th>Australia in 2005 by SANE Australia. The campaign hopes to educate the public by directing people to get real facts via the SANE Web site and the SANE toll-free helpline number. 2012 SANE StigmaWatch worked with national news groups, metropolitan media outlets, regional newsrooms, businesses and celebrities to reduce stigma and encourage responsible reporting of suicide-related issues. Media outlets contacted included Channel 9, Channel 7, the ABC, <em>The Australian, The Age</em>, 6PR, and Fox FM. Quarterly Stigma Bulletins were sent to over 2,000 members, updating members on activity undertaken throughout the year. Community members can subscribe to the mailing list. SANE StigmaWatch does not aim to stop media reports on issues such as mental illness and suicide, rather, StigmaWatch encourages more accurate and responsible reporting of these complex and sensitive issues.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target Population/Audience</td>
<td>Media outlets: newspaper, television, radio, and engages community listeners.</td>
</tr>
<tr>
<td>Goals</td>
<td>Mental Illness is Real - The campaign aims to overcome community stigma and misunderstanding about mental illnesses by challenging the stereotypes that exist. SANE Stigma Watch - to reduce stigma and encourage responsible reporting of suicide-related issues.</td>
</tr>
<tr>
<td>Costs Involved</td>
<td>Operates from grants and donations.</td>
</tr>
<tr>
<td>Cultural Appropriateness</td>
<td>Not indicated.</td>
</tr>
<tr>
<td>Location (Local, national, etc.)</td>
<td>Throughout Australia</td>
</tr>
</tbody>
</table>

**Category or Approach:** Education, Contact

<table>
<thead>
<tr>
<th>Name of Program</th>
<th>Breaking the Silence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Organization</td>
<td>NAMI Queens/ Nassau</td>
</tr>
</tbody>
</table>
| Contact Information/Person/Developer | 1981 Marcus Avenue C117  
Lake Success, NY 11042  
Phone: 516-326-0797  
E-mail: btslessonplans@aol.com |
<table>
<thead>
<tr>
<th>Links</th>
<th><a href="http://www.btslessonplans.org/">http://www.btslessonplans.org/</a> Facebook</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description of Program</td>
<td>Breaking the Silence (BTS) is a nationwide educational program to educate students about the facts and myths of mental illness, teaches tolerance, and promotes early treatment. BTS explains the causes, symptoms, and warning signs of mental illness, and what a person can do to overcome the stigma and help others. Toolkits, fully scripted lesson plans and suggested activities, teaching videos, eye-catching posters and board game.</td>
</tr>
<tr>
<td>Target Population/Audience</td>
<td>For upper elementary, middle and high school classrooms</td>
</tr>
<tr>
<td>Goals</td>
<td>Students learn to how to overcome stigma</td>
</tr>
<tr>
<td>Costs Involved</td>
<td>Plans can be purchased on-line.</td>
</tr>
<tr>
<td>Cultural Appropriateness</td>
<td>Not indicated.</td>
</tr>
<tr>
<td>Location (Local, national, etc.)</td>
<td>National</td>
</tr>
</tbody>
</table>

**Category or Approach:** **Education, Contact**

<table>
<thead>
<tr>
<th>Name of Program</th>
<th>Stigma Watch</th>
</tr>
</thead>
</table>
| Name of Organization | Wisconsin United for mental health  
Wisconsin Women's Health Foundation |
| Contact Information/Person/ | 2503 Todd Drive  
Madison, WI 53713 |
<table>
<thead>
<tr>
<th>Developer</th>
<th>Phone: 800-448-5148</th>
</tr>
</thead>
<tbody>
<tr>
<td>Links</td>
<td><a href="http://www.wimentalhealth.org/about/contact.php">http://www.wimentalhealth.org/about/contact.php</a> Facebook</td>
</tr>
<tr>
<td>Description of Program</td>
<td>Wisconsin United for Mental Health (WUMH) is a coalition of State, nonprofit, advocacy, and consumer mental health organizations formed in 2002. The coalition actively promotes mental health awareness and eliminates barriers to recovery through statewide anti-stigma activities and events including Webcasts, trainings, presentations for the public, and the support of local legislator and media briefing activities. If someone in the media uses labels, write them a letter educating them about how their choice of words is derogatory or misinformed. The following link is a sample letter from Stigma Watch: Sample Letter</td>
</tr>
<tr>
<td>Target Population/Audience</td>
<td>Public and community at large.</td>
</tr>
<tr>
<td>Goals</td>
<td>Education and awareness about mental illnesses to reduce stigma and promote recovery.</td>
</tr>
<tr>
<td>Costs Involved</td>
<td>Not Indicated.</td>
</tr>
<tr>
<td>Cultural Appropriateness</td>
<td>Not Indicated.</td>
</tr>
<tr>
<td>Location (Local, national, etc.)</td>
<td>Michigan.</td>
</tr>
</tbody>
</table>

**Category or Approach:** Education, Contact

<table>
<thead>
<tr>
<th>Name of Program</th>
<th>Puppet Troupe Theatre</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Organization</td>
<td>The Kids on the Block, Inc.</td>
</tr>
</tbody>
</table>
| **Contact Information/Person/Developer** | Westminster, Maryland 21157  
1-800-368-KIDS (5437)  
(443)297-9564 |
| **Links** | http://kotb.com/  
Facebook |
| **Description of Program** | The Kids on the Block (KOB) is an educational puppet theatre company that researches, develops and performs live programs addressing a wide range of topics, including children’s mental health, emotional and behavioral disorders, and ADHD. Each topic is thoroughly researched and field-tested before it becomes available to schools, community service organizations, hospitals and special interest groups. A complete curriculum accompanies each topic area including scripts, answers to questions children ask, background information on the topic, character biographies, resource materials, follow-up information, and continued support from the KOB National Office. KOB Troupes purchase kits to use in their communities. teaching children through informative, entertaining, interactive puppetry for more than 28 years. |
| **Target Population/Audience** | Troupes can include anyone interested in using this curriculum to conduct theatre performances in their communities for the public at large, schools, organizations, and other groups. |
| **Goals** | To present a well-researched, comprehensive curriculum designed to educate elementary school age children about important issues |
| **Costs Involved** | Request a price quote on-line from the creators. |
| **Cultural Appropriateness** | Diverse topics and demographic characteristics. Disabilities, deaf and hard of hearing, children & youth focus. |
| **Location (Local, national, etc.)** | Can be performed anywhere nationally. |

**Category or Approach:** **Education, Protest**

<p>| <strong>Name of Project</strong> | Bavarian Anti-Stigma Initiative (BASTA) |</p>
<table>
<thead>
<tr>
<th>Name of Organization</th>
<th>SANE (Stigma Alarm Network)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact Information/Person/Developer</td>
<td>Dr. Werner Kissling; E-Mail: <a href="mailto:info@openthedoors.de">info@openthedoors.de</a></td>
</tr>
<tr>
<td>Links</td>
<td><a href="http://openthedoors.de/de/sane.php">http://openthedoors.de/de/sane.php</a></td>
</tr>
<tr>
<td>Description of Program</td>
<td>BASTA works to protest against stigmatizing and discriminating organizations. Holds events and works with the World Psychiatric Association “Open the Doors” project to educate the public about mental illnesses.</td>
</tr>
<tr>
<td>Target Population/Audience</td>
<td>General Public; Police Officers Teachers; Young People</td>
</tr>
<tr>
<td>Goals</td>
<td>The goal of this German organization is to end discrimination against people living with mental illnesses.</td>
</tr>
<tr>
<td>Costs Involved</td>
<td>N/A Accepts donations</td>
</tr>
<tr>
<td>Cultural Appropriateness</td>
<td>Focuses on all persons, but does not specify any particular demographic characteristic.</td>
</tr>
<tr>
<td>Location (Local, national, etc.)</td>
<td>International, World Psychiatric Association Munich, Germany</td>
</tr>
</tbody>
</table>

Category or Approach: **Advocacy, Protest**
<table>
<thead>
<tr>
<th><strong>Name of Program</strong></th>
<th>“News &amp; Links to Battle Bias”</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Name of Organization</strong></td>
<td>National Stigma Clearinghouse</td>
</tr>
</tbody>
</table>
| **Contact Information/Person/Developer** | National Stigma Clearinghouse  
245 8th Avenue #213  
New York, NY 10011 |
| **Links** | [http://stigmanet.net/](http://stigmanet.net/)  
has links to Advocacy, anti-stigma programs and others |
| **Description of Program** | The National Stigma Clearinghouse is an independent volunteer anti-bias project and was created to track and respond to stigmatizing media images of mental illnesses and to provide information about stigma to advocates. |
| **Target Population/Audience** | Advocates, Consumers and Family Members, General Public |
| **Goals** | To educate advocates and consumers on responding to stigmatizing media images and stories to combat negative and inaccurate portrayals of persons with mental illness. |
| **Costs Involved** | N/A |
| **Cultural Appropriateness** | All information is in English |
| **Location (Local, national, etc.)** | National, International |
**Category or Approach:** Advocacy, Protest

<table>
<thead>
<tr>
<th>Name of Program</th>
<th>The Stigma of Cinemania</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Organization</td>
<td>Mental Health Stigma</td>
</tr>
<tr>
<td><strong>Contact Information/Person/Developer</strong></td>
<td><a href="mailto:David@mentalhealthstigma.com">David@mentalhealthstigma.com</a></td>
</tr>
<tr>
<td>Links</td>
<td><a href="http://www.mentalhealthstigma.com">www.mentalhealthstigma.com</a></td>
</tr>
<tr>
<td><strong>Description of Program</strong></td>
<td>The site was established and maintained by an individual who has experienced mental illness. The site is intended to illustrate the ways the media may foster prejudice and discrimination against those labeled as having a psychiatric disorder. It contains many examples of media depictions of mental illnesses and discussion of the ways these depictions may affect public perceptions and public policy. Site addresses the media and its practices of setting apart individuals with mental illness.</td>
</tr>
<tr>
<td><strong>Target Population/Audience</strong></td>
<td>General Public</td>
</tr>
<tr>
<td><strong>Goals</strong></td>
<td>To alert consumers and others about the depth of stigma in the media.</td>
</tr>
<tr>
<td><strong>Costs Involved</strong></td>
<td>Not indicated</td>
</tr>
<tr>
<td><strong>Cultural Appropriateness</strong></td>
<td>Not indicated.</td>
</tr>
<tr>
<td><strong>Location</strong></td>
<td>National</td>
</tr>
</tbody>
</table>
Category or Approach: **Advocacy, Contact, Education, Protest**

<table>
<thead>
<tr>
<th>Name of Programs</th>
<th>NAMI In Our Own Voice</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NAMI Provider Education</td>
</tr>
<tr>
<td></td>
<td>NAMI Peer to Peer</td>
</tr>
<tr>
<td></td>
<td>NAMI Family to Family</td>
</tr>
<tr>
<td></td>
<td>NAMI Parents and Teachers as Allies</td>
</tr>
<tr>
<td></td>
<td>NAMI Stigma Busters</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of Organization</th>
<th>National Alliance on Mental Illness (NAMI)</th>
</tr>
</thead>
</table>

| Contact Information/Person /Developer | NAMI  
3803 N Fairfax Drive, Suite 100  
Arlington, VA 22203  
Phone: 703-524-7600 |
|--------------------------------------|------------------------------------------|

| Links                                | www.NAMI.org  
On all social Networking sites |
|--------------------------------------|---------------|
| In Our Own Voice Link: website: nami.org/ioov  
watch program video |
| NAMI Provider Education: website: nami.org/providereducation |
| NAMI Peer to Peer Education: website: nami.org/peertopeer  
watch program video |
| NAMI Parents and Teachers as Allies: website: nami.org/template.cfm?section=Schools_and_Education |

| Description of Program              | The National Alliance for the Mentally Ill is a large grassroots organization dedicated to improving the lives of people with severe mental illnesses. The majority of its over 210,000 members are people who have relatives with mental illnesses, but a growing number of members are people who have been diagnosed with a psychiatric disorder. Below are four of its education programs: |
- NAMI In Our Own Voice is a consumer program for the general public, recurring one time presentations on subjects affecting persons with mental illness including stigma and discrimination. A one-and-a-half hour interactive, multi-media presentation by consumers for consumers and others about living with mental illness. This project is a unique informational outreach program, developed by the National Alliance on Mental Illness (NAMI) that offers insight into the recovery that is possible for people with severe mental illnesses. The program aims to meet the need for consumer-run education initiatives, to set a standard for quality education about mental illness from those who have been there, to offer genuine work opportunities for consumers, to encourage self-confidence and self-esteem in presenters, and to focus on recovery and the message of hope.

- NAMI Provider Education is for providers of mental health services, Meets for 6 week. This course has consumers and family members present to providers about the experiences of living with mental illness. The topics cover stigma and how negative affects in seeking help from providers.

- NAMI Peer to Peer is a consumer program for consumers (people living with a mental illness), 10-week course. Covers recovery, stigma and self-advocacy. For any person with a mental illness, this course contains individual relapse prevention planning, a debriefing/storytelling week, and an advance directive for psychiatric care.

- NAMI Family to Family is a 12 week course for family members, partners and friends of someone living with a mental illness. Addresses stigma, symptoms, treatment and resources available to families.

- NAMI Parents and Teachers as Allies is a two hour in-service program for school professionals. Helps teachers understand the importance of their role in early recognition of kids with symptoms of mental illness and the urgency of early intervention.

- NAMI Stigma Busters - NAMI CAMPAIGN STIGMA BUSTERS Email ALERT - Allows advocates to take action to fight stigma against people with mental illness. NAMI StigmaBusters, dedicated advocates across the country and around the world, are fighting pervasive, hurtful prejudice and discrimination that exists toward people with mental illnesses-while commending leaders who communicate accurate messages to the public about mental illness. Stigma discourages people from getting help when they need it. It dehumanizes individuals. It contributes to lack of investment in the mental healthcare system, with catastrophic costs and consequences.
<table>
<thead>
<tr>
<th><strong>Target Population/Audience</strong></th>
<th>Greater Population, Veterans, persons of different faith communities, family members and consumers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Goals</strong></td>
<td>To build better lives for Americans with mental health. To advocates for access, services, research on mental health.</td>
</tr>
<tr>
<td><strong>Costs Involved</strong></td>
<td>Free of charge to participants.</td>
</tr>
</tbody>
</table>
| **Cultural Appropriateness**  | Website materials in Spanish: Has a Multicultural Action Center  
  - In Our Own Voice materials are available in Spanish  
  - Peer to Peer materials are available in Spanish  
  - Family to Family materials are available in Spanish (Includes Familia a Familia) |
| **Location (Local, national, etc.)** | 1,200 Local Affiliates, State Organizations and National Organization. Includes NAMI Texas, NAMI El Paso, and NAMI Austin (who conducts In Our Own Voice); NAMI New Mexico and NAMI Dona Ana County conduct Family to Family programs. |
### Category or Approach: **Advocacy, Contact, Education**

<table>
<thead>
<tr>
<th>Name of Program</th>
<th>Real Lives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Organization</td>
<td>Mental Health America</td>
</tr>
</tbody>
</table>
| Contact Information/Person/Developer | 2000 N. Beauregard Street; 6th Floor Alexandria, VA 22311  
1-800-969-6642  
info@mentalhealthamerica.net |
| Links | www.mentalhealthamerica.net/go/action/stigma-watch  
Facebook and Twitter |
| Description of Program | Mental Health America is an advocacy organization which addresses mental health seeking to inform, advocate for, and enable individuals with these diagnoses. Works with employers to identify corporate affects and an education campaign. Real Lives is an on-line forum for individuals to address the issues and challenges affecting their lives including stigma and other barriers. |
| Target Audience | General Public; Individuals with mental illness diagnoses; Employers and Federal Government |
| Goals | To build awareness and understanding about mental illness through advocacy and to educate the public about mental and substance use conditions and their causes and treatments; and to fight stigma and prejudice and promote social justice and recovery from mental and substance use conditions. |
| Costs Involved | N/A |
### Cultural Appropriateness

Incorporates culturally competent strategies to ensure that it is effectively treatment and psychosocial needs of individuals with mental illness and their family members.

### Location

340 State and Local Affiliates Nationwide

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**Category or Approach:** **Advocacy, Contact, Education**

| Name of Program                          | Social Inclusion Program  
|                                         | Peers Envisioning and Engaging in Recovery Services (P.E.E.R.S) |
| Name of Organization                    | Alameda County            |
| Contact Information/Person/Developer    | 333 Hegenberger Road      
|                                         | Oakland CA 94621          
|                                         | Phone (510) 832 7337      |
| Links                                   | [http://www.peersnet.org/programs](http://www.peersnet.org/programs)  
|                                         | For PEER Radio contact: Jenee Darden, Media and Marketing Coordinator, at jdarden@peersnet.org |
| Description of Program                  | Peers Envisioning and Engaging in Recovery Services (P.E.E.R.S) is a social inclusion campaign using a social marketing research approach. P.E.E.R.S is a consumer-run, nonprofit organization that advocates for mental health consumers on every level of the mental health system. The P.E.E.R.S social marketing program aims to increase anti-mental health stigma activism for users of the popular social network Facebook using application pledges. P.E.E.R.S.  
|                                         | Social Inclusion Campaign is a groundbreaking effort to end stigma and discrimination against people with mental health issues throughout Alameda County. The campaign uses outreach, empowerment trainings and media look outs to fight stigma. Outreach facilitates contact between people with mental health issues and the general community, PEERS will educate and inform those who hold the power to change discriminatory practices. Empowerment trainings use tools |

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such as strength-based trainings, spirituality, and education about wellness and recovery, PEERS will help individuals build on their talents and capacities, thereby decreasing internalized stigma. Media tracking and responding to how mental health is portrayed in the media as well as producing our own media, PEERS will shape the messages society is exposed to about mental health.

PEERS TV, an online repository of mental health video content and resources. Whether you are interested in watching PEERS events, conference highlights, news in the mental health field, or episodes of our cable access show *Mental Health Matters*, you can find it all on PEERS TV.

PEERS Radio, Welcome to PEERS Radio, where you will find episodes of PEERS' original "Mental Health and Wellness Radio" podcast.

<table>
<thead>
<tr>
<th><strong>Target Population/Audience</strong></th>
<th>Consumers and the community and public at large.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Goals</strong></td>
<td>The program envisions an authentically inclusive community that welcomes people with mental health and substance abuse issues, and their families, with equal opportunities to live, love, learn, lead, work, pray and play. We see a community in which people with mental health issues are not defined by their diagnosis, but by the life they lead.</td>
</tr>
<tr>
<td><strong>Costs Involved</strong></td>
<td>Not indicated.</td>
</tr>
<tr>
<td><strong>Cultural Appropriateness</strong></td>
<td>Has produced videos that addresses the stigma facing African Americans, Asian American Community, and Latino Community</td>
</tr>
<tr>
<td><strong>Location (Local, national, etc.)</strong></td>
<td>Oakland, California</td>
</tr>
<tr>
<td>Category or Approach: <strong>Advocacy, Contact, Education</strong></td>
<td></td>
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<tr>
<td>---------------------------------------------------</td>
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</tr>
<tr>
<td><strong>Name of Program</strong></td>
<td>Mental Health Interpreter Training Program</td>
</tr>
<tr>
<td></td>
<td><em>Paz Y Calma</em></td>
</tr>
<tr>
<td></td>
<td><em>Tenemos Voz Resource Bank</em></td>
</tr>
<tr>
<td><strong>Name of Organization</strong></td>
<td>National Latino Behavioral Health Association (NLBHA)</td>
</tr>
<tr>
<td><strong>Contact Information/Person/Developer</strong></td>
<td>6555 Robin Cochiti Lake, New Mexico 87083 505-980-5156</td>
</tr>
<tr>
<td><strong>Links</strong></td>
<td>Website: <a href="http://www.nlbha.org">www.nlbha.org</a></td>
</tr>
<tr>
<td></td>
<td><a href="http://lapazycalma.blogspot.com/">http://lapazycalma.blogspot.com/</a></td>
</tr>
<tr>
<td></td>
<td>On Facebook and Twitter</td>
</tr>
<tr>
<td><strong>Description of Program</strong></td>
<td><strong>Mental Health Interpreter Training Program:</strong> This training program trains interpreters and monolingual speaking providers to ensure language access to behavioral health services. The training covers: (1) Causes of stigma and Shame - It's possible to unlearn Stigma and (2) Cultural reasons for stigma associated with mental health conditions.</td>
</tr>
<tr>
<td></td>
<td><strong>Paz Y Calma:</strong> The goal behind this joint venture is to inspire, provide comfort, and serve as a platform for women to speak out about living in the shadows of their anxieties and fears. Most importantly the intent is to bring awareness that anxiety, depression, and panic disorder are not simply mental conditions, but an affliction that can manifest into physical conditions, which may be treated.</td>
</tr>
<tr>
<td></td>
<td><strong>Tenemos Voz Resource Bank</strong> - an on-line resource directory for Latino consumers on resources, services, programs and self-help and advocacy programs that address empowerment, stigma reduction, help seeking, toll-free numbers for help, links to publications and relevant reports.</td>
</tr>
<tr>
<td><strong>Target Population/Audience</strong></td>
<td>MHIT is targeted for two audiences: interpreters and for monolingual English speaking providers on how to use interpreters.</td>
</tr>
<tr>
<td></td>
<td><strong>Pay Y Calma</strong> seeks to engage Latinas experiencing depression and anxiety to share their experiences through an on-line blog to manage for the risks of being stigmatized by more traditional methods of seeking mutual and peer support.</td>
</tr>
</tbody>
</table>
### Goals

**Tenemos Voz** is intended to serve Latino consumers.

**MHIT:**
- Increases the organization’s capability to provide appropriate cultural and linguistic services to culturally diverse communities
  - Increases the number of qualified skilled interpreters within the organization
  - Enhances the skills and knowledge of interpreter staff
  - Improves communication between client and service provider
  - Improves capacity to gather accurate background information
  - Increases the accuracy of diagnosis, treatment and intervention
  - Lowers the risk associated with using untrained interpreters
  - Enables providers to partner effectively with their interpreters in the communication process, and
  - Improves Quality of Care

**Paz Y Calma:** The goal behind this joint venture is to inspire, provide comfort, and serve as a platform for women to speak out about living in the shadows of their anxieties and fears. Most importantly the intent is to bring awareness that anxiety, depression, and panic disorder are not simply mental conditions, but an affliction that can manifest into physical conditions, which may be treated.

**Tenemos Voz** - To provide information and resources to help inform and educate Latino consumers about mental health, wellness, stigma, and self-help.

### Costs Involved

MHIT Training - Contact NLBHA for costs.

*Paz Y Calma* is free of charge.

*Tenemos Voz* is free of charge.

### Cultural Appropriateness

Both programs are focused on benefit Latino/a populations. Use of Spanish language is commonly used with both programs.

### Location (Local, national, etc.)

The MHIT is a face program and is provided nationally. *Paz Y Calma* is an on-line service accessible to persons with access to the internet.

*Tenemos Voz* is an on-line resource bank for persons with access to the internet.


<table>
<thead>
<tr>
<th>Category or Approach: <strong>Advocacy, Contact, Education, Protest</strong></th>
</tr>
</thead>
</table>
| **Name of Programs** | Speak Out Santa Fe  
Candlelight Vigils  
Mental Health Awareness Month  
Mental Health Dialogues  
**Quinto Lunes** |
| **Name of Organization** | NAMI Santa Fe |
| **Contact Information/Person/Developer** | PO Box 8658  
Santa Fe, New Mexico  87501 |
| **Links** | www.namisantafe.org |

<table>
<thead>
<tr>
<th><strong>Description of Program</strong></th>
<th>Multiple Programs:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Speak Out Santa Fe</strong> (Protest and Advocacy) Community forums with panels speaking out about the issues and challenges in finding help and resources for individuals and families struggling with mental illness. Includes how barriers such as stigma, isolation and social exclusion affect individuals and their families. Panels are facilitated and included a wide range of participants such as law enforcement, hospital, court, provider, advocates, consumers, family members and local officials.</td>
</tr>
<tr>
<td></td>
<td><strong>Candlelight Vigils</strong> (Contact): Held during Mental Health Awareness months to draw attention to the lives lost of persons suffering from mental illness. Engages families and consumers to support participants experiencing loss and grief but creating moments of silence, personal prayers, and personal testimonies. Press and media is invited.</td>
</tr>
<tr>
<td></td>
<td><strong>Mental Health Awareness Month</strong> (Education and Advocacy) - Proclamations and resolutions: the local affiliate seeks public record documents to acknowledge the issues, challenges, barriers, stigma, lack of services and needs of persons who are disabled with mental illness.</td>
</tr>
<tr>
<td></td>
<td><strong>Mental Health Dialogues</strong> (Education and Contact) - These are high publicity events with guest speakers in community auditoriums or public venues to speak about their mental illness, the erosion of social and financial support and the misunderstandings and stigma that persons struggled with that they can recover from.</td>
</tr>
<tr>
<td><strong>Quinto Lunes (Education and Contact)</strong> - A charla amongst Spanish speaking family members about the health, well-being and mental illness affecting their loved one. These sessions are held on the fifth Monday each quarter of the year. Currently, not in operation.</td>
<td></td>
</tr>
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</tr>
<tr>
<td><strong>Target Population/Audience</strong></td>
<td>The general public is the audience, engages consumers and family members.</td>
</tr>
<tr>
<td><strong>Goals</strong></td>
<td>To educate the community about mental illness and how to address the needs of persons facing life altering and life threatening conditions: homelessness, suicide, stigma, untreated ailment, shortened life span, and lack of crisis services.</td>
</tr>
<tr>
<td><strong>Costs Involved</strong></td>
<td>No costs to the public. The programs are supported from donations, member dues, and small grants.</td>
</tr>
<tr>
<td><strong>Cultural Appropriateness</strong></td>
<td>The involvement of diverse communities oscillates due to the voluntary, open forums and fear of stigma. The leadership that represents and support diverse communities.</td>
</tr>
<tr>
<td><strong>Location (Local, national, etc.)</strong></td>
<td>Santa Fe County</td>
</tr>
</tbody>
</table>
**Category or Approach: Advocacy, Contact, Education**

<table>
<thead>
<tr>
<th>Name of Program</th>
<th>Behavioral Health Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Organization</td>
<td>Local Collaborative 6</td>
</tr>
</tbody>
</table>
| Contact Information/Person/Developer | Susie Kimball  
Las Cruces, New Mexico |
| Links | Susie.Kimble@uhsinc.com |
| Description of Program | Behavioral Health Day at the Legislature: This is advocacy day intended to convene legislators, state officials, Governor's office, consumers and stakeholders from across the state one day during state legislative session in Santa Fe, NM. The program recognizes the work of advocates and consumers in their communities to advance the need and efforts to address mental health barriers and stigma. The event is help to raise awareness about the need for mental health services and support for consumers and families struggling with mental illness. |
| Target Population/Audience | Elected Officials, State Government policy makers, General Community |
| Goals | To educate, raise awareness and combat stigma keeping individuals and families from accessing mental health services. |
| Costs Involved | Stipends are provided for consumers from the state's local collaboratives. |
| Cultural | The attendees come from across the state including tribal communities. |
The events include diverse individuals of different backgrounds.

Local Collaborative 6 serves Dona Ana and Otero Counties

**Category or Approach:**  **Advocacy, Contact, Education**

| Name of Program | With an OPEN mind  
| Anti-stigma and Anti-discrimination Initiative |
| Name of Organization | St. Josephs Care Group  
| Mental Health Commission of Canada |
| Contact Information/Person/Developer | Brook Latimer, Public Education Coordinator  
| **Calgary Office**  
| Suite 800, 10301 Southport Lane SW  
| Calgary, AB  
| T2W 1S7  
| Tel: 403.255.5808  
| Fax: 403.385.4044 |
| [www.mentalhealthcommission.ca/English/Pages/OpeningMinds.aspx](http://www.mentalhealthcommission.ca/English/Pages/OpeningMinds.aspx) |
| Description of Program | The Mental Health Commission of Canada (MHCC) has launched its 10-year Anti-stigma / Anti-discrimination Initiative, Opening Minds. The initiative is the largest public education systematic effort to reduce the stigma of mental illness in Canadian history. More than 50 anti-stigma programs have been identified and selected for review. |
| Target Population/Audience | Health care providers, youth, communities, schools and other public organizations |
| Goals | It aims to reduce myths and misconceptions surrounding mental illness through the shaping of public attitudes so that people with mental illnesses have an improved sense of acceptance, purpose, and freedom in their communities. *Opening Minds* serves as a catalyst; mobilizing and focusing the actions of others to make a real |
difference in the area of anti-stigma.

<table>
<thead>
<tr>
<th>Costs Involved</th>
<th>Not indicated.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cultural Appropriateness</td>
<td>Programs included indigenous populations and other demographic groups.</td>
</tr>
<tr>
<td>Location (Local, national, etc.)</td>
<td>Regional and national</td>
</tr>
</tbody>
</table>

**Category or Approach:** **Education, Contact, Self-Management**

<table>
<thead>
<tr>
<th>Name of Program</th>
<th>Emotional CPR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Organization</td>
<td>National Coalition for Mental Health Recovery</td>
</tr>
</tbody>
</table>
| Contact Information/Person/Developer | 1101 15th Street, NW #1212, Washington, DC 20005  
Contact: Lauren Spiro, 877-246-9058 (Toll Free) |
| Links | http://ncmhr.org/index.htm |
| Description of Program | The National Coalition of Mental Health Recovery is a coalition of people with psychiatric diagnoses who counter stigma and discrimination through the evidence of their recovery.  
Emotional CPR, an NCMHR project, is a public health education program designed to teach people the skills to assist others through emotional crisis and regain a sense of hope and purpose in their lives. This workbook was developed for the eCPR certification training and provides a thoughtful discussion of the values of eCPR, the features of dialogue, and the primary components of eCPR: C = Connection, P = emPowering, and R = Revitalizing. |
| Target Population/Audience | Consumers, consumer organizations, and the public at large. |
| **Goals** | The organization ensures that consumer/survivors have a major voice in the development and implementation of health care, mental health, and social policies at the state and national levels, empowering people to recover and lead a full life in the community. |
| **Costs Involved** | Not indicated. |
| **Cultural Appropriateness** | Not indicated. |
| **Location (Local, national, etc.)** | National |

**Category or Approach:**  **Advocacy, Contact, Education**

<p>| <strong>Name of Program</strong> | Train The Trainer: A Beginner’s Guide to Stamp Out Stigma |
| <strong>Name of Organization</strong> | Heart and Soul Inc., |
| <strong>Contact Information/Person/Developer</strong> | Carmen Lee, Director 1572 Winding Way, Suite A Belmont, CA 94002 Phone: 650-592-2345 E-mail: <a href="mailto:CarmenSOS@aol.com">CarmenSOS@aol.com</a> |
| <strong>Description of Program</strong> | Stamp Out Stigma is a mental health consumer-driven advocacy and educational outreach program. It strives to make positive changes to the public perception of mental illness and to inform the community about the personal, social, economic, and political challenges faced by people living with mental illnesses. The Train the Trainers program is designed to have consumers on panels to present to community groups and audiences on the lived experience of mental illness and to focus on increase understanding of negative impact that stigma has on persons who are diagnosed with mental illness. |</p>
<table>
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<tr>
<th><strong>Target Population/Audience</strong></th>
<th>Public and community at large. Have conducted over 1,500 presentations and reached 80,000 people.</th>
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<td><strong>Goals</strong></td>
<td>Delivers public presentations to dispel the common myths and stereotypes surrounding mental illness. To stamp out stigma and to reduce the barriers and fear associated with mental illness.</td>
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<td><strong>Costs Involved</strong></td>
<td>Costs for consumer participation on panels.</td>
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<td><strong>Cultural Appropriateness</strong></td>
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<td><strong>Location (Local, national, etc.)</strong></td>
<td>California</td>
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Mental Illness Stigma Reduction in the United States–México Border Region

**Literature Review**

March 8, 2013

Submitted by Behavioral Assessment, Inc. in conjunction with

The National Latino Behavioral Health Association

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Introduction

Mental illness is a treatable medical condition. Yet hundreds of thousands of people, including a disproportionate number of Latinos, suffer needlessly because they do not have access to the latest scientific advancements that promote recovery (U.S. Department of Health and Human Services, 2001). It is estimated that one in four will experience a serious mental, neurological, or substance abuse condition in their lifetime, with a higher burden affecting the poor due to the low access of care, social stigma and discrimination (O’Donnell, 2012). Research reveals that the stigma of being labeled as “mentally ill” is so great that people would rather suffer in silence than seek the help they need (Bell et al., 2011; Corrigan, 2004; Loya, Reddy, & Hinshaw, 2010). This decision affects not only the individual, their friends and family; it causes additional strain and burden on the social and economical wellbeing of the community as a whole (U.S. Department of Health and Human Services, 2001). The United States-Mexico border region is no exception and as a rural area with two of the busiest metropolitan areas in the world in El Paso, Texas/Cd. Juarez, Chihuahua and San Diego, California/Tijuana, Baja California, it poses additional challenges in a bi-national area with high rates of poverty, unemployment and lack of health care providers. Research suggests an upward trend of mental illness, mainly depression, in border communities (O’Connor et al., 2008) making the need to address stigma and promote recovery in this region imperative.

The United States-Mexico border region runs from the southern tip of Texas to California, stretches 62.5 miles north and south of the international boundary (La Paz Agreement) and is the home to approximately 13 million people, the majority Latinos. Specific border counties in New Mexico (Luna, Dona Ana, and Otero), Texas (El Paso and Hudspeth) and Chihuahua, Mexico (Cuidad Juarez) comprise the area known as the Paso Del Norte region. Enrique Mata, Senior Program Officer for the Paso Del Norte Health foundation describes the area in the following statement:

In this region of more than 2 million residents a paradoxical combination of connection and isolation exists. In this area three states and two countries converge, yet the region’s cities are isolated from their state capitols and other metropolitan areas by hundreds of miles of desert. This unique geography challenges organizations and people to be resourceful and united.
(Personal communication, March 28, 2013)

The United States–México border population is growing rapidly and if trends continue, the total inhabitants on both sides will reach an estimated 20 million by 2020 (United States–México Border Health Commission, 2010). People interrelate socially and economically across the geopolitical boundaries daily. A border may determine which economies and political system governs the north or south side of the street however, it does not deflect commonalities such as cultures, languages and social supports (Mier, Bocanegra-Alonso, Dongling, Zuniga & Acosta, 2008; United States–México Border Health Commission, 2010). Although the United States and Mexico have begun to address the needs and acknowledge the impact of mental illness on the wellbeing and health of their communities, the state investment in mental health programs within the Paso Del Norte region has been minimal when
compared to the national average. The National Association of State Mental Health Program Directors Research Institute (as cited by the Kaiser Family Foundation, 2012) reported in the 2010 fiscal year, the United States spent an average of $120.56 per capita on mental health services. New Mexico spent $93.37 and Texas spent $38.99 per capita. Information regarding expenditures on mental health in Cuidad Juarez was searched for but not found. Literature available for the border region is sparse. Very few studies evaluating the mental health state of the inhabitants of the area were found.

In this literature review, we examine 95 peer and non-peer reviewed articles and reports dated from 2001 though 2012 that addressed stigma and mental illness. We searched for articles that were relevant to historically underserved populations and took into consideration the unique challenges of rural communities. We focused on topics that included labeling, discrimination, and belief systems regarding mental illness. We also sought out perspectives addressing children, military, and senior adults. We examined some of the literature from Mexico and Latin America. The literature review concludes with interventions that might be used to reduce stigma in the border region.

**Historical Perspective of Mental Illness**

Historically, people suffering from mental illness had very few options; prior to being locked away in asylums, banishment from their home and community was most likely to occur. People were sent off on ships with no intention to disembark; they were thought to be possessed or defective usually by some fault of their own and they were treated with low social value (Caplan et al., 2011). Early advocates, such as Father Gilbert Jofre, a priest in fifteenth century Spain, became fed up with the daily injustices and inhuman treatment to people suffering from mental illness and inspired his community to build a *Hospital of the Lunatics, Insane, and Innocents* in Valencia, Spain (Arboleda-Flórez, & Stuart, 2012). In nineteenth century Europe, reform of mental health care institutions and the treatment of people with mental illness reentered advocates agendas. This was largely in part due to the living conditions; residents were reportedly chained to walls, sat on straw, and were whipped into submission (Ellis, 2008). Even into the twentieth century, inhumane conditions continued. Andrade Marín (2003), recorded a doctor’s visit to a psychiatric hospital in Quito, Ecuador in 1903, stating the patients “were treated like animals... writhing in unclean yards, enclosed in dirt[y] and gloomy dungeons, fed like wild beasts... naked and maltreated (as cited by Bell, 2010, p.438).”

Mexico, in the early 1900s, during the last ruling years of Porfirio Diaz and the time of the Mexican Revolution, erected the largest state institution dedicated to serving the mentally ill. The general Porfirian philosophy of the institution was to create a “barrier separating the ‘strong and competent’ from the ‘week and corrupted’”(Rivera-Garza, 2001, p. 659). Porfrian psychiatry was especially oppressive to women, committing them to the asylums for violating social norms, including disobeying parents or husbands, seeking revenge for husbands’ infidelity, or acting sexually inappropriate, as defined by the male psychiatrist who diagnosed them. Two common themes were expressed by
women patients; domestic violence and grief (there was a great loss of life during this period) and neither were considered when determining the woman’s diagnosis (Rivera-Garza, 2001).

The United States also was experiencing changes in mental health care during the early 1900s. Small private institutions catered to paying clients incorporated arts, crafts and social activities into the therapeutic treatment. However, many of the larger public institutions, filled with a majority of non-paying residents, became human research labs for diseases such as syphilis and dementia praecox (Geller, 2006).

The care and treatment of people with mental illness throughout the years has been inconsistent and low on society’s list of priorities creating challenges for social and professional support systems, inequities in funding, and service delivery undermining recovery and participation. Later in the century, there was a nationwide push to deinstitutionalize patients, move them back into communities, and provide treatment needs through community based programs (Gittleman, 2008). In 1963, President John F. Kennedy signed into law the Mental Retardation and Community Mental Health Center Construction Act to help create community services to help address the large number of mentally ill; horrific conditions in hospitals and to offer hope offered by new therapeutic techniques and psychotropic medications (Kofman, 2012). Although the treatment for people suffering from mental illness has improved, the idea of social undesirables lingers on. In the twenty-first century, Gittleman (2008) argued many people were merely moved from psychiatric hospitals to correction facilities and even with today’s improvements, people with mental illness still have a 25 year discrepancy in their life expectancy.

**Stigma**

The stigma associated with mental illness is a common reason cited by people for not seeking mental health services (Aromaa et al., 2011). Arboleda-Flórez & Stuart (2012) define stigma as “a feeling of being negatively differentiated owing to a particular condition, group membership, or state in life.” (p.458) Corrigan (2004) further distinguished between what he referred to as public stigma; the way the public reacts to a group based on stereotypes and labels; and self stigma, the way in which an individual turns against themselves because they are a member of a stigmatized group (p. 114). Both public and self-stigmas are detrimental to an individual’s wellbeing. Stigma prevents people from fully engaging in their communities (Bell et al., 2011; Couture & Penn, 2003) due to fear and discrimination based on stereotypes and social intolerance. Stigma has been and continues to be amplified by inaccurate media portrayals depicting mental health patients as unpredictable, dangerous and violent (Corrigan, 2004). This common belief, combined with the misconceptions that people with mental illness are to blame for their condition, have weak character, and that they are incompetent to make their own decisions, feeds the social intolerance that perpetuates prejudice and discrimination both on an individual and societal level (Barney, Griffiths, Christensen & Jorm, 2009; Corrigan, 2004). Studies show that many people with a mental illness are being ostracized from their community; guised as
criminalization, unemployment, and general social intolerance (Bell et al., 2011; Reavley & Jorm, 2011). If a person also suffers from drug dependence, the family is more likely to be blamed for the relative’s condition and socially shunned (Corrigan, Watson, & Miller, 2006). The social inequities caused by power differential of stigmatization are complex because the process is not linear and permeates throughout all walks of life.

Descendants and immigrants from Mexico, Puerto Rico, Dominican Republic, Ecuador, Nicaragua, and other nationalities from the Caribbean, Central and South America, as well as indigenous groups from Mexico and their beliefs on mental illness were studied by Callejas, Nesman, Mowery, and Hernandez (2008). Based on their findings, participants were hesitant to receive mental health services because they did not want to be or have any of their family members identified as “crazy.” Many reported mental illness was shameful. Multiple respondents also stated that they believed emotional or behavioral disturbances in children were “disciplinary problems” and could be resolved with more/harsher discipline (p. 25).

**Discrimination Based on Stigma**

Mental disorders account for the highest rates of unemployment (The World Health Organization, 2011). Mental health stigma impedes a person’s ability to find housing and employment (Couture & Penn, 2003; Overton, & Medina, 2008; Link, Yang, Phelan, & Collins, 2004; Stromwall, Holley & Kondrat, 2012; Corrigan, 2004) possibly due to a misconception that they are irresponsible or incompetent (Bell et al., 2011; Corrigan, Powell, & Rüsch, 2012). The employed exceptions chose to suffer in silence (Corrigan et al., 2009) exacerbating their symptoms and affecting their overall health (Quinn & Chaudoir, 2009). In studies conducted by Barney, Griffiths, Christensen and Jorm (2009) and Corrigan et al (2009) employees with mental illnesses stated that they would rather not seek help, even if programs were offered in the workplace, due to possible repercussions, stigma, and reactions from their employer and co-workers.

The unemployment rate in border counties has been chronically high; the economy is characterized by low wages and composed mostly of services, manufacturing, and agribusiness industries that typically do not provide employer sponsored insurance coverage (United States–México Border Health Commission, 2010). Instead of access to preventive care many families are forced to wait for the health condition to become dire leaving the emergency room the only option (Leal, 2005). Even for those who may carry health insurance, companies have been known to discriminate against mental illness and the treatment it requires (Arboleda-Flórez, 2003).

**Cultural, Family, and Religious Values**

The Mexican culture has historically maintained very strict gender roles for both men and women; men were expected to be dominant and prideful and the women submissive, religious and family focused
(Wilkerson, Yamawaki & Downs, 2009). In a comparative study by Mull et al. (2001), as cited by Ayón (2011) Mexican women experienced more hardships but led healthier lifestyles than Mexican American and non-Hispanic women in the US, but health, both physical and mental, has been shown in many Mexicans to deteriorate with each new generation born in the United States. U.S. born Latinos have a higher risk of developing unhealthy habits and lifestyles such as higher rates of active drug abuse, cognitive impairment, poor parenting skills, history of maltreatment, recent history of arrest and high family stress levels (Ayón et al., 2011; Caplan, et al., 2011). Latina adolescents represent a disproportionate number of suicide attempts; parent-child conflicts were identified as a risk factor (Kuhlberg et al., 2010; Hausmann-Stabile, Kuhlberg, Zayas, Nolle, & Cintron, 2012) and this could possibly be compounded by the fact that they are also at an age most vulnerable to sexual violence (Gaviria & Rondon, 2010).

In Latino cultures, there is a value known as familismo, which stresses the importance of family and often acts as a protector of the emotional and behavioral health of its members (Kuhlberg, Pena, & Zayas, 2010). However, domestic violence (Gaviria & Rondon, 2010), fear of deportation for undocumented immigrants, acculturation, social isolation, and poverty may often strain these strong family bonds (Wilkerson, Yamawaki & Downs, 2009). Studies showed that Mexican immigrant families’ mental wellbeing is affected by high family stress and the lack of social networks (O’Connor et al., 2008; Callister et al., 2011) which has also contributed to illness and premature mortality (Fricks, 2013).

In a study reported by the Pew Hispanic Center and the Pew Forum on Religion and Public Life (2006) examining religiosity of approximately 2000 Latinos, the majority of participants believed that prayer or faith in God could relieve depression (as cited by Caplan et al., 2011, p. 591). Other studies confirm cultural and religious values influence Latino’s causal beliefs about mental illness. Behavioral Health News Service (2011) compiled information from a variety of studies that revealed the cultural stigma for Latinos is so powerful that patients would rather suffer in silence than admit to being “crazy.” These findings support other studies (Guarnaccia, Martinez, & Acosta, 2002; Nadeem et al., 2009; Callister, Beckstrand, & Corbett, 2011; Pollack, & Aponte, 2001) that found Latinos who met the criteria for a mental illness were least likely to perceive or admit the need for professional help. In a study conducted by Nadeem, Lange and Miranda (2008) of low income immigrant and nonimmigrant women (n=1893, 1.7 percent U.S. born Latinas, 39 percent immigrant Latinas), researchers explored mental health care preferences, they found 66 percent of the women were in need of mental health services, but only 10 percent were actually receiving treatment. Out of treatment options nearly 91 percent of immigrant women reported that they would prefer to use faith over medications and counseling to help them when dealing with an emotional problem. In a study conducted by Aguilar-Gaxiola et al (2012), researchers found a sizable percentage of their participants believed that mental illnesses are caused by God’s will or evil done by others (p.23) and can only be healed through a cleansing (limpa) by a folk healer (curandera/o).
Special Considerations

Schools

Approximately 1 in 5 children between the ages of 0 and 18 will meet the criteria for one or more mental disorders at some point in their lives; only one-third of these children will seek help from the mental health system (Starr, Campbell & Herrick, 2002). Research suggests that students with emotional and behavioral disorders (EBD) are underserved and under identified; the longer they are left untreated the more dire the consequences can be for the children’s overall health and wellbeing and the child will likely need extensive and costly treatment in the future (Kauffman, Mock, & Simpson, 2007). Children and adolescents with mental disorders are targets of stigmatization during a time critical to social and emotional development and self-identity formation (Bell et al., 2011; Cooney, Jahoda, Gumley & Knott, 2006). The danger of this stigma is that children, and parents, often accept the negative beliefs held by others about them and a self fulfilling prophecy may result (Lauchlan & Boyle, 2007; Moses, 2010). Theories such as the Pygmalion effect, otherwise know as the self-fulfilling prophecy, and the stigma theory provide evidence of the power labeling has in affecting children’s beliefs about themselves as well as the perceptions teachers, parents and others have of them, negative or positive (Gates, 2010). Challenges in meeting these children’s needs included parents’ negative attitudes towards the special education program, the stigma associated with mental illness, and doubting the ability of the mental health system to actually help their child (Kauffman et al., 2007; Starr et al., 2002; Lauchlan & Boyle, 2007).

In the border region exists one of the world’s most violent cities, Ciudad Juárez, Mexico. Many families living in the area deal with traumatizing events including kidnappings, torture and death, leaving children confused, scared and worried (Leiner et al., 2012). Researchers examined the mental health state of Latino children in the border region in 2007 and 2010. They evaluated a total of 1,261 male and female children between the ages of 6-18 (U.S. n=630, Mexico n=631). Their findings revealed poverty combined with the daily exposure to violence puts children at an even greater risk for mental health issues including depression and cognitive disorders. Leiner et al. (2012) argued the complexity of the problems children face combined with the lack of services are leaving too many of these children untreated producing a dire effect on the overall health of the community both in the short and long term.

Veterans

More than 2.2 million U.S. veterans have served in Afghanistan and Iraq since 2001 (Substance Abuse and Mental Health Services Administration, 2012). Bryan and Morrow (2011) estimated as many as one in four personnel who served in Operation Iraqi Freedom (OIF) and Operation Enduring Freedom has some mental health problem. In an anonymous study of US combat infantry units (total n=6201)
conducted by Hoge et al (2004) it was revealed that only 23-40 percent of those with mental disorders sought treatment and were twice as likely as those who tested negative for a mental disorder, to report stigmatization and other unspecified barriers as reasons preventing mental health care. Straits-Tröster et al (2011) argues that in addition to stigma, access to care would fall into the category unspecified of barriers. Especially for the one third of American veterans who live in rural or highly rural areas. Rural veterans often turn to community providers who may not understand military culture or deployment related mental health issues (Straits-Tröster et al., 2011) that contribute to the increasing rates of suicide, illicit drug use, and other high risk behaviors (United States Army, 2010). The military culture revolves around strength and discipline and views mental disorders as a weakness and admission of a deficit in character; Bryan and Morrow (2011) described it as “Mental toughness and an expectation to master stress without difficulty... with an emphasis on inner strength and self-reliance in order to ‘shake off’ injury and illness (p. 17)” For those who seek mental health treatment, military personal reported the following fears: leaders will treat you different, peers will not have faith in your inability to perform duties, and seeking help will negatively affect a military career (Bryan & Morrow, 2011; Straits-Tröster et al., 2011). The literature search did not produce results specific to United States Veterans originating from or living in the United States/ Mexico border region.

Senior Adults

Benek-Higgins, McReynolds, Hogan and Savickas (2008) reported that only 20 percent of the estimated senior adult population with a mental illness seeks treatment; they contribute this to stigmatizing beliefs about mental illness and misdiagnosis general practitioners. There are many misconceptions regarding senior adults and depression including: mental illness limits and impedes senior adults independence and lifestyle, depression is a natural consequence of aging, and that senior adults would not really benefit from certain kinds of treatment due to their age (Benek-Higgins et al., 2008). Many physicians share this belief and do not consider depression as a viable diagnosis since it mimics many physical problems; with a larger portion of the population entering this age group and the fact that senior adults represent 19 % of the suicide deaths in the United States the consequences of ignoring the mental state of senior adults could be devastating (Benek-Higgins et al., 2008).

Rural Communities

The stigma, both public and self inflicted, of mental disorders afflicts rural clients more than most (Larson & Corrigan, 2010). There are multiple and complex barriers to receiving appropriate treatment for mental health problems, such as, the lack of health care services in the community, financial concerns, and the denial that an mental illness exists (Komiti, Judd & Jackson, 2006; Robinson, et al., 2012). Rural residents are limited to their choices in receiving mental health services; often it’s their general practitioner (Komiti et al., 2006; Trinh et al., 2011; Wrigley, Jackson, Judd, & Komiti, 2005) or a clergy member (Brown, 2009). This can bring other unique challenges if the religious community does
not understand mental disorders as treatable illnesses (Gregg-Schroeder & Nemec, 2007) or if the lack of understanding on the part of the patient discourages them from bringing the subject up to the general practitioner (Wrigley et al., 2005).

**Literature from Mexico and Latin America**

Mexican researchers conducted studies linking children’s mental wellbeing with that of their mother’s (Ozer, Fernald & Roberts, 2008); they recommended that the health system in Mexico do more to serve women clients including providing health literacy, advocating for improved job conditions and addressing the “current epidemic of interpersonal violence” (Gaviria & Rondon, 2010). Portal, Suck, & Hinkle (2010) recommended the government address historical deficiencies in public health policies. They found poverty among Mexican families is creating a need for women and children to join the workforce, causing stressors such as lost educational opportunities, exploitation, drug use and prostitution; indigenous communities are the most affected and underserved (Portal, Suck, & Hinkle, 2010). Sex workers asserted motivations, such as providing for their children, escaping poverty or an abusive relationship, gave them strength to keep working in the industry despite the potentially severe mental health consequences (Choudhury, 2010). Fortuna, Porche, and Alegria (2008) found Latino men were unlikely to seek mental health services despite exposure to political violence and multiple traumatic experiences. Studies showed the majority of adolescents suffering from mental illness are not being treated suggesting a greater priority should be given to adolescent mental health in Mexico (Benjet, Borges, Medina-Mora, Zambrano, & Aguilar-Gaxiola, 2009). In Brazil, researchers found that mental illness, specifically schizophrenia, was incorrectly attributed and explained as drug use, isolation and/or “Lack of faith in God” (Peluso, Peres, & Blay, 2008).

**Mental Health Professionals**

Aguilar-Gaxiola et al (2012) report showed *confianza* (trust) was identified as critical for Latinos when establishing a therapeutic relationship with a mental health practitioner. Trust, they stated, is gained through respect between the practitioner and the individual. When a practitioner does not speak the same language challenges in creating *confianza* arise. Language accessibility is essential to the treatment of mental and physical health disorders. A mental health care provider that does not speak the patient’s language contributes to challenges including the patients’ inability to understand the disorder, their ability to explain current concerns and symptoms, and affects a person’s willingness to comply with and/or successfully complete treatment; it also adds to the overall patient dissatisfaction with the experience (Hodgkin, Volpe-Vartanian, & Alegría, 2007; Sanchez, Chapa, Ybarra, & Martinez, 2012; Zayas, Torres, & Cabassa, 2009). In a study discussed by the Behavioral Health News Service (2011) community based clinics serving Latinas’ seeking help for somatic symptoms would approach the women to explore if mental discord was a possible cause, they reacted by strongly denying the
possibility that they could be “loca” (crazy). The stigma of mental illness is too great and treatment is too often not an option.

Few studies have been done around Latino peoples and their interactions with practitioners but the following studies reveal common themes in today’s society. Goldston et al (2008) found many people distrust mental health professionals. Arboleda-Flórez and Stuart (2012) reported patients stating that were told by mental health professionals such things as that they would never recover, find work, or be able to engage in challenging activities (p.460). They also reported that they were being excluded from treatment decisions, assumed to lack capacity to be responsible for their own lives, and were spoken to as if they were children. Barney et al (2009) and Horsfall, Cleary, and Hunt, (2010) found many mental health professionals were more negative about long-term outcomes for people with mental illness and reported frustration with people with mental illness stating they felt some of the patients were abusing resources that could be used to help treat others. Flanagan, Miller, & Davidson (2009) found many practitioners were becoming overly consumed with treating the diagnosis found in the chart using a one size fits all sort of approach instead of considering the unique needs and strengths of the individual.

Alternatives to the primary care physicians for rural residents include promotoras, spiritual leaders and school nurses. Promotoras, or community health workers, have proven to be extremely valuable to primary care providers (PCP) in underserved communities by helping PCPs identify patients’ needs providing cultural perspective to treatments provided (Waitzkin et al., 2011). Spiritual leaders may be inexperienced and uninformed about how best to provide support but this provides an opportunity to collaborate with these community leaders to increase outreach efforts to make appropriate referrals (Gregg-Schroeder & Nemec, 2007). School nurses may help identify health needs of Latino children and form relationships that foster family connections with mental health services (DeSocio, Elder, & Puckett, 2008).

**Current Efforts to Eliminate Stigma**

Evidence base supporting best practices in anti-stigma programming are currently being developed and are limited in the literature. However, the following section briefly discusses six areas researchers have identified that have been shown to make an impact on reducing stigmatizing views. The six areas combined address stigma through an ecological approach tackling stigma on an individual, family, community and societal level. Examples of items addressed include ways to support the individual’s recovery, community cohesiveness, and the challenge of inaccurate portrayals found in pop culture. Corrigan et al are credited with identifying the first 3 strategies: protest, education and contact. Arboleda-Flórez & Stuart (2012) contributed the next three: legislative reform, advocacy, and stigma self-management.

**Protest**
Corrigan (2004) described protest as a formal objection targeted at influential stigmatizers, such as, politicians, journalists and movie producers. It is used to change misinformed and misguided organizational policies, practices, or public statements that disadvantage people with a mental illness. The goal is to openly object and suppress negative stereotypes of mental illness. It has been employed successfully by advocacy organizations often through letter writing campaigns. What is less certain is if the efforts are having an impact either negative or positive on public perspectives (Arboleda-Flórez, & Stuart, 2012).

**Education**

Education refers to public outreach efforts to replace misconceptions and myths with accurate information. The goal is to improve mental health literacy, reduce the fear often associated with mental illness, and promote early help seeking (Corrigan, 2004). Studies have shown educational programs reduce stigmatizing views towards people with mental illness (Spagnolo, Murphy & Librera, 2008; Reavley & Jorm 2011; Kirkwood & Stamm, 2006) and have been successful in increasing mental health literacy and help seeking behaviors using tools created from pop culture (López et al., 2009). Trainings, such as Mental Health First Aid, have been shown to improve trainees’ knowledge, attitudes and helping behaviors within the community (Kitchener & Jorm, 2006). Appropriate language training for individuals with mental illness reduces linguistic obstacles to receiving proper treatment and empowers individuals to express themselves and actively participate in society (European Union, 2010).

**Contact-Based Education**

Contact-based education reduces stereotypes, reduces the desire for interpersonal distance and improves attitudes regarding mental illness by providing an opportunity to learn and interact with people who are successfully managing mental illness (Corrigan, 2004; Boyd, Katz, Bruce, & Phelan, 2010). People in recovery and who are productive members of society challenge stigmatizing views when they share their experience with others (Hyman, 2008). Social inclusion, which promotes participation, contribution, and recovery, in all aspects of everyday living, not only reduces stigma through interaction, it is a successful intervention and crisis prevention promoting mental health within the community (Mental Health Coordinating Council, 2013).

**Legislative Reform**

Legislative reform includes the development and enactment of protective legislations in order to improve protections for rights and freedoms and reduce social inequities (Arboleda-Flórez & Stuart, 2012). An example includes the push for peer educators’ and promotoras’ services to be reimbursable service through Medicaid, especially since their services are invaluable in providing services to underserved populations (Waitzkin et al., 2011).
Advocacy

Advocacy includes multiple approaches designed to increase priority of mental health on agendas of policymakers and other power groups. The goal is to improve available services, improve avenues of redress, and reduce social inequities (Arboleda-Flórez, & Stuart, 2012). An example is the Family to Family Network, an advocacy organization dedicated to fighting the stigmatizing labels used in society by promoting what they call “people first language.” People first language focuses on the individual first and the disability last (Family to Family Network, 2012).

Stigma-Self Management

Self-stigma can be more detrimental to an individual and their family than stigma from the public. It can be a contributing factor undermining treatment adherence and recovery (Fung, Tsang, & Corrigan, 2008). Stigma-self management includes structured peer-supported self-learning programs that may challenge irrational statements, empower individuals and improving self esteem (Corrigan & Deepa, 2012; Lucksted et al., 2011).

Conclusion

The stigma of mental illness is detrimental to the health of communities in the border region. Untreated mental illness can negatively affect relationships, encourages high risk behaviors such as drug use, and often results in pre-mature death. Yet the shame of being labeled as “crazy” is too great. Many Latinos refuse to believe their condition could be a mental illness and instead often attribute their problems to personal transgressions or malevolent forces (Caplan et al., 2011). The current belief system of many Latinos in the region may be preventing families from seeking help for loved ones, including the children. Kauffman, Mock, and Simpson (2007) argued the consequences can be dire for the children’s overall wellbeing the longer mental illness goes untreated.

There has been very limited research conducted regarding the mental health state of people residing in the United States–México border region and even less regarding the indigenous tribes located in the area. The research that was available found poverty, unemployment and lack of access to care were similar on either side of the border.

Due to the lack of health care professionals and treatment options for rural communities, community-based solutions may lie in non-traditional mental health professionals including peer educators, promotoras and clergy members. The spirituality that many Latinos use instead of seeking mental health treatment is a strength that could be incorporated into anti-stigma efforts. Trainings such as Mental Health First Aid, has been shown as a possible way for communities to outreach and help individuals who are needlessly suffering when proven treatments are available. Efforts to reduce stigma, promote the overall health, provide culturally appropriate interventions, must take into account
multiple and complex challenges the individuals with mental illness continue to face today including the stigma challenges unique to this culture.
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