

Stigma Work Group Recommendations June 16, 2006

I. Work Group 1 Stigma and Suicide Prevention

II. President's New Freedom Goals and Sub-Goals

AMERICANS UNDERSTAND THAT MENTAL HEALTH IS ESSENTIAL TO OVERALL HEALTH

1.1 Advance and implement a national campaign to reduce the stigma of seeking care and a national strategy for suicide prevention.

1.2 Address mental health with the same urgency as physical health.

Introduction:

The New Freedom Commission Final Report stated that “in a transformed mental health system Americans will seek mental health care when they need it – with the same confidence that they seek treatment for other health problems”. Too often people in Connecticut are prevented from seeking this care due to the stigma that surrounds mental health care. In addition, individuals with mental illness or their family members are often uninformed about the range of effective mental health treatments available. A transformed mental health system would empower consumers to make informed decisions about their overall health care. A goal of a transformed mental health system would be to eliminate the barriers that prevent individuals from accessing care through increased awareness about treatment interventions. At the same time we must also seek to eliminate stigma by educating the general public of the importance of mental health for overall health.

Stigma and the lack of knowledge regarding mental health treatment also contribute to unacceptable rates of suicide within Connecticut. While considerable emphasis is being placed on suicide prevention in the state, much remains to be accomplished. Resources need to be better coordinated and target individuals who may be at the highest degree of risk for suicide. Certain groups such as adolescents may developmentally be at greater risk but reluctant to access traditional health and mental health care. Their isolation from the general health care system places them in a vulnerable position during a period where they could benefit from mental health supports.

When individuals are seeking mental health care, they are often turning to health care settings such as community or school-based health clinics, primary care providers, or through specialty health providers such as Ob-Gyn's or cardiologists. These settings offer opportunities for early screening and intervention but health professionals may be inadequately trained to recognize the signs and symptoms of serious mental illness. A transformed mental health system would recognize these trends and establish strategies and interventions that integrate mental health care with primary and specialty health care

settings. These strategies must also focus on the elimination of barriers that prevent individuals from accessing mental health or physical health care.

Our effort must go beyond this and focus on primary community institutions such as schools, day care centers, businesses, and church organizations. Vulnerable individuals spend large portions of their day in these settings, often exhibiting troubling symptoms that may not be responded to. Particular attention must be directed toward critical developmental periods where individuals may be at greater risk for the development of mental health problems or for suicide. Colleges and universities must be incorporated into a comprehensive strategy. Staff working in these systems must be provided with tools and resources that enable them to assist these individuals.

Finally culture contributes significantly to decisions individuals make about accessing care. Often traditional health and mental health systems are not welcoming to persons of different cultures, alienating these persons from needed care. A transformed mental health system would acknowledge the important role culture plays and would seek to develop culturally competent approaches for service delivery as well as for community education.

It is the goal of our group that stigma and barriers that prevent individuals from seeking mental health care are reduced. It is our hope that the public comes to recognize that “good mental health” contributes to overall physical health. “Good mental health is good business” and should be everybody’s concern.

Guiding Principles

Recommendations within our group have been guided by core principles. These principles provide a foundation for which to continue transformation activities in the state. The foundation for many of these principles is derived from the New Freedom Commission Report, the State of Connecticut’s Department of Mental Health and Addiction Services (DMHAS) Recovery Initiative, and Department of Children and Families (DCF) Community KidCare Initiative. These principles were central to Connecticut’s proposal in response to the Substance Abuse and Mental Health Services Administration’s (SAMHSA) Transformation State Incentive Grant (TSIG). The guiding principles are as follows:

- Addresses stigma and suicide prevention across the lifespan.
- Is sensitive to the diverse cultures represented in Connecticut and responds to different cultural backgrounds through various mechanism including culturally sensitive communication and education and culturally competent service delivery.
- Treats mental health with the same urgency as physical health.
- Educates the public about the wide array of effective mental health treatments, relationship between mental health and physical health, and serves to reduce the stigma associated with seeking treatment.
- Coordinates with and builds upon initiatives currently underway nationally or within the state to address stigma or suicide prevention.

- Reduces fragmentation by employing a cross-system approach that invites participation of a broad range of stakeholders including other state departments, providers, and people in recovery.
- Expands and builds upon existing infrastructure so as to avoid duplication and the creation of parallel structures.
- Utilizes existing, evidence-based program models that are developmentally appropriate to address unique needs such as those of children and the elderly. Some examples of evidence-based program models include In Our Own Voice, Peer to Peer, and Family to Family.
- Transforms the system through infrastructure enhancements rather than service expansion.
- Targets populations or groups deemed to be at highest risk.
- Expands activities beyond traditional stakeholders and includes business and industry, faith leaders and communities, and other institutional settings where people are in need of mental health care such as corrections or the criminal justice system.
- Is consistent with the New Freedom Commission Goals and Recommendations.

Recommendations

1. Anti-stigma Task Force and Public Relations Campaign

Discussion: The group reviewed the scope of anti-stigma activities within the state through the distribution of an informal survey to our members. While the survey responses highlighted that a range of anti-stigma activities were occurring throughout the state, these activities were not part of comprehensive, coordinated anti-stigma campaign. Instead activities varied considerably coordinated from region to region and the extent of anti-stigma activities fluctuated significantly. State agencies could not identify specific line item budget accounts for anti-stigma activities even though many of these agencies did directly or indirectly fund anti-stigma activities. There was a strong consensus that an oversight group should be formed and charged with developing an anti-stigma campaign. Considerable group discussion focused on the strategies for achieving the recommendations and that discussion is highlighted in the bullets following the recommendations.

Recommendation 1:

Convene a high level (Governor endorsed and appointed) statewide Mental Health Anti-Stigma Task Force co-chaired by representatives from health and mental health that includes broad representation of stakeholders from across the lifespan including state departments, providers, people in recovery, and family members.

Time Frame: January 1, 2007

Recommendation 2:

Direct the Anti-stigma Task Force to develop, implement, and evaluate a comprehensive anti-stigma campaign that reduces the stigma of seeking care while educating the general public about the importance of mental health. The anti-stigma campaign should:

- Include broad representation of stakeholders from state agencies serving individuals across the lifespan, education and higher education, people in recovery, family members, provider organizations, and advocacy groups such as National Alliance for the Mentally Ill (NAMI), Advocacy Unlimited, and Connecticut Community for Addiction Recovery (CCAR).
- Use a multi-faceted approach including a range of public education strategies such as media campaigns including Public Service Announcements (PSA's), Speaker's Bureaus, Consumer and family driven training and builds upon already existing, evidence-based models. The anti-stigma campaign should rely heavily on strategies that emphasize personal contact between persons with mental illness and targeted groups.
- Focus specifically on policies that reduce or perpetuate stigma. The campaign should propose a set of policy recommendations that if enacted serve to reduce stigma. Policies that create barriers to employment, housing and overall community integration must be eliminated. It is suggested that the Task Force consider whether state agencies implement anti-stigma training for all employees modeled after training that is already made available through the DMHAS Recovery Institute.
- Target individuals who are experiencing developmental or life stage transitions that leave them at increased risk for mental illness or suicide. Much of this has already been identified in the Statewide Comprehensive Suicide Prevention Plan.

Time Frame: June 2007

Recommendation 3:

Provide annualized funding to support the anti-stigma campaign.

Time Frame: June 2007

2. Suicide Prevention Campaign

Discussion: The group conducted a similar informal survey to identify the range of activities that were already occurring in the state related to suicide prevention. The group benefited from membership that were already involved in a wide range of suicide prevention activities. Our group membership included individuals who were active with the Interagency Suicide Prevention Network which was responsible for developing the State Comprehensive Suicide Prevention Plan, the Youth Suicide Advisory Board and with initiatives that are occurring through the State Department of Education and the Department of Mental Health and Addiction Services. Upon reviewing the suicide prevention activities, it is clear that the TSIG activities needs to build on what has already been finalized and needs to carefully evaluate the Comprehensive Suicide Prevention Plan to determine whether aspects of the Plan could benefit from TSIG funds or enhanced integration with this initiative.

The group felt strongly that Early Screening and Intervention across the lifespan was critical in this area and suicide prevention activities needed to be expanded into primary healthcare settings, schools and school-based health clinics, and universities as well as in nursing homes agencies serving the elderly who may be at greater risk. Special screening emphasis should be focused on gay and lesbian youth who are at much higher risk for suicide and isolated from community support. While these screening activities are being addressed in another TSIG work group, it was the group's consensus that these interventions must be part of a comprehensive suicide prevention campaign. Additional group discussion is summarized in the bullets that follow the recommendations.

Recommendation 1:

Identify all state/federal funds currently available in Connecticut agencies for suicide prevention activities across the lifespan. The review should:

- Identify all revenue sources and the funding cycles for these funds.
- Clarify activities already funded and the target groups in order to determine gaps or comprehensiveness of activities.

Time Frame: September 06

Recommendation 2:

Implement and evaluate a statewide suicide prevention campaign based on the strategies and recommendations from the State's Comprehensive Suicide Prevention Plan developed in 2005 by the Interagency Suicide Prevention Network. The Suicide Prevention Campaign should:

- Address risk factors across the lifespan paying careful attention to developmental periods of higher risk and vulnerability.
- Target families of the specific priority/vulnerable populations such as teens or college age students to help families to better understand how to recognize the warning signs and to support (be there) their child who has either expressed suicidal ideation or has attempted suicide.
- Link to existing suicide prevention initiatives such as the State Department of Education's (SDE) Suicide Prevention Guidelines, Youth Suicide Advisory Board, and the Interagency Suicide Prevention Network, or the Connecticut Suicide Prevention Initiative. TSIG support should be extended to critical aspects of these initiatives that may be unfunded or require additional resource allocation based on the review in Recommendation 1.
- Target specific priority/vulnerable populations such as teens or college age students who are separating from natural sources of support. Special emphasis should be placed on the needs of gay and lesbian youth who are often isolated from social supports and up to three (3) times more likely to commit suicide. These groups are specifically targeted in the Connecticut Suicide Prevention Initiative. Attention should also be focused on increasing family awareness of risk factors and available interventions.
- Integrate with the new DMHAS Suicide Prevention Grant

- Consider specific policy issues such as required mental health screening integrated in annual physicals, mandatory annual screenings for elders in nursing facilities, and funding through the Medicaid authority to support these policy changes.

Time Frame: January 1, 2007

Recommendation 3:

Encourage local school districts to disseminate and adopt suicide prevention and anti-stigma modules as part of comprehensive school health curriculums. Curriculums should:

- Include component information about mental health, mental illness, risk factors, and resources.
- Expand on Suicide Prevention Guidelines issued by the State Department of Education in 2004.
- Have sufficient flexibility so as to allow for modifications that address the special needs associated with children in pre-school, elementary and middle school and high school.
- Consider the various cultural differences for families and communities relevant to mental health, mental illness, death and suicide.

Time Frame: September 2007

Recommendation 4:

Provide funding for suicide prevention training that would be made broadly available to professionals working with individuals determined to be at-risk. Training programs and curriculums should:

- Focus on developing or adopting an existing (evidence-based) "Peer to Peer" or "Train the Trainer" model to allow for sustainability and cost-effective expansion of suicide prevention / training programs.
- Build on and expand already developed training curriculums such as that of DCF and the SDE.
- Be developed in a flexible manner in order to allow for customization to address the needs of special populations such as teenagers, adolescents, college students, elderly and those working in the corrections arena.
- Target staff in primary healthcare settings.
- Be offered to personnel serving vulnerable individuals across the lifespan (i.e., schools, day care, nursing homes, senior centers, employee assistance programs).
- Provide age-specific suicide prevention screening tools that could be employed in a range of settings.
- Include information and referral resources for individuals that are determined to be at-risk.

Time Frame: January 1, 2007

3. Eliminate Policies that Contribute to Stigma and Restrict Access to Care.

Discussion: The group identified a number of policies that contributed to stigma or served as barriers to care. Policies related to housing, employment, health care parity, and reimbursement all play a role in perpetuating stigma. These policies may also affect access to care when needed services are not reimbursed (screening and intervention) by traditional payment mechanisms such as Medicaid or not fully utilized by the state as in the case of the Medicaid Rehabilitation Option. The state has begun to expand services under the Rehab Option but this must be expanded further.

It was felt that mental health parity was critical if individuals were to seek mental health care in the same way they obtain health care. It was recognized that true parity does not yet exist. While Connecticut has enacted parity legislation, it was felt that the legislative change had not gone far enough. The legislation applies only to a portion of Connecticut's citizens and does not include provisions for holding businesses accountable for mental health parity. The issue of parity needs to be further examined in order to determine mechanisms for strengthening the existing legislation.

It was felt that the TSIG planning process did not afford the group sufficient opportunity to carefully review policy modifications or additions. While many policies were viewed as contributing to or reducing stigma, no single policy was identified for elimination, expansion, or modification. Instead, the group felt strongly that the Anti-stigma Task Force should be charged with completing a comprehensive policy review that would lead to specific recommendations.

Recommendation 1: Direct the Anti-Stigma Task Force to complete an annual policy review as one component of its campaign. The review would lead to the identification of specific policy recommendations. The review should consider the following policy areas:

- Funding or strategies that expand access to care through the Rehabilitation Option or provide funding for services such as early screening and intervention. It was discussed that policy decisions such as requiring primary care to conduct mental health screenings would not be enacted unless funding were made available to provide these services.
- Mental health parity and opportunities for expanding Connecticut's legislation. The review should also explore provisions that could strengthen enforcement and regulatory authority as it relates to mental health parity.
- Housing and employment policies as they relate to stigma and persons with mental illness need to be more fully explored. Barriers that restrict access to housing and work serve to perpetuate stigma.
- Training regarding stigma and suicide prevention should be made widely available within the state. Certain training components could be required by state agencies for their staff and providers. Policies regarding required training should be evaluated to consider the feasibility of such an approach.