Special Topic Report – June 2021

REDUCING MENTAL HEALTH STIGMA IN SAN DIEGO COUNTY

County of San Diego Behavioral Health Services

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EXECUTIVE SUMMARY

In the last decade, significant efforts have been made in the County of San Diego to reduce mental health stigma and discrimination, with many of those efforts funded by the Mental Health Services Act (MHSA) Prevention and Early Intervention (PEI) program. This report provides a comprehensive overview of mental health stigma, with the intent to reach a broad audience. To provide a comprehensive report on mental health stigma to San Diego County Behavioral Health Services (SDCBHS) and the greater San Diego population, findings from the 10-item Internalized Stigma of Mental Illness (ISMI-10) assessment, which was included in the Fall 2018 MHSIP Supplemental Report (HSRC, 2019), and the 2020 Community Survey report and data (EVALCORP, 2021) are included. Together these two data sources comprise the perspective of SDCBHS clients (ISMI-10) and San Diego area community members (2020 Community Survey). Additional findings from both data sets, focusing on specific demographic groups that were not included in the original reports, are also included in this report. Some demographic groups, such as race/ethnicity, gender identity, age, sexual orientation, and mental health diagnosis, showed differences in stigmatizing attitudes towards mental health, which will inform continued and future strategies and programs to focus on mental health stigma reduction in the San Diego region.

GENERAL FINDINGS

The ISMI-10 showed that adult and older adult SDCBHS client respondents reported mild levels of internalized stigma. Likewise, there were positive general results from the 2020 Community Survey that showed significant improvement in three of the four mental health stigma domains (social acceptance, mental health openness, and mental health literacy) in 2020 compared to prior years. The domain of mental health knowledge and access remained about the same as in 2018. As a part of the 2020 Community Survey, people read a vignette, which was either a short story about a person with schizophrenia or depression, then answered questions based on the vignette. For some of the vignette questions and other items regarding mental health stigma, there were some differences based on demographic groups of race/ethnicity, gender identity, age, sexual orientation, and mental health diagnosis. Unless otherwise indicated, all results in the Executive Summary are statistically significant ($p < .05$). It is important to note that statistical significance does not always indicate clinical significance. Caution should be taken with reviewing the findings for groups with small sample sizes.

RACE AND ETHNICITY

Trends in the 2020 Community Survey data included some interesting findings that continue to show a need in the San Diego area to provide culturally relevant information regarding mental health and stigma reduction.

Looking at the mental health stigma domains of social acceptance, mental health knowledge, mental health openness, and mental health literacy, respondents who identified their race/ethnicity as Black, Indigenous, and People of Color (BIPOC) often had more positive beliefs regarding mental health stigma, compared to those who identified their race as White. High means shown below indicate less stigmatizing attitudes regarding mental health. Specifically, the data indicated:

- White respondents had better mental health literacy (3.37) than Black/African American (3.36) or Asian (3.31) respondents ($p < .05$).
- Black/African American or multiple race/ethnicity respondents had slightly greater social acceptance of people with mental illness (2.95 and 2.86, respectively) than individuals identifying as White (2.77).
- Individuals identifying their race/ethnicity as Black/African American, Asian, or multiple race/ethnicity (3.07, 2.98, and 3.03, respectively) had greater mental health openness than the overall White respondent mean (2.89).
- Black/African American and multiple race/ethnicity respondents reported better mental health knowledge and access means (3.10 and 2.95, respectively) than White respondents (2.89), but the difference was not statistically significant.

Hispanic/Latino respondents were less sympathetic towards people with mental illness and more reluctant towards mental health treatment in comparison to other race/ethnicity group respondents. Some specific findings include:

- Hispanic/Latino respondents (90%) were least likely to feel sympathy towards people with mental illness, compared to White (98%), Black/African American (96%), Asian (98%), or multiple race/ethnicity respondents (99%) ($p < .05$).
- Among those who indicated they had sought mental health services, Hispanic/Latino respondents (69%) were the most likely to agree they were prevented from seeking treatment sooner because they did not recognize the early symptoms of mental health problems, compared to White (20%), Black/African American (50%), Asian (35%), or multiple race/ethnicity respondents (0%) (not statistically significant).
- Among those who indicated they had sought mental health services, Hispanic/Latino respondents (91%) were least likely to agree that mental illness would improve with treatment, compared to White (98%), Black/African American (96%), Asian (94%), or multiple race/ethnicity respondents (99%) (not statistically significant).

While data on the reasons for not seeking mental health services earlier were not statistically significant, the information for Hispanic/Latino respondents regarding reluctance in seeking help is useful for improving programs by focusing on this vital mental health stigma reduction strategy for this ethnic group.

Promising Attitudes Regarding Stigma Among Racial and Ethnic Groups

Some noteworthy trends emerged from the 2020 Community Survey data about positive attitudes and beliefs regarding mental health stigma among racial and ethnic groups.

- Hispanic/Latino respondents were more likely than non-Hispanics respondents to agree that individuals with mental illness were as productive as others (66% vs. 55%*).*
- Hispanic/Latino and Black/African American respondents were more likely to be willing to work closely with someone who had a mental illness than non-Hispanic respondents (82% vs. 74%*)*, or non-Black/African American respondents (93% vs. 76%).
- Asian and Black/African American respondents were most likely to agree that individuals with mental illness were as productive (100% and 81%).
- Black/African American respondents were the most likely to agree (91%) they would be willing to spend time socializing with someone who had a mental illness.
- White respondents were more likely to agree they were willing to have someone with a mental illness as a neighbor than non-white respondents (89% vs. 81%).

- White respondents were less likely than non-white respondents to agree the person with mental illness in the vignette read should keep the mental health problem a secret from their family (4% vs. 10%).

TAY, ADULTS, AND OLDER ADULTS

While the ISMI-10 data showed no significant differences in results based on age for Transitional Age Youth (TAY), adult, or older adult groups, there were some differences in the 2020 Community Survey. As previously noted, caution should be taken when reviewing the findings for groups with small sample sizes.

Mental Health Stigma Items for TAY

- TAY respondents were less likely than adult respondents to be willing to spend time socializing with a hypothetical person with mental illness (75% vs. 89%), and older adult respondents scored lowest on this item (71%).
- TAY respondents were four times more likely than adult and older adult respondents to believe the family of someone who had a mental illness would be better off keeping it a secret (28% vs. 6% vs. 1%).
- Although most TAY respondents agreed that mental health issues were common, they were less likely to agree with this statement than adult and older adult respondents (88% vs. 97% vs. 92%).
- Although most TAY respondents agreed that suicide is preventable, they were less likely to agree with this statement than adult and older adult respondents (86% vs. 96% vs. 92%).
- Although most TAY respondents reported agreeing that they felt sympathy for people suffering from mental illness, they were less likely to agree with this statement than adult and older adult respondents (81% vs. 98% vs. 98%).
- Although most TAY respondents reported that they would attempt to get help for themselves if they were having mental health problems, they were less willing to seek help than adults and older adult respondents (83% vs. 97% vs. 96%).
- TAY respondents were less likely than adult or older adult respondents to report they would be comfortable talking to a friend or family member about their mental health problems (87% vs. 95% vs. 91%, not statistically significant).

Positive Attitudes Regarding Mental Health Stigma for TAY

- TAY respondents were more likely than adult and older adult respondents to be willing to work closely on a job with someone who had a mental illness (84% vs. 80% vs. 57%).
- TAY and adult respondents were more likely to agree that people with mental illness should be hired just like other people compared to older adult respondents (80% vs. 80% vs. 65%).
- TAY respondents were less likely than adult or older adult respondents to feel that a person with mental illness would lose friends if people knew about his/her mental health problem (30% vs. 35% vs. 51%).

Findings for Adults and Older Adults

- Adult respondents were more likely to agree they would be willing to spend time socializing with someone who had mental illness than TAY or older adult respondents (89% vs. 75% vs. 71%, respectively).
- Older adult respondents were more likely than adults or TAY to agree that the protagonist would lose friends if people knew about his/her mental health problems (51% vs. 35% vs. 30%, respectively).
- Adult respondents were more likely than TAY or older adult respondents to agree that mental health issues are common (97% vs. 88% vs. 92%, respectively).

GENDER

Generally, the ISMI-10 and 2020 Community Survey showed that male respondents were more likely than female respondents to have stigmatizing beliefs about mental health and were more likely to delay accessing treatment, with the exception that males disagreed more than females that people took them less seriously because they have a mental illness. Since 1% (n=20) of the IMSI-10 respondents and less than 1% (n=3) of the 2020 Community Survey respondents did not identify as a binary gender, nonbinary people were not included in comparison group analysis.

According to the ISMI-10 assessment,

- Male respondents were more likely than female respondents to disagree that people ignore them or take them less seriously just because they have a mental illness (65% vs. 57%).
- Female respondents were more likely than male respondents to disagree that they can't contribute anything to society because they have a mental illness (82% vs. 77%).

Based on 2020 Community Survey data,

- Female respondents were more likely to agree they were willing to have someone with a mental illness as a neighbor than were male respondents (92% vs. 80%).
- Female respondents were more likely to agree they would be willing to spend time socializing with someone who had mental illness than male respondents (89% vs. 81%).
- Female respondents were more likely to agree they would be willing to have someone with a mental illness marry into the family than male respondents (51% vs. 36%).
- Male respondents were more likely than female respondents to agree that individuals with mental health problems are more likely to be dangerous (40% vs. 28%).
- Male respondents were more likely than female respondents to delay in obtaining help because they were concerned about what others would think (52% vs. 15%)
- Male respondents were more than twice as likely as female respondents to think treatment would not be effective (48% vs. 15%).
- Male respondents were five times as likely to not recognize early symptoms than female respondents (57% vs. 13%).

SEXUAL ORIENTATION

The 2020 Community Survey data showed a couple of differences when looking at sexual orientation. There were 57 respondents who identified as a sexual orientation other than heterosexual. While this is not a small group size, caution should still be taken in considering these results as they may not be representative of this population. These results include:

- Individuals who identified as other than heterosexual were more likely to currently be in treatment compared to heterosexual/straight respondents (8% vs. 1%).
- Individuals who identified as other than heterosexual had higher mental health stigma domain means compared to those who identified as heterosexual/straight, indicating more positive attitudes in social acceptance (2.89 vs. 2.76), mental health openness (2.96 vs. 2.93), and mental health literacy (3.42 vs. 3.33) domains. These differences were not statistically significant.

MENTAL HEALTH STATUS

Overall, the ISMI-10 data showed that individuals with any mental health diagnosis had mild internalized stigma. There were a few findings regarding diagnosis and level of care worth noting.

- Individuals with an anxiety diagnosis had mean scores indicating minimal internalized stigma (1.88) compared to all other diagnoses.
- The greatest stigma score based on level of care was for those in crisis residential (2.32).

Respondents to the 2020 Community Survey expressed more stigma towards individuals with schizophrenia than depression. Compared to respondents who read the depression vignette, respondents who read the schizophrenia vignette were:

- Less likely to agree that they would be willing to spend time socializing with someone with mental illness (81% vs. 89%).
- Less likely to be willing to work closely with someone with mental illness in the workplace (72% vs. 82%).
- Twice as likely to agree that people with mental health problems are more likely than others to be dangerous (47% vs. 23%).
- More than twice as likely to agree to be around someone with mental illness would make them feel nervous or uncomfortable (44% vs. 19%).
- More likely to agree that people with mental illness shouldn't be allowed to care for children (54% vs. 29%).

RECOMMENDATIONS

The findings from the ISMI-10 assessment and the 2020 Community Survey may help identify areas for continuous improvement in the County of San Diego. First, there continue to be mixed results regarding differences between race/ethnicity groups that show a need to provide culturally relevant and appropriate information about the signs of mental illness, access to treatment, and mental health stigma. For instance, individuals who identify as Hispanic/Latino may benefit from culturally specific educational materials as the data showed they were more likely to delay accessing mental health services and less sympathetic towards people with mental illness compared to other race/ethnic groups.

Regarding gender-specific programming, the data in this report indicate males may benefit from mental health literacy and educational materials tailored to them because they show more stigmatizing beliefs regarding socialization and concerns about what others think. PEI programs like Father 2 Child are a step in the right direction for San Diego. While limited data were available in this report on nonbinary gender identity and mental health stigma, the literature available suggests there is social stigma for those who share their identity as a nonbinary gender, thus resulting in possible challenges to mental health because of this social stigma. Therefore, it is recommended the behavioral services workforce is diversified to include clinicians and program staff who identify as a nonbinary gender, especially those who are transgender so that participants can have nonbinary gender and trans-mental health providers if they so choose.

Throughout the results of the 2020 Community Survey, it was observed that those who read the vignette about someone with schizophrenia had more stigmatizing beliefs towards the hypothetical person in the vignette than those who read the vignette about someone with depression. This shows that community members in San Diego would benefit from positive information about schizophrenia and especially opportunities to connect with individuals who have lived experiences. Programs like In Our Own Voice are powerful in connecting the general community to individuals with lived experiences in a creative and empowering way.

While the data from the ISMI-10 and Community Survey do not include children and youth respondents, the literature presented in this report shows there is a need for school-aged programs and materials. Therefore, we recommend the development and installation of a school-based PEI program focused on mental health stigma reduction. It is important to note that currently, several of the children, youth, and family (CYF) PEI programs include a stigma component in their programming, including Kickstart and HERE Now. Additionally, as the research on effective stigma reduction programming continues to develop, it will be important to monitor advances in the literature to ensure PEI programs are following best practices. The long-term recommendation for addressing mental health stigma specific to youth in San Diego is to engage in a strategic planning process. This process would require collaboration across multiple stakeholder groups to develop and implement a comprehensive, multifaceted stigma reduction plan tailored to the needs of our youth.

Overall, it would be beneficial to increase the amount of data on the topic of mental health stigma, including further longitudinal results. It is recommended that in Spring 2022, the MHSIP should again include the supplemental questions from the ISMI-10 to track progress. Likewise, it is recommended to disseminate the Internalized Stigma of Mental Illness-Adolescent Form (ISMI-AF) with the Spring 2022 Youth Satisfaction Survey (YSS) to gather information on internalized stigma risks among SDCBHS youth clients ages 12 to 21 years of age.

We may never truly know what another person has gone through but by listening empathetically we may get some idea.
-Consumer Advocate

INTRODUCTION

PURPOSE

In the last decade, significant efforts have been made in the County of San Diego Behavioral Health Services (SDCBHS) to reduce mental health stigma and discrimination, with many of those efforts funded through the Mental Health Services Act (MHSA) Prevention and Early Intervention (PEI) funds. This report provides a comprehensive overview of mental health stigma, intending to reach a broad audience. Two data sources already exist that provide the consumer and community perspective on mental health stigma. These are the *Fall 2018 MHSIP Supplemental Report* (HSRC, 2019) and the *Suicide Prevention and Stigma Reduction Media Campaign: Community Survey Full Report: 9 Year Post-Launch* (EVALCORP, 2021). The first report provides findings regarding SDCBHS client perceptions of mental health stigma that were assessed using the 10-item Internalized Stigma of Mental Illness (ISMI-10) assessment, included as a supplement to the Fall 2018 Mental Health Statistics Improvement Plan (MHSIP) Consumer Survey. The second report, recently prepared by EVALCORP, is in response to assessing the effectiveness of the *It's Up to Us*, a mental health stigma reduction campaign, and includes findings from questions concerning mental health stigma. By sharing findings from each of these reports, as well as additional data analysis not included in the original reports, this current report will provide specific mental health stigma findings that can be utilized by SDCBHS staff, PEI, Innovations, Community Services and Supports program staff and community partners such as the Suicide Prevention Council. This report aims to provide a general overview of how attitudes regarding mental health stigma for SDCBHS clients and San Diego community members as shown through the ISMI-10 and longitudinal and 2020 Community Survey data. Also included for both data sets are the findings for demographic group differences and recommendations on how these differences and general mental health stigma can be addressed through specific strategies and programming.

BACKGROUND

Mental health illnesses are common, and access to mental health care and treatment is becoming increasingly available and tailored to individuals in a way that facilitates recovery. However, the health and social consequences of mental health stigma continue to exist. This includes barriers for individuals to seek care and treatment, exposure to discrimination for mental health issues, and individuals internalizing stigma that leads to having negative feelings about themselves. Stigma may generate discrimination and rejection towards people with mental illness. Some may internalize these social beliefs, which may reduce self-esteem and self-efficacy and decrease quality of life. Additionally, stigma could impact mental health problems being left untreated, and the individual's symptoms may worsen. Mental health stigma strongly predicts unwillingness to seek psychological help and often interferes with recovery efforts (Sarkin et al., 2014). Less than half of people with mental illness seek treatment, and among those that do, many do not fully adhere to the protocol or duration of their prescribed treatment (Sickel et al., 2019). Mental health stigma experiences may be influenced and may differ by demographic group characteristics such as race/ethnicity, age, and gender. Some researchers suggest the fear of 'double stigma' (i.e., being discriminated against for both mental illness and being in a minority group) or cultural conflicts may also increase experiences of mental health stigma (Sarkin et al., 2014). Lastly, it appears that demographic and clinical factors are related to mental health stigma experiences (Sarkin et al., 2014).

The California Well-Being Survey (CWBS), a surveillance tool designed to track prevention and early intervention activities and the critical targeted outcomes, sampled California adults who were at risk for or were experiencing mental health problems from 2013-2014. Results showed most CWBS respondents did not perceive the public to be supportive of people with mental health problems but instead perceived high levels of stigma and discrimination. Meanwhile, CWBS respondents held favorable attitudes toward recovery and mental health treatment. Findings indicate a need for stigma and discrimination reduction efforts in California but also account for potential cultural variations, such as racial/ethnic and language differences (Wong et al., 2015).

Mental Health Stigma: Diverse Populations

Mental health stigma is experienced among minority populations and is a factor in individuals seeking help and accessing services. Furthermore, misunderstanding of culture and diverse populations contributes to barriers in recovery for these groups (American Psychiatric Association, 2017a). Interventions, programs, and mental health public campaigns need to address public and internalized stigma while dispelling inaccurate knowledge regarding mental health and disparate populations. However, further studies are needed to reveal how demographic predictors contribute to stigma experiences and engagement in mental health services.

Racial and Ethnic Disparities

Racial and ethnic differences in mental health stigma vary in California as it is a racially and ethnically diverse state. Previous research has found individuals who identify their race/ethnicity as Hispanic/Latino, Asian American, or Black/African American have more stigmatizing views of mental illness compared to those who identify as White race category (Collins et al., 2014). A survey conducted by the California Mental Health Service Authority (CalMHSA) and the RAND Corporation measured the willingness to interact with people experiencing symptoms of mental illness in various situations as an aspect of mental health stigma. Results showed Asian Americans expressed the highest level of concern about interacting with people with mental illness (40%), whereas Whites expressed the lowest level of concerns (15%). Blacks/African Americans' and Hispanic/Latinos' level of concern most resembled that of Whites, but Hispanic/Latinos were the least willing to work closely with someone experiencing symptoms of mental illness (Collins et al., 2014). Another group impacted by mental health stigma is refugees and asylum seekers. Due to stigma based on culture, refugees and asylum seekers may be more resistant to seeking help in fear that doing so would interfere with obtaining a job, housing, and permanent citizenship (American Psychiatric Association, 2017b). If mental health stigma impacts minority racial and ethnic groups disproportionally, this influences the attitudes and intentions toward seeking mental health services for Black, Indigenous, and People of Color (BIPOC).

Age Disparities

The causes, consequences, and burden of mental health stigma during childhood and adolescence are under-researched and poorly understood (Corrigan et al., 2012; Heary et al., 2017; Hefflinger & Hinsahw, 2010). While the literature on mental health stigma in adulthood is more robust, experts caution against applying these findings to youth because children's social experiences and cognitive development are unique (Corrigan et al., 2012; Heary et al., 2017).

The available evidence suggests mental health stigma is likely widespread among children. Research has found both adults and peers view children with mental illness as more dangerous and violent, more likely to "get in trouble," and lazier than their peers (Parcesepe & Cabassa, 2013). Adults and children also express a preference to socially distance themselves from children with ADHD and depression (Parcesepe & Cabassa, 2013). High levels of "parent-blaming" for childhood mental health disorders indicate that stigma may extend beyond children to their family and caregivers, further complicating intervention efforts (Heflinger & Hinshaw, 2010, Pescosolido et al., 2007). Experiences of stigma can lead to social exclusion by peers and affect how adolescents view themselves (Bulanda et al., 2014). Additionally, mental health stigma has been found to negatively impact help-seeking behaviors and may contribute to low rates of mental health treatment, increased risk of suicide, and lower quality of life among children already suffering from the burden of mental illness (Nearchou, 2017; Heary et al., 2017).

Among the younger population from ages 12-25 years old, a national survey found this group held stereotypes of those with mental illness as dangerous and as 'weak not sick' (Heary et al., 2017). Moreover, the influence of perceived public stigma appears to be a predictor of help-seeking for adolescents with symptoms of depression, anxiety, and self-harm, which likely is due to the high value youth place on the perception of peers and others in their social circles (Finiki et al.,2018).

When considering mental health stigma for adults and older adults, one study showed that those between the ages of 55-74 years old were estimated to be two to three times more likely to report positive help-seeking attitudes than younger adults (Mackenzie et al., 2009). However, these results vary when adding in race and ethnicity. Another study suggested that African American older adults were more likely to internalize stigma and have less positive attitudes towards seeking mental health treatment than individuals who identify as White (Conner et al., 2010). Likewise in a study using the Centers of Disease Control (CDC) and Prevention Behavioral Risk Factor Surveillance System (BRFSS) survey, Hispanic adults aged 55 and older had the least favorable views on the effectiveness of mental health treatment. Therefore, looking at the impact of age on help-seeking behaviors and mental health stigma should be considered in conjunction with race/ethnicity disparities.

Gender Disparities

Studies on mental health stigma show varying findings for gender differences. Some studies reveal women are less likely to be stigmatized for having a mental illness and less likely to stigmatize others but are more likely to internalize stigma to a greater degree compared to men (Sarkin et al., 2014). Additionally, while the overall prevalence of mental illness in men is lower than in women, men are also less likely to "endorse the potentially positive aspects of facing mental health challenges" (Sarkin et al., 2014, p.1) and less likely to seek mental health treatment (Chatmon, 2020). Gender disparities with mental health stigma start at an early age. A questionnaire given to 274 eighth-graders revealed that girls were more willing to use mental health services than boys and that boys had less knowledge about mental health and greater stigmatizing attitudes than girls (Chandra, 2006). These differences in seeking help are believed to be attributed to traditional gender norms (e.g., men being dominant and masculine) (Chatmon, 2020).

Additionally, individuals who identify as a nonbinary gender also experience mental health stigma and are subject to prejudice, systematic oppression, and discrimination due to their

gender identification. Research has also shown gender-related discrimination for those choosing a nonbinary gender was positively associated with psychological distress such as depression and anxiety (Valente et al., 2020). Specifically, concerning transgender, gender stigma operates on several levels including, individual, interpersonal, and structural dimensions, influencing health-related effects, including mental health (Hughto, 2015). Knowledge of stigma, mental health, factors of resilience, and minority coping mechanisms remains limited among sexual and gender minority populations (Bockting et al., 2013 and Hughto, 2015). Future mental health interventions and longitudinal studies are needed to better understand the role of gender literacy, development of identity and resilience, and mental health among transgender and gender nonbinary people (Valente et al., 2020).

Sexual Orientation Disparities

People who are other than heterosexual may face multilevel variables of mental health stigma (e.g., public stigma against sexual minorities, insurance companies, provider bias, etc.), and the Minority Stress Model explains that socially produced disparities do exist. Sexual orientation discrimination among racial, ethnic, and gender minorities can lead to external stress (i.e., discrimination), interactive proximal stress (i.e., the anticipation of external stress to occur), and internalized stressors (Valentine, 2018). As a result, people who are other than heterosexual are at a greater risk of facing emotional problems such as suicide, major depression, and anxiety disorders compared to heterosexual individuals. Studies also reveal that while people who are other than heterosexual are more likely to receive mental health services, they also have higher self-reported suicidal attempts (Meyer, 2013).

Mental Illness Diagnosis Differences

There are differences in stigmatizing views based on mental illness diagnosis. Stigmatizing perceptions of people with mental illness as a danger to themselves and others is widespread and has increased over time but recently appeared to have stabilized. Perceptions of dangerousness varied by mental health illness, causal attributions of mental health illness, and sociodemographic characteristics (Parcesepe and Cabassa, 2013). People with a mental illness are more likely to experience housing and employment discrimination, homelessness, compromised financial autonomy, and are more likely to be restricted from opportunities. This may also lead to coercive treatment and reduced independence through institutionalization (Parcesepe and Cabassa, 2013). Previous stigma research focused on specific serious mental illness (SMI) diagnoses, such as schizophrenia, major depressive order, and bipolar disorder. People diagnosed with schizophrenia are more stigmatized than people diagnosed with major depression. However, there is a lack of social insight among individuals with schizophrenia, as "people with mood disorders reported more discomfort with disclosing mental illness than people with schizophrenia" (Sarkin et al., 2014).

A study conducted by Pescosolido et al. explored the public's perception of social acceptance or rejection of people with schizophrenia, major depression, and alcohol dependence. Results showed although two-thirds of the public attributed major depression to neurobiological causes and high proportions of the respondents endorsed treatment, social acceptance, and perceived danger associated with people with schizophrenia, major depression, and alcohol dependence (Pescosolido et al., 2010). Stigma could be a source of healthcare disparities and other population health inequities because the public may not stigmatize all mental health disorders to the same degree. For example, people with anxiety disorders may not be

discriminated against as much in comparison to people with SMI diagnoses because anxiety may be viewed as less severe. Thus, people with SMI diagnoses would report more stigma related to their mental health illness (Sarkin et al., 2014). With the increase of mental health clinical research, more of the public understand the neurobiological aspects of mental illness. This can translate the support for services but not a decrease in stigma (Pescosolido et al., 2010). Stigma reduction strategies will require providers and mental health advocates to emphasize competency and inclusion. Anti-stigma campaigns will need to "focus on abilities, competencies, and community integration of people with mental illness and substance use disorders to address public stigma" (Pescosolido et al., 2010).

As mentioned above in the brief review of mental health stigma literature, this demonstrates that there is a need for more research to clearly understand the complexities of stigma, especially regarding demographic group disparities. This report will present findings from the County of San Diego data regarding attitudes and beliefs about mental health stigma from the perspective of clients and community members. This report includes topics about the stigma that continue to be addressed and improved over time in the San Diego area. The report concludes with an overview of strategies that have proven successful and recommendations about further work to reduce mental health stigma in the greater San Diego region.

UNDERSTANDING STIGMA FROM THE PERSPECTIVE OF CLIENTS

On a bi-annual basis, adult and older adult (AOA) clients of the SDCBHS System of Care (SOC) complete the MHSIP Consumer Survey to share thoughts on service provision. The administration of the survey in the Fall of 2018 included supplemental survey items on mental health stigma, including the 10-item Internalized Stigma of Mental Illness (ISMI-10) assessment. The ISMI-10 is a shortened version of the original 29-item Internalized Stigma of Mental Illness (ISMI) scale that is used to assess perceptions of mental health stigma when participant survey burden is a concern (Boyd, Otilingam, & DeForge, 2014). There is strong evidence that the ISMI-10 is a practical, reliable, and valid alternative to the original tool (Boyd, Otilingam, & DeForge, 2014).

The assessment was offered to all AOA clients of SDCBHS services who received services during the week of November 5-9, 2018. Responses to at least one of the ISMI-10 items were received from 1,979 AOA clients of the SDCBHS SOC. Findings from the supplemental ISMI-10 assessment are highlighted in this report.

WHO PROVIDED FEEDBACK?

Respondents of ISMI-10 represented slightly more female respondents (51%) than male (48%). Additionally, 1% (n=20) of respondents reported one of the following nonbinary gender identities: genderqueer, transgender, questioning/unsure, or another gender identity (Table 1).

Respondents represented various race and ethnic groups. The respondents that completed the supplemental survey identified their race/ethnicity as Asian/Pacific Islander (9%), Black/African American (14%), Hispanic (30%), and White (41%) (Table 1). The remaining respondents (6%) reported their race/ethnicity as Native American, other, or unknown.

Most respondents (72%) were between the ages of 26 and 59. The remaining respondents were ages 60 years or older (16%), referred to as older adults (OA), as well as respondents less than 18 through 25 years of age (12%), referred to as transition-aged youth (TAY) (Table 1).

Table 1: ISMI-10 Respondent Characteristics

Gender (N=1,815)		
	Male	48%
	Female	51%
	Another Gender Identity	1%
Race/Ethnicity (N=1,816)		
	Asian/Pacific Islander	9%
	Black/African American	14%
	Hispanic	30%
	Native American	1%
	White	41%
	Another Race/Ethnicity	4%
	Unknown	1%
Age (N=1,816)		
	<18 thru 25 (TAY)	12%
	26 thru 59 (Adult)	72%
	60+ (Older Adult)	16%
Level of Care (N=1,355)		
	OP	54%
	ACT	37%
	CM	4%
	CR	4%
	Other	1%
Diagnosis (N=1,814)		
	Schizophrenia & Other Psychotic Disorders	64%
	Bipolar Disorders	16%
	Depressive Disorders	16%
	Stressor & Adjustment Disorders	2%
	Anxiety Disorders	1%
Co-occurring SUD (N=1,814)		
	SUD	59%
	No SUD	41%
Living Situation (N=1,816)		
	Lives Independently	72%
	Board & Care	14%
	Homeless	8%
	Institutional	3%
	Justice-related	<1%
	Other/Unknown	3%

Respondents included individuals engaged in varying levels of care (LOCs), including outpatient (OP), Assertive Community Treatment (ACT), Case Management (CM), Crisis Residential (CR), and other services. When the survey was administered, more than half of the respondents (54%) were receiving OP services, and more than one-third (37%) were receiving ACT services. The remaining respondents were receiving CM (4%), CR (4%), or other (1%) services. Information regarding LOC was unavailable for 624 survey respondents, and those respondents have been excluded from the percentages displayed in Table 1.

Almost two-thirds of the respondents (64%) reported having a primary diagnosis of schizophrenia or other psychotic disorders, followed by bipolar disorders (16%) and depressive disorders (16%). The remaining respondents reported having stressor and adjustment disorders (2%) or anxiety disorders (1%) (Table 1). In addition to a primary mental health diagnosis, more than half (59%) of respondents also had a substance-use disorder.

Most survey respondents (72%) lived independently. The remaining respondents reported their living situations as board and care (14%), homeless (8%), institutional (3%), justice-related (<1%), or other/unknown (3%) (Table 1).

HOW ARE PEOPLE AFFECTED BY MENTAL HEALTH STIGMA?

The supplemental survey is important in helping understand how people are affected by mental health stigma. As part of the survey, respondents were asked whether they strongly disagreed, disagreed, agreed, or strongly agreed with ten statements regarding their experiences and beliefs about mental health stigma. Each item was rated on a 4-point scale ranging from 1 (strongly disagree) to 4 (strongly agree). In general, items with greater agreement suggest greater perceived stigma and are displayed in blue in Table 2. However, two items are reverse-coded, and therefore greater disagreement on these items also suggests greater perceptions of stigma. These two items are marked with an asterisk and displayed in grey in Table 2.

Overall, many respondents endorsed the ten mental health stigma items asked via the supplemental survey. Almost half of the respondents (44%) agreed or strongly agreed with the statement, “I don’t socialize as much as I used to because my mental illness might make me look or behave ‘weird.’” Additionally, many respondents agreed or strongly agreed with the statements, “having a mental illness has spoiled my life” (41%) and “people ignore me or take me less seriously just because I have a mental illness” (39%). The proportions of respondents that agreed or strongly agreed with the remaining statements provided on the survey are displayed in blue, and the respondents that disagreed or strongly disagreed with the two reverse-coded items are displayed in grey in Table 2. The average rating and standard deviation for each item are also displayed in Table 2.

Responses to at least half of the ISMI-10 items were received from 1,960 consumers. While the ten items comprising the ISMI-10 encompass all five dimensions of the original 29-item tool, a total ISMI-10 score was calculated and reported here instead of subscale scores, based on the recommendations outlined in Boyd, Otilingam, & DeForge (2014). Data from the 1,960 respondents who completed at least half of the items were averaged together to generate an overall Internalized Stigma score of 2.21 (Table 2).

A 4-category score interpretation utilized for ISMI scores (Lysaker, Roe, & Yanos, 2007) classifies average scores in the following way:

- 1.00-2.00 (minimal to no internalized stigma),
- 2.01-2.50 (mild internalized stigma),
- 2.51-3.00 (moderate internalized stigma), and
- 3.01-4.00 (severe internalized stigma).

Based on these categories, on average, the respondents who completed the ISMI-10 reported mild internalized stigma.

Table 2: Beliefs about and Experiences with Mental Health Stigma

ISMI-10 Item	Agreement	Average**
1. Mentally ill people tend to be violent (n=1,947).	24%	2.07 (0.74)
2. People with mental illness make important contributions to society (n=1,935).*	25%	2.14 (0.78)
3. I don't socialize as much as I used to because my mental illness might make me look or behave "weird" (n=1,935).	44%	2.38 (0.85)
4. Having a mental illness has spoiled my life (n=1,939).	41%	2.35 (0.86)
5. I stay away from social situations in order to protect my family or friends from embarrassment (n=1,941).	33%	2.20 (0.82)
6. People without mental illness could not possibly understand me (n=1,936).	36%	2.28 (0.81)
7. People ignore me or take me less seriously just because I have a mental illness (n=1,937).	39%	2.33 (0.82)
8. I can't contribute anything to society because I have a mental illness (n=1,938).	20%	1.98 (0.75)
9. I can have a good, fulfilling life, despite my mental illness (n=1,932).*	26%	2.11 (0.82)
10. Others think that I can't achieve much in life because I have a mental illness (n=1,938).	36%	2.26 (0.83)
Internalized Stigma Score (n=1,960)		2.21 (0.48)

*Items are reverse coded.

**Standard deviations are reported in parentheses.

Legend: Agree or Strongly Agree; Disagree or Strongly Disagree

HOW DOES MENTAL HEALTH STIGMA DIFFER ACROSS DEMOGRAPHICS?

The ISMI-10 responses were also examined by key demographic variables including 1) LOC provided within the SDCBHS SOC, 2) age group, 3) gender, 4) primary diagnosis, and 5) history of a co-occurring substance use disorder.

Stigma Score Classification

- 1.00-2.00 (minimal to no internalized stigma)
- 2.01-2.50 (mild internalized stigma)
- 2.51-3.00 (moderate internalized stigma)
- 3.01-4.00 (severe internalized stigma)

Mental Health Stigma by LOC

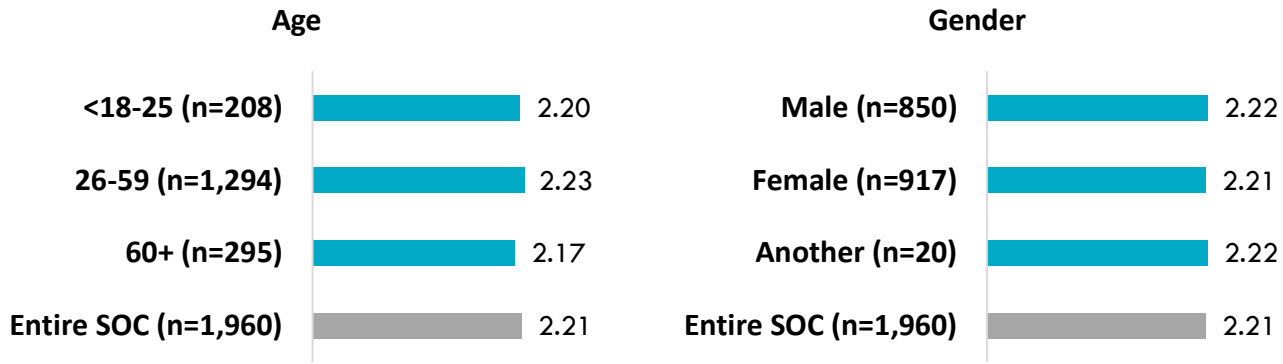
Average stigma scores were similar across LOCs, and all suggest **mild internalized stigma**. On average, respondents at CR had slightly greater perceived stigma compared to other LOCs [2.32 (SD 0.57)], followed by OP [2.23 (SD 0.48)] and CM [2.22 (SD 0.56)] services.

Figure 1: Mental Health Stigma by LOC (N=1,960)

Mental Health Stigma by Age Group and Gender

Average stigma scores did not vary greatly between age groups or genders, and average scores for all suggest **mild internalized stigma**.

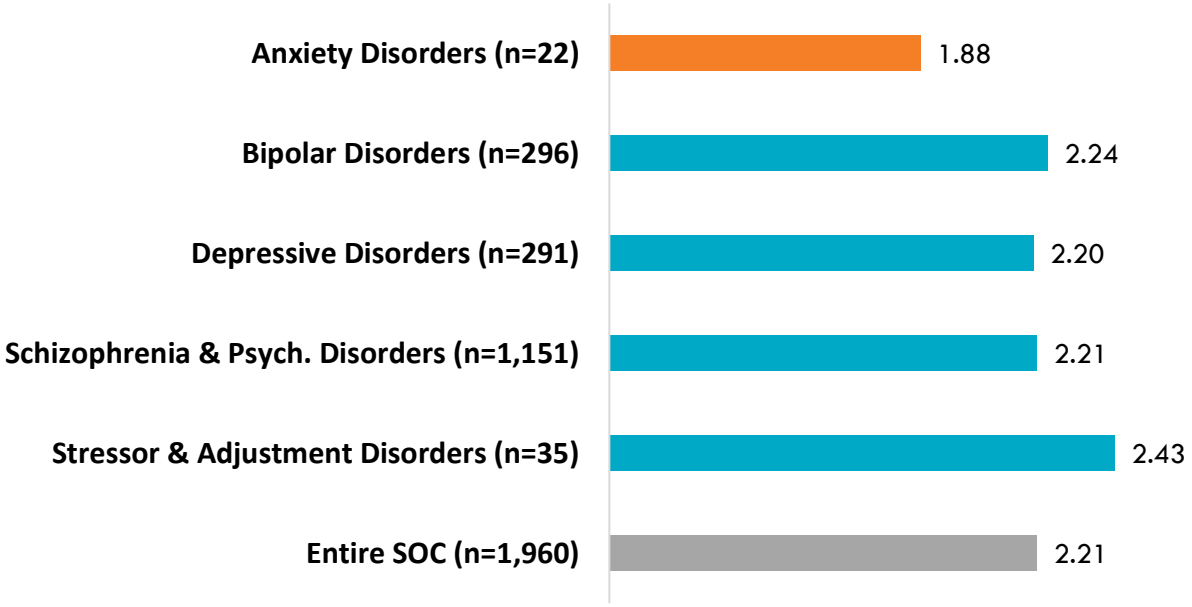
Figure 2: Mental Health Stigma by Age and Gender (N=1,960)



Mental Health Stigma by Diagnosis and SUD History

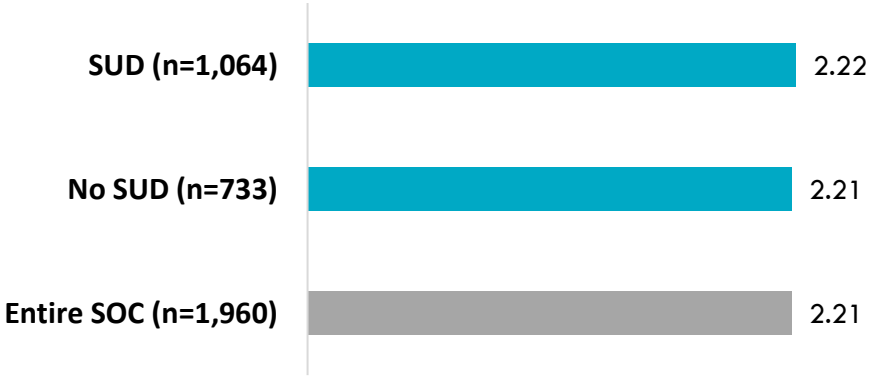
There were notable differences in perceptions of mental health stigma between the listed primary mental health diagnoses. Respondents with an anxiety disorder reported less internalized stigma [1.88 (SD 0.42)] than all other diagnosis categories ($p < .01$). Additionally, on average, respondents with a primary diagnosis of a stressor or adjustment disorder reported greater internalized stigma [2.43 (SD 0.37)] compared to respondents with other diagnoses. However, the average rating still suggests **mild internalized stigma** among respondents with this diagnosis, as well as those with bipolar, depressive, and schizophrenia, and other psychotic disorders.

Figure 3: Mental Health Stigma by Diagnosis (N=1,960)



Average stigma scores did not differ between respondents with a co-occurring SUD and those without a co-occurring SUD. Average scores from both groups of respondents suggest **mild internalized stigma**.

Figure 4: Mental Health Stigma by SUD History (N=1,960)



ISMI-10 Items by Demographic Groups

Age

- ***TAY respondents were more likely*** than adult and older adult respondents to ***agree/strongly agree*** that people with mental illness make important contributions to society (82% vs. 74% vs. 76%, *p < .001*).
- ***TAY respondents were more likely*** than adult and older adult respondents to ***agree/strongly agree*** that they can have a good, fulfilling life, despite their mental illness (83% vs. 73% vs. 74%, *p < .05*).

Gender

- ***Male respondents were more likely*** than female respondents to ***disagree/strongly disagree*** that people ignore them or take them less seriously just because they have a mental illness (65% vs. 57%, *p < .01*).
- ***Female respondents were more likely*** than male respondents to ***disagree/strongly disagree*** that they can't contribute anything to society because they have a mental illness (82% vs. 77%, *p < .05*).

Mental Health Diagnosis

- Individuals with ***anxiety disorders were more likely*** (71%) than those with bipolar disorders (58%), depressive disorders (56%), schizophrenia and other psychotic disorders (68%), and stressor and adjustment disorders (24%) to ***disagree/strongly disagree*** that people without mental illness could not possibly understand them (p < .001).
- Individuals with ***anxiety disorders were more likely*** (96%) than those with bipolar disorders (87%), depressive disorders (78%), schizophrenia and other psychotic disorders (79%), and stressor and adjustment disorders (69%) to ***disagree/strongly disagree*** that they can't contribute anything to society because they have a mental illness (*p < .01*).

Level of Care

- Individuals in ***OP and CR*** (56% and 54%, respectively) were ***less likely*** than those in CM (74%), ACT (70%), and Other (70%) to ***disagree/strongly disagree*** that people without mental illness could not possibly understand them (*p < .001*).

Overall, the ISMI-10 respondents had mild levels of internalized stigma. There were differences between those with anxiety disorders (lowest stigma score) and stressor and adjustment disorders (highest stigma score). However, because the number of respondents with these disorders was small compared to the other diagnoses, caution must be used in interpreting these results. There were significant differences in stigma found across demographics, including age, gender, mental health diagnosis, and LOC. Nevertheless, the level of internalized stigma was low across the various demographics.

SAN DIEGO COMMUNITY BELIEFS AND EXPERIENCES OF MENTAL HEALTH STIGMA

BACKGROUND ON LONGITUDINAL COMMUNITY SURVEY

Since 2010, a crucial part of the Mental Health Service Act (MHSA) Prevention and Early Intervention (PEI) program for the County of San Diego is the *It's Up to Us* media campaign, which supports the vision of Live Well San Diego. The goal of this campaign is to provide multi-faceted education and mental health literacy to reduce stigma and prevent suicide in San Diego County. The campaign utilizes a variety of media sources from printed to public service announcements to social media, all with the desire to help San Diegans talk openly about mental health, recognize symptoms, and become knowledgeable about accessing resources and services.

The San Diego Community Survey was developed to determine the effectiveness of the *It's Up to Us* campaign and continue to understand and address mental health stigma in the San Diego region. The survey has been administered seven times in April 2010, March 2011, March 2012, December 2013, May 2017, December 2018, and December 2020.

Figure 5: Overview of the Community Survey Administration Timeline

The seventh administration was conducted by Rescue Agency through a web-based survey completed by 582 San Diego County residents between October 28, 2020, to January 15, 2021 (EVALCORP, 2021). Participants were required to be 18 years of age or older and a resident of San Diego County. Surveys before 2018 were conducted through a 20-minute telephone survey. However, with changes in resident usage and availability of online resources, the last two administrations of the survey have been web-based.

For this report, the analysis will focus on mental health attitudes and knowledge, particularly when impacted by stigma. The survey includes four scales on social acceptance, mental health literacy, mental health knowledge and access, and mental health openness. The domain termed "social acceptance" was previously labeled "social distancing". During the COVID-19 pandemic, "social distancing" has had a significant connotation regarding health safety measures. For this report, "social acceptance" will be used to avoid confusion with the current pandemic terminology. This report will look at changes over time for these scales and any specific survey items relevant to stigma. Additionally, findings that show differences based on respondent characteristics (e.g., race/ethnicity, age, gender) will be included. For this report, race and ethnicity data were recoded into single response categories of Asian, Black/African American, Hispanic, American Indian/Alaska Native, Native Hawaiian/Pacific Islander, White, and multiple race/ethnicities. Both the single response categories and dichotomous race/ethnicity groups, which were utilized by EVALCORP (2021), will be included when the results are significant.

While the data from the Community Survey has been reported in prior reports using probability values test against four thresholds (.1, .05, .01, and .001) and the current findings reported by EVALCORP (2021) for probability thresholds of .01 and .001, for this report we will use three thresholds (.05, 01, and .001). The purpose of this report is to provide SDCBHS with findings useful for program improvement rather than evidence-based research. Thus, the inclusion of the .05 probability value allows findings to be included that are worth addressing in mental health programs[1].

Respondent Characteristics

The table below shows the characteristics of those who responded to the 2020 Community Survey based on the EVALCORP report (2021).

Table 3: Demographic Distribution of Respondents[2,3,4]

	Apr 2010 N=602	Mar 2011 N=601	Mar 2012 N=604	Dec 2013 N=600	May 2017 N=605	Dec 2018 N=611	Dec 2020 N=582	SD Pop %
Gender								
Male	44%	45%	45%	39%	41%	46%	38%	50%
Female	56%	55%	55%	61%	59%	53%	62%	50%
Another Gender Identity	NA	NA	NA	NA	NA	NA	<1%	NA
Race/Ethnicity								
White	59%	61%	57%	58%	53%	61%	67%	48%
Hispanic/Latino	29%	29%	30%	30%	31%	24%	24%	32%
Black/African American	2%	2%	2%	3%	2%	3%	6%	5%
Asian	3%	3%	4%	3%	11%	8%	11%	11%
Native Hawaiian and Pacific Islander	NA	NA	NA	NA	NA	NA	2%	<1%
American Indian and Alaska Native	1%	1%	<1%	<1%	<1%	<1%	2%	<1%
Multiple	3%	3%	4%	3%	2%	1%	NA	3%
Another Race/Ethnicity	1%	1%	1%	3%	1%	2%	2%	<1%
Age								
18-24	11%	10%	6%	6%	11%	10%	7%	14%
25-34	16%	15%	14%	11%	21%	20%	19%	21%
35-44	16%	16%	17%	19%	18%	18%	25%	17%
45-54	23%	22%	25%	24%	17%	16%	20%	17%
55-59	11%	9%	11%	10%	8%	9%	11%	8%
60-65	9%	11%	10%	13%	10%	9%	9%	7%
66-74	9%	8%	9%	9%	8%	10%	8%	9%
75+	6%	8%	8%	8%	7%	8%	1%	7%
Other								
Children in household	39%	36%	35%	34%	29%	33%	36%	34%
Veteran	13%	12%	11%	10%	11%	15%	6%	9%
Employed or student	53%	51%	54%	54%	66%	67%	73%	NA

[1] There may be very small differences in data reported in comparison to the EVALCORP report. These differences are small and do not impact findings.
[2] Hispanics may be of any race in the Census data (U.S. Census Bureau, 2017).
[3] Data may not always add to 100% due to rounding
[4] Race/ethnicity data report per EVALCORP 2021 and SANDAG 2010 Census, datasurfer.sandag.org/dataoverview

The 2020 survey, compared to previous administrations, had the smallest sample size (N=582). EVALCORP (2021) noted in their report on the 2020 survey that there were low response rates among male and Hispanic/Latino respondents. Thus, to address the potential sampling bias that may be due to non-representative sampling, EVALCORP used weights in the analysis (2021, Mercer et al., 2018). Analysis from the 2020 survey included in this report will also use the applied weights for gender and race/ethnicity (see Appendix, EVALCORP 2021). All findings (percentages, means, etc.) were based on the weighted values. It is important to note, the greatest proportion of Asian (same as 2017) and Black/African American respondents occurred in 2020 compared to past survey administrations. Also, the greatest number of the participants were in the 35-44 and 45 to 54 age groups (17% each). The 75+ age group and Employed or Student (73%) were greater in 2020 compared to any other year.

Table 4 provides detail on respondents' sexual orientation. Heterosexual respondents comprised 90% of the sample, while 10% identified as a sexual orientation other than heterosexual including, gay or lesbian (5%), bisexual/pansexual (3%), questioning/unsure (1%), queer (<1%), or another sexual orientation (<1%).

Table 4: Sexual Orientation

	Sample %	Sample N
Sexual Orientation		
Gay/Lesbian	5%	30
Bisexual/Pansexual	3%	19
Questioning or Unsure	1%	6
Another Sexual Orientation	<1%	3
Queer	<1%	1
Heterosexual	90%	522

RESULTS

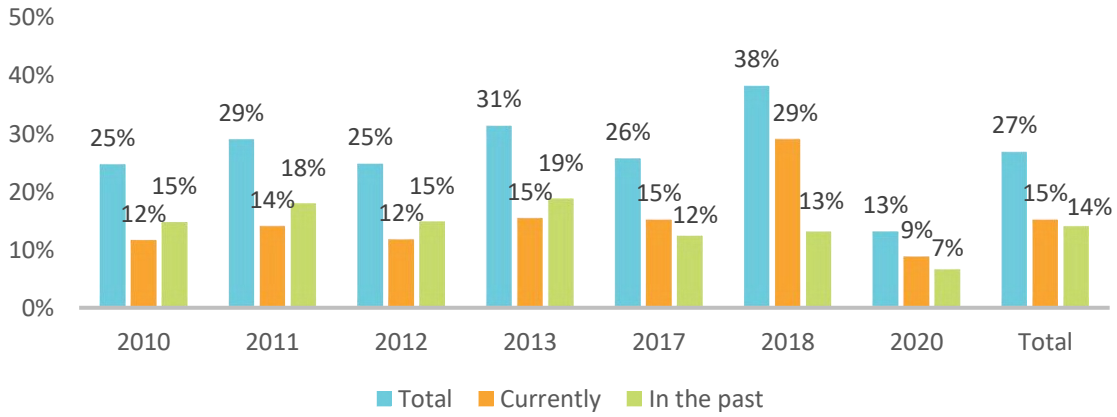
The following section provides the results of analysis over time and a comparison of demographic groups. First, the respondents' own mental health experiences are reviewed.

Experiences with Mental Health

Respondents were asked if they were currently receiving mental health treatment or had received mental health treatment in the past year. While in prior years, the combined percentage ranged from 25% in 2010 to a high of 38% in 2018, the percentage of those that reported receiving treatment was at the lowest in the most recent administration in 2020 (13%, $p < .001$) (Figure 6). The difference between 2020 and other years could be due to the COVID-19 stay-at-home orders that began in March 2020.

One interesting finding noted below is that individuals that identified as a sexual orientation other than heterosexual were more likely to currently be in treatment. According to Mental Health America, 4.5% of the U.S. population identifies as other than heterosexual, yet 39% of this group reported having a mental illness in the past year. Thus, a disproportionate number are represented in behavioral health services (Mental Health America, 2021).

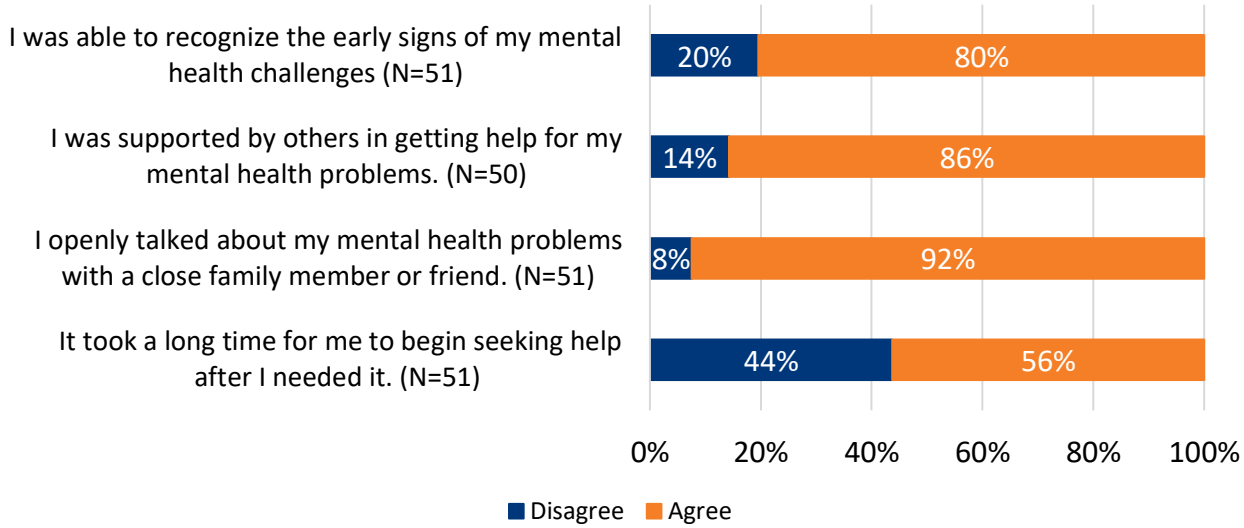
Figure 6: Currently Receiving Treatment or Received Treatment in the Past



	Respondents who identified as **other than heterosexual** were more likely to currently be in treatment compared to heterosexual/straight respondents (8% vs. 1%, *p<.01*).
	Female respondents were more likely to be in treatment currently than male respondents (12% vs. 7%, *p<.01*) and be in treatment in the past year (9% vs. 4%, *p<.01*).
	Respondents with lower social satisfaction were more likely to currently be in treatment than those with higher social satisfaction (24% vs. 3%, *p<.01)* and be in treatment in the past year (13% vs. 4%, *p<.01*).

Respondents that reported they either received treatment in the past or were currently receiving services were also asked about their behaviors related to seeking help (Figure 7).

Figure 7: How Much Do You Agree or Disagree with the Following Statements



Most respondents had positive attitudes toward recognizing the signs of mental health challenges (80%), being supported by others (86%), and talking to others (92%). Over half of respondents (56%) noted it took a long time for them to seek help.

To better understand help-seeking behaviors, the respondents were asked how much they agreed or disagreed with six statements regarding seeking help. Table 5 provides the responses based on age to reveal some interesting trends. Statistical significance is reported whenever the probability threshold of .05 or less is met. However, the small sample size for TAY (N=7) and older adults (N=8) necessitates caution when generalizing findings.

Table 5: Agreement with Help-Seeking Statements by Age

What prompted you to seek help?	TAY (N=7)	Adult (N=36)	Older Adult (N=8)
My symptoms grew worse	100%	78%	68%
My family or friends encouraged me	68%	39%	40%
My health insurance coverage changed	0%	13%	0%
I recognized symptoms I was having could be related to mental health	47%	68%	60%
My mental health caused issues (ex. issues at work, issues with relationships)	47%	57%	60%
I saw a flyer, ad, webpage, or other information that encouraged me to seek help	27%	3%	13%

Table 5 shows that TAY were more likely than adults and older adults to seek help because their ***family or friends encouraged them*** (68% vs. 39% vs. 40%). The most frequently reported reason for seeking help for all age groups was that ***the symptoms grew worse*** (100% vs. 78% vs. 68%, $p < .05$).

It is also important to understand why respondents did not seek help sooner. Table 6 includes 15 statements for which respondents were asked to either agree or disagree. All three age groups had the highest response rate to the statement ***I wanted to solve it by myself*** (81% vs. 43% vs. 79%). However, TAY were more likely than other age groups to respond ***it was difficult for me to find resources*** (47% vs. 5% vs. 17%, $p < .05$), ***I didn't recognize the early symptoms*** (65% vs. 29% vs. 0%), ***I didn't think treatment would be effective*** (65% vs. 21% vs. 31%), and ***I was concerned about what others would think of me if they knew*** (63% vs. 24% vs. 27%). The high rate of responses for TAY being concerned about what others would think suggests this age group is more concerned about public mental health stigma, which impacts help-seeking behaviors. Meanwhile, older adults were more likely to respond***, I had received treatment before, but it was ineffective*** (0% vs. 16% vs. 52%), ***I was concerned about the financial cost*** (30% vs. 34% vs. 48%), and ***I had transportation difficulty that made it difficult to seek help*** (16% vs. 0% vs. 42%).

Table 6: Reasons Why Respondents did not Seek Help Sooner by Age

What reasons, if any, prevented you from seeking treatment sooner?	TAY (N=6)	Adult (N=34)	Older Adult (N=6)
I wanted to solve it by myself	81%	43%	79%
I didn't recognize the early symptoms	65%	29%	0%
I didn't know where or who should I seek help from	49%	28%	17%
It was difficult for me to find resources	47%	5%	17%
I started taking steps to get support	30%	24%	27%
I had transportation difficulty that made it difficult to seek help	16%	0%	42%
I had scheduling conflicts that made it difficult to seek help	30%	18%	31%
I was concerned about the financial cost	30%	34%	48%
I didn't have health insurance	0%	12%	0%
I didn't think treatment would be effective	65%	21%	31%
I had received treatment before, but it was ineffective	0%	16%	52%
Someone I know had a bad experience with treatment	30%	8%	0%
I was concerned about what others would think of me if they knew	63%	24%	27%
I was afraid of being hospitalized involuntarily	47%	8%	0%
I was dissatisfied with the current medical services	30%	14%	31%

Tables 7 and 8 provide an overview of help-seeking responses for males and female respondents. A few interesting trends emerged when looking at help-seeking behavior differences between males and females. Those differences that were statistically significant are noted with the corresponding probability value. Table 7 shows that both male and female respondents were most likely to seek help for their mental health concerns because ***their symptoms grew worse*** (81% vs. 78%). However, male respondents were more likely than female respondents to seek help because they were ***encouraged to do so by family and friends*** (57% vs. 34%) or because ***mental health symptoms caused issues in their life*** (71% vs. 46%). Both help-seeking behaviors point to components of public health stigma and appear to show that males had more support from family and friends. Meanwhile, the impact on social relationships was also more of a motivator for males to seek help.

Table 7: Agreement with Help-Seeking Statements by Gender

What prompted you to seek help?	Male (N=20)	Female (N=31)
My symptoms grew worse	81%	78%
My family or friends encouraged me	57%	34%
My health insurance coverage changed	10%	8%
I recognized symptoms I was having could be related to mental health	67%	62%
My mental health caused issues (ex. issues at work, issues with relationships)	71%	46%
I saw a flyer, ad, webpage, or other information that encouraged me to seek help	14%	4%

Male respondents compared to female respondents appeared to have more barriers to seeking treatment sooner. Both males and females were most likely to respond the reason that prevented them from seeking treatment sooner was they ***wanted to solve it by themselves*** (62% vs. 47%). However, more male respondents than female respondents indicated a concern with public mental health stigma and agreed ***I was concerned about what others would think of me if they knew*** (52% vs. 15%, *p < .01*).

Additionally, more male respondents than female respondents noted the following reasons for not seeking help sooner ***I didn't recognize the early symptoms*** (57% vs. 13%, *p < .01*), ***I didn't know where or who should I seek help from*** (54% vs. 13%, *p < .01*), ***I didn't think treatment would be effective*** (48% vs. 15%, *p < .01*), ***someone I knew had a bad experience with treatment*** (23% vs. 2%, *p* < .05), and ***I was afraid of being involuntarily hospitalized*** (26% vs. 3%, *p < .05*).

Table 8: Reasons Why Respondents did not Seek Help Sooner by Gender

What reasons, if any, prevented you from seeking treatment sooner?	Male (N=18)	Female (N=28)
I wanted to solve it by myself	62%	47%
I didn't recognize the early symptoms	57%	13%
I didn't know where or who should I seek help from	54%	13%
It was difficult for me to find resources	16%	10%
I started taking steps to get support	38%	17%
I had transportation difficulty that made it difficult to seek help	16%	2%
I had scheduling conflicts that made it difficult to seek help	30%	15%
I was concerned about the financial cost	47%	28%
I didn't have health insurance	16%	4%
I didn't think treatment would be effective	48%	15%
I had received treatment before, but it was ineffective	21%	17%
Someone I know had a bad experience with treatment	23%	2%
I was concerned about what others would think of me if they knew	52%	15%
I was afraid of being hospitalized involuntarily	26%	3%
I was dissatisfied with the current medical services	31%	10%

In the following section, help-seeking behavior responses by race/ethnicity are reported. There were no responses for Native Hawaiian/Pacific Islander and American Indian/Alaska Native for these items. Additionally, none of the differences were statistically significant, but a review of the percentages by groups may be useful for treatment engagement. Sample sizes for multiple race/ethnicity (N=6), Asian (N=5), and Black/African American (N=3) respondents were very small. Thus, caution should be taken when generalizing the findings for these groups and, in comparison, to other race/ethnicity respondent groups. As shown in Table 9, the most reported reason for seeking help across most of the race categories was ***my symptoms grew worse*****.** However, while the group size was small, Asian respondents were most likely to choose ***I recognized symptoms I was having could be related to mental health*** (100%). In comparison to the other race categories, Asian respondents were most likely to respond ***my mental health caused issues*** (78%). Likewise, Asian respondents (57%) and Hispanic/Latino respondents (58%) were most likely to respond ***my family or friends encouraged me.*** Across all demographic

groups reviewed, the most common reason for seeking help was the symptoms grew worse. It has been shown that public stigmatizing beliefs about mental health and negative beliefs about the effect of treatment influence help-seeking behavior. (Henderson et al.,2013).

Table 9: Agreement with Help-Seeking Statements by Race/Ethnicity

What prompted you to seek help?	White (N=26)	Hispanic/ Latino (N=12)	Black/ African American (N=3)	Asian (N=5)	Multiple Race/ Ethnicity (N=6)
My symptoms grew worse	80%	84%	67%	78%	70%
My family or friends encouraged me	46%	58%	0%	57%	13%
My health insurance coverage changed	17%	0%	0%	0%	0%
I recognized symptoms I was having could be	67%	48%	67%	100%	49%
My mental health caused issues (ex. issues at work, issues with relationships)	58%	48%	33%	78%	51%
I saw a flyer, ad, webpage, or other information that encouraged me to seek help	6%	16%	0%	0%	0%

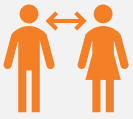
Table 10 shows that the most common reported reason for not seeking help sooner for the race categories overall was ***I wanted to solve it by myself***. However, the most frequently reported response for Hispanic respondents was ***I didn't recognize the early symptoms*** *(69%).* This may point to the importance of continuing to provide culturally appropriate mental health information to individuals who identify as Hispanic/Latino.

Table 10: Reasons Why Respondents did not Seek Help Sooner by Race/Ethnicity

What reasons, if any, prevented you from seeking treatment sooner?	White (N=24)	Hispanic /Latino (N=10)	Black/ African American (N=2)	Asian (N=5)	Multiple Race/ Ethnicity (N=6)
I wanted to solve it by myself	51%	57%	50%	78%	32%
I didn't recognize the early symptoms	20%	69%	50%	35%	0%
I didn't know where or who should I seek help from	36%	38%	0%	0%	19%
It was difficult for me to find resources	12%	19%	0%	22%	0%
I started taking steps to get support	31%	19%	0%	0%	31%
I had transportation difficulty that made it difficult to seek help	7%	19%	0%	0%	0%
I had scheduling conflicts that made it difficult to seek help	18%	38%	0%	35%	0%
I was concerned about the financial cost	44%	38%	0%	35%	0%
I didn't have health insurance	9%	19%	0%	0%	0%
I didn't think treatment would be effective	26%	57%	0%	0%	19%
I had received treatment before, but it was ineffective	16%	38%	0%	22%	0%
Someone I know had a bad experience with treatment	3%	19%	0%	0%	31%
I was concerned about what others would think of me if they knew	30%	38%	0%	57%	0%
I was afraid of being hospitalized involuntarily	4%	38%	0%	0%	13%
I was dissatisfied with the current medical services	8%	38%	0%	22%	31%

Description of the Four Domains

In 2018, four scales were developed to better understand the community's perception of mental health stigma, knowledge, and access to services through specific responses to individual items in the community survey. These four domains compare overall knowledge and attitudes about mental illness. This report will primarily focus on the changes over time and differences based on demographics for these four scales. In recognition of the use of "social distancing" during the COVID-19 pandemic in the prior year, we have changed this domain to "social acceptance". This terminology also emphasizes the desired healthy attitude towards mental health rather than using a deficit approach. The descriptions of the scales and individual items that were included in the report *Suicide Prevention and Stigma Reduction Media Campaign: Community Survey Full Report: 9 Year Post-Launch* (EVALCORP 2021) are provided below.



Social Acceptance: Willingness to be socially connected to people with mental illness

- Willing to work closely with them
- Willing to have them marry someone in the family
- Willing to have as a neighbor
- Willing to spend time socializing
- Hired just like others
- As productive as others
- More likely to be dangerous (reverse scored)
- Makes me nervous or uncomfortable (reverse scored)
- Shouldn't care for children (reverse scored)

Mental Health Openness: Openness to disclosing mental health problems

- Would lose friends (reverse scored)
- Better off keeping it a secret (reverse scored)
- Afraid to tell people (reverse scored)

Mental Health Literacy: Beliefs about mental illness and treatment

- Mental health is as important as physical health
- I feel sympathy for people with mental illness
- Comfortable talking about mental health
- I would get help
- Suicide is preventable
- Will improve with treatment
- Mental health issues are common
- Experiencing mental illness
- Experiencing the correct disorder
- Caused by bad character (reverse scored)

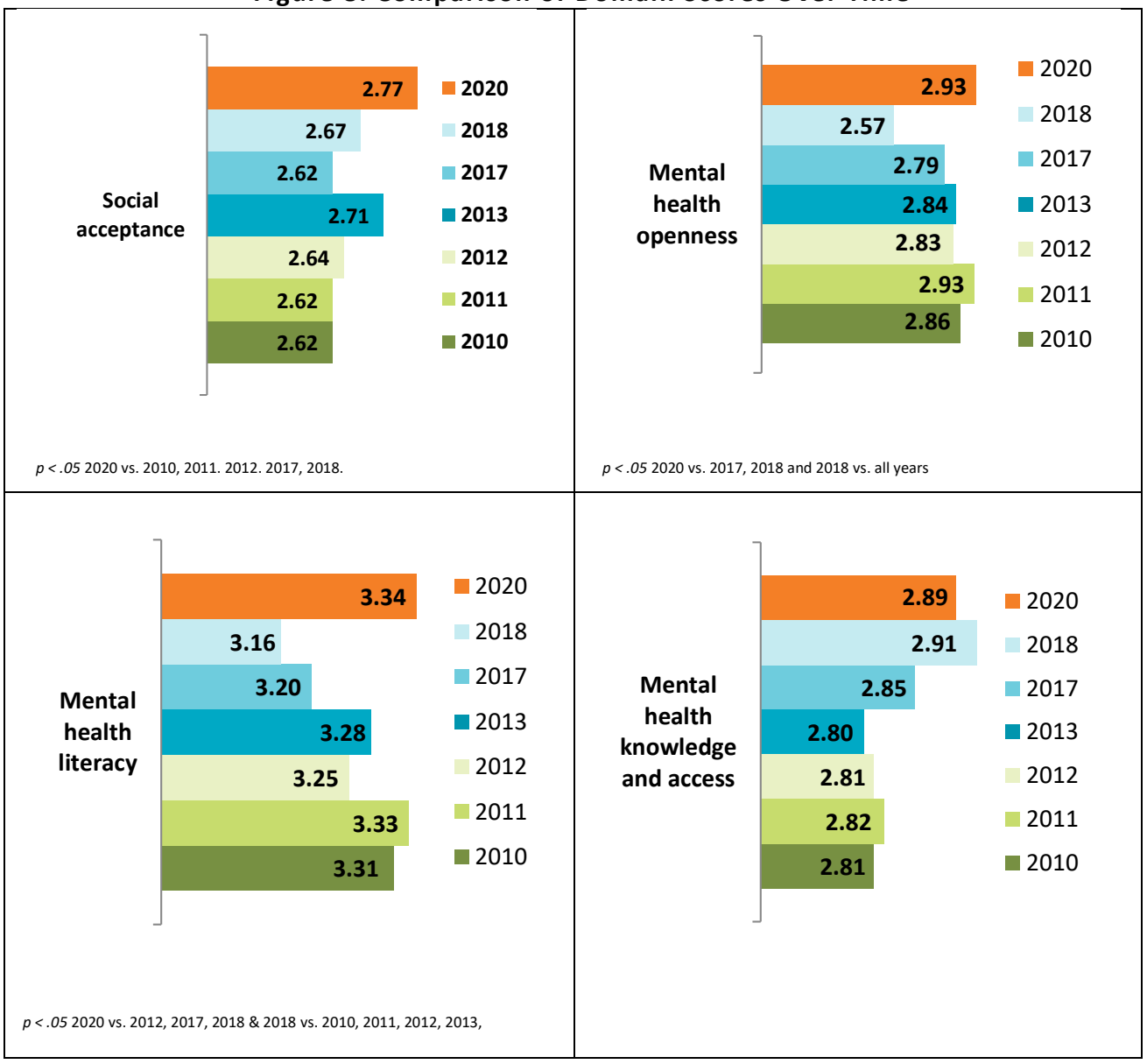
Mental Health Knowledge and Access: Knowledge of and willingness to use community resources for mental illness

- Know where to get help in the community for mental health problems
- Can recognize the warning signs of suicide
- Know how to get help if someone has signs of suicide
- Can recognize emotional/behavioral problems in children
- Can find help for emotional/behavioral problems in children

Domain Comparisons Over Time

In 2020, there was a significant improvement in three of the four domains: social acceptance, mental health openness, and mental health literacy. In the figures below, it is evident that a noticeable increase occurred in 2018 and continued into 2020, with only the domain of mental health knowledge and access showing no significant change between 2018 and 2020. These findings may be the result of real changes in attitudes over time or could be influenced by other confounding variables not accounted for in this study. In Figure 8, post hoc statistical significance is shown.

Figure 8: Comparison of Domain Scores Over Time



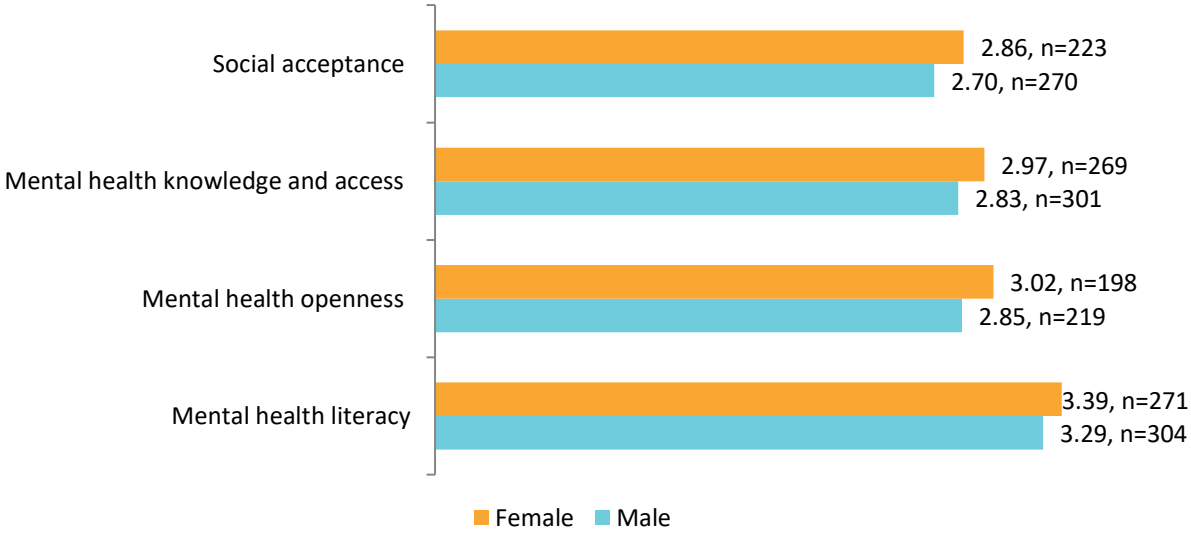
I hear about people's distress a lot because as a mental health advocate I am open about my own disorders. People are experiencing more difficulty than we hear about in society at large.

-Consumer Advocate

Gender Differences Across Domains

Across each of the four domains, the mean for respondents who identified as female was greater, indicating more positive attitudes about mental health stigma than those who identified as male ($p < .05$). The most significant difference between the means was in the social acceptance domain ($p < .001$), which may show that female respondents were more willing to be socially connected to individuals with mental health problems.

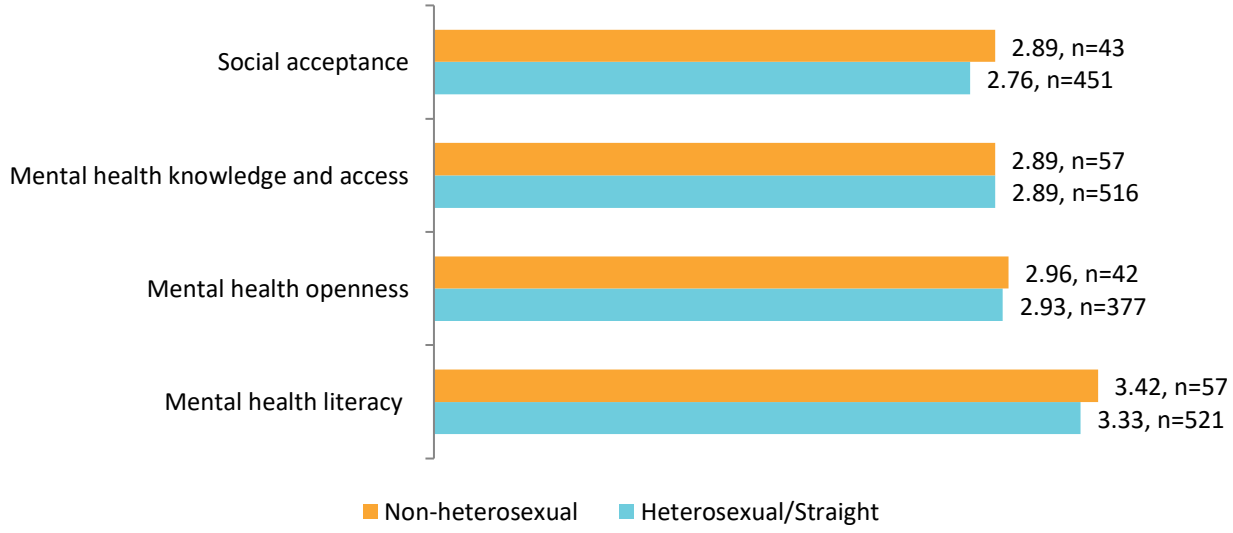
Figure 9: Comparison of Domain Scores by Gender



Sexual Orientation Differences Across Domains

Respondents who identified as non-heterosexual had higher mean scores in three of the four domains, indicating more positive attitudes in the areas of social acceptance, mental health openness, and mental health literacy domains in comparison to those that identified as heterosexual/straight, however, these differences were not statistically significant. Likewise, there was no difference in the mental health knowledge and access domain.

Figure 10: Comparison of Domain Scores by Sexual Orientation



Race/Ethnicity Differences Across Domains

Table 11 shows that across domains in general, Black/African American, Native Hawaiian/Pacific Islander, and American Indian/Alaska Native respondents tended to have a higher domain means in comparison to those of the other race/ethnicity groups. Findings for racial and ethnic differences may not be representative for some groups due to the low sample sizes of BIPOC respondents. There was a significant difference ($p < 0.05$) among racial and ethnic subgroups in the mental health literacy domain.

Table 11: Comparison of Domain Scores by Race/Ethnicity

Domain	Race/Ethnicity	Count	Mean
Social acceptance			
	White	214	2.77
	Hispanic/Latino	135	2.74
	Black/African American	21	2.95
	Asian	47	2.67
	Native Hawaiian and Pacific Islander	2	3.09
	American Indian and Alaska Native	1	3.11
	Multiple race/ethnicity	74	2.86
	Total	494	2.77
Mental health knowledge and access			
	White	249	2.89
	Hispanic/Latino	158	2.86
	Black/African American	24	3.10
	Asian	57	2.81
	Native Hawaiian and Pacific Islander	2	3.09
	American Indian and Alaska Native	1	3.90
	Multiple race/ethnicity	83	2.95
	Total	573	2.89
Mental health openness			
	White	179	2.94
	Hispanic/Latino	124	2.82
	Black/African American	21	3.07
	Asian	39	2.98
	Native Hawaiian and Pacific Islander	2	2.97
	American Indian and Alaska Native	0	NA
	Multiple race/ethnicity	54	3.03
	Total	420	2.93
Mental health literacy*			
	White	250	3.37
	Hispanic/Latino	161	3.25
	Black/African American	24	3.36
	Asian	57	3.31
	Native Hawaiian and Pacific Islander	2	3.39
	American Indian and Alaska Native	1	3.67
	Multiple race/ethnicity	83	3.40
	Total	577	3.34

Mental Health Diagnosis Differences Across Domains

Across all four domains, respondents who reported having no depression, per the Patient Health Questionnaire 9 (PHQ9) measure, had a significantly higher mean score, indicating more positive attitudes, than those who have depression. There was a significant difference ($p < .05$) in the mental health openness domain among depression diagnosis subgroups. Respondents who reported an anxiety disorder, per the Generalized Anxiety Disorder 2 item (GAD2) measure, had higher means in the social acceptance, mental health openness, and mental health literacy domains. Whereas those who reported no anxiety had a higher mean in the mental health knowledge and access domain, however, these differences were not statistically significant.

Figure 11: Comparison of Domain Scores by Mental Health Diagnosis – Anxiety

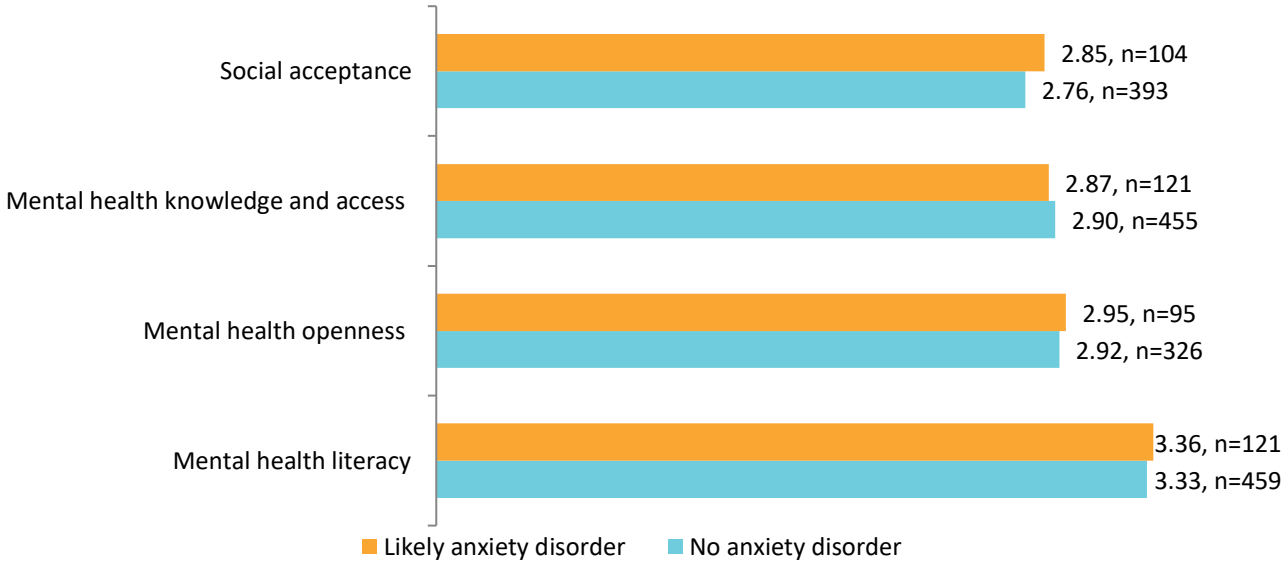
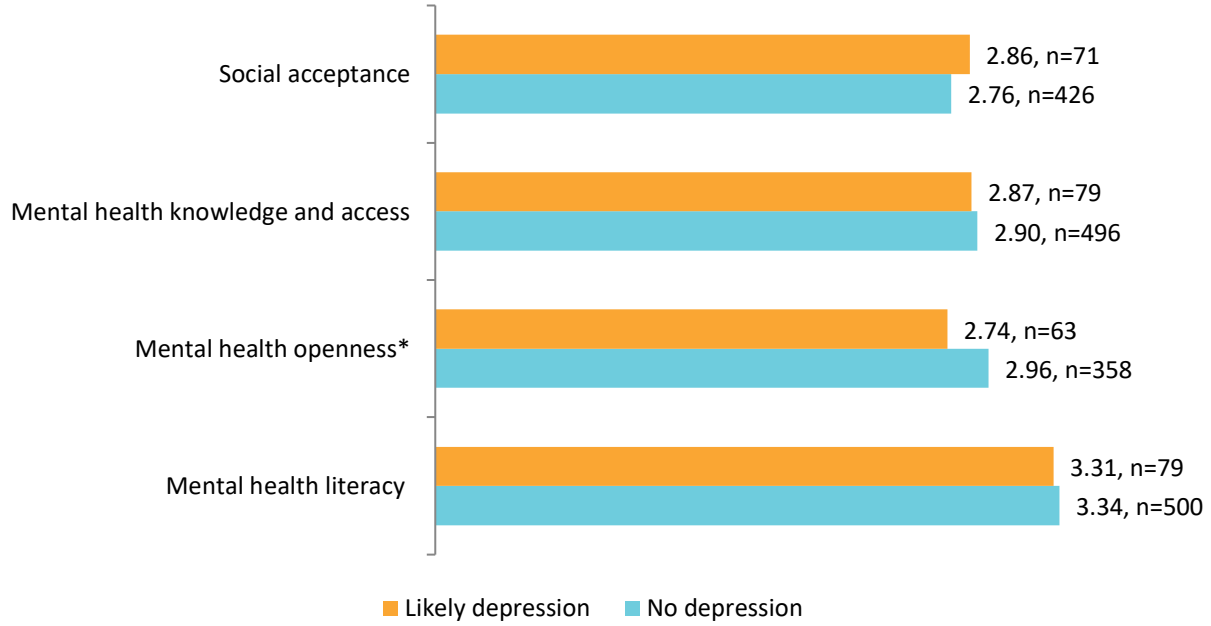


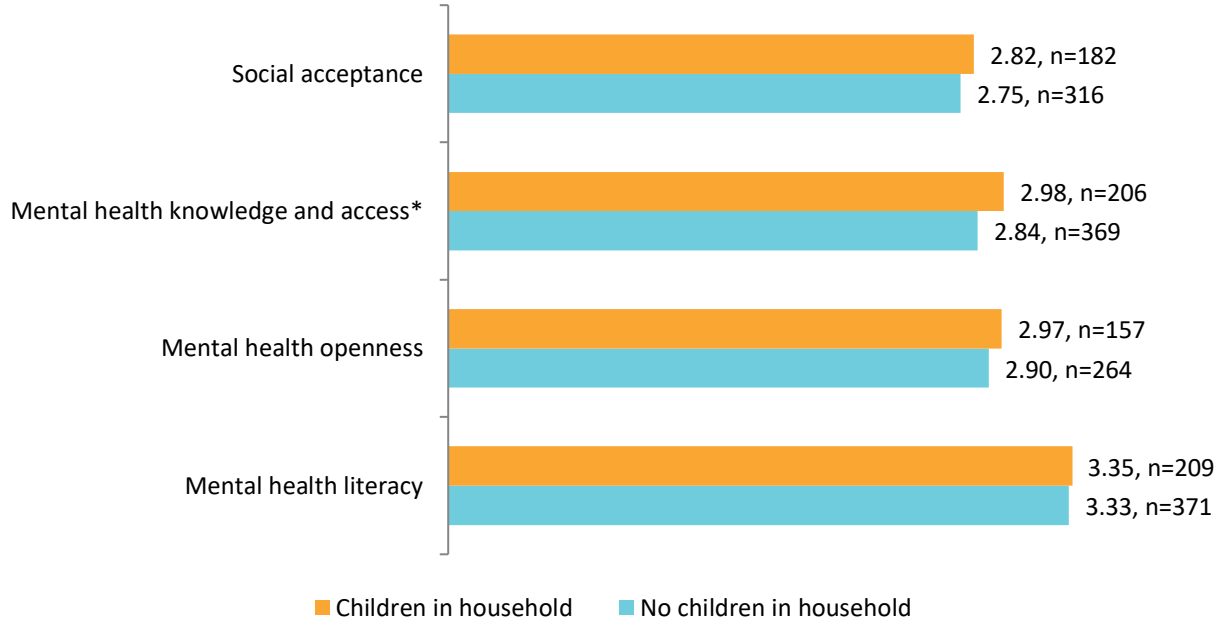
Figure 12: Comparison of Domain Scores by Mental Health Diagnosis - Depression



Children in the Household Across Domains

Respondents who reported having children in the household had higher mean scores across all four domains in comparison to those who reported not having children in the household. There was a significant difference (*$p < .05$) in the mental health knowledge and access domain between the two groups.

Figure 13: Comparison of Domain Scores by Children in the Household



TAY: Domain-Specific Findings from the 2020 Community Survey

The following section provides specific results based on the age groups TAY (16 to 25), adult (26 to 59), and older adult (60+), with an emphasis on highlighting differences for TAY. Other age-related results are included later in this report.

Social Acceptance

Although the mean score for the social acceptance domain was not significantly different for TAY respondents, responses to individual items revealed some significant differences. Specifically, TAY respondents reported being less comfortable socializing with those with mental health challenges than adult respondents but held less stigmatizing views about employment than older adult respondents.

+	**TAY** respondents were ***more likely*** than adult and older adult respondents ***to be willing to work closely on a job with someone who had a mental illness*** (84% vs. 80% vs. 57%, $p < .001$).
+	**TAY** and **Adult** respondents were more likely ***to agree that people with mental illness should be hired just like other people*** compared to older adult respondents (80% vs. 80% vs. 65%, $p < .001$).

−	**TAY** respondents were ***less likely*** than adult respondents ***to be willing to spend time socializing with a hypothetical person with mental illness*** (75% vs. 89%, $p < .01$), although older adult respondents scored lowest on this item (71%).

Mental Health Openness

TAY respondents had a significantly lower mean score on the mental health openness domain than adult respondents (2.70 vs. 2.96, $p < .05$). However, responses to the individual domain items suggest the relationship may be more complex. Specifically, compared to older respondents, TAY respondents appear to perceive more openness around friends but less openness around family.

+	**TAY** respondents were ***less likely*** than adult or older adult respondents ***to feel that someone would lose friends*** **if people knew about his/her mental health problem** (30% vs. 35% vs. 51%, $p < .05$).
−	**TAY** respondents were ***four times more likely*** than adult and older adult respondents ***to believe the family of someone who had a mental illness would be better off keeping it a secret*** (28% vs. 6% vs. 1%, $p < .001$).

Mental Health Literacy

Although the mean score for the mental health literacy domain was not significantly different for TAY respondents, on several items, TAY respondents scored lower than adult and older adult respondents. These data suggest, that in some ways, TAY may hold more stigmatizing beliefs about mental illness and treatment.

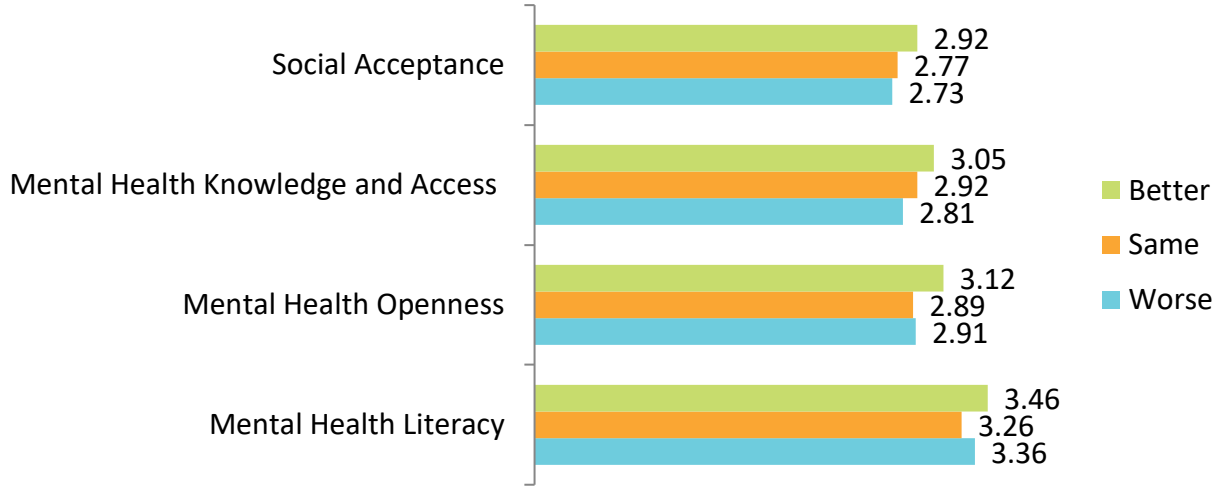
−	Although most **TAY** respondents agreed that mental health issues were common, ***they were less likely to agree about mental health issues being common*** than adult and older adult respondents (88% vs. 97% vs. 92%, $p < .001$).
−	Although most **TAY** respondents agreed that suicide is preventable, ***they were less likely to agree suicide is preventable*** than adult and older adult respondents (86% vs. 96% vs. 92%, $p < .01$).
−	Although most **TAY** respondents reported feeling sympathy for people suffering from mental illness, ***they were less likely to report feeling sympathy*** than adult and older adult respondents (81% vs. 98% vs. 98%, $p < .001$).
−	Although most **TAY** respondents reported that they would attempt to get help for themselves if they were having mental health problems, ***they were less willing to seek support*** than adult and older adult respondents (83% vs. 97% vs. 96%, $p < .001$).
−	**TAY** respondents were less likely than adult or older adult respondents to report ***they would be comfortable talking to a friend or family member about their mental health problems***, although the difference was not statistically significant (87% vs. 95% vs. 91%).

Based on these data, it is difficult to conclude if TAY in San Diego experience more mental health stigma overall than adults or older adults. For many indicators in the 2020 Community Survey, no significant age effects were observed. However, on a subset of items, some insights emerged. Particularly, TAY held more positive beliefs regarding working with people who have a mental illness. Meanwhile, other items appear to reflect TAY may be less inclined to disclose their mental health problems or seek support.

MENTAL HEALTH CHALLENGES IN THE LAST YEAR

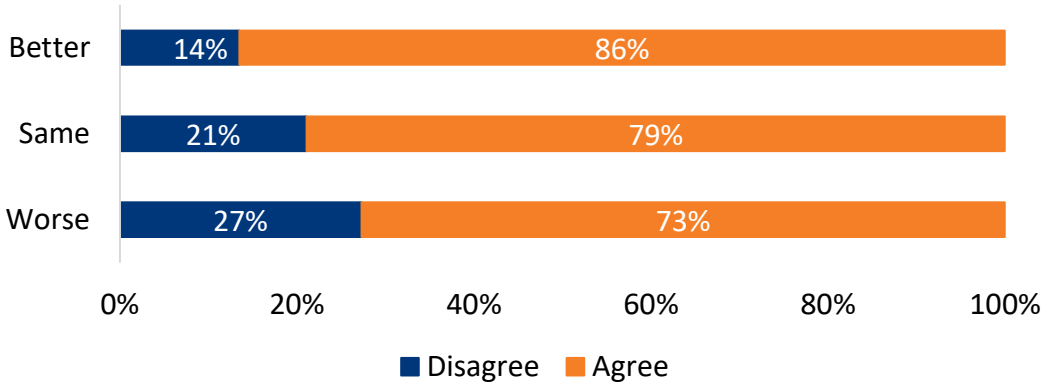
Considering all the challenges of 2020, the following section reviews the impact of respondents' mental health in the last year in comparison to the prior year. Figure 14 shows respondents who said their mental health improved compared to a year ago had the highest mean across all four domains ($p < .05$). The mental health literacy domain had the highest mean (3.46, $p < .001$) for those who felt their mental health improved in comparison to all four domains.

Figure 14: Comparison of Domain Scores by Mental Health Now Vs. A Year Ago



Respondents who felt their mental health improved compared to a year ago were ***more likely to know where to get services*** compared to those whose mental health was the same or worse than a year ago (86% vs. 79% vs. 73%, *p < .05*).

Figure 15: Knowledge of Where to Get Services: Now Vs. A Year Ago



These data are worth noting since 2020 brought so many health and social challenges for the Nation, which likely impacted mental health in general.

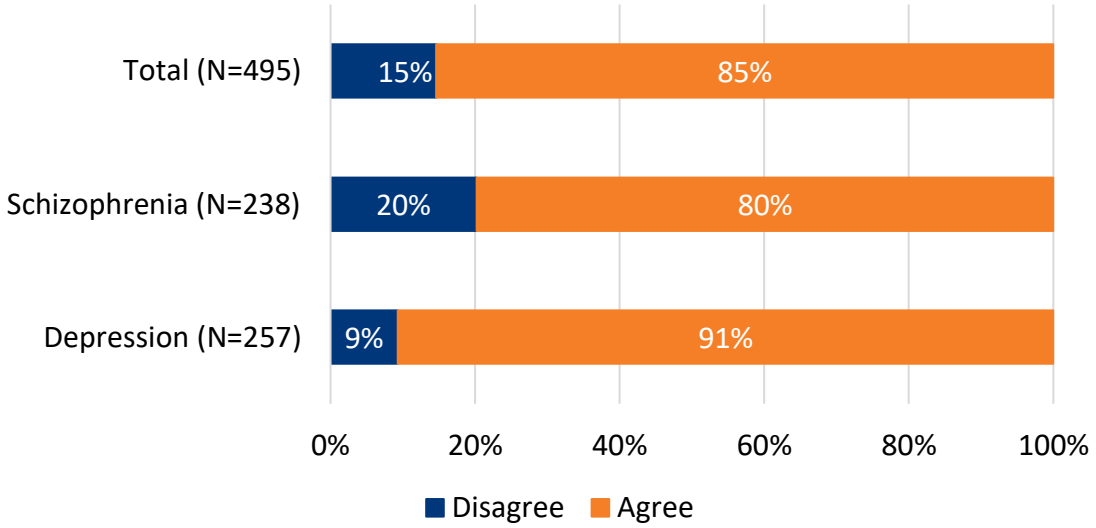
SOCIAL ACCEPTANCE

The domain of social acceptance includes the willingness of a person to be socially connected to people with mental illness in their personal and work life. This domain includes many items that measure the attitudes and beliefs regarding mental health stigma. For the items in this domain, respondents were asked to read a vignette about a person (John or Mary) with depression or schizophrenia and respond to statements based on their understanding and attitudes about that vignette. The findings in this section will show the differences based on the vignette type and highlight significant demographic comparison group results that demonstrate how mental health stigma varies by demographic group.

Personal Social Connections

During one's life, we may connect with others who have mental illness who live in our neighborhood or are within our social circles. The next few figures depict willingness to have someone with a mental illness as a neighbor, friend, or in their family by marriage. Overall, ***most respondents were willing to have someone with a mental illness as a neighbor***. Those who read the schizophrenia vignette were less willing to agree than those who read the depression vignette (80% vs. 91%, *p = .001*).

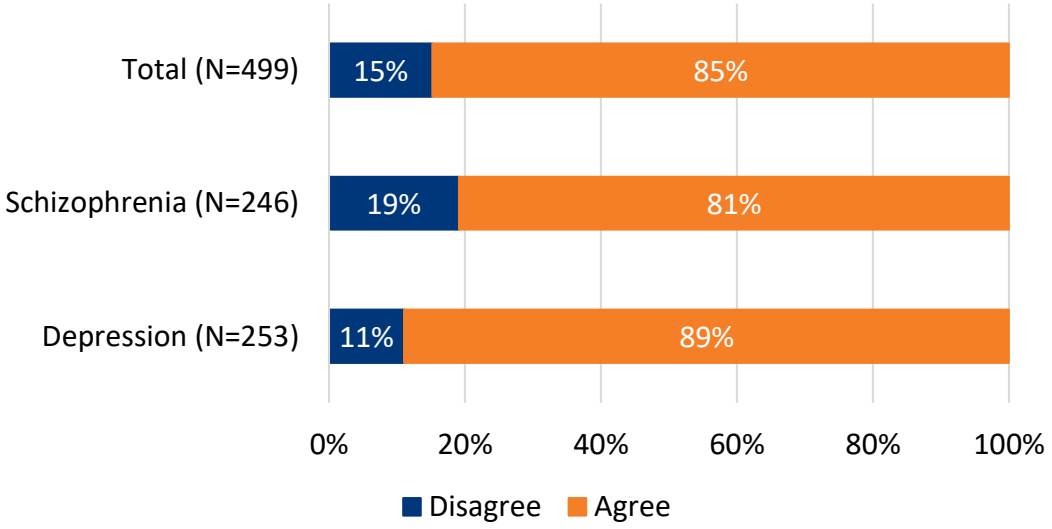
Figure 16: I would be willing to have John/Mary as a neighbor



	Female respondents were ***more likely to agree they were willing to have someone with a mental illness as a neighbor*** than were male respondents (92% vs. 80%, *p < .001*).
	White respondents were ***more likely to agree they were willing to have someone with a mental illness as a neighbor*** than non-white respondents (89% vs. 81%, *p = .01*).

Likewise, Figure 17 shows ***most respondents were willing to spend time socializing with someone who had a mental illness***, with those who read the schizophrenia vignette a little less likely than those who read the depression vignette (81% vs. 89%, $p < .05$). However, there were a few differences in demographic groups of gender, children in the household, age, and race/ethnicity that are worth noting below.

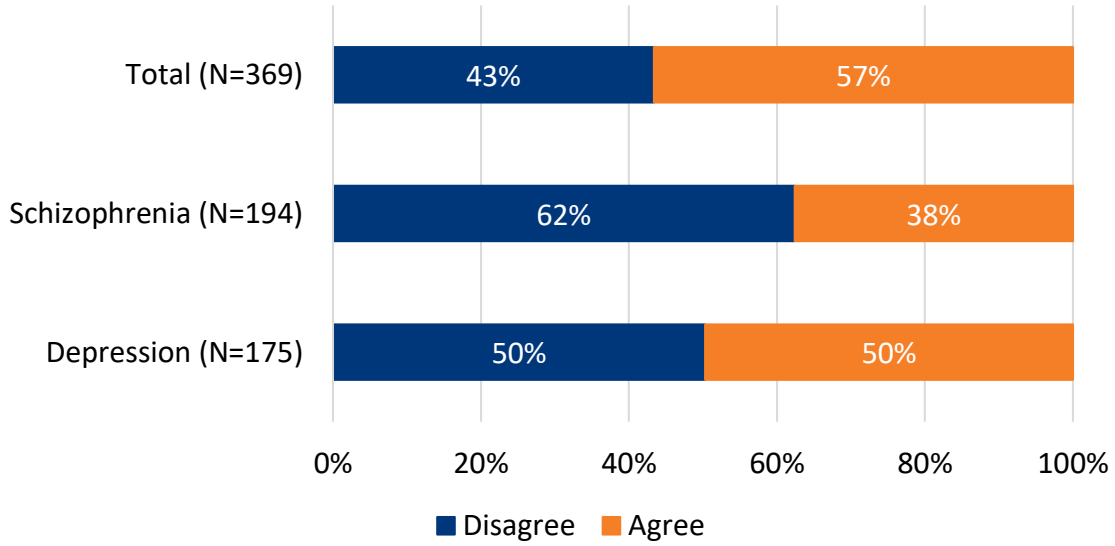
Figure 17: I would be willing to spend time socializing with John/Mary



	Female respondents were ***more likely to agree they would be willing to spend time socializing with someone who had mental illness*** than male respondents (89% vs. 81%, $p < .05$).
	Respondents with children in the household were ***more likely to agree they would be willing to spend time socializing with someone who had a mental illness*** than respondents without children in the household (90% vs. 82%, $p < .05$).
	Adult respondents were ***more likely to agree they would be willing to spend time socializing with someone who had mental illness*** than TAY or older adult respondents (89% vs. 75% vs. 71%, respectively, $p < .001$).
	Black/African American respondents were the ***most likely to agree*** (91%) they would be willing to spend time socializing with someone who had a mental illness, while **Asian** respondents were the ***least likely to agree*** (75%, $p < .05$).

Social acceptance decreased when respondents were asked if they would be willing to have the person in the vignette marry into the family. The trend of people being more stigmatizing towards the schizophrenia vignette continued with this item, with 38% of those who read the schizophrenia vignette agreeing compared to 50% of those who read the depression vignette (*p = .01*).

Figure 18: I would be willing to have John/Mary marry someone in my family.



Female respondents were ***more likely to agree they would be willing to have someone with a mental illness marry into the family*** than male respondents (51% vs. 36%, *p < .01*).

The way we will get through this is to be there for each other. Dropping judgments we hold of people experiencing emotional distress is important.

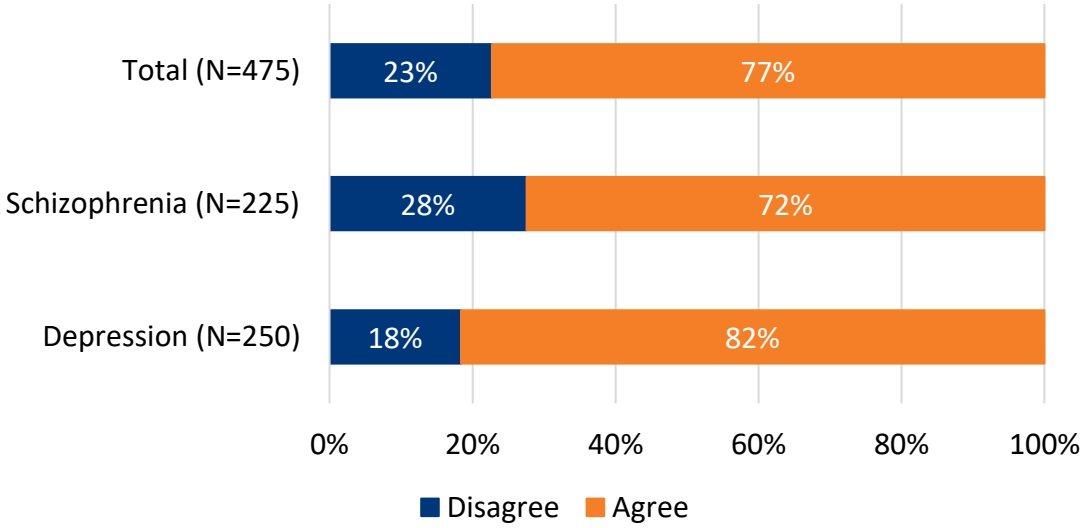
-Consumer Advocate

Social Acceptance in the Workplace

The next few figures provide the findings regarding social acceptance attitudes in the workplace. There are several demographic differences regarding workplace stigma that will be highlighted. Figure 19 shows the respondents who agree or disagree regarding the statement that they would be willing to work closely with the person in the vignette.

The trend in the workplace continues with those who read the schizophrenia vignette being less likely to be socially accepting than those who read the depression vignette (72% vs. 82%, $p < .05$).

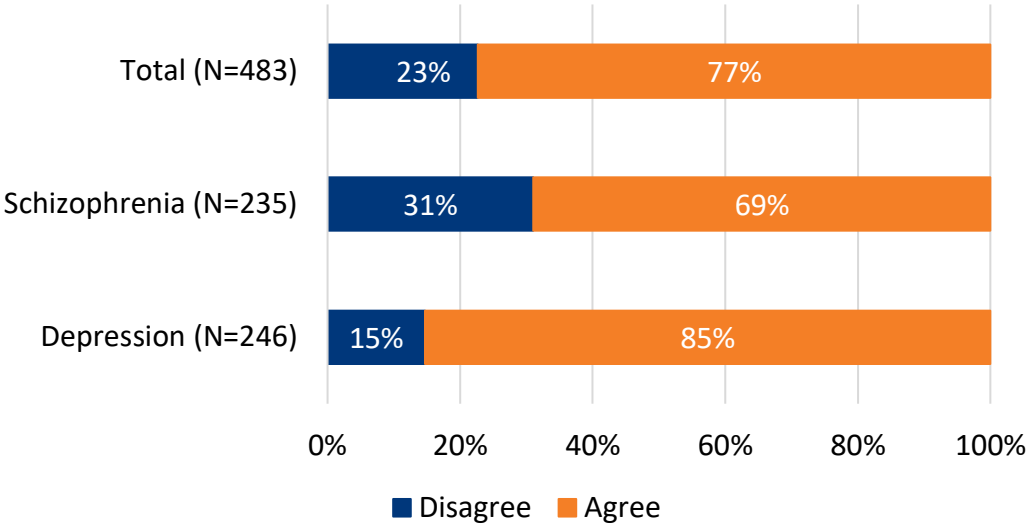
Figure 19: I would be willing to work closely with John/Mary on a job



	Respondents with children in the household were ***more likely to be willing to work closely with someone who had a mental illness*** than those respondents without children in the household (84% vs. 73%, $p < .01$).
	Hispanic/Latino and Black/African American respondents were ***more likely to be willing to work closely with someone who had a mental illness*** than non-Hispanic respondents (82% vs. 74%, $p < .05$), or non-Black/African American respondents (93% vs. 76%, $p < .05$).

Over three-quarters of the respondents agreed that someone with mental illness should be hired just like other people. Respondents that read the schizophrenia vignette were less likely to agree that people with mental illness should be hired just like other people than those who read the depression vignette (69% vs. 85%, *p <. 001*).

Figure 20: John/Mary should be hired just like other people

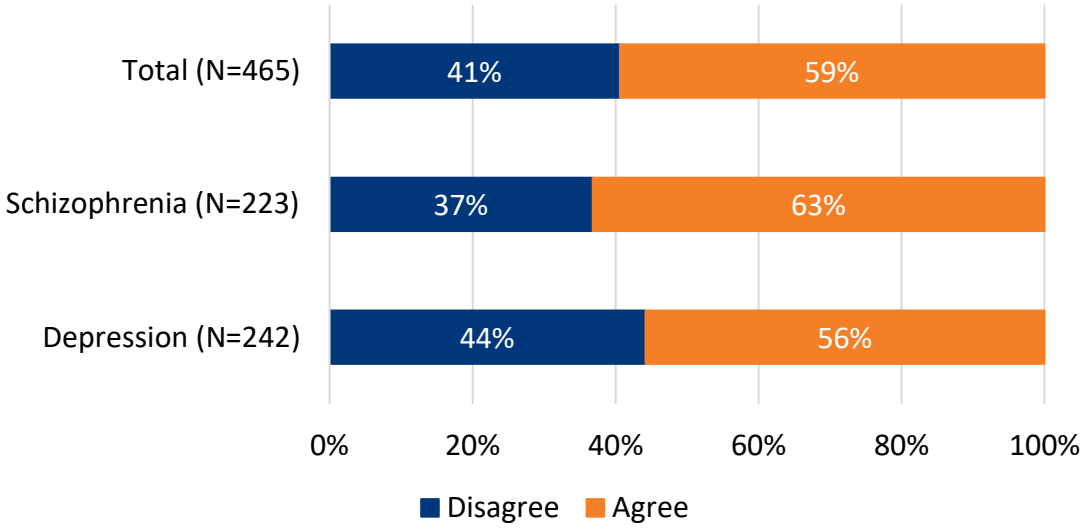


Compassion, the willingness to listen, and the effort to be present for those with difficulties makes a difference.

-Consumer Advocate

In comparison to a willingness to work with someone who has a mental illness, respondents were less likely to believe individuals with mental illness are as productive as others. For this social acceptance statement, ***respondents who read the schizophrenia vignette were more likely to agree that those with mental illness are just as productive as others*** (63% vs. 56%). However, this difference was not at the level of statistical significance. For this item, there were some interesting trends when looking at demographic groups.

Figure 21: People like John/Mary are just as productive as others

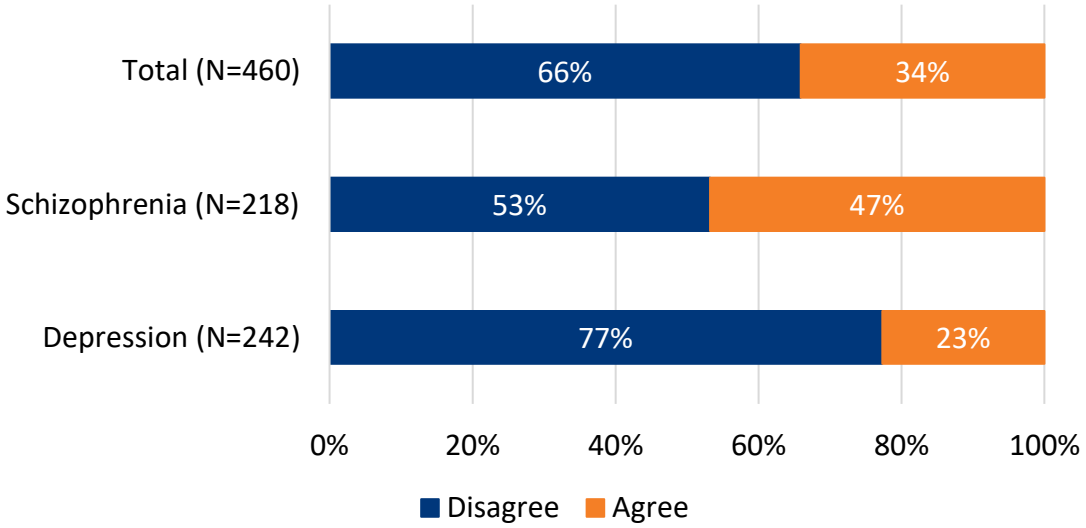


	Black/African American respondents were the ***most likely*** (81%) to agree that individuals with mental illness are as productive as others than other race groups. Whereas White respondents (50%) were the ***least likely*** (*p < .05*).
	Hispanic respondents were ***more likely to agree that individuals with mental illness are as productive as others*** than non-Hispanic respondents (66% vs. 55%, *p < .05).*
	Respondents with high social satisfaction were ***more likely*** than those with low social satisfaction to agree that someone with mental illness should be hired just like other people (63% vs. 50%, *p < .05).*

Other Social Acceptance Items

In the social acceptance domain, respondents provided their beliefs regarding safety and comfort in social settings. Overall, ***one-third of respondents agreed individuals with mental health problems are more likely than others to be dangerous***. Those respondents who read the schizophrenia vignette were twice as likely as those who read the depression vignette to agree (47% vs. 23%, *p. < .001*).

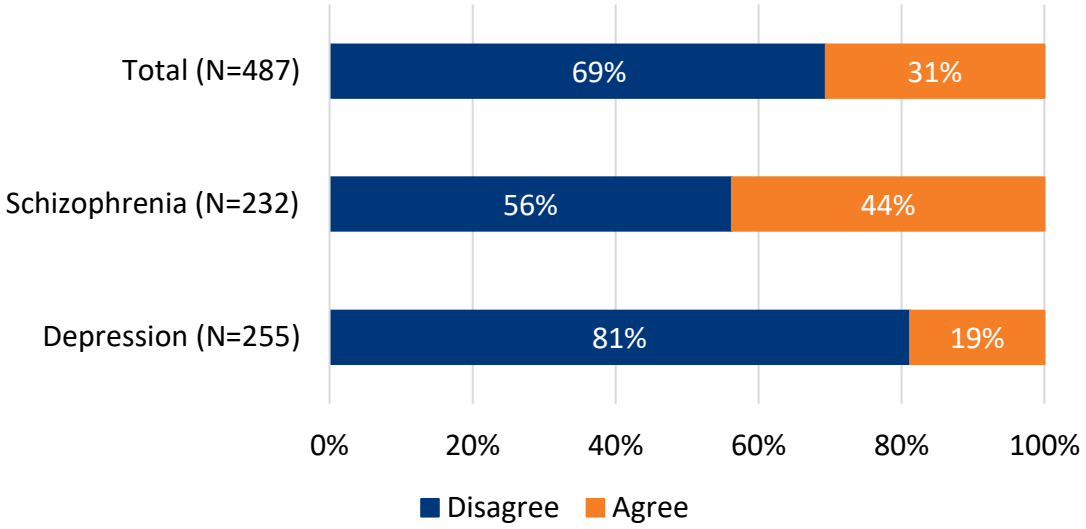
Figure 22: People like John/Mary with mental health problems are more likely than others to be dangerous



	**Respondents who have anxiety** were ***more likely*** than those who did not have anxiety to agree that individuals with mental health problems are more likely to be dangerous (37% vs. 24%, *p < .05*).
	Respondents who have depression were ***more likely*** than those who do not have depression to agree that individuals with mental health problems are more likely to be dangerous (36% vs. 24%, *p < .05*).
	**Male** respondents were ***more likely*** than female respondents to agree that individuals with mental health problems are more likely to be dangerous (40% vs. 28%, *p < .01*).
	**White** respondents were ***more likely*** than non-white respondents to agree that individuals with mental health problems are more likely to be dangerous (39% vs. 30%, *p < .05*).

Likewise, ***one-third of respondents agreed being around someone with a mental illness would make them feel nervous or uncomfortable***. Those who read the schizophrenia vignette were more than twice as likely to feel nervous or uncomfortable compared to those who read the depression vignette (44% vs. 19%, *p < .001*).

Figure 23: Being around John/Mary would make me feel nervous or uncomfortable

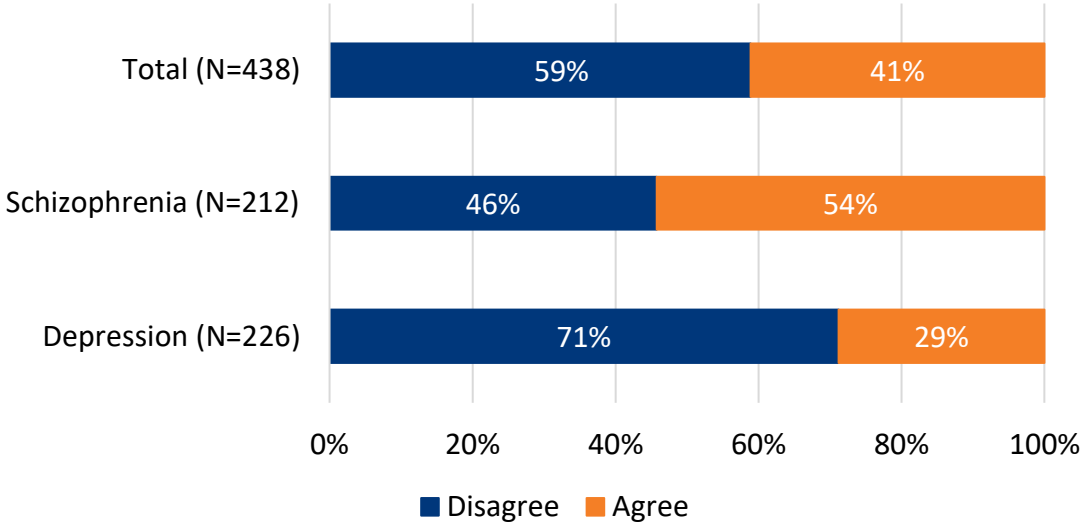


	Respondents who do not have depression were ***more likely*** than those who do have depression to agree that to be around the person in the vignette would make the respondent feel nervous or uncomfortable (32% vs. 20%, *p < .05*).
	Male respondents were ***more likely*** than female respondents to agree being around the person in the vignette would make the respondent feel nervous or uncomfortable (37% vs. 24%, *p = .001*).

Never give up on someone with mental illness. When "I" is replaced by "we", illness becomes wellness.
-Shannon L. Adler

In response to reading the vignettes on schizophrenia and depression, respondents were asked if the person in the vignette shouldn't be allowed to care for children. Over 40% of the respondents agreed the person in the vignette shouldn't be allowed to care for children, with a greater percentage of those reading the schizophrenia agreeing compared to those who read the depression vignette (54% vs. 29%, $p < .001$).

Figure 24: People like John/Mary shouldn't be allowed to care for children



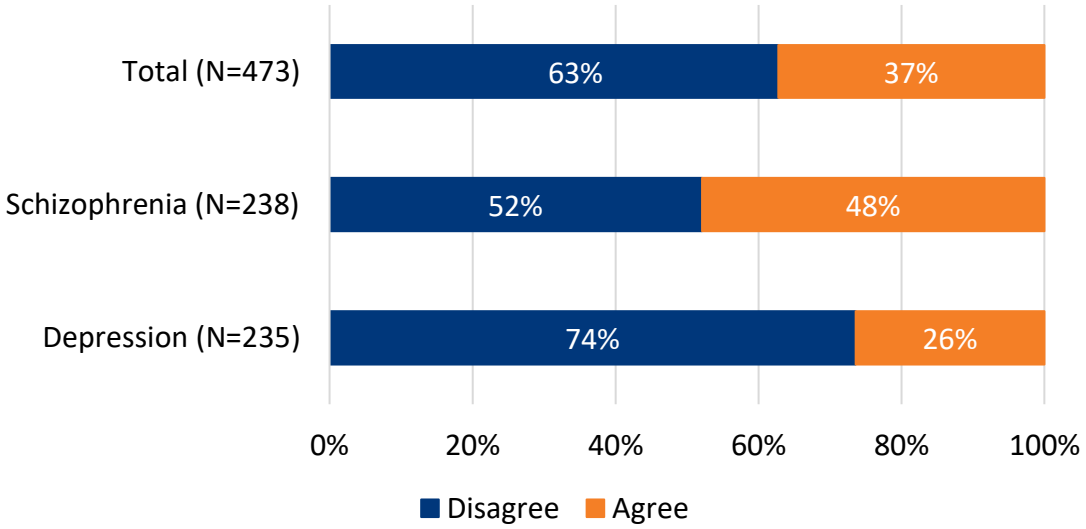
	Respondents who have anxiety were ***more likely*** than those who do not have anxiety to agree that the protagonist in the vignette should not care for children (45% vs. 29%, $p < .01$).
	Black/African American respondents were the ***least likely*** (10%) compared to other race groups to agree the protagonist in the vignette should not care for children. Whereas **Hispanic/Latino** respondents (53%) were ***most likely*** to agree that the protagonist in the vignette should not care for children ($p < .01$).

Mental Health Openness

The mental health openness domain focuses on the willingness to be open to disclosing mental health concerns, which is a personal stigma. The restrictions one may personally feel in being able to share about their challenges could impact their desire to seek help and engage in treatment. This section provides the results of the three items within the mental health openness domain and discusses any demographic differences.

Figure 25 shows that ***one-third of the respondents agreed the protagonist in the vignette would lose friends if people knew about his/her mental health problems***. Nearly twice as many respondents who read the schizophrenia vignette agreed they would lose friends if people knew about his/her mental health problems compared to those who read the depression vignette (48% vs. 26%, $p < .01$).

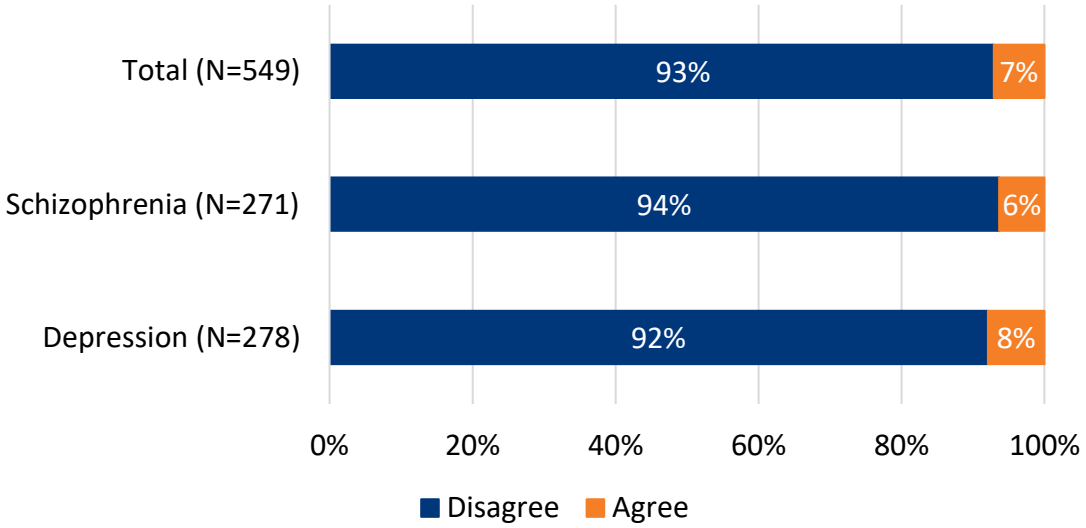
Figure 25: H/she would lose friends if people know about his/her mental health problems



	Male respondents were ***more likely*** than female respondents to agree that the protagonist would lose friends if people knew about his/her mental health problems (43% vs. 31%, $p = .01$).
	Older adult respondents were ***more likely*** than adults or TAY to agree that the protagonist would lose friends if people knew about his/her mental health problems (51% vs. 35% vs. 30%, $p < .05$).
	Respondents with low social satisfaction were ***more likely*** than those with high social satisfaction to agree that the protagonist would lose friends if people knew about his/her mental health problems (46% vs. 34%, $p < .05$).

Less than one in ten respondents (7%) agreed the protagonist's family would be better off keeping his/her mental health problem a secret, with no statistically significant difference between those that read the schizophrenia vignette compared to the depression vignette (6% vs. 8%). However, some interesting trends emerged when analyzing data by some demographic characteristics.

Figure 26: John's/Mary's family would be better off keeping his/her problem a secret



	**Respondents who have depression** were ***more likely*** than those who do not have depression to agree that the protagonist's family should keep the mental health problem a secret (18% vs. 5%, *p < .001*).
	Black/African American respondents were the ***least likely*** (0%) compared to other race groups to agree the protagonist's family should keep the mental health problem a secret. Whereas **Hispanic/Latino** respondents (14%) were ***most likely*** to agree the protagonist's family should keep the mental health problem a secret (*p < .01*).
	**White respondents** were ***less likely*** than non-white respondents to agree the protagonist's family should keep the mental health problem a secret (4% vs. 10%, *p < .01*).
	**Male respondents** were ***more likely*** than female respondents to agree the protagonist's family should keep the mental health problem a secret (12% vs. 3%, *p < .001*).

Lastly, 44% of respondents said they would be afraid to tell people about their situation if they had mental health problems.

Figure 27: I would be afraid to tell people about my situation if I had mental health problems (N=519)

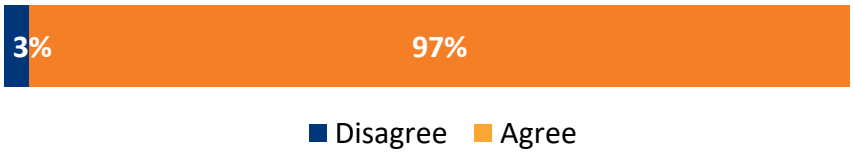
The only demographic group that showed a statistically significant difference for this item were those who had depression responding that they were more likely than those who did not have depression, to be afraid to tell people about their situation (55% vs. 42%, $p < .05$).

Mental Health Literacy

Mental health knowledge has been shown to predict intentions to seek help for a mental illness and disclose the illness to family and friends. Individuals with positive help-seeking attitudes, coupled with knowledge about mental health, have fewer stigmatizing attitudes (Henderson et al., 2013). Knowledge itself helps to break barriers of mental health stigma, which makes campaigns like *It's Up to Us* crucial in addressing stigma. This section focuses on specific items in the mental health literacy domain that address the importance of mental health wellness, causes of mental health concerns, knowledge about treatment effectiveness, and suicide prevention. Additionally, demographic group differences are described when significant, which may be helpful to consider when developing mental health information and educational materials.

Most respondents agreed that mental health is as important as physical health, as shown in the figure below.

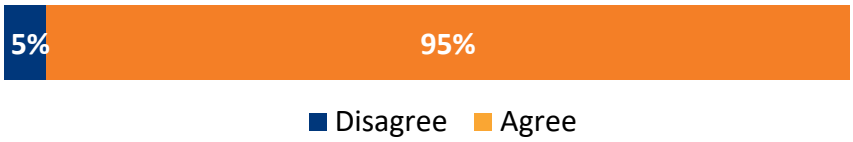
Figure 28: Mental health is as important as physical health (N=575)



TAY and adult respondents were ***more likely*** than older adult respondents to agree that mental health issues are as important as physical health (98% vs. 98% vs. 87%, respectively, $p < .001$).

Likewise, most respondents agreed mental health issues are common, as shown in the figure below.

Figure 29: Mental health issues are common
(N=553)

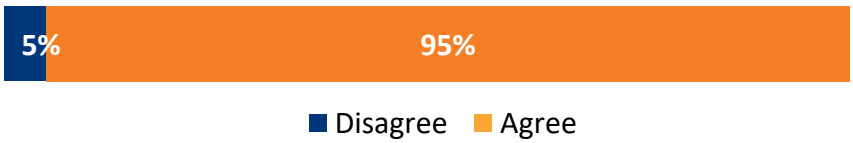


There were a few differences in beliefs for age and race/ethnicity groups that are worth noting.

	Adult respondents were ***more likely*** than TAY or older adult respondents to agree that mental health issues are common (97% vs. 88% vs. 92%, respectively, $p < .01$).
	Black/African American and Hawaiian Native/Pacific Islander respondents were the ***most likely*** (100%) compared to other race groups to agree mental health problems are common. Whereas **Hispanic/Latino** respondents (88%) were ***least likely*** to agree mental health problems are common ($p < .001$).

Respondents also had favorable beliefs about suicide prevention, with nearly all agreeing suicide is preventable.

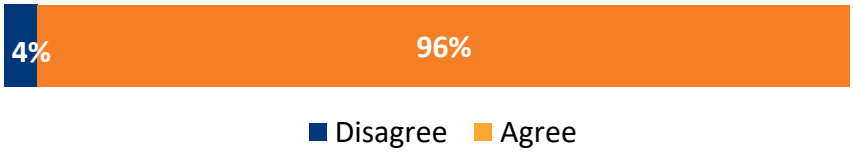
Figure 30: Suicide is preventable
(N=510)



	Respondents who have depression were ***less likely*** than those who do not have depression to agree that suicide is preventable (86% and 96%, $p < .01$).
	Hispanic/Latino respondents were ***less likely*** than non-Hispanic respondents to agree suicide is preventable (91% and 97%, $p < .01$).

Most respondents also agreed they felt sympathy for people with mental illness.

Figure 31: I feel sympathy for people with mental illness (N=580)



One of the interesting findings was that those with either depression or anxiety were less likely than those without either of these mental health concerns to feel sympathy for people with mental illness. This may be due to contextualizing the illness in their journey.

	**Respondents who have depression** were ***less likely*** than those who do not have depression to feel sympathy for people with mental illness (88% and 97%, $p < .001$).
	Respondents who have anxiety were ***less likely*** than those who do not have anxiety to feel sympathy for people with mental illness (91% and 98%, $p < .001$).
	**Hispanic/Latino** respondents (90%) were ***least likely*** to feel sympathy towards people with mental illness.

Knowledge About Mental Health

Respondents were asked about their knowledge of mental health challenges through a review of a vignette on either depression or schizophrenia. The focus was to identify respondent's ability to identify the symptoms of mental illness generally and specifically by disorder, as well as their beliefs about treatment.

Nearly all respondents were able to recognize the person in the vignette was experiencing a mental illness (93%). Overall, 76% of the respondents were able to correctly identify the specific mental illness. When looking at the respondents based on the vignette they read, those who read the depression vignette were more likely to correctly identify the illness compared to those who read the schizophrenia vignette (93% vs. 60%, $p < .001$). The same percentage of respondents agreed the protagonist's symptoms of mental illness would improve with treatment (97%). However, those who read the depression vignette were twice as likely to agree depression would get better on its own compared to those who read the schizophrenia vignette (N=262, 13% vs. 6%, $p < .01$).

Table 12: Mental Health Knowledge (N=580)

It is likely that he/she is experiencing mental illness	93%
Correctly identified mental illness	76%
Correctly identified depression	93%
Correctly identified schizophrenia	60%
Depression will improve with treatment	97%
Schizophrenia will improve with treatment	97%
Depression will get better on its own	13%
Schizophrenia will get better on its own	6%

There were a few demographic differences when looking at age, gender, and race/ethnicity differences regarding beliefs about the mental illness improving with treatment.

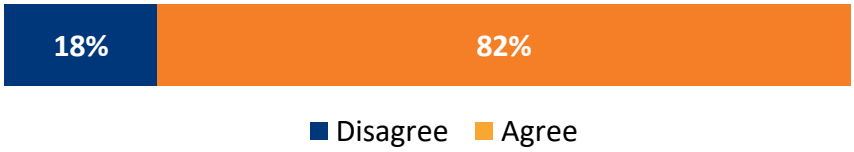
	**TAY** respondents were ***less likely*** than adult or older adult respondents to agree the mental illness would improve with treatment (84% vs. 98% vs. 100%, $p < .001$).
	Female respondents were ***more likely*** than male respondents to agree the mental illness would improve with treatment (100% vs. 94%, $p < .01$).
	**Hispanic/Latino** respondents (91%) ***were least*** likely to agree the mental illness would improve with treatment ($p < .05$).

The Likeliness of Seeking Help

Lastly, the mental health literacy domain also includes items regarding understanding the warning signs of mental illness, feeling comfortable talking to a friend, and seeking help and resources.

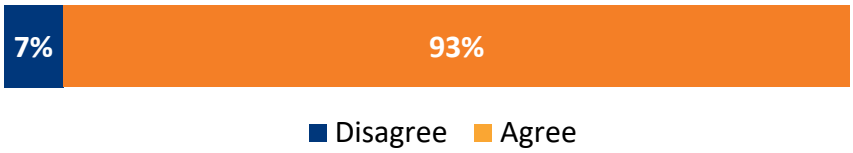
Over three-quarters of the respondents (82%) agreed that they know how to recognize the warning signs of mental health challenges in others and themselves.

Figure 32: I know how to recognize the early warning signs of mental health challenges (N=499)



Most respondents (93%) also agreed they would be comfortable talking to a friend or family member about their mental health (Figure 33).

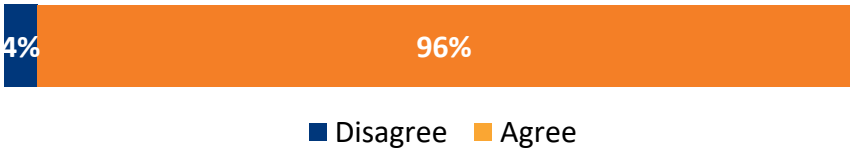
Figure 33: I would be comfortable talking to a friend or family member about their mental health (N=553)



Female respondents were ***more likely*** than male respondents to agree they knew how to recognize the early warning signs of mental health challenges in themselves and others (90% vs. 75%, $p < .001$). **Female** respondents were also ***more likely*** than male respondents to feel comfortable talking to a friend or family member about their mental health (97% vs. 90%, $p < .01$).

It was encouraging to see that most respondents (96%) agreed they would attempt to get help for themselves if they were experiencing mental health problems.

Figure 34: I would attempt to get help for myself if I was having mental health problems (N=543)

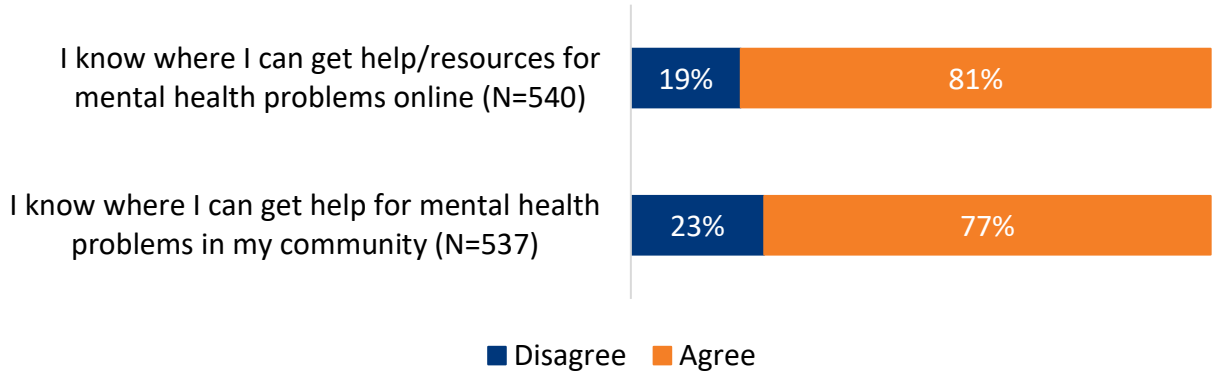


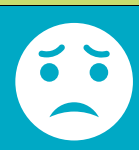
	**Respondents who have depression** were ***less likely*** than those who do not have depression to agree they would attempt to get help if they were having mental health problems (88% vs. 97%, *p < .001*).
	Respondents with children in the household were ***more likely*** to agree they would attempt to get help if they were having mental health problems compared to those respondents without children in the household (99% vs. 94%, *p < .05*).

Tapping into the experience of others in support groups can provide a great deal of help and hope.
-Consumer Advocate

As shown in the figure below, respondents were more likely to know where to get help online than in their community.

Figure 35: I would attempt to get help for myself if I was having mental health problems



	**Female** respondents were ***more likely*** than male respondents to know where to get help in the community (84% vs. 72%, *p < .01*). **Female** respondents were also more likely than male respondents to know where to get help online (85% vs. 78%, *p < .05*).
	Respondents with children in the household were ***more likely*** to know where to get help in the community compared to those respondents without children in the household (83% vs. 74%, *p < .05*).
	**Respondents who did not have anxiety** were ***more likely*** to know where to get help online than those who had anxiety (83% vs. 74%, *p < .05*).

In the review of the outcomes of the 2020 Community Survey specifically regarding mental health stigma, a few trends are worth considering when exploring stigma reduction strategies. These include:

- ✓ Overall, the media campaign strategies in the County of San Diego have been shown to reduce stigmatizing beliefs and attitudes toward mental illness over the last decade.
- ✓ In general, there were more stigmatizing beliefs from those who read the schizophrenia vignette compared to those who read the depression vignette, showing community members may have more stigmatizing beliefs towards people with schizophrenia.
- ✓ Male respondents had more stigmatizing and negative beliefs and attitudes towards mental health challenges and treatment than female respondents.
- ✓ Differences based on age are worth considering, with TAY respondents having less knowledge about mental health challenges and were less likely to seek help. Whereas the question-specific items also showed positive attitudes about social connectedness with those who have mental health challenges and less stigmatizing views about employment for those with mental illness.
- ✓ Race/ethnicity may play a role in stigmatizing beliefs but also showed that BIPOC groups often had more favorable beliefs and attitudes towards those with mental illness and willingness to be socially connected. However, Hispanic respondents were least likely to agree mental health problems are common or that suicide is preventable.

DISCUSSION

In the review of the ISMI-10 and 2020 Community Survey data, the *It's Up to Us* media campaign, and other mental health stigma reduction efforts, appear to be making an impact in addressing internalized and public stigma. However, there is still work to be done to address some demographic differences. Nearly half of respondents of the ISMI-10 did note they do not socialize as much as they used to and felt mental illness had spoiled their life. When looking at the level of care for respondents, those at crisis residential had the highest stigma score on the ISMI-10, showing there may be a negative effect of higher levels of care and the degree of internalized stigma one feels. Interestingly, respondents with anxiety reported less internalized stigma than other disorders. Lastly, TAY appeared to have more resilient, positive attitudes about people with mental illness making important contributions and having a fulfilling life.

The 2020 Community Survey provided insight about internalized and public stigma from the County of San Diego community members. Overall, the results showed that fewer people were receiving treatment in 2020 than in prior years, which may be due to COVID-19 challenges. Most respondents stated they sought treatment because their symptoms were getting worse. However, TAY respondents were more likely than any other age group to seek help because family or friends encouraged them. Additionally, most respondents wanted to solve the mental health problem on their own. Unfortunately, TAY respondents were twice as likely to not recognize the early symptoms of mental illness and twice as likely to think treatment would be ineffective compared to adult respondents, showing a greater need for mental health education among TAY. In contrast, older adult respondents were most likely to be concerned about the cost of mental health treatment and feel based on prior experience, that treatment was ineffective.

When looking at the 2020 Community Survey data concerning help-seeking attitudes for individuals identifying as male or female, male respondents were more likely to be encouraged by family and friends to seek help. However, male respondents were five times more likely to not recognize the early symptoms of mental illness and more than twice as likely to believe treatment would not be effective. Male respondents also were twice as likely to be concerned about what others would think if they knew about their mental health problem. This trend continued when looking at specific question items regarding concern about what others think. These findings point to the need for specific education for males about early symptoms and addressing stigma associated with what others may think. Lastly, the most significant finding regarding experiences with mental health when looking at race/ethnicity groups was that Hispanic/Latino respondents were the most likely to not recognize the early symptoms of mental illness, also showing a need for educational materials that are culturally appropriate for this ethnic group.

In the review of the 2020 Community Survey data over time for the four mental health stigma domains, the mean increased since 2018 for three of the four domains, and generally, 2020 had the highest mean compared to prior years. This shows the media campaign continues to have a positive impact in addressing stigma in the County of San Diego. Using a high p-value (.05, .01, and .001) for this report ensures useful findings about mental health stigma were included that that may help improve mental health campaigns and programs. There also were some interesting trends regarding gender, race, children in the household, and age groups that were worth mentioning.

Overall, female respondents were significantly more likely to have a higher mean in the social acceptance domain compared to male respondents. This trend continued when looking at individual items such as willingness to have someone with a mental illness as a neighbor, spending time socializing with someone who has a mental illness, willingness to have someone with a mental illness marry someone in the family, disagreeing that people with a mental health problem are dangerous or disagreeing she would feel uncomfortable with someone with mental illness. Female respondents also have more mental health knowledge in the areas of believing the illness would improve with treatment, feeling comfortable talking to others, and would attempt to get help. Male respondents were more likely to be concerned with what others would think regarding their personal mental health. Meanwhile, female respondents showed more positive beliefs and attitudes around mental illness. Thus, it appears there would be a benefit in continuing to encourage programs and educational materials for males.

Due to small sample sizes for both the ISMI-10 and 2020 Community Survey for those who identify as a nonbinary gender and those who identify as other than heterosexual, limited findings emerged. However, while limited research is available, what has been shown is that there is stigma associated with nonbinary gender identity. An insightful article, including testimonies from trans and nonbinary people, noted that many trans and nonbinary people feel alienated from their mental health providers and felt they would benefit more from providers who identified as trans or nonbinary (Kim, 2019).

There were variable results for race/ethnic groups, and caution should be taken when reviewing these findings since the sample sizes were small for Black/African American, American Indian and Alaskan Native, and Native Hawaiian and Pacific Islanders respondents. However, American Indian and Alaskan Native, and Native Hawaiian and Pacific Islander, and the multiple-race group respondents had higher mental health literacy domain means than other race/ethnic group respondents. Black/African American and Hispanic respondents appeared to have the most positive attitudes regarding employment of those with mental illness, while Hispanic respondents were least likely to agree mental health problems are common or that suicide is preventable. Overall, it appears it would be helpful for educational materials and prevention and early intervention programs to continue to provide culturally appropriate information and consider cultural differences when addressing mental health stigma.

One positive finding emerged for households with children. Respondents with children in the household had a significantly higher mean in the mental health knowledge and access domain. Specifically, looking at single-question items, those with children in the household were more likely to get help than those without children. This finding is very encouraging as it is likely those households with children that are knowledgeable about mental health and willing to get help will more likely do so for their children as well if needed.

For many indicators in the 2020 Community Survey, no significant age effects were observed. However, on a subset of indicators, young adults held more stigmatizing views compared to other age groups. Most notably, more than one-quarter of young adult respondents agreed or strongly agreed that the family of someone with a mental illness should keep it a secret, compared to only 6% of adults and 1% of older adults. Young adult respondents were also significantly less likely to report feeling sympathy for people suffering from mental illness, said they would be less likely to seek support if they were suffering from a mental illness, and were less likely to agree or strongly agree that suicide is preventable. Yet, in other ways, youth demonstrated more openness and less stigma, especially compared to older adult respondents.

For instance, youth respondents were less likely to feel that someone with a mental illness would lose friends if people knew about their condition. Youth respondents also appeared to hold less stigmatizing views about employment for individuals with mental illness than their older counterparts.

These somewhat inconclusive results are perhaps not surprising given the literature. Although numerous studies have examined differences in mental health stigma between older and younger adults, findings have been mixed. Some studies have found young adults are at greater risk for mental health stigma (Mackenzie et al., 2019a; Mackenzie et al., 2019b, Farrer et al., 2008) while, other studies have concluded older adults are at greater risk (Angermery & Dietrich, 2006; Collins et al., 2014). Both the literature and our findings suggest experiences of mental health stigma are complex, difficult to measure, and may be modified by numerous factors other than age.

Based on these findings, stigma reduction programming in San Diego should continue to target all age groups. Additionally, research into the prevalence, causes, and consequences of mental health stigma on children younger than 18 is needed. We currently lack data to reliably assess stigma among children in San Diego or compare risks among this age group to their older counterparts. Yet observing some of the differences based on age that did emerge in the data, it is recommended that interventions should be specifically developed for and targeted to specific age groups and their unique social experiences. Experts suggest school-based interventions may prove most effective at reducing stigma when they target young children before stigma develops and are continuously delivered across the years, and provide developmentally appropriate curriculum (Corrigan et al., 2012; Economou et al., 2012; Greenwood et al., 2016; Gronholm et al., 2018; Mueller et al., 2016; Schacter et al., 2008).

STRATEGIES FOR ADDRESSING MENTAL HEALTH STIGMA AND DISCRIMINATION

ADULT AND OLDER ADULT STRATEGIES

Common evidence-based strategies to reduce personal and public mental health stigma include mental health literacy, education, and contact. Descriptions and applications of these three current strategies used within the County of San Diego are detailed below, as well as examples of programs from other jurisdictions.

Mental Health Literacy

Mental health literacy is the enhancement of knowledge to help differentiate attributes of mental disorders from general stress. It also includes sharing knowledge about risk factors, treatments, available resources, and professional help (Cheng et al., 2017). Individuals with a higher mental health literacy have attitudes that make them more inclined to seek psychological help and recommend professional help for others (Cheng et al., 2017).

Education

Mental health stigma education is the means of teaching participants about stigma and its effect on health. It includes addressing inaccurate stereotypes about mental illnesses and replacing them with facts (Corrigan et al., 2010). An example of an educational campaign is countering the idea that people with mental illness are more inclined to violent crimes by presenting statistics that show homicide rates are similar among people with mental illness and

the general population. Educational strategies have included public service announcements, lectures, books, flyers, podcasts, and other audio-visual aids to reduce mental health stigmas (Nyblade et al., 2019).

Learning Through Contact with People with Lived Experience

The strategy of contact occurs by providing opportunities for people to connect with persons with a lived experience with mental illness (Corrigan et al., 2010). Low interaction between those with mental illness and those who do not have a mental illness can lead to uncomfortable feelings such as distrust and fear (NASEM, 2016). Contact interventions aim to overcome this divide by creating positive interactions between these groups. One way this is accomplished is when people with lived experiences of mental illness describe their challenges and success stories to the general public (Wong et al., 2018). The strategy of contact can also combat self-stigma by increasing self-esteem and enhancing a sense of empowerment (Corrigan et al., 2013). Likewise, contact with people with lived experience can include ensuring the client and provider have similar identities that are important for the client. This requires diversifying the behavioral health workforce so that clients have access to providers of the same gender, race/ethnicity, or sexual orientation identity.

San Diego County Adult Program Examples

Currently, there are programs in the County of San Diego that use the strategies of mental health literacy, education, and learning through contact with people with lived experience. While not necessarily evidenced-based programs, examples of local programs that use these three strategies are discussed below, along with program examples outside of San Diego.

NAMI San Diego Next Steps is a peer and family support program connected to the San Diego County psychiatric hospital that assists participants in achieving personal goals related to mental health, physical health, and substance use. The program heavily utilizes the strategy of contact, coupled with mental health literacy, by utilizing staff with their own lived experience, who empower participants by modeling self-management, assisting participants in developing self-care skills, and linking them to community resources and services. Next Steps is funded through the Mental Health Service Act (MHSA) provisions for Prevention and Early Intervention (PEI) programs in San Diego County.

namisandiego.org/services/next-steps

It's Up to Us SD is a multi-media education and awareness campaign, made possible through MHSA funds, that endorses open communication about mental illness, symptoms of mental conditions, and the resources available for treatment. As a media campaign, It's Up to Us incorporates the strategies of mental health literacy and education to encourage San Diegans to speak up and seek help or be a support to those around them with mental health challenges. The prerecorded testimonials from those with lived experience with mental illness serve as an example that mental health obstacles can be overcome and that a successful life is possible. Utilizing a contact strategy, those without a mental health condition are also able to see the people beyond the condition.

up2sd.org

NAMI San Diego In Our Own Voice is a program that trains mental health clients to be presenters and facilitators to speak to community groups, including college classes, about their lived experiences of mental illnesses. Utilizing the strategy of contact, In Our Own Voice uses prerecorded video segments that set up the themes of each section interspersed with first-person testimony from individuals with mental illness. This type of virtual contact with individuals with lived experience helps educate community members who may have little contact with "real" mental health clients. Stigma is addressed by presenting realistic information along with contact with those who suffer various disorders.

namisandiego.org/services/in-our-own-voice

Other Program Examples

No stigma No Barriers is a California program funded by MHSA that provides training, outreach, and advocacy campaign to TAY and is designed to eliminate mental health stigma and make care more accessible. The campaign utilizes mental health literacy by sharing statistics. For instance, half of the students aged 14 and older with a mental illness drop out of high school. Literacy and education material is disseminated at public health events to educate the public about mental illness and stigma. Live social events that include food and live music are also held to have conversations about health and wellness. No Stigma No Barriers utilizes contact strategies, sharing quotes and stories to encourage individuals to seek help if needed.

Nostigmanobarriers.org

Wise Wisconsin is a campaign that provides multiple approaches to reduce stigma. Mental health education lesson plans are provided for leaders of schools, healthcare facilities, and other workplaces to use in their organization. The campaign also aims to increase resilience, build inclusion, and offer hope within the mental health community through the use of mental health literacy videos and PowerPoint presentations. The mental health literacy and contact approaches are used in prerecorded videos of people who share information about their illness and recovery.

wisewisconsin.org

NAMI Pledge to be Stigma Free is a campaign that utilizes mental health literacy strategies to reduce stigma by providing easy-to-understand information about common mental illnesses, their warning signs and symptoms, treatments, statistics on mental health, and ongoing research in the mental health field. Virtual contact strategies via video recordings are also used by showing personal stories to emphasize seeing the person and not just the condition. Pledge to be Stigma Free provides further steps to reduce stigma by providing mental health news, ways to contact policymakers, and a platform to share one's own story.

www.nami.org/Get-Involved/Pledge-to-Be-StigmaFree

Each Mind Matters and SanaMente, California's English and Spanish language mental health awareness campaigns, combat mental health stigma and prevent suicide and are funded by the Mental Health Services Act. These campaigns utilize an educational strategy through its website that includes resources for young adults, children and families, veterans, older adults, and diverse communities to understand mental health challenges and reduce stigma. The website also uses a combined mental health literacy

www.eachmindmatters.org

and contact approach by including personal narratives and information about mental health disorders. Additionally, the campaign sponsors screenings, awareness walks, and seminars to promote prevention and early intervention. Lastly, the campaign partners with many local, state, county, and national organizations to have a broad reach.

STRATEGIES FOR CHILDREN, YOUTH, AND FAMILIES

There have been calls from researchers for decades to gain a better understanding of the problem of mental health stigma among children and adolescents and to design and implement evidence-based interventions. School-based interventions, especially education-based interventions, have been one of the most common strategies for addressing stigma in this population (Hartog et al., 2020). Some individual studies have demonstrated lasting positive changes in children's beliefs and attitudes following participation in stigma programs (Economou et al., 2011; Bulanda et al., 2014). Unfortunately, two large-scale systematic reviews found that there is insufficient evidence to determine the effectiveness of classroom-based programs at reducing mental health stigma (Mellor, 2014; Schacter et al., 2008).

Lacking conclusive evidence to recommend specific interventions, experts in the field have offered the following research-based guidelines to inform stigma programming for children and adolescents:

- **Content**: Although both education and contact interventions have demonstrated positive effects, education may be more effective for adolescents, while contact is more effective for adults (Corrigan et al., 2012). Schacter and colleagues (2008) hypothesize a developmental, empathy-based approach may be most effective, where the curriculum would incorporate more direct contact as children age.
- **Mode of Delivery**: Face-to-face contact is more effective than video presentations (Corrigan et al., 2012).
- **Timing**: Interventions should start early before stigma develops (Mueller et al., 2016; Schacter et al., 2008). Greenwood and colleagues (2016) suggest that primary schools could actively teach about mental health stigma, with interventions targeting children as young as seven.
- **Duration**: Instead of one-time presentations, experts recommend interventions be continuously delivered across years to help produce long-term changes (Schacter et al., 2008; Economou et al., 2012).
- **Child Focused**: Children's interventions should be designed with children's needs and development in mind (Schacter et al., 2008). In qualitative interviews across multiple studies, students wanted interventions to focus on relational components with providers and coping strategies instead of clinical descriptions. Students also emphasized the need for choice and control in help-seeking, trust-building opportunities with providers, and improved privacy (Gronholm et al., 2018).

San Diego County Children, Youth, and Family Program Examples

The MHS) prioritizes stigma and discrimination reduction through their CYF PEI programs. In San Diego County, local mental health advocates and providers work to address the problem of stigma during childhood, even as the evidence base for the most effective interventions is forthcoming. In the fiscal year 2019-20, MHSA funded CYF PEI programs that provided services and outreach to over 25,000 San Diegans. Approximately 77% of CYF PEI program participants completing satisfaction surveys reported that they were more comfortable seeking help after

they participated in the PEI programs (San Diego County Child & Family PEI Programs Systemwide Summary, Annual Report FY 2019-2020). These data suggest CYF's PEI stigma reduction efforts may improve help-seeking among participants.

Addressing stigma and reducing barriers to care is a key component of many PEI services. Below are two CYF PEI programs that incorporate stigma reduction activities: Kickstart and the HERE Now program.

Kickstart provides prevention and early intervention services to youth and young adults who may have clinical high risk (CHR) symptoms of psychosis or have had their first episode of psychosis (FEP). The program uses the PIER model to addresses stigma through outreach presentations and monthly psychoeducation workshops for families, clients, providers, and community members. These efforts focus on normalizing mental health issues, addressing misrepresentation of psychosis, positively reinforcing early intervention, and sharing success stories from former Kickstart graduates.

www.piertraining.com/pier-model

The Helping, Engaging, Reconnecting, and Educating (HERE) Now Program provides the evidence-based SOS Signs of Suicide Prevention® curriculum to thousands of San Diego high school students every year. The program focuses on decreasing suicide and suicide attempts, encouraging help-seeking, and reducing mental health stigma. Specifically, the program's curriculum addresses barriers like stigma, myths, and shame that discourage youth from speaking out and getting help. Screening and referrals also help connect high-risk youth to needed services.

Sossignsofsuicide.org/parent/signs-suicide-program

RECOMMENDATIONS FOR ADDRESSING MENTAL HEALTH STIGMA IN SAN DIEGO

MAINTAIN AND EXPAND CURRENT EFFECTIVE STRATEGIES

The San Diego region has employed many strategies to reduce mental health stigma and discrimination in the past decade. The *It's Up to Us* campaign has provided mental health literacy and education to a vast audience and encouraged individuals to open up and reach out for help. Programs in the County have used strategies that have shown to be effective such as employing staff with lived experiences at programs like Next Steps and Peer Links. Another strategy employed lived experience presentations from mental health clients that provide education and contact with individuals who have traveled the mental health journey, such as In Our Own Voice. Lastly, throughout the County, psychoeducational workshops and suicide prevention curriculum are provided to youth through programs such as Kickstart and HERE Now.

AREAS FOR CONTINUED AND ADDITIONAL FOCUS

The findings from this report show that a few specific groups could use additional support in addressing stigma. The 2020 Community Survey showed there were more stigmatizing beliefs towards individuals with schizophrenia compared to those with depression. Therefore, promoting positive information about those with schizophrenia could be beneficial. Both the ISMI-10 and Community Survey data had findings that showed male respondents have more

stigmatizing beliefs than female respondents. Thus, men may benefit from mental health literacy and educational materials strategic to them.

With limited information available regarding mental health stigma for nonbinary people and individuals who identify as other than heterosexual, we inquired with current PEI staff to learn about what the needs of these individuals are for mental health services. In consultation with the staff of Breaking Down Barriers (a program operated by Jewish Family Service and funded by the County of San Diego through PEI), regarding the needs of individuals that identify as Trans, Nonbinary, or Gender Nonconforming served through mental health providers in San Diego; it is recommended that the behavioral health services workforce is diversified to be more reflective of the Trans community, specifically ensuring Trans people can work with Trans mental health providers who understand the complexities of their identities.

While the data showed some age group differences, it appears mental health literacy among TAY could be improved. Likewise, TAY were not as knowledgeable about the signs of mental illness. As noted in the strategies above, outreach and programs that are in person, developmentally and age-appropriate, and delivered consistently across a year are most effective for children and youth. Several CYF PEI programs currently include a stigma component in their programming, such as Kickstart and HERE Now. In alignment with existing youth stigma research, we recommend the development and installation of a school-based PEI program focused on mental health stigma reduction. Additionally, as the research on effective stigma programming continues to develop, it will be important to monitor advances in the literature to ensure PEI programs are following best practices. The long-term recommendation for addressing mental health stigma specific to youth in San Diego County is to engage in a strategic planning process. This process would be time- and resource-intensive and requires collaboration across multiple stakeholder groups to develop and implement a comprehensive, multifaceted stigma reduction plan tailored to the needs of our youth.

San Diego's PEI programs provide outreach to specific race/ethnicity groups. A couple of examples include the Dream Weaver program for American Indians in the region and Elder Multicultural Access and Support Services, which serves Iraqi, Chaldean, Filipino, Black/African American, Somali, and Hispanic/Latino seniors. The County could benefit in continuing to consider mental health literacy and educational outreach for BIPOC individuals and the impact culture has on mental health stigma.

The data from both sources in this report show stigma is being addressed and reduced in the San Diego region. However, it is recommended that in Spring 2022, the MHSIP include as supplemental questions the ISMI -10. Additionally, we currently lack data to reliably assess stigma among youth in San Diego or monitor stigma experiences following the onset of COVID-19. We recommend dissemination of the ISMI-AF with the Spring 2022 YSS, to gather much-needed information on internalized stigma risks among CYFBHS clients ages 12 and older.

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APPENDIX

Weighted Demographics

Data from the Community Survey were analyzed using the weighted sampling procedures used in the report *Suicide Prevention and Stigma Reduction Media Campaign: Community Survey Full Report: 9 Year Post-Launch* (EVALCORP 2021). Therefore, the information below was included as Appendix C from this report and is included here to provide details concerning the weighted sampling procedures.

> *"A proportional sampling was planned to recruit participants on the observed variables of gender, ethnicity, and age cohort. However, there were low response rates among men and Latinxs and the proportional sampling quotas were not reached. To address potential sampling bias that can arise from non-representative sampling, design weights were used. It is important to note that design weights can never fully compensate for sampling bias and even the most sophisticated weighting strategies may compensate for less than half of sampling bias (Mercer et al., 2018). Moreover, there are always multiple possible weighting schemes, contributing to unmodeled researcher degrees of freedom (Wicherts et al., 2016). This is particularly true when multiple, overlapping categories of persons (e.g. gender, ethnoracial background) require weighting.*
>
> *Design weights work by counting members of under sampled groups more than once and oversampled groups less than once along with a continuous interval. The sample is rebalanced so that, once weights are applied, it is relatively indistinguishable from a representative sample. One common statistical rule for design weights is to avoid weights outside the range of .2 to 2 – this rule is followed for the 2020 Community Survey as well.*
>
> *The results of applying weights to the 2020 Community Survey are shown in the two tables below. The final column on the right shows the distribution of subgroups after weights have been included. As the table shows, all subgroups moved closer to the population distribution after weights were applied. Due to rounding, weights do not average exactly to 1 across the sample" (EVALCORP, 2021).*

GENDER	POPULATION %	SAMPLE %	WEIGHTED %
Male	50%	38%	53%
Female	50%	62%	47%
ETHNICITY	**POPULATION %**	**SAMPLE %**	**WEIGHTED %**
Hispanic or Latino	35%	24%	38%
White alone not Hispanic	46%	67%	56%
Black or African American	5%	6%	6%
American Indian and Alaskan Native	1%	2%	2%
Asian	12%	11%	13%
Native Hawaiian and Other Pacific Islander	<1%	2%	1%
Other	1%	2%	<1%