California's Historic Effort to Reduce the Stigma of Mental Illness: The Mental Health Services Act

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In a historic effort to reduce the stigma of mental illness, California voters approved the Mental Health Services Act in 2004. The law funds a comprehensive statewide prevention initiative that places stigma and discrimination reduction at its center, with 25 projects providing interventions at the institutional, societal, and individual levels.

Stakeholders selected specific strategies from the research-based *California Strategic Plan on Reducing Stigma and Discrimination.* Strategies range from social marketing to increase public knowledge to capacity building at the local level, including training that emphasizes participation by consumers of mental health services and cultural competence. Collectively, these strategies aim to foster permanent change in the public perception of mental illness and in the individual experience of stigma.

We examined the context, planning, programming, and evaluation of this effort. (*Am J Public Health.* 2013; 103:786–794. doi:10.2105/AJPH.2013.301225)

MORE THAN A DECADE AGO, the US surgeon general identified the stigma of mental illness as the most formidable obstacle to progress in improving mental health.[1] Goffman refers to stigma as a spoiled identity.[2] In the case of mental illness, stigma includes negative beliefs (e.g., people with mental health problems are dangerous), prejudicial attitudes (e.g., desire to avoid interaction), and discrimination (e.g., failure to hire or rent property to such people). The desire to avoid labeling oneself negatively or to conceal one's problems from others appears to cause treatment avoidance, increase dropping out, and reduce adherence.[3] Today, California is addressing this social injustice and improving the well-being of its communities through a comprehensive statewide initiative supported by Proposition 63, the Mental Health Services Act (MHSA).[4]

Passed by California voters in 2004 amid calls for fundamental changes to mental health care, the MHSA begins to fulfill California's 30-year-old promise to build a community-based mental health system as an alternative to institutionalization.[4] By imposing a 1% tax on personal income in excess of $1 million, the MHSA provides funding and a framework to transform California's traditional community mental health system to one focused on prevention and wellness, while expanding services to underserved populations and California's diverse communities.

In several ways, the MHSA resembles a blueprint for fulfilling the transformative goals identified in the New Freedom Commission's *Achieving the Promise: Transforming Mental Health Care in America* in 2003.[5] The MHSA provides resources to mend a fragmented service delivery system, invest in strategies that support recovery from symptoms, promote community integration rather than institutionalization, and empower clients of mental health services (consumers) and their families to direct their own care. Like the commission's report, the MHSA makes an explicit commitment to reduce stigma and its negative consequences. Furthermore, following the surgeon general's call to apply a public health approach to mental health,[1] the MHSA requires that 20% of all funds (which average $1 billion annually) must support a wide range of prevention and early intervention strategies,[6] including programs to reduce not only the stigma of mental health diagnosis and treatment but also discrimination against people with mental illness.[7] Efforts supported by the MHSA aim to improve knowledge, change attitudes, increase help-seeking behaviors, reduce stigma, and challenge discriminatory policies.

STIGMA REDUCTION AT FOREFRONT OF TRANSFORMATION

Although policy directives called for transformation, it took the involvement of individuals and families who had experienced the negative consequences of stigma and discrimination to ensure the MHSA's commitment to adequately addressing it. Consumers and their families were partners in the process, from drafting the MHSA to campaigning for its passage. Together with the voices of underserved ethnic and cultural groups, the involvement of these stakeholders enriched—and lengthened—planning and implementation efforts.[8] The MHSA mandated stakeholder participation in planning, implementation, and oversight of MHSA programs at the state and local levels.[9–12] Such stakeholder involvement meant new ways of doing business for state and local entities, but they saw significant success: by 2008, more than 100 000 people had participated in MHSA planning throughout the state.[13]

An example of stakeholder involvement was the development of the *California Strategic Plan on Reducing Mental Health Stigma and Discrimination*, a comprehensive 10-year plan to "fight the stigma and discrimination associated with mental health challenges."[14(p10)] Because the MHSA stipulates that a Mental Health Oversight and Accountability Commission (MHSOAC) develop strategies to overcome stigma,[15] the MHSOAC, in partnership with the California Department of Mental Health, established an advisory committee of diverse experts and stakeholders, especially consumers and families, to

develop and publicly vet the state strategic plan. The plan was adopted in 2009 after 2 years of development, and applies scientific knowledge to practice by identifying methods to reduce public, institutional, and self-stigma through the implementation of 4 strategic directions with more than 25 specific activities.[14]

PREVENTION AND EARLY INTERVENTION STATEWIDE PROJECTS

The MHSOAC further sought to fulfill its role by taking a public health approach to stigma reduction. By exercising a statutory mandate to approve prevention and early intervention expenditures, the MHSOAC made stigma reduction an essential part of these efforts.[16] In May 2008, the MHSOAC approved an investment of $160 million in prevention and early intervention funds for 3 statewide projects to be implemented within 4 years: $40 million for suicide prevention, $60 million for improved student mental health, and $60 million for stigma and discrimination reduction.[17] Although MHSA funds flow directly to counties to administer mental health programs, a statewide approach could supply infrastructure and coordination to launch such a significant change to service delivery and to supplement local prevention and early intervention programs. Guidelines developed by the MHSOAC for the statewide initiative required use of strategies from the state strategic plan.[17] This ensured that this 1-time allocation of funds would apply well-researched, stakeholder-supported recommendations to preventing and reducing stigma and discrimination.

The counties decided to act collectively and determined that the most efficient and effective method to administer the initiative would be to form a joint-powers authority and pool their local funds for a statewide effort. The California Mental Health Services Authority represents county governments whose members provide public mental health services. Along with stakeholders, it developed an approach to respond to the guidelines for the initiative that could reach across California's diverse populations. The impact of this single investment, in which short-term outcomes must be measured within 4 years, was maximized by applying strategic policy and program principles, such as leveraging other local, state, and federal resources and using data-driven policies and evidence-based, promising, and community-defined practices.[18]

Figure 1 provides a timeline of key events that led to California's historic effort to reduce the stigma of mental illness through a comprehensive statewide initiative. Such an approach would not have been possible without the framework and funding that the MHSA provided and support from state and local governments and stakeholders.

EMPHASIZING STIGMA AND DISCRIMINATION REDUCTION

As in similar national efforts,[19,20] the California Mental Health Services Authority approached the initiative as

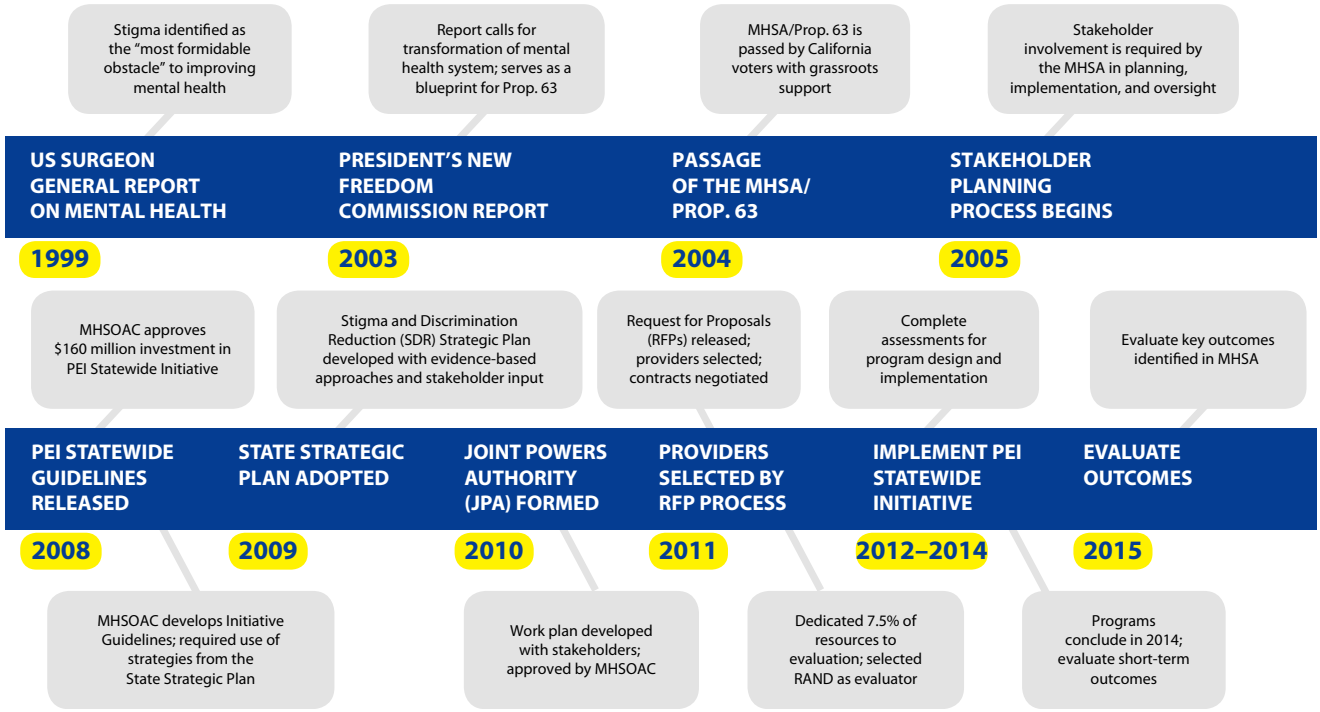
> an opportunity for mental health to become a part of wellness for individuals and the community, reducing the potential for stigma and discrimination against individuals with mental illness.[21(p13)]

After delays occurred in the design phase of the initiative, the authority moved promptly and developed an implementation work plan to achieve the recommendations made in the state strategic plan and conducted a 52-day public comment process to solicit stakeholders' priorities for funding.[22] The work plan places stigma and discrimination reduction strategies as the centerpiece, ensuring that these efforts are included in the suicide prevention and student mental health components. Attaining a measurable reduction in stigma and a measurable increase in the understanding of mental health challenges is part of the approach to preventing suicide and improving student mental health. The final work plan consists of 3 complementary components—stigma and discrimination reduction, student mental health, and suicide prevention—that are being implemented through 25 projects, with an independent statewide evaluation conducted by the RAND Corporation.

The work plan to implement the initiative incorporates elements some theorists argue are necessary to achieve shifts in deeply ingrained attitudes and behaviors, by producing mutually reinforcing changes at multiple levels, typically with a multicomponent approach.[23] Figure 2 depicts how stigma can exist at the level of the institution, society, and individuals and shows that these levels influence one another. Successful interventions capitalize on these interdependencies. This model of change suggests that reductions in mental illness stigma will likely occur to the extent that social norms, individual actions and beliefs, and institutional practices and policies converge to support acceptance of individuals with mental health problems and to the extent that interventions are targeted at these multiple levels.

The work plan uses this conceptual model to employ effective strategies identified in the state strategic plan and consistent with Corrigan's research results, which indicate that stigma reduction efforts are more effective if they are targeted to specific populations or population groups (e.g., employers, landlords, teachers), continuous, credible (using people from the same population groups and similar socioeconomic level to communicate the message in a culturally relevant manner), local, and focused on contact with people with lived experience instead of on dispelling myths.[3] The resulting work plan for the initiative has a stigma and discrimination reduction component consisting of 4 program areas, with 10 projects, all designed to promote permanent change in public perception of mental illness and individual experience of stigma. Table 1 has a detailed description of the research base, program design, objectives, and intended outcomes for all 10 projects.

The Strategies for a Supportive Environment Program aims to create a supportive environment for people with mental illness, their families, and communities by establishing social norms that recognize mental health as integral to well-being. The program addresses findings that many people are unwilling to work closely or socialize with someone with schizophrenia or to have such a person marry into their family.[39] In addition, many adults describe individuals with mental illness as likely to be violent toward others and themselves.[39] The program consists of 3 projects, each emphasizing active involvement of stakeholders within and outside the mental health community. The networking project uses a consortium of members



Note. MHSA = Mental Health Services Act; MHSOAC = Mental Health Oversight and Accountability Commission; PEI = prevention and early intervention; Prop. = proposition.

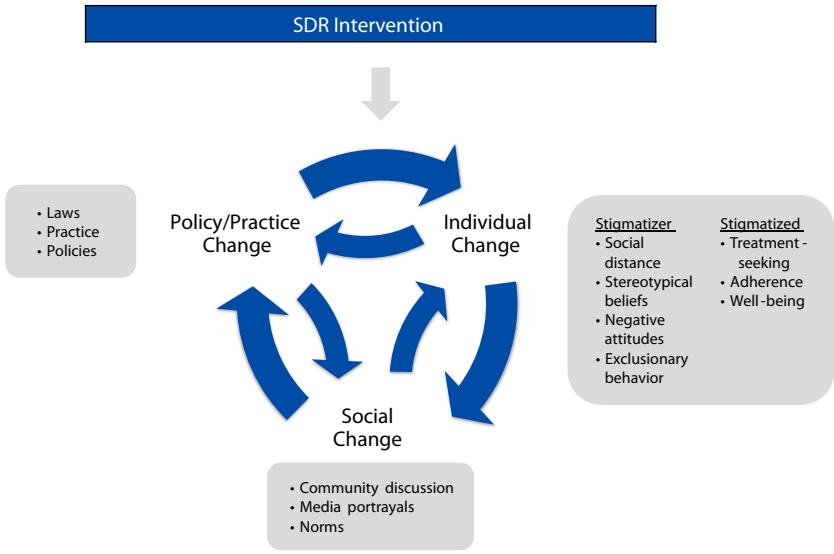
FIGURE 1—Timeline of the Mental Health Services Act/Proposition 63: Prevention and Early Intervention Statewide Initiative.

responsible for coordination of strategies and outreach to various key targets of stigma reduction efforts, such as law enforcement and education. The social marketing project disseminates stigma and discrimination reduction messages to targets of change in knowledge, attitudes, and behaviors, such as youths and people of influence (e.g., property owners and employers). The capacity-building project uses contact strategies to supply messages at the individual and local level, which, evidence suggests, may effect attitudinal changes more successfully than do educational or protest strategies.[40–42]

The Values, Practices, and Policies Program promotes awareness, accountability, and changes in values, practices, policies, and procedures within systems and organizations to encourage respect for and to protect the rights of people with mental health challenges. The program acknowledges that stigma and discrimination occur daily in our communities, a leading reason why three quarters of the 2.2 million Californians (8.3% of the state's population) who report mental health needs also report unmet needs.[43] Individuals aged 18 to 24 years report the most unmet needs, along with adults older than 65 years, Asians, African American males, and Latinos and Asians born abroad.[43] This demonstrates the demand for approaches tailored to specific age, ethnic, and cultural groups. Although evidence exists about the short-term impact of educational interventions on attitudes toward mental illness,[44–46] identifying the longer-term impact and effectiveness of the components of educational and training interventions can be challenging.[47–50] The 5 projects in this program will be evaluated to determine whether their approach has enough efficacy to warrant continued funding. As training interventions with an educational basis, they are a relatively low-cost stigma and discrimination reduction approach that can be disseminated widely.[51–53]

The Promising Practices Program identifies existing stigma and discrimination programs that are successful but have gone unrecognized, particularly in underserved communities of color. This program assesses the presence, penetration, and range of stigma and discrimination reduction programs for underserved communities of color and establishes a baseline for comparison and a gap analysis for project planning and implementation statewide. The project is a partnership among research entities, such as Columbia University's Mailman School of Public Health, and mental health advocates and stakeholders.

The Advancing Policy to Eliminate Discrimination Program aims to identify and eliminate discriminatory practices and policies. The program examines existing laws, policies, and practices that explicitly or implicitly result in discrimination. The program will provide information and activities that increase awareness and understanding of existing laws and regulations that protect people with mental illness and their family members against discrimination.



Note. SDR = stigma and discrimination reduction.

FIGURE 2—Change at multiple levels expected from stigma and discrimination reduction intervention.

To achieve synergetic impact, the statewide initiative targets stigma at the institutional, societal, and individual levels in its suicide prevention and student mental health efforts.

Approximately 90% of persons who die by suicide are found to have had a mental disorder.[54] The Suicide Prevention Social Marketing Program aims to increase public awareness that suicide is preventable, improve recognition of those at risk, encourage help-seeking behavior, and establish links to mental health services. As in the stigma and discrimination reduction campaign, multiple social marketing strategies target high-priority and high-risk populations, such as older adults, youths, and Latinas.

The Suicide Prevention Training and Workforce Enhancement Program strengthens Californians' abilities to recognize mental illness signs and symptoms by providing a range of training options for gatekeepers, caregivers, and other community members through Applied Suicide Intervention Skills Training, safeTALK and e-suicide safeTALK. Training targets range from first responders such as campus police to peer support providers. Many gatekeeper training efforts have demonstrated effectiveness.[55]

The Regional and Local Suicide Prevention Capacity-Building Program expands accredited local suicide prevention hotlines and warmlines to support help-seeking behavior throughout California. Some evidence indicates that crisis lines effectively link individuals in need with mental health services.[56]

The Student Mental Health Program recognizes that educational institutions are key to successful prevention and early intervention strategies, which incorporate stigma and discrimination reduction strategies in appropriate training, materials, speakers bureaus, and other educational strategies. Mental health programs provide opportunities for students (from preschool through higher education), families, and staff to better understand mental wellness and to recognize signs of bullying or other stigmatizing practices, which delay the identification of students at risk for mental health problems, who may have poor self-image. Stigma and discrimination reduction resources will be incorporated into student mental health activities at all levels.

SUPPORTING LASTING CHANGE THROUGH RIGOROUS EVALUATION

In light of the unprecedented breadth and scope of the statewide initiative, the work plan mandated a comprehensive multilevel evaluation. All projects are required to conduct their own program evaluations as well as to participate in an independent statewide evaluation conducted by the RAND Corporation. Goals for the statewide evaluation include establishing baselines and community indicators; improving data collection, surveillance, and program evaluation; identifying innovative programs with potential for replication; and launching a research agenda to design responsive policies and effective programs that reduce stigma and discrimination, prevent suicide, and improve student mental health.[21]

RAND's comprehensive evaluation will assess changes in structures, processes, and short- and long-term outcomes of the statewide initiative (Table 2). Within each area, RAND distinguishes changes attributable to training sessions and other in-person outreach (e.g., speakers bureaus) from changes attributable to social marketing and media advocacy.

Finally, RAND will attempt to identify expected changes associated with each outcome specified in the relevant portion of the stigma and discrimination reduction evaluation conceptual model: individual-level changes, social changes, and institutional and policy changes (Figure 2). As the conceptual model indicates, these changes are reciprocal—likely to build on one another and provide momentum for additional change as stigma and discrimination reduction efforts continue. However, the changes are likely to occur in the order listed, with individual change happening most rapidly in response to the various efforts and social and institutional change taking longer.

INITIAL FINDINGS

At the close of the first year of implementation (June 2012), emerging baseline and assessment data established that stigma was prevalent in California. Data

TABLE 1—Stigma and Discrimination Reduction Projects Funded by the Mental Health Services Act: California, 2011–2014

Project	Description	Research Base for Program Design	Objectives/Intended Outcomes
Networking	Consortium comprises ethnically and culturally diverse representatives from across life span: employers, law enforcement personnel, veterans, primary care physicians, etc.	Members represent targets of stigma and discrimination reduction efforts, helping to tailor strategies to appeal to key targets of change. Consortium supplies credibility aspect of Corrigan's model.[23]	Support coordination and sustainability of SDR programs. Support meaningful roles for consumers and families. Incorporate SDR practices in advocacy activities. Engage diverse communities.
Social marketing	Reduces stigma and discrimination through education, support, and social norm change with targeted campaigns in partnership with community organizations to deliver messages locally. Messages target Californians across the lifespan: pre-inoculation, age 0–8 y; inoculation, age 9–11 y; mobilization, age 14–24 y; people with Influence, age ≥ 25 y.	Consistent with Corrigan's model, delivers targeted, local, continuous, and credible contact strategies.[23] Mobilization campaign launches ReachOutHere.com, Web-based forums with a virtual contact strategy in which trained peer facilitators lead discussions about mental health topics and encourage help-seeking behavior. People with influence campaign focuses local social marketing on power groups, such as landlords and employers. Tactics include a PBS-produced documentary, speakers bureaus, ethnic press and outreach events in cultural communities, and parent and caregiver blogs.	Age ≤ 13 y: increase knowledge of mental health and illness and effect of stigma and achieve behavior change by maturing into teens willing to disclose and offer support to others. Age 14–24 y: increase awareness and engagement with peers, decrease perceptions of stigmatizing difference, increase perception of power to influence change, and achieve behavioral change through disclosure, support, and activism. Age ≥ 25 y: increase awareness of documentary, community forums, and speakers bureaus; decrease perceptions of stigmatizing difference; increase perceptions of new norms; achieve behavioral change through increased willingness socialize, hire, and be a neighbor to persons living with mental illness.
Capacity building	Builds statewide capacity to address stigma through contact strategies. Improves social integration while reducing self-stigma by going into communities, identifying existing local speakers bureaus, and strengthening their capabilities, especially related to cultural competence.	Strategies selected are supported with evidence that using individuals with mental illness experience to combat stigma can foster feelings of empowerment, self-reliance, self-esteem, and can increase knowledge of services, rights, housing, employment, and other relevant issues.[14]	Identify gaps in local capacity and build on existing programs. Implement community contact strategies that are culturally competent, including unique approaches for LGBTQ persons and veterans. Increase public's knowledge, attitudes, and behaviors toward people with mental illness, and in the long term sustain SDR efforts through contact strategies.
Resource development	Identifies existing best practices and gaps in SDR training across multiple systems (schools, primary care, law enforcement, etc.) to disseminate and develop effective resources.	Provides resources to resolve dilemmas communities face when they are interested in implementing an SDR program but are uncertain which to use effectively to achieve intended objectives.	Design instruments and tools to evaluate existing SDR programs. Disseminate best practices and training materials through an Internet clearinghouse. Support the statewide use of more effective SDR programs.
Standards and guidelines for accurate portrayals	Partners with consumer advocates and experts in ethnic media to reduce stigma by working with entertainment, news, and social media professionals.	Aims to combat images of mental illness disseminated by media and entertainment industry,[24] whose portrayals are often inaccurate, associate mental illness with violence, and promote stigma, according to research.[25,26]	Increase media knowledge of mental illness. Decrease stereotypical attitudes among people in media, because portrayals of the mentally ill can negatively or positively affect self-efficacy. Increase accurate stories and encourage changes in organizational policies.

Continued

TABLE 1—*Continued*

Promoting integrated health	Achieves SDR by supporting the integration of behavioral health, primary care, and social services, including strategies to achieve parity between medical and mental health services and financing.	Encourages integration to address association between poor mental health and comorbid chronic health conditions, risky health behaviors, increased physical disability, and decreased quality of life.[20] Recognizes that stigma must be reduced to break down barriers between systems that serve people with mental illness.	Work toward positive changes in organizational policies, practices, and level of integration. Decrease stigmatizing attitudes and behaviors among providers. Decrease stigmatizing attitudes and beliefs among stakeholders. Increase individual empowerment, service satisfaction, and health.
Mental health and system partners	Supplies cultural competency enhancements to National Alliance on Mental Illness affiliates who will provide educational interventions to mental health providers, teachers, school administrators, parents, and students statewide.	Addresses stigma in the mental health provider community, which can cause people to avoid or discontinue services.[14] Employs IOOV, interpersonal contact strategies with success in reducing stigmatizing attitudes and social avoidance.[27–29]	Create positive changes in knowledge, attitudes, and behaviors among public, especially teachers, school administrators, and youths. Change teacher/school disciplinary actions and referrals. Decrease stigma among health care providers and criminal justice staff. Increase reach to ethnic and cultural communities.
Mental health in the workplace	Implements a workplace mental health program aimed at fostering systems change, adapting and deploying existing best practices, and providing supports for managing mental illness in the workplace.	Addresses evidence that workplace wellness programs are cost effective for employers,[30] against whom the second most common ADA complaint involves discrimination and harrassment because of mental illness.[31]	Reduce stigmatizing attitudes and behaviors by increasing employee productivity and decreasing absenteeism. Address workplace mental health issues such as stress and maternal and family mental health.
Promising practices	Assesses the presence, penetration, and range of SDR programs for underserved communities of color and establish a baseline for comparison and a gap analysis for project planning.	Recognizes that stigma and discrimination are understood and experienced differently within underserved communities of color and attempts to addresses gaps in understanding of culturally relevant approaches to mental health service delivery in California.[32–35]	Design instruments and tools to evaluate whether programs employ promising practices in communities of color. Create an accessible database and provide statewide dissemination. Support more culturally responsive SDR programs statewide.
Advancing policy	Examines laws, policies, and practices that explicitly or implicitly result in discrimination. Provide information and activities to increase understanding of existing protections.	Acknowledges that despite powerful antidiscrimination laws, including the Fair Housing Act and the ADA, with mechanisms for enforcement, people with mental illness continue to experience discrimination.[36–38]	Increase awareness of laws, policies, and practices that address discrimination through training. Create policy recommendations for action needed. Launch long-term change to eliminate discriminatory practices.

Note. ADA = Americans with Disabilities Act; IOOV = In Our Own Voice ; LGBTQ = lesbian, gay, bisexual, transgender, queer; PBS = Public Broadcasting Service; SDR = stigma and discrimination reduction.

collected by the Field Research Corporation on middle school youths (aged 11–13 years) are of particular concern. Overall knowledge of mental illness was low, confirming misconceptions and stereotypes. For example, 80% believed that "people with mental illness are more likely to act in ways you don't expect," and two thirds believed that "violent behavior is a form of serious mental illness."[57] More encouraging was that youths saw mental illness as a highly relevant subject— 9 out of 10 believed that "young people my age can have a mental illness just like adults," and 61% believed that it is "very common in the U.S."[57]

Data collected by Field from adults confirmed a prevalence of stereotypical attitudes and demonstrated ambivalence toward stigma's impact, especially among Hispanics and Asians/Pacific Islanders. Less than a majority (46.5%) believed that persons with mental illness are just like everyone else; a majority were unsure about whether treatment is possible (54%) and whether people with mental illness are dangerous (61.7%).[57] Only a slight majority (52%) believed discrimination occurs.[57] Acceptance of persons with mental illness as friends, family members, students, and patients was high, but respondents reported high levels of rejection of such individuals as babysitters, job applicants, tenants, coworkers, and neighbors.

Findings from a media analysis of the largest California newspapers further established stigma's prevalence. In English-language media, negative portrayals of people with mental illness (37.1%) outnumbered the positive (24%), but 51.1% of stories acknowledged treatment and 54.5%

provided sources for help seeking.[58] In Spanish-language media, 70% of the portrayals were negative, with only 14% acknowledging treatment and 1% providing sources for help seeking.[58]

In focus groups conducted among diverse populations statewide, most participants did not know how to define mental health stigma. Those who identified as having a diagnosis of mental illness felt that they had been labeled unfairly, leading to negative perceptions of their character. Focus groups with military respondents revealed the greatest desire to hide a mental illness diagnosis for fear of being shunned or losing job opportunities. Overall, most respondents were not aware of efforts to reduce the impact of stigma and discrimination.[59]

These initial findings validate the need for the initiative and are already being used to further focus project objectives and strategies. The social marketing campaign, in collaboration with the Student Mental Health Program, has prioritized efforts to educate elementary school students, rather than beginning in middle school. The Entertainment Industries Council, whose project is to educate content creators, is strengthening efforts targeting Spanish-language media to provide needed assistance with reducing potentially stigmatizing messages. The capacity-building project is redirecting resources to enhance the capacity of small, community-based organizations to address multiple stigmas that uniquely affect underserved communities of color. Through the use of data to inform implementation, as required by the initiative's design, more effective interventions are already emerging.

CHALLENGES AND DIRECTIONS

California's historic initiative to reduce the stigma of mental illness puts into practice more than a decade of knowledge and advocacy. Key elements aligned to support this comprehensive approach were federal leadership; the MHSA, which provides funding for mental health prevention and early intervention strategies; a research-based and stakeholder-supported strategic plan; and an administrative mechanism to facilitate a significant but time-limited statewide initiative.

The magnitude of the statewide scope, aiming to reach California's more than 37 million ethnically and culturally diverse residents,[60] poses substantial challenges. It is essential to maximize the opportunity provided by this 1-time investment to plan, implement, and evaluate programs so that strategies that work are sustained and able to support long-term change.

An analysis of effective structures, processes, and short-term outcomes is possible, but it will be several years before an analysis of lasting changes in knowledge, attitudes, and behaviors can be conducted. The initiative's role is to launch fundamental change by providing infrastructure, fostering collaboration across systems, and contributing to the knowledge base of effective stigma reduction efforts. Projects that show initial promise may be adopted as prevention and early intervention strategies to sustain in the future, but others will not. At the end of 4 years, the initiative must provide a roadmap for change that is as constructive as possible.

The synergy created by the 25 projects is already shifting the dialogue about mental illness in California to emphasize not only recovery but also the outcomes beyond it: prevention and essential well-being. This approach promotes mental health through innovative methods. By design, California's stigma and discrimination reduction efforts will provide new knowledge on effective strategies and how to achieve them, identify noneffective strategies and how to avoid them, recommend ways to eradicate mental health stigma, and create sustainable measures for

TABLE 2—Evaluation of Projects Funded by the Mental Health Services Act: California, 2011–2015

Evaluation Question	Evaluation Approach
What structures have been created to reduce stigma and discrimination?	Synthesis of individual program evaluations, articulating major products such as new training programs, materials and resources, organizations, and Web sites.
Are they likely to be effective/of good quality?	Assess short-term program outcomes such as participant evaluations and shifts in knowledge and attitudes from training.
	Review curricula to determine whether training and Web sites include elements known to reduce stigma.
	Test media message efficacy through experiments.
Are they sustainable?	Qualitatively review activities undertaken and obstacles and successes experienced during program implementation.
Are they reaching the right people?	Identify people who used/were reached by program and their demographics, focusing on key subgroup targets and geographic location.
	For media-related programs, include items on the statewide survey.
Are they increasing knowledge, reducing stigma and discrimination, and increasing help-seeking in California, among individuals?	Analyze statewide longitudinal survey data.
At the societal level?	Analyze content of entertainment media and journalism coverage.
	Analyze social norms reported in statewide survey.
At the institutional level?	Analyze responses of people with mental illness in statewide survey regarding problems in previous year with schools, employment, corrections officers, the health care system (behavioral and physical), and housing.

monitoring progress at the individual, social, and institutional levels. We invite you to follow our efforts as we report on them at http://www.calmhsa.org. ■

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Human Participant Protection

No protocol approval was required because no human participants were involved.

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Reducing Self-Stigma by Coming Out Proud

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Self-stigma has a pernicious effect on the lives of people with mental illness. Although a medical perspective might discourage patients from identifying with their illness, public disclosure may promote empowerment and reduce self-stigma.

We reviewed the extensive research that supports this assertion and assessed a program that might diminish stigma's effect by helping some people to disclose to colleagues, neighbors, and others their experiences with mental illness, treatment, and recovery.

The program encompasses weighing the costs and benefits of disclosure in deciding whether to come out, considering different strategies for coming out, and obtaining peer support through the disclosure process. This type of program may also pose challenges for public health research. (*Am J Public Health.* 2013; 103:794–800. doi:10.2105/AJPH.2012.301037)

PEOPLE WITH MENTAL ILLNESS who internalize stigma (self-stigma) often experience significant loss of self-esteem and self-efficacy,[1,2] which may interfere with the course of their illness,[3] achievement of personal goals,[3–5] and participation in evidence-based services.[5,6] An interesting empirical question is the role of identity and disclosure on self-stigma. A medical perspective, which attempts to eliminate disease, might recommend that people distance themselves from a mental illness identity and might see disclosure as harmful to self-esteem and self-efficacy. However, research shows that sharing one's experiences with mental illness and corresponding treatments can be empowering and may actually enhance self-esteem for some people.[7,8]

We sought to make sense of these seemingly contrary circumstances and to discover theoretical ground for the essential public health goal of informing the advocacy community about how it might develop an effective approach to self-stigma change. The gay, lesbian, bisexual, transgender, and questioning (GLBTQ) community calls this coming out: announcing to the world one's sexual orientation proudly to assert control over one's life. Although the experiences of GLBTQ individuals and people with mental illness are not precisely equivalent, they have sufficient parallels to render research and theory from the coming-out literature useful to the self-stigma reduction goals of people with mental illness.

THE PROBLEM OF SELF-STIGMA

Sociologists since Mead and Morris have framed deviance and stigma as social constructions[9]; rather than being inherent, the meaning of behavior is subject to interpretation and definition bounded by the constraints of language and symbol.[10] This has been further described in terms of identity[11]—the conceptualization of self meant to foster a sense of personal esteem and efficacy—and identity threat, the harm that occurs when one's sense of self is challenged by association with a stigmatized group.[12,13] Identity threat appraisals have pernicious effects on emotional well-being (increased anxiety and vigilance) and corresponding health.[13] Social psychologists have further described stigma in terms of cognitive structures, perspectives that are especially useful for making sense of identity threat and self-stigma in people with mental illness: stereotypes (usually negative beliefs about a group, e.g., people with mental illness are dangerous), prejudice (endorsement of these