Active Minds for Every Mind Equity Initiative

A Student Workbook

Workbook Credits

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Chapter 1: Introduction

About Active Minds

Welcome to Active Minds! Active Minds (www.activeminds.org) is the nation's premier nonprofit organization supporting mental health awareness and education for students. Through award-winning programs and services, Active Minds is empowering a new generation to speak openly, act courageously, and change the conversation about mental health for everyone.

All of you have different levels of familiarity with Active Minds starting off, so to begin, here is our story.

Active Minds was founded by Alison Malmon when she was a junior at the University of Pennsylvania, following the suicide of her older brother, Brian. Brian, also a college student, had been experiencing depression and psychosis for three years but had concealed his symptoms from everyone around him. In the middle of his senior year, he returned to the family's Potomac, Maryland home and began receiving treatment for what was later diagnosed as schizoaffective disorder. A year and a half later on March 24, 2000, as Alison was wrapping up her freshman year at Penn, Brian ended his life.

Recognizing that few Penn students were talking about mental health issues though many were affected, Alison was motivated to change the culture on her campus. She wanted to combat the stigma of mental illness, encourage students who needed help to seek it early, and prevent future tragedies like the one that took her brother's life. After searching unsuccessfully for existing groups that she could simply bring to her campus, Alison created her own model and formed what was then known as Open Minds.

After a great first year, Open Minds at Penn gained enough support that it expanded onto other campuses. The constant growth continued, and the National headquarters was established in Washington, DC during the summer of 2003. The new non-profit organization, and all of the affiliated campus chapters, was then renamed Active Minds, to reflect the progressive nature of this form of student advocacy in the mental health movement.

Today, Active Minds is on more than 450 campuses throughout the United States. There are over 12,000 student chapter members throughout all 50 states, The Commonwealth of Puerto Rico, and 17 countries. Our peer to peer mental health messaging reaches more than five million people a year.

There are many ways to be part of the Active Minds movement.

1. Create or join a chapter! Chapters are an excellent avenue by which to mobilize action on your campus and galvanize a student-led movement on your campus.
2. Raise awareness by implementing one of our National Awareness Campaigns such as Stress Less Week, National Day without Stigma, or Suicide Prevention Month.
3. Host a speaker from the Active Minds Speakers Bureau, or Send Silence Packing, the nationally renowned suicide awareness backpack display
4. Join our network by following our social media and blog. You can find us on Facebook, Instagram and Twitter.

Active Minds Research Brief

In July 2018, the RAND Corporation released the results of a landmark study that illustrated the powerful impact of Active Minds on students' knowledge, attitudes, and behavior. The major findings are listed below and you can find more details and coverage at www.activeminds.org/study

RESEARCH BRIEF

Active Minds' Lifesaving Model is Validated by Groundbreaking Research

The longitudinal study, conducted by the RAND Corporation, of more than 1,100 students at 12 colleges found that Active Minds has a significant impact on student well-being. The research, published in the *Journal of the American Academy of Child & Adolescent Psychiatry** (July 2018), underscores how Active Minds' model is a path forward to combatting the mental health crisis among young people. Here are the major takeaways:

1. As students become more involved with Active Minds' education programs, they are more likely to reach out to a classmate or friend who is struggling with a mental health issue such as depression, anxiety, or suicidal thoughts.

2. Among the general student body, even basic familiarity with Active Minds increases knowledge and positive attitudes about mental health, creating a more supportive campus climate and increasing the potential that students in distress will seek mental health services.

3. Active Minds' educational programs meaningfully influence not only students' knowledge and attitudes toward mental health issues, but also their behaviors.

4. Active Minds' impact is swift. Knowledge, attitudes, and behaviors examined in the study positively changed on campuses within a single academic year.

*Strengthening College Students' Mental Health Knowledge Awareness, and Helping Behaviors: The Impact of Active Minds, a Peer Mental Health Organization. *Journal of the American Academy of Child and Adolescent Psychiatry*, Volume 57, Issue 7. For more information and a link to the full text visit activeminds.org/study.

Changing the conversation about mental health | activeminds.org

Background

Findings from a series of recently released research reports on student mental health throughout California systems of higher education demonstrate that "unmet need for mental health treatment among college students is a significant public health problem."[1] Furthermore, evaluations of California's mental health efforts to date have identified gaps in reaching minority racial and ethnic groups, including people who are Latino, African American, and Asian American/Pacific Islander, as well as other populations at high risk for suicide, including veterans and LGBTQ students.

With this initiative, you'll be working to enhance the mental health messaging on your campus in an effort to promote inclusivity and culturally responsive programming. This project aims to help expand and diversify chapters' membership base and overall campus reach.

Overview of Activities

This workbook will serve to guide you through the following recommended activities.

- Perform an Environmental Assessment to…
    - Learn about the demographics of student populations on their campuses
    - Find out what services exist on your campus that offer support to students already (student groups, departments, services, etc.)
- Build partnerships with campus organizations that reach diverse populations
- Collaborate with stakeholders
- Implement survey at event(s) when applicable
- Connect with peers and Active Minds staff regarding your progress
- Engage with the Student Slack Channel to discuss questions, activities, and guidance with peers and National Staff.

Pro-tip: All students have access to peers who are conducting the same project on their campuses and professional Active Minds staff to address and troubleshoot any conflicts, barriers, or concerns that may impede their ability to complete the project.

SMART Goal

A SMART goal is one that is **Specific, Measurable, Achievable, Relevant, and Time-Bound.** You'll be building your own SMART goal later in the workbook for your campus-based work, and here is the overall SMART goal of the initiative.

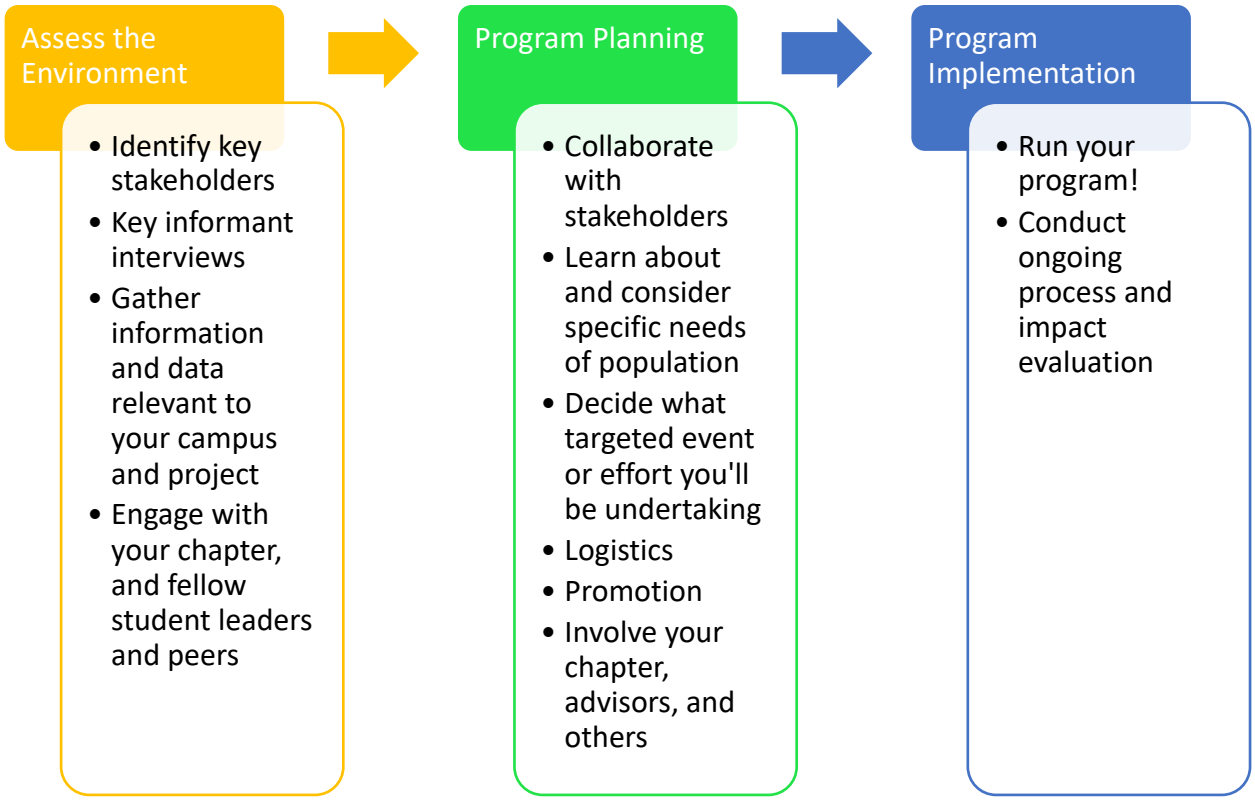
By the end of the school year, student leaders will conduct a qualitative campus needs assessment to learn about the demographics and key stakeholders among an underrepresented student population on their campuses. They will organize and implement a targeted event in collaboration and with the guidance of key stakeholders. Students will have access to ongoing support in order to accomplish their goals and will discuss their progress via Slack. Attendees of the events, as a result of attending, will experience an

[1] Sontag-Padilla, L., et al. (2016). Factors Affecting Mental Health Service Utilization Among California Public College and University Students. *PS Psychiatric Services*.

increase in their awareness of mental health and Active Minds. This will be measured with post-event surveys.

Components

In general, this project will involve the following steps.



Engaging with Peers Using Slack

To support your success with this endeavor, we recommend ongoing communication and connection with your peers. Among them you'll find a richly diverse array of experiences, perspectives, and expertise. Though the distance between us, in some cases, is great, we can work together to support and enhance one another's work. Enter: Slack!

Slack is an online collaboration and team-building tool that can be used to foster communication, share chapter successes, challenges, and celebrations, and support one another from afar! Through this app, you are able to directly message teammates, discuss relevant topics with the group overall, and respond to optional Slack prompts throughout this Workbook. You can also start group chats and new channels if you'd like to discuss a certain topic or talk to a few people on the team.

You are invited to join the Active Minds National Student Network Slack, where we will have a channel to talk about content within this workbook, as well as the ongoing activities, questions, challenges, and successes of your work.

This Slack team already has students from all over the country involved, so you are also eagerly invited to join broader conversations with your fellow Active Minds leaders who are also doing great work.

To Sign Up

Follow the link **activeminds.org/slack** to request an invitation to the Slack team. You will be added to the team and sent the following "Getting Started on Slack" how-to guide.

When you join the Slack team, feel free to join the #am4em channel which is where specific project conversations and responses to Slack prompts will take place.

Getting Started on slack

Welcome to the Active Minds Chapter Network Slack team! At Active Minds, we are constantly striving to enhance our ability to communicate with our phenomenal student leaders around the country, and provide space in which to communicate with one another. Enter: Slack! This is a comprehensive platform that gives you the ability to ask questions, provide ideas, share successes, and overall build a more cohesive network of Active Minds mental health advocates and activists! Several people from Active Minds National are part of the Slack team as well, and we look forward to Slack-ing with you!

To Do:

1. Read the Community Dos and Don'ts below.
2. Sign up for Slack and download the app onto your phone and/or computer.
3. Set your notifications to your liking (see screenshots below).
4. Hop into the Slack and start interacting!

Before we get started, some important dos and don'ts of the Slack team.

Feel free to:

- Follow Slack and participate in channels and conversations that seem appealing to you
- Use Slack primarily within standard business hours: Monday-Friday, 8:30am-5:00pm (in time zones across the United States)
- Pose questions and ideas to Active Minds staff, interns, and fellow Active Minds chapter leaders
- Start conversation threads off of posts that you would like to engage with further
- Chat with a specific peer, or several, using Direct Messages
- Express appreciations, share successes, troubleshoot challenges, etc.
- Add reaction emojis to posts!
- Request that a unique channel be created to discuss a specific topic or connect with leaders who have commonalities (i.e. geographic regions, type or size of school, awareness campaigns, specific events, etc.)
- Report any posts that cause you concern or distress.

active minds

Refrain from:

- Engaging in negative or controversial discussions, including those of a political nature
- Expressing current, personal mental health struggles in a public forum, as it may be distressing to others – **if you are currently struggling, please seek support from the National Suicide Prevention Hotline or the Crisis Text Line**. You are not alone.
- Disparaging or slandering another person or entity. Our Slack team is for constructive, productive, and hope-based communication!

National Suicide Prevention Lifeline: 24/7, free and confidential support for people in distress, prevention and crisis resources for you or your loved ones 1-800-273-8255

Crisis Text Line: Free, 24/7 support for people in crisis. Text "BRAVE" to 741-741

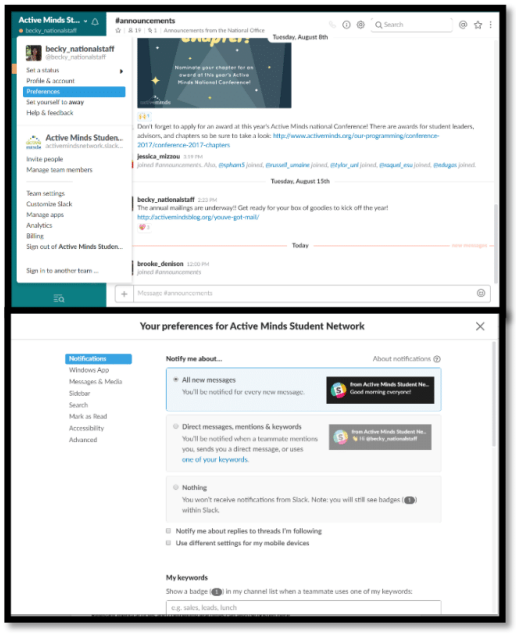
Keep in mind that:

- Active Minds staff and interns are monitoring all Slack communications; comments that violate our community agreements will be promptly removed, and the person who posted the comment(s) in question may be expelled from the Slack team.
- As a federally recognized 501c(3) nonprofit organization, Active Minds is prohibited from engaging in partisan political discussions. Doing so may compromise our tax-exempt organizational status. Please respect that boundary.

Now, let's start Slack-ing!

First up, Notifications & Profile:

Be sure to customize your notifications so that you are seeing everything that you want to see, while not being overwhelmed. You can customize your notifications for each individual channel, set "Do Not Disturb" hours, change the sounds and appearance, and customize settings for your phone and computer.



Once you've set up your account, download the Slack app to your cell phone and/or computer. (Whatever you do on one device is reflected everywhere — Slack apps keep your place, letting you pick up wherever you left off.)

- Edit your profile to include additional information about you and a photo!
- In the menu you'll find "Preferences": top right corner in cell phone app, top left corner in computer app. Here you can customize your notification preferences so you don't miss anything that's important to you, and to ensure that you are not receiving too much.
- This can always be changed if you find that you are seeing too many notifications, or too few.

What's the deal with all these Slack channels?

This is the beauty of Slack. You can opt in or out of many different conversations within this platform. All members will be automatically added to the **#announcements, #celebrations, and #chaptersupport** channels. Each of these are unique in their purposes, and will house different types of discussions:

#announcements: A space for Active Minds announcements and national initiatives; National Staff will post opportunities and pertinent current events in this channel.

#chaptersupport: Have some questions? Need an idea? Have a great idea for other chapters? Post them here! Relevant media articles and compelling learnings can also be posted here.

#celebrations: We love celebrating the outstanding work that you all are doing all over the country! Tell us about what your chapter is doing that is working! What successful program did you recently implement? What is something amazing you heard from one of your chapter members about their involvement with your chapter? Uplifting messages and testimonials are always welcomed here too.

To find these channels and any others that are available, click "CHANNELS" in the left column of the Slack app or web client, and you'll see what channels are available to join. Or…

Request a new channel!

Want to have a conversation with your peers about something specific? Email slack@activeminds.org or Direct Message a National Staff person (indicated by their "firstname_nationalstaff" username), to request that a new channel be created. For example, you may want to request something like…

#communitycolleges, #smallschools, #southerncalifornia, #transformyourcampus, #fundraising, etc.

For more information…

Visit www.slack.com for more about the platform and general support. This is a free service, and is available for use by any group.

If you have questions or would like to report a concerning post on the Active Minds Student Network Slack, email chapters@activeminds.org. We will respond as soon as possible.

Optional Slack Prompt

Visit the #am4em channel and say hello! Tell the team where you're from and what you're up to.

Notes: _____

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Chapter 2: Research on Mental Health Disparities

RAND Report: Racial and Ethnic Differences in Mental Illness Stigma and Discrimination among Californians Experiencing Mental Health Challenges

The RAND Corporation is a prestigious research organization that has been studying student mental health, in partnership with the state of California, for many years. Their findings have changed the landscape of mental health promotion and programming and brought to light some critical disparities among populations.

Optional Slack Prompt

1. What was new and/or surprising to you about the article?
2. How does this information inform our work on college campuses?
3. What additional research do you think needs to be conducted regarding mental health among diverse audiences?

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Racial and Ethnic Differences in Mental Illness Stigma and Discrimination Among Californians Experiencing Mental Health Challenges

Eunice C. Wong, Rebecca L. Collins, Jennifer L. Cerully, Rachana Seelam, Elizabeth Roth

Racial and ethnic minorities are significantly more likely than whites to delay or forego needed mental health care, and, if they do seek treatment, they are more likely than whites to drop out (McGuire and Miranda, 2008). Mental illness stigma and discrimination are thought to contribute to these racial/ethnic disparities in service utilization (U.S. Department of Health and Human Services, 2001). The negative attitudes, beliefs, and behaviors that the public holds toward people with mental illness (i.e., *public stigma*) may lead people to deny or conceal their mental health symptoms and avoid treatment (Clement et al., 2015; Corrigan, 2004). Moreover, when people with mental health challenges internalize negative societal beliefs about mental illness (i.e., *self-stigma*), this can lead to feelings of hopelessness or the "why try" effect, whereby individuals give up on treatment, employment, or other important endeavors that are integral to recovery (Corrigan, Larson, and Rüsch, 2009).

A limited number of studies have examined whether mental illness is more highly stigmatized in racial/ethnic minority communities. Studies conducted with samples representative of general populations in the United States have yielded mixed findings; racial and ethnic minorities have been found to have higher (Anglin, Link, and Phelan, 2006; Collins et al., 2014; Whaley, 1997), lower (Anglin, Link, and Phelan, 2006), or no different levels of stigma than whites (Kobau et al., 2010; Martin, Pescosolido, and Tuch, 2000). Fewer still are studies of representative samples of the general U.S. population that have examined racial/ethnic differences in stigma and discrimination among individuals who are experiencing mental health challenges. One study, involving a 2002 national survey of U.S. adults, examined the extent to which stigma and treatment attitudes figured as barriers to care among individuals who had acknowledged needing treatment but had not obtained it. This study found no significant racial/ethnic differences in reports of avoiding treatment out of fear of others finding out about their mental health problem or in beliefs about whether treatment is effective (Ojeda and Bergstresser, 2008). In another study conducted with a nationally representative sample of U.S. adults who met criteria for a mental health disorder, African-Americans were less embarrassed about seeking mental health care than whites (Diala et al., 2001).

Key Findings

- Regardless of race or ethnicity, the majority of California adults experiencing mental health challenges believe that individuals with a mental illness encounter high levels of prejudice and discrimination.
- Asian-Americans reported higher levels of self-stigma (with respect to feeling inferior to others who have not had a mental health problem) and were less hopeful than whites that individuals with mental health problems could be contributing members of society.
- Latinos interviewed in English also experienced higher levels of self-stigma (with respect to feeling embarrassed, ashamed, and not being understood because of a mental health problem) and were more likely to say that they would conceal a potential mental health problem from coworkers or classmates than whites.
- Although Latinos interviewed in Spanish reported lower levels of stigma in a number of respects compared with whites, they were the least likely to have used mental health services of all the racial/ethnic groups included in the study.
- Despite overall positive attitudes toward treatment across all racial and ethnic groups, many who needed mental health services were not receiving them. This was particularly true among Asian-Americans and Latinos surveyed in Spanish.

The mixed findings of prior studies may be due to the fact that stigma manifests itself in a wide variety of ways (Link et al., 2004), and different studies have focused on different aspects of stigma, often confined to a single or only a few dimensions of stigma, such as perceptions of dangerousness (Anglin, Link, and Phelan, 2006; Whaley, 1997). In addition, some studies have been constrained by the combining of racial/ethnic minority groups likely due to small sample sizes (Martin, Pescosolido, and Tuch, 2000), by the inclusion of only a single racial/ethnic minority group (Anglin, Link, and Phelan, 2006; Diala et al., 2001), or by the inability to assess for differences within a racial/ethnic group based on English-language proficiency (Kobau et al., 2010; Ojeda and Bergstresser, 2008). Significant disparities have been found, with non–English-speaking individuals from racial/ethnic minority groups being significantly less likely to obtain needed mental health treatment than their English-speaking counterparts (Sentell, Shumway, and Snowden, 2007).

To address the gaps in our understanding of how mental illness stigma affects racial and ethnic minorities, the present study capitalized on data collected for the California Well-Being Survey (CWBS), a RAND survey conducted with a representative sample of California adults who are experiencing psychological distress. The CWBS was developed and administered in 2014 to track exposure to, and the impact of, prevention and early intervention (PEI) activities administered by the California Mental Health Services Authority (CalMHSA). With funding from California's Mental Health Services Act (Proposition 63), CalMHSA implemented three statewide PEI initiatives focusing on mental illness stigma and discrimination reduction (SDR), suicide prevention, and student mental health that began in 2011. The CWBS assesses a wide variety of factors that may influence how individuals would respond if they were to experience mental health challenges, including *perceptions of public stigma*, *recovery beliefs*, *treatment attitudes*, *self-recognition of mental health problems*, *mental health service utilization*, and *exposure to PEI activities*. The CWBS is also the first study to assess the pervasiveness of *self-stigma* (i.e., negative feelings about one's own mental illness) and experiences of mental illness–related *discrimination* using a sample that is representative of individuals who are at risk for or are experiencing mental health problems. In contrast, previous studies examining mental illness stigma and discrimination among individuals experiencing mental health challenges have been largely limited to individuals recruited from mental health service or advocacy organizations (Brohan et al., 2011; Henderson et al., 2012), which may yield biased estimates given that a large percentage of the broader population of individuals affected by mental health challenges do not engage in treatment.

In this report, we examine whether there are racial/ethnic differences among California adults experiencing mental health challenges with respect to stigma, including their views of the public's treatment of people with mental health challenges, attitudes toward recovery from mental illness, self-recognition of mental health problems, self-stigma, discrimination, mental health treatment attitudes and utilization, and exposure to CalMHSA's SDR activities. Given that California is one of the most racially and ethnically diverse states in the nation, the CWBS affords us a unique opportunity to systematically examine whether mental illness stigma disproportionately affect racial and ethnic minorities.

Our findings indicate that perceptions of public stigma and experiences of discrimination are high across all racial and ethnic groups. However, Asian-Americans and Latinos surveyed in English are disproportionately affected by higher levels of self-stigma in particular. The picture is complex for Latinos surveyed in Spanish, who simultaneously had greater levels of stigma in certain domains (e.g., beliefs that people with mental illness are never going to contribute to society) and lower levels in others (e.g., concealment of a mental health problem from coworkers/classmates). Even though all racial and ethnic groups had positive attitudes toward treatment, we nonetheless found that a large proportion of individuals experiencing psychological distress had not obtained mental health services. Asian-Americans and Latinos who completed the survey in Spanish were the least likely to acknowledge having a mental health problem and had disconcertingly low levels of mental health service use, even among those with serious levels of distress.

Method

The CWBS is a follow-up survey of adults (aged 18 years or older) who participated in the 2013 California Health Interview Survey (CHIS). The CHIS is a random-dial telephone survey conducted with a representative sample of Californians focusing on a variety of health issues, including mental health. All adults who had completed the 2013 CHIS (N = 20,724), were willing to be recontacted, had completed the interview in English or Spanish, and had mild to moderate or serious levels of psychological distress as assessed by the Kessler-6 (K-6) scale were eligible to participate in the CWBS (N = 2,395). The K-6 is a brief six-item scale used to screen for clinically significant mental health problems (Kessler et al., 2003). A K-6 score greater than 12 is indicative of probable serious mental illness. Various cut-points have been used for defining other levels of psychological distress. We chose scores ranging from 9 to 12 to indicate mild to moderate psychological distress, following the original proponents of a polychotomous (multiple subgroups) approach to the K-6 (Furukawa et al., 2003).

The CWBS was administered in English or Spanish between May and August 2014. A total of 1,066 adults completed the CWBS, representing a final response rate of 45.2 percent. Fifty-four percent (N = 578) had K-6 scores in the mild to moderate range and 46 percent (N = 488) had scores in the serious distress range at the time that they were screened by CHIS. Characteristics of the sample are provided in Table 1. Latinos who chose to complete the survey in English and those who chose to complete the survey in Spanish were studied separately. People who endorsed multiple racial backgrounds were categorized as "other."

Table 1. Characteristics of Participants in the 2014 California Well-Being Survey

Characteristics	Unweighted Frequency	Weighted Percentage
Female	694	59
Age		
18–29	141	30
30–39	79	19
40–49	158	18
50–64	447	27
65 or older	241	7
Race/Ethnicity[a]		
Asian-American	29	7
African-American	48	6
Latino (English survey)	156	26
Latino (Spanish survey)	103	16
White	646	39
Other	84	6
Employment[b]		
Employed for wages	325	41
Self-employed	93	9
Looking for work	91	13
Retired	277	10
Homemaker/keeping house	80	12
Disabled	261	16
Student	76	14

NOTES: To provide estimates that are representative of the California distressed population, weighted percentages were calculated to adjust for undercoverage, subsample selection, nonresponse, and ineligibility resulting from when the CHIS 2013 sample was recontacted to participate in the CWBS. Sample-based raking, a multidimensional poststratification procedure, was used to compute the weights. Key variables used to create raking dimensions were age, sex, race/ethnicity, home ownership, region of the state, educational attainment, and cell phone versus landline phone. Percentages may not add to 100 due to rounding.

[a] Racial/ethnic minority groups (with the exception of Latinos) and respondents aged 65 years or older comprised only a small proportion of the CWBS sample. This is reflective of the sociodemographic profile of eligible CHIS 2013 respondents. Respondents of "other" ethnicity were excluded from the analyses given the heterogeneity of this group.

[b] Participants could select more than one category.

Results

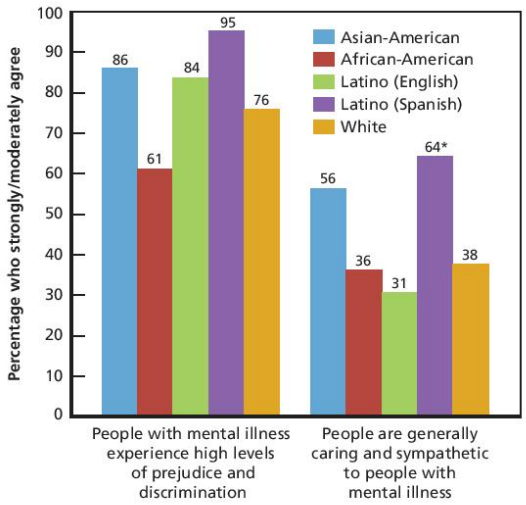
Perceptions of Public Stigma and Support

Perceptions of how the public views and treats those with mental illness may influence an individual's decision to disclose a mental health problem as well as his or her willingness to seek treatment (Clement et al., 2015; Corrigan, 2004). Irrespective of race or ethnicity, most people surveyed believe that individuals with mental illness experience high levels of stigma and discrimination (see Figure 1). Across most groups, only a small proportion viewed the public as being caring and sympathetic toward people with mental illness. There was one exception: A significantly greater proportion of Latinos surveyed in Spanish (64 percent) viewed the public as being supportive of people with mental illness relative to whites (38 percent).

Recovery Beliefs

Beliefs about recovery from mental illness may affect whether individuals experiencing mental health challenges reach out for help from family or professionals (Centers for Disease Control and Prevention et al., 2012; Clement et al., 2015). We found that the majority of those surveyed, regardless of racial or ethnic background, believed that a person who seeks treatment for a mental illness can eventually recover and lead a normal life (see Figure 2). Asian-Americans were significantly more likely than whites to agree that individuals with a mental illness can lead a normal life with treatment. However, on the question of whether people who have experienced a mental illness will ever be able

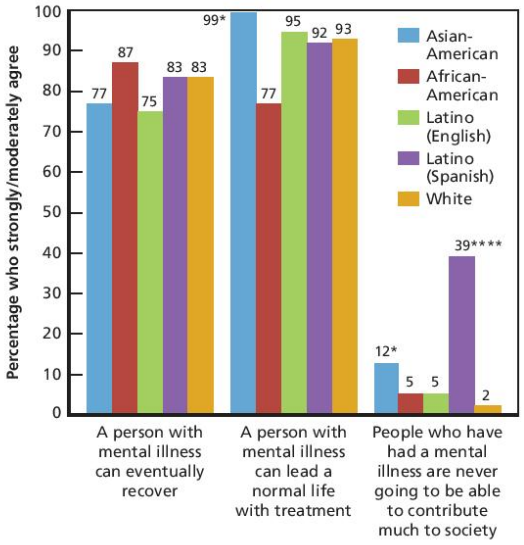
Figure 1. Perceptions of Public Stigma and Support



NOTE: Significant differences relative to whites are indicated by * $p < 0.05$.

RAND *RR1441-1*

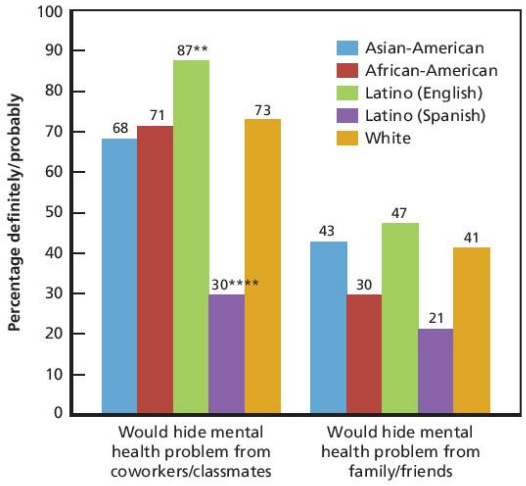
Figure 2. Recovery Beliefs



NOTE: Significant differences relative to whites are indicated by * $p < 0.05$; **** $p < 0.0001$.

RAND *RR1441-2*

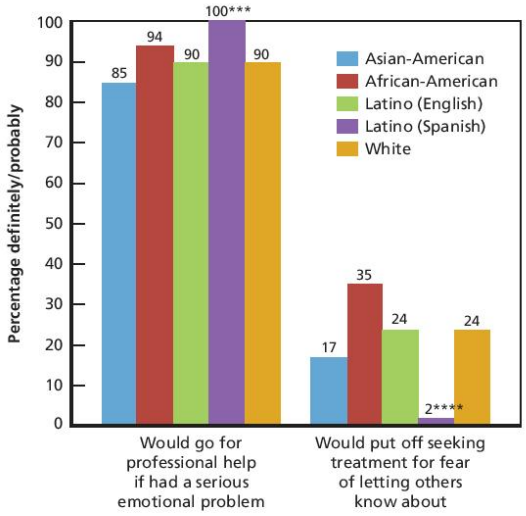
Figure 3. Concealment of Mental Health Problems



NOTE: Significant differences relative to whites are indicated by ** $p < 0.01$; **** $p < 0.0001$.

RAND *RR1441-3*

Figure 4. Treatment Attitudes



NOTE: Significant differences relative to whites are indicated by *** $p < 0.001$; **** $p < 0.0001$.

RAND *RR1441-4*

to contribute much to society, we observed notable racial/ethnic differences. Relative to whites (2 percent), a significantly greater proportion of Asian-Americans (12 percent) and Latinos surveyed in Spanish (39 percent) believed that those who have experienced a mental illness are never going to be able to contribute to society.

Concealment of Mental Health Problems

Fear of social judgment, rejection, and discrimination may motivate individuals to conceal mental health challenges (Clement et al., 2015). Nearly 90 percent of Latinos surveyed in English indicated that they would conceal a mental health problem from coworkers or classmates (see Figure 3). Conversely, Latinos surveyed in Spanish were the group least likely to conceal a mental health problem from coworkers or classmates, with only one-third endorsing such an intention. This may be related to the fact that Latinos surveyed in Spanish were more likely to perceive the public as caring and sympathetic toward people with mental health challenges (see Figure 1). No significant racial or ethnic group differences were found in concealing a mental health problem from family or friends.

Treatment Attitudes

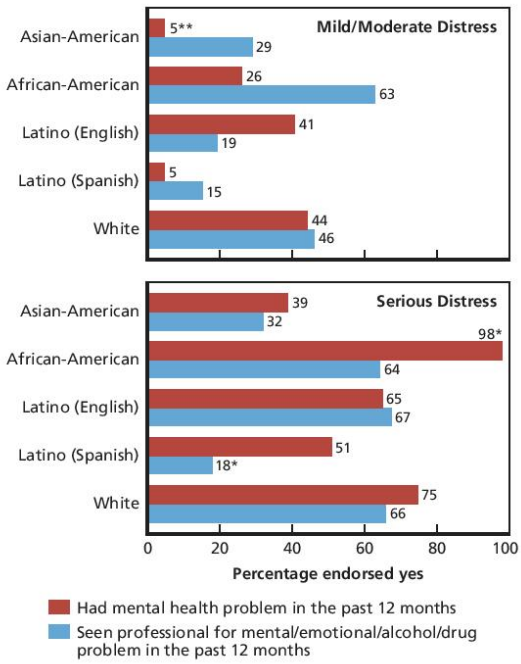
Nearly everyone surveyed, across all racial/ethnic groups, indicated that they would seek professional help for a serious emotional problem, including 100 percent of Latinos surveyed in Spanish, which was significantly higher than whites (see Figure 4). Latinos surveyed in Spanish were also the group least likely to report that they would delay treatment out of fear of letting others know about a mental health problem (2 percent), a rate significantly lower than that reported by whites (24 percent). These findings are consistent with a study involving a representative sample

of U.S. Latinos, in which Latinos with limited English proficiency were less likely to report being embarrassed if friends found out they were getting mental health treatment than were Latinos with a higher English proficiency (Bauer, Chen, and Alegría, 2010).

Self-Recognition and Treatment of Mental Health Problems

People experiencing psychological distress may not recognize their symptoms as a sign of a mental health problem or may be reluctant to do so out of a desire to avoid being labeled as having a mental illness (Corrigan and Wassel, 2008; Jorm, 2012). Among individuals with mild to moderate distress (i.e., those with K-6 scores between 9 and 12), we found that Asian-Americans (5 percent) and Latinos surveyed in Spanish (5 percent) were the least likely to report having a mental health problem in the past 12 months (see Figure 5). No significant racial/ethnic group differences in treatment use, however, were found for these individuals. Among those with serious distress (i.e., K-6 scores greater than 12 and most likely to meet criteria for a mental disorder), we found that African-Americans (98 percent) were significantly more likely to report experiencing a mental health problem in the past 12 months than whites (75 percent). This could be related to African-Americans experiencing greater disability and impairment when affected by a mental health condition (Williams et al., 2007). As similarly observed in the lower-distress group, Asian-Americans with serious distress were the least likely to report a recent mental health problem (39 percent). With respect to treatment use in the group with serious distress, Latinos surveyed in Spanish (18 percent) were the least likely to obtain mental health services (differing significantly from whites, 66 percent); Asian-Americans had the second lowest rate of treatment use (32 percent). Contrary to prior findings (Ault-Brutus, 2012; Wang et al., 2005), African-Americans did not use mental health services at lower rates than whites.

Figure 5. Self-Recognized Mental Health Problem and Treatment Use Among Participants with Mild to Moderate Versus Serious Distress



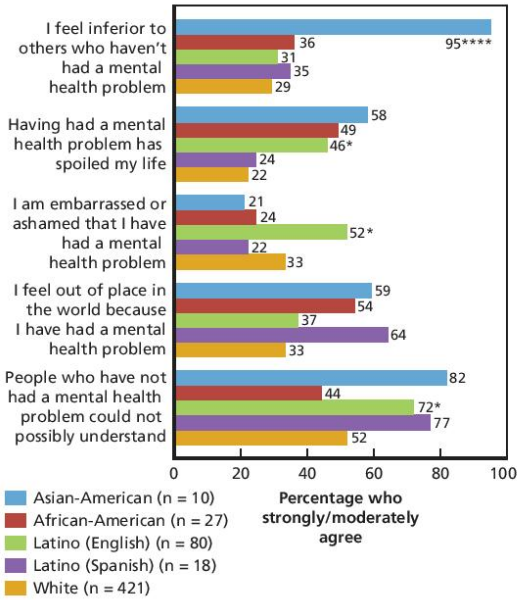
NOTE: Significant differences relative to whites are indicated by * p < 0.05; ** p < 0.01.

RAND RR1441-5

Self-Stigma and Experienced Discrimination

Self-stigma and discrimination are corrosive experiences that can impede one's recovery from a mental health challenge and worsen a person's quality of life (Corrigan, Larson, and Rüsch, 2009; Mittal et al., 2012). One of the most frequently reported types of self-stigma is alienation, which is related to subjective experiences of having a "spoiled identity" (Goffman, 1963) or not feeling fully part of society (Brohan et al., 2011; Ritsher, Otilingam, and Grajales, 2003). In our sample, Asian-Americans and Latinos surveyed in English were significantly more likely to feel alienated because of their mental health challenges than whites (see Figure 6). Ninety-

Figure 6. Self-Stigma



NOTE: Significant differences relative to whites indicated by * p < 0.05; ** p < 0.01; *** p < 0.001; **** p < 0.0001.

RAND RR1441-6

five percent of Asian-Americans who reported experiencing a mental health problem said that they felt inferior to those who had not experienced a mental health problem, compared with 29 percent of whites. Latinos surveyed in English were significantly more likely than whites to report that having a mental health problem had spoiled their life (46 percent), made them feel embarrassed or ashamed (52 percent), and that people who have not experienced mental health issues cannot understand them (72 percent).

The self-stigma items were administered only to individuals who indicated having experienced a mental health problem, given that the items asked about the negative impact of having a mental health problem. Only a very small number of Asian-Americans and Latinos surveyed in Spanish reported a mental health problem, so percentages in this section should be interpreted with caution. For the same reason, some apparent differences for these groups are not reliable enough to achieve statistical significance. For instance, Latinos surveyed in Spanish were also more likely to endorse several of the self-stigma items than whites, but the differences were not statistically significant.

We assessed recent experiences of discrimination (i.e., being treated unfairly in the prior 12 months because of a mental health problem) among individuals who indicated experiencing a mental health problem in the prior 12 months. As seen in Table 2, a greater proportion of Latinos surveyed in English (49 percent) reported experiencing discrimination by the police, and a significantly smaller proportion of African-Americans (3 percent) reported experiencing discrimination with regard to housing (both relative to whites). Most groups experienced discrimination most frequently within the realm of intimate social relationships (e.g., family, dating, marriage, friends), although there were some exceptions. For instance, Latinos surveyed in Spanish experienced the highest levels of discrimination in their interactions with physical health providers and the legal system. Consistent across all racial/ethnic groups, the large majority of individuals experiencing recent mental health challenges reported being discriminated against in at least one of the domains assessed.

The sample sizes in this subset were very small for some groups, especially for Asian-Americans and Latinos surveyed in

Table 2. Percentage Who Reported Experiencing Discrimination in Prior 12 Months

	Asian-American (n = 7)	African-American (n = 19)	Latino (English) (n = 54)	Latino (Spanish) (n = 9)	White (n = 247)
During the past 12 months, because of your mental health problem, how often have you been treated unfairly . . .					
. . . by your family (not including your spouse/live-in partner)	99	76	69	24	65
. . . in dating/intimate relationships	75	75	72	11	59
. . . in your marriage, live-in partnership, divorce, or separation	27	67	65	16	60
. . . when trying to make/keep friends	75	59	66	20	52
. . . by one or more of your employers	15	36	51	8	48
. . . in school or on the job training	50	37	59	19	39
. . . in your social activities	65	15	51	4	38
. . . by the police	70	59	49**	10	22
. . . by potential employers when looking for a job	15	29	45	6	35
. . . by the people in your neighborhood	49	36	37	16	34
. . . by physical health care providers and staff	7	51	30	75	32
. . . by mental health care providers and staff	14	57	38	5	32
. . . by other people in the legal system (lawyers, judges, or corrections officers)	64	30	35	70	24
. . . when trying to find/keep housing	1	3**	33	6	21
Any Discrimination	100****	89	92	100****	84

NOTES: *Often*, *sometimes*, and *rarely* responses were considered reports of discrimination, in order to correspond with estimates from the Corker et al. (2013) study, which reported on the percentage that endorsed *a lot*, *moderately*, or *a little* response options. Significant differences relative to whites indicated by ** $p < 0.01$; **** $p < 0.0001$.

Spanish. Consequently, these results should be viewed with caution as well. What appear to be large differences between groups are not statistically significant, and the apparent differences may be unreliable given the small samples. With these caveats in mind, very few racial/ethnic differences in these domains were found.

Exposure to CalMHSA and Other Stigma and Discrimination Reduction Activities

CalMHSA's SDR initiative included a social marketing campaign, the creation and distribution of informational materials (including via websites), efforts to alter portrayals of mental illness in entertainment media and journalism, and educational presentations and trainings in community and work settings. The CWBS asked people about their exposure to these activities during the 12 months prior to their survey interview. Some activities were clearly "branded," such as those from the social marketing campaigns, and so could be specifically attributed to CalMHSA. Other activities were funded by CalMHSA, including a wide variety of educational presentations and materials, but were administered by a range of organizations and under a range of different labels. Additionally, other entities in the state were simultaneously conducting similar activities. Thus, it is difficult to determine whether people who were exposed to SDR activities were reached by CalMHSA or by one of these other efforts. We categorized activities that could be directly linked to CalMHSA as "CalMHSA reach," and the others as "other reach."

CalMHSA Reach. CalMHSA SDR social marketing campaigns included "Each Mind Matters" and "ReachOut," which had Spanish-language versions, "SanaMente" and "BuscaApoyo," respectively. ReachOut targeted young people aged 14 to 24. The SDR social marketing campaign also included the distribution of a documentary entitled "A New State of Mind: Ending the Stigma of Mental Illness," which showcases the lives of people who have experienced mental health challenges and recovery. The documentary debuted on California Public Television (CPT) during primetime and was re-aired on various CPT stations at different times and days. The documentary was also distributed at planned community screening events and on CalMHSA's Each Mind Matters website, which also houses other SDR materials. EachMindMatters.org has become a hub for CalMHSA's PEI resources more broadly, and the slogan "Each Mind Matters" now accompanies all CalMHSA resources and activities.

We found that the television documentary "A New State of Mind" reached a significantly greater proportion of Latinos surveyed in Spanish (30 percent) than whites (7 percent) (see Table 3). In contrast, only 1 percent of Asian-Americans viewed the documentary. There were no significant group differences in the level of awareness of the "Each Mind Matters" slogan or in the number of visits to EachMindMatters.org. More than 40 percent of Latinos surveyed in Spanish had heard about or seen an advertisement for ReachOut.com, which is more than six times the rate reported by whites (7 percent). Only 1 percent of Asian-Americans had heard or seen advertisements for the ReachOut website. Although actual visits to the ReachOut website were low across all groups, relative to whites, rates were significantly lower for African-Americans and Latinos surveyed in English, none of whom reported any visits. The ReachOut website also had not reached any Asian-Americans. In terms of activities that could be directly linked to CalMHSA, efforts appeared to be more effective in reaching African-Americans (49 percent) and Latinos surveyed in Spanish (59 percent) than whites (27 percent).

Other Reach. The reach of activities that cannot be directly linked to, but could still be part of, CalMHSA's activities varied in notable ways across racial and ethnic groups (see Table 3). For example, Asian-Americans (12 percent) were less likely to report having received informational resources about mental illness than whites (37 percent). In contrast, African-Americans (65 percent) were more likely to have received such informational resources than whites. African-Americans (50 percent) were also more likely to have received on-the-job guidance about mental health issues than whites (22 percent). Latinos surveyed in English were more likely to report having seen a documentary about mental illness (38 percent), but less likely to have seen or heard a news story about mental illness (55 percent) than whites (21 percent and 69 percent, respectively). Latinos surveyed in Spanish were also more likely to have seen a documentary about mental illness, but were less likely to have been reached by other websites containing information about mental illness (4 percent), educational presentations or trainings (3 percent), or informational resources (5 percent). In spite of these variations in exposure to specific activities, we found no differences in reach overall. Members of different racial and ethnic groups were equally likely to report being reached by at least one of the "other reach" SDR activities, with the large majority of respondents (83–97 percent) reporting some such exposure.

Conclusions

This study examined whether racial and ethnic groups differ in their experiences of mental illness stigma and discrimination across a broad array of domains, and is unique in its use of a representative sample of individuals who are experiencing mental health challenges. Across all racial/ethnic groups, most people surveyed believed that individuals with mental illness experience high levels of prejudice and discrimination. This fits with the fact that a substantial proportion of those surveyed reported being discriminated against because of their mental illness. Yet, significant racial/ethnic differences were found. In a number of domains, Asian-Americans and Latinos held more negative views of mental illness, though the patterns were more complex for Latinos, for whom substantial variations were found depending on the language they chose for their interviews. For Asian-Americans, stigma appears to figure most prominently in their beliefs about the level of functioning and status of individuals with mental health problems. Compared with whites, Asian-Americans were less likely to view individuals with mental health problems as being able to contribute much to society, and they were more likely to feel inferior to those who have not had a mental illness. This may be due in part to the

Table 3. Potential Exposure to SDR Activities

	Asian-American	African-American	Latino (English)	Latino (Spanish)	White
CalMHSA reach					
Watched television documentary "A New State of Mind"	1**	14	15	30**	7
Seen or heard slogan or catch phrase "Each Mind Matters" or "SanaMente"	10	37	20	23	22
Visited website EachMindMatters.org	0	0	3	2	1
Seen or heard ad for "ReachOut" or "BuscaApoyo"	1	19	7	43****	7
Visited the website ReachOut.Com	0	0***	0*	1	3
Other reach					
Watch any documentary about mental illness	11	25	38**	46*	21
Seen an advertisement or promotion for a television documentary about mental illness	12	43	41*	40	29
Watched some other movie or television show in which a character had a mental illness	53	56	61	69	74
Seen or heard a news story about mental illness	47	76	55*	79	69
Visited another website to get information about mental illness	25	36	33	4****	37
Attended an educational presentation or training either in person or online about mental illness	13	35	13	3**	17
As part of your profession, received advice about how to discuss mental illness or interact with a person with mental illness	25	50*	24	21	22
Received documents or other informational resources related to mental illness through the mail, email, online, or in person	12**	65*	44	5****	37
Any CalMHSA reach	11	49*	32	59**	27
Other reach	97	86	85	83	92

NOTES: Significant differences relative to whites indicated by * $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$; **** $p < 0.0001$.

emphasis in some Asian cultures on high levels of achievement and social comparison to others, particularly when failures are encountered (Kramer et al., 2002; White and Lehman, 2005). Studies conducted with general samples of individuals who have not necessarily experienced a mental health problem have similarly found that, relative to whites, Asian-Americans hold more negative attitudes toward people with mental illness, perceive them to be more dangerous, and desire greater social distance from them (Collins et al., 2014; Eisenberg et al., 2009; Rao, Feinglass, and Corrigan, 2007; Whaley, 1997). A growing body of evidence indicates that Asian-Americans may harbor more stigmatizing attitudes toward those with mental illness, which in turn may translate into higher levels of self-stigma (i.e., feeling inferior to others who have not had a mental health problem) for Asian-Americans who themselves experience mental health challenges.

For Latinos, substantial differences were found depending on the language in which they were surveyed. Latinos surveyed in English experienced greater stigma in several respects. They reported higher levels of self-stigma (e.g., feeling ashamed because of their mental health problem) and were more likely to conceal a potential mental health problem from coworkers or classmates than whites. In contrast, relative to whites, Latinos interviewed in Spanish seemed to experience lower levels of stigma in several domains: They were less likely to report intentions to delay treatment or hide a mental health problem from coworkers or classmates, and were more likely to report

intentions to obtain treatment if needed. Latinos surveyed in Spanish also were more likely to perceive others as being caring and sympathetic toward individuals with mental illness than whites. Yet, at the same time, Latinos surveyed in Spanish were nearly 20 times more likely than whites to doubt that individuals with mental health problems could be contributing members of society. Moreover, the recognition of a mental health problem and the use of mental health services were lowest among Latinos surveyed in Spanish.

We used the language in which Latinos completed the survey as a crude measure of acculturation, the degree to which Latinos adopt U.S. cultural norms. Our results suggest that acculturation may affect Latinos' experience of stigma in important ways. Perhaps Latinos surveyed in Spanish may not have viewed their symptoms as a sign of a mental health problem. Some Latino groups have been found to employ culturally specific conceptualizations of mental illness, such as the use of the idiom "nervios" (i.e., nerves) to describe mental illness symptoms, which some see as a way of decreasing stigma and garnering family support (López, 2002). There is also evidence that Latinos with limited English proficiency may be less likely to stigmatize treatment for a mental health problem. In a study conducted with a representative sample of Latinos in the United States who had a diagnosable mental health condition, Latinos with limited English proficiency were significantly *less* likely to report feeling embarrassed about obtaining mental health treatment than were Latinos with greater English proficiency (Bauer et al., 2010). Additional research could help us better understand these findings and examine why less-acculturated Latinos on the one hand appear to view treatment favorably and see the public as generally supportive of people with mental illness, but on the other appear to be the least likely to seek treatment or recognize in themselves a mental health problem.

African-Americans did not appear to differ from whites on the various indicators of stigma assessed in the CWBS. This is consistent with prior studies involving population-based samples with established mental health needs. In a survey of a representative sample of community residents in Pittsburgh, Pennsylvania, African-Americans and whites who had depressive symptoms exhibited no significant differences in their perceptions of public stigma or their experiences of self-stigma (Brown et al., 2010). Moreover, in a nationally representative sample of U.S. adults who met criteria for a mental disorder, African-Americans were significantly less likely to be embarrassed about seeking mental health care and more likely to report intentions to seek professional help than whites (Diala et al., 2001). African-Americans have also expressed more positive attitudes toward treatment than whites (Anglin et al., 2008).

The vast majority of CWBS respondents across all racial and ethnic groups felt that it was possible to recover from mental illness. Most respondents, regardless of their racial or ethnic background, indicated that they would obtain mental health treatment if needed. Yet unmet need for mental health treatment (i.e., people not getting the treatment they need) continues to be a significant public health issue. Among CWBS respondents with serious psychological distress, more than one-third of African-Americans and Latinos surveyed in English had not obtained treatment. Rates were even higher for Asian-Americans and Latinos surveyed in Spanish, 68 percent and 82 percent of whom, respectively, had not sought treatment despite serious levels of distress. One of the primary goals of CalMHSA's PEI initiative is to reduce the unmet need for mental health services. Our findings indicate that CalMHSA's PEI activities were particularly effective at reaching African-Americans and Latinos surveyed in Spanish, and these were also the two groups that expressed the most willingness to seek treatment. Further research is warranted on how exposure to CalMHSA's PEI activities affects stigmatizing attitudes and beliefs across racial and ethnic groups.

Our study had certain limitations. To assess for potential mental health need, we relied on the K-6 scale, a nonspecific psychological distress screener, which has been a valid screener for serious mental illness but may be more strongly correlated with anxiety and depression than with other mental disorders (Andrews and Slade, 2001; Kessler et al., 2010). Analyses were limited by small sample sizes for some racial and ethnic groups, and analyses involving self-stigma and discrimination were subject to particularly restricted sample sizes since these items were administered only to the subset of people who acknowledged experiencing a mental health problem. Findings need to be verified with larger numbers of racial and ethnic minorities, even though doing so will be a challenge. This study also did not contain sufficient sample sizes to examine potential subgroup differences among Asian-Americans and Latinos from different countries, who have varied cultural experiences. Because our only measure of acculturation among Latinos was the language they chose for their interview, we were limited in our ability to investigate how varying levels of acculturation may relate to experience of stigma and discrimination. Moreover, our study was limited to Asian-Americans who were able to complete the interview in English.

Despite these limitations, this is the first study to take a comprehensive look at racial and ethnic differences across a wide variety of stigma domains with a representative sample of individuals who are experiencing mental health challenges. Emerging evidence suggests that Asian-Americans are disproportionately affected across a range of stigma experiences. Further, more-acculturated Latinos appear to experience higher levels of self-stigma than their less-acculturated counterparts, who also, surprisingly, have more positive attitudes toward treatment than whites. Finally, African-Americans and whites appear to experience similar levels of mental illness stigma and discrimination.

Our findings underscore the importance of understanding how mental illness stigma affect racial and ethnic minorities, both in terms of how widespread it is and its impact on recovery. Further study examining how the effects of stigma and discrimination on mental health service use may differ across racial and ethnic groups could aid in the development of tailored interventions to address widely known and persistent treatment disparities.

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RAND Health

This research was conducted in RAND Health, a division of the RAND Corporation. A profile of RAND Health, abstracts of its publications, and ordering information can be found at http://www.rand.org/health.

CalMHSA

The California Mental Health Services Authority (CalMHSA) is an organization of county governments working to improve mental health outcomes for individuals, families, and communities. Prevention and early intervention programs implemented by CalMHSA are funded by counties through the voter-approved Mental Health Services Act (Prop. 63). Prop. 63 provides the funding and framework needed to expand mental health services to previously underserved populations and all of California's diverse communities.

www.rand.org

The RAND Corporation is a nonprofit institution that helps improve policy and decisionmaking through research and analysis. RAND focuses on the issues that matter most, such as health, education, national security, international affairs, law and business, the environment, and more. As a nonpartisan organization, RAND operates independent of political and commercial pressures. We serve the public interest by helping lawmakers reach informed decisions on the nation's pressing challenges. RAND's publications do not necessarily reflect the opinions of its research clients and sponsors. **RAND**® is a registered trademark.

RR-1441-CMHSA

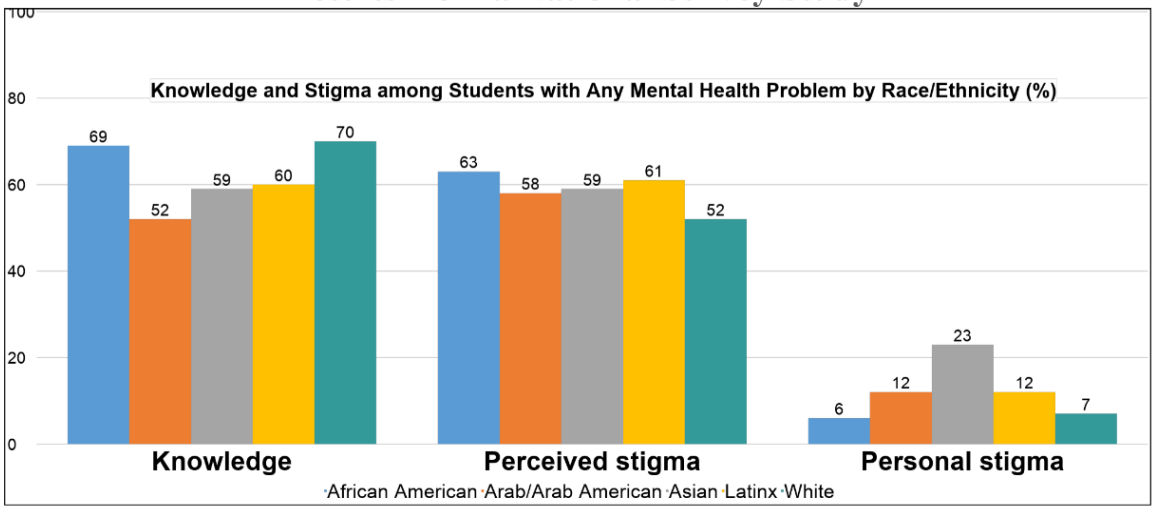
Other Research & Key Players

Healthy Minds Network

The Healthy Minds Network is one of the key researchers in the student mental health arena. Their studies are among the most comprehensive and wide-reaching in the field. Of particular note, they released a study in April 2018 entitled "Mental Health Disparities Among College Students of Color" which explores levels of mental health services usage among different populations.

www.healthymindsnetwork.org

Mental Health Knowledge and Attitudes among College Students of Color: Results from a National Survey Study



Data: 2012-2015 Healthy Minds Study N=9,851 students on 60 campuses

Values are weighted percentages among students with any mental health problem, defined as a positive screen for depression (PHQ-9≥10), anxiety (GAD-7≥10), eating disorder (SCOFF≥2), past-year non-suicidal self-injury, and/or past-year suicidal ideation. Knowledge is a response of "strongly agree" or "agree" to the item "If you needed to seek professional help for your mental or emotional health while attending [school], you would know where to go;" perceived stigma is a response of "strongly agree" or "agree" to the item "Most people think less of a person who has received mental health treatment"; personal stigma is a response of "strongly agree" or "agree" to the item "I would think less of a person who has received mental health treatment".

Results from Lipson et al. (2018) in *Journal of Adolescent Health* | see www.healthymindsnetwork.org/research/publications for full list of publications

The Steve Fund

The Steve Fund is an organization devoted to addressing the mental and emotional well-being of students of color throughout the United States. They provide resources, presentations, white papers and more to build awareness of issues that pertain specifically to the mental health of students of color. From their website:

"Right at this moment, there are students of color who are failing academically, suffering emotionally and/or in some cases are facing serious risk, because population-specific factors influencing mental health are too poorly understood and not acted upon. We are taking action."

Of particular note, the Steve Fund released an **Equity in Mental Health Framework** which outlines "ten actionable strategies colleges can use to bridge mental health disparities facing college students of color."

www.stevefund.org

Each Mind Matters

Each Mind Matters is California's Mental Health Movement. Their immense array of resources is available for purchase and download to anyone. Each Mind Matters is unique in its multi-lingual collection of mental health resources.

From their website:

"We are millions of individuals and thousands of organizations working to advance mental health. The mental health movement certainly didn't start with us, but Each Mind Matters was created to unite all of us who share a vision of improved mental health and equality."

www.eachmindmatters.org

Pause: Check-in!

Self-Care

That's a lot of information you just absorbed! Throughout this project, we encourage self-care. Not only are we addressing potentially challenging issues, but we're also doing a ton of other stuff! Self-care is of the utmost importance.

Mutual Support

We are here for one another. There are other students doing the exact same work as you! Take a moment to reach out to someone else to offer support.

Optional Slack Prompt

What are your favorite activities for self-care?

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Chapter 3: Conducting an Environmental Assessment

Definition and Principles of Community-Based Participatory Research

We have designed this project around the principles of Community-Based Participatory Research (CBPR). CBPR is rooted in the notion that only a community themselves know what that community needs. This project requires each of you to engage with diverse populations who have diverse needs. It is critical that we approach this work with the assumption that we may not already know what is appropriate, effective, and needed. When seeking to address a need in a specific population, we will engage that population in every step, from the formulation of the idea itself, to the promotion and planning of the content, all the way through to the follow-up after the event's conclusion. The goal will be to partner intrinsically with key stakeholders and align your goals.

> "Organizers are encouraged to take the role of the learner in approaching a community and discovering its problems and strengths… Efforts to learn the strengths of the community as they are exemplified in daily learning activities within the community would be a primary activity for the organizer. In this way, [community members] would, in time, recognize the organizer's willingness to use the culturally competent perspective of noninterference, and more opportunities for work with that community might be revealed."
> – Lorraine M. Gutiérrez & Edith A. Lewis

Community-based participatory research in public health focuses on social, structural, and physical environmental inequities through active involvement of community members, organizational representatives, and researchers in all aspects of the research process. Partners contribute their expertise to enhance understanding of a given phenomenon and integrate the knowledge gained with action to benefit the community involved.[2]

Even more specifically…

Israel et al defined CBPR as focusing on social, structural, and physical environmental inequities through active involvement of community members, organizational representatives, and researchers in all aspects of the research process. Partners contribute their expertise to enhance understanding of a given phenomenon and integrate the knowledge gained with action to benefit the community involved.

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[2] Israel BA, Schulz AJ, Parker EA, Becker AB; Community-Campus Partnerships for Health. Community-based participatory research: policy recommendations for promoting a partnership approach in health research. Educ Health (Abingdon). 2001;14(2):182-97. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/14742017

Characteristics of the CBPR approach include (a) recognizing the community as a unit of identity, (b) building on the strengths and resources of the community, (c) promoting co-learning among research partners, (d) achieving a balance between research and action that mutually benefits both science and the community, (e) emphasizing the relevance of community-defined problems, (f) employing a cyclical and iterative process to develop and maintain community/research partnerships, (g) disseminating knowledge gained from the CBPR project to and by all involved partners, and (h) requiring long-term commitment on the part of all partners.

The strengths or advantages of CBPR are that it allows for the innovative adaptation of existing resources; explores local knowledge and perceptions; empowers people by considering them agents who can investigate their own situations; the community input makes the project credible, enhancing its usefulness by aligning it with what the community perceives as social and health goals; joins research participants who have varied skills, knowledge, and expertise to address complex problems in complex situations; provides resources for the involved communities; through its collaborative nature, provides a forum that can bridge across cultural differences among the participants; and helps dismantle the lack of trust communities may exhibit in relation to research.[3]

Optional Slack Prompt

1. Why do you think that Active Minds has designed this initiative around principles of Community-Based Participatory Research?
2. What will we want to be sure to consider while addressing the mental health needs of identity-related populations?

Notes: _____

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[3] Holkup, P. A., Tripp-Reimer, T., Salois, E. M., & Weinert, C. (2004). Community-based Participatory Research: An Approach to Intervention Research With a Native American Community. ANS. Advances in Nursing Science, 27(3), 162–175. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2774214/

Assessing the Environment

Step 1: Learn about your campus' student body

Question: How do I find demographic information about students on my campus?

Google it!

Google search: "student demographics [your school]" You'll likely be directed to a few helpful sites:

- Office of Undergraduate Admissions, Office of Enrollment, school registrar
  - Example: www.admission.ucla.edu/campusprofile.htm
- Office of Institutional Data
  - Example: www.aim.ucla.edu

Find the demographics of your campus and fill out as much of the following table as you can. Feel free to fill in the "Other" rows with any more information that you find and consider relevant and/or interesting!

Undergraduate	
Graduate	
Male	
Female	
Transgender	
Hispanic/Latino/a	
White, Non-Hispanic	
Black, non-Hispanic	
Asian or Pacific Islander	
American Indian/Alaskan Native	
Two or more/other/unknown race	
International	
Veteran	
Registered with the Office of Disabilities	
Speak English as a Second Language	
Full-time students	
Live on campus	
Other:	
Other:	
Other:	
Other:	

Optional Slack Prompt

What did you find interesting about your campus' demographics? Was there anything new or surprising to you?

Step 2: Select a specific population of focus.

Based on your research and your own experiences on campus, what population(s) would you like to focus your project on? Questions to consider:

1. Are there disparities between resources and/or usage of resources and the population present on campus?
    a. *Ex. 50% of your campus population is male-identifying, but only 20% of those who utilize campus mental health services identify as male. 42% of your campus population identifies as Asian/Pacific Islander, but there are no mental health organizations that are targeting messages towards that population. Etc.*
2. Do you or your friends have personal connections to organizations and/or individuals who are connected to sub-populations of interest on your campus?
    a. *Ex. Your roommate is a member of the Latina sorority on campus. You have a friend who works at the multi-cultural center. A couple of your Active Minds members are also members of the PRIDE Alliance. Etc.*
3. Did something recently happen on campus or in your community at-large that may have specifically impacted the mental health of a particular sub-population of students?
    a. *Ex. A discriminatory piece of legislation is being considered (DACA, marriage equality, etc.) Violence against a member of a sub-population. Etc.*

The goal is to broaden access to mental health messaging on your campus to populations who are historically underserved. You are the experts of your campus. We encourage you to think critically about who may be best served with this unique, specialized project.

Select a population (or populations) that you will target!

Step 3: Learn about the resources available

Find out what services, organizations, and departments are available that pertain to the population that you are seeking to serve. These are your stakeholders.*

Be sure to include departments on campus who provide services specific to this population, clubs, professional associations, organizations, etc. Where are these students finding support on campus? Where are their voices being heard? Where do they feel understood?

*Stakeholder: A person, group or organization that is involved in or affected by a course of action. Stakeholders can affect or be affected by the organization's actions, objectives and policies.

Make a list of stakeholders and potential collaborators:

_____

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Step 4: What research has been done on your campus?

Many colleges around the country have participated in population-level mental health assessments conducted by third parties. The biggest evaluations that your school may have participated in are the Health Minds Study or the American College Health Assessment. These involve a survey of your entire student population or a large, representative sample of your student population.

Find out if your college has participated in one of these studies on your campus website using the search function. Or, you can always simply Google it!

If your college has participated, explore the mental health statistics! Read the executive summary of the studies and learn more about what the mental health of the population on your campus. They can compare some basic mental health outcomes (like depression or thoughts of suicide) across gender, race, sexuality and more, depending on what assessment they used.

Whether or not your school has participated in a population-level study, visit the Healthy Minds Study website, explore the data, and respond to the following prompt on Slack.

HEALTHY MINDS STUDY

Visit http://data.healthymindsnetwork.org/login

If your school participated in the Healthy Minds Study you should have access to a login that lets you just see your school's data. **Otherwise, login as a guest.** Looking at data from all years combined, you can examine several outcomes (such as "any depression (PHQ-9)" or "suicidal ideation") with a "race/ethnicity" sample breakdown to see differences in these outcomes across racial and ethnic groups.

Optional Slack Prompt

Share in the #am4em channel what statistics you explored. What surprised you? What did you learn about student mental health in the United States?

Step 5: Key Informant Interviews

Thinking about the potential stakeholders in Step 3, identify 3-5 people who are experts of your target population on campus. These can be students, staff, or faculty members. Indeed, seek to diversify your key informant interviews among these roles on campus; each will offer a unique perspective that will inform your work.

Plan your questions ahead of time. (Others will likely arise naturally in conversation, but it helps to have a set of questions to get the conversation going.)

Consider recording your conversation on your phone, or with an audio recorder.

What are you seeking to learn with these interviews?

Brainstorm Your Interview Questions

The list on the next page is designed to help you think through your own questions. You can use any of them verbatim or use them as a launch point for your own thinking/interview design.

Campus Community

- What's happening on campus that pertains to this population?
- What support structures are in place already?
- Who are the stakeholders that we should be sure to speak/collaborate with?
-
-
-

Cultural Considerations

- When addressing mental health in this population, what are some specific considerations we should center?
- What issues are most beneficial to focus on with regard to mental health? What services and/or support could be improved upon on our campus within this community?
- What type of event would best reach this population? When, where, etc.
- What should we be sure to include?
-
-
-

Common Pitfalls

- What are some potential barriers?
- What should we be certain NOT to do?
-
-
-

Other

- What else?
-
-
-

Informant Interview #1

Name: _____

Phone/Email:_____

Position:_____

Date/Time of Interview: _____

Notes: _____

Informant Interview #2

Name: _____

Phone/Email:_____

Position:_____

Date/Time of Interview: _____

Notes: _____

Informant Interview #3

Name: _____

Phone/Email:_____

Position:_____

Date/Time of Interview: _____

Notes: _____

Informant Interview #4

Name: _____

Phone/Email:_____

Position:_____

Date/Time of Interview: _____

Notes: _____

Informant Interview #5

Name: _____

Phone/Email:_____

Position:_____

Date/Time of Interview: _____

Notes: _____

Step 6: Bringing It All Together

You've now researched the demographics of your campus, identified potential stakeholders, and interviewed key informants.

What are your main take-home lessons? Are there other sources of information you want to consider? For example…

- Campus news coverage or current events
- Insight of other events or efforts on campus already
- Partnerships with off-campus organizations
- Etc.

Notes: _____

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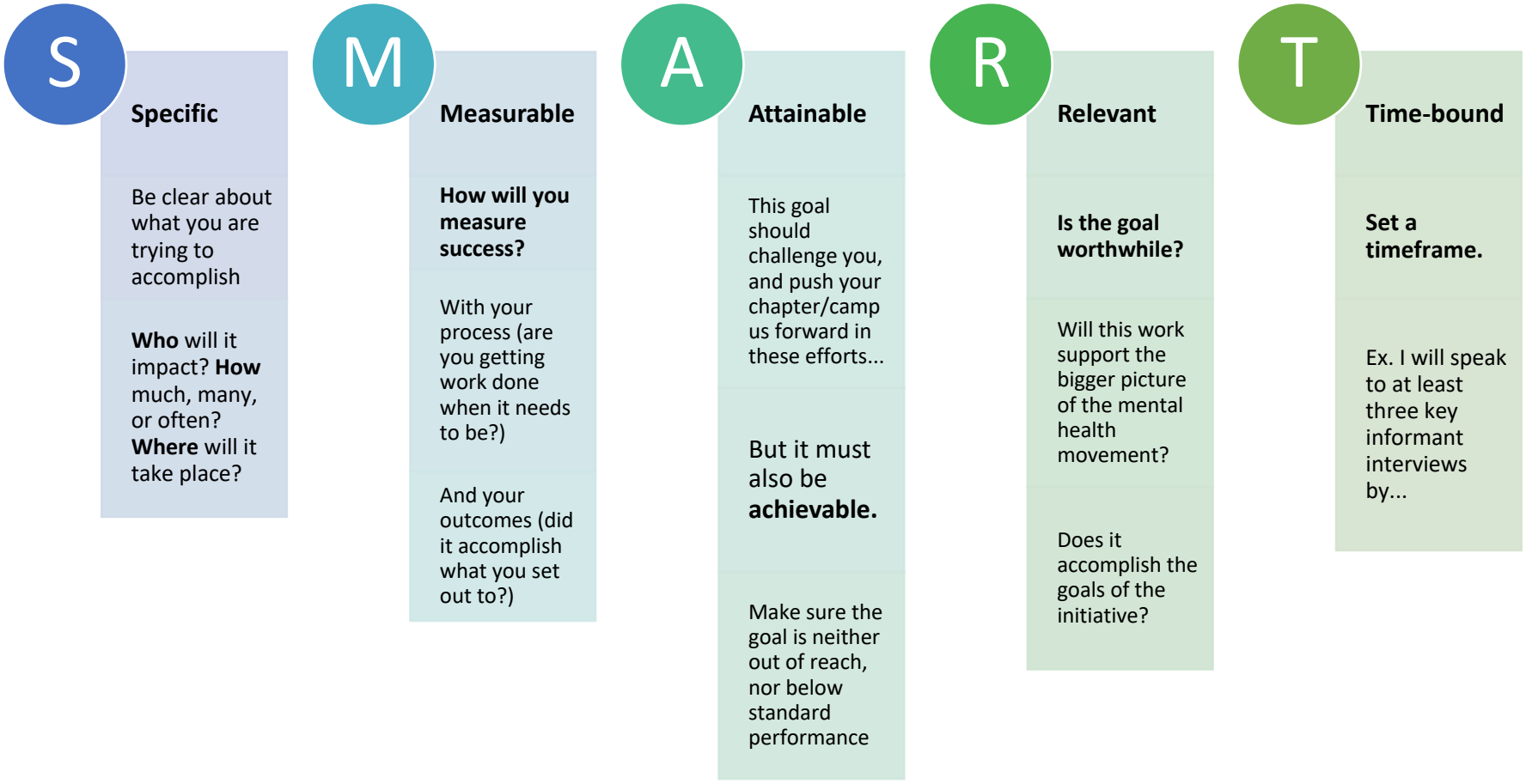
Optional Slack Prompt

Offer the #am4em channel 1-2 pieces of valuable insight that you gained from your key informant interviews.

Creating Your SMART Goal

Once you have a general plan for your project, turn your attention towards creating your SMART goals to that will enable you to be successful.



Let's break down our SMART Goal for the overall project from Chapter 1 with color-coded segments.

By the end of the school year, student leaders will conduct a qualitative campus

Timebound: Illustrates end date

needs assessment to learn about the demographics and key stakeholders among

Specific: Describes exactly who, what, and where

an underrepresented student population on their campuses. They will organize

and implement a targeted event in collaboration and with the guidance of key

stakeholders. Students will have access to ongoing support in order to

Achievable: Student leaders will receive the training and time needed to accomplish their goals

accomplish their goals and will discuss their progress via Slack. Attendees of the

Measurable: Ongoing progress reports

events, as a result of attending, will experience an increase in their awareness of

Relevant: Raising awareness of mental health among college students is a pertinent issue in higher education, and directly advances the mission of Active Minds and Each mind Matters

mental health and Active Minds. This will be measured with post-event surveys.

Measurable: Impact of event will be measured with surveys

Now, your turn!

Using the information that you have collected from your key informant interviews, create SMART goals that illustrate your plans. The Overall SMART Goal is intended to demonstrate the end date or your project, and the broad sweeping steps that will successfully lead you there. The sub-SMART goals can be utilized to break down each step (research/environmental assessment, key informant interviews, program planning, etc.)

Overall SMART Goal for the project (fill in the blanks):

By _____ *(date)*, we will implement at least one event that addresses the mental health needs of _____ *(population)* at _____ *(school)* and reaches at least _____ students *(target goal for students reached*)*. We will collaborate with _____ *(stakeholder person/organization 1)*, _____ *(stakeholder person/organization 2)*, and _____ *(stakeholder person/organization 3)* to organize and implement an event that most effectively targets the needs of this population. Every attendee at the event will complete the evaluation survey at the end of the event.

**Be thoughtful about the target number of students for the event; in some cases, a big event is the best approach, and in others, a smaller, more intimate event is most effective.*

When writing your SMART goal, it's helpful to literally check off each of the steps.

Is your goal:

- ☐ **Specific**
- ☐ **Measurable**
- ☐ **Achievable**
- ☐ **Relevant**
- ☐ **Time-bound**

Additional Notes: _____

_____

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Your sub-SMART goals are optional, and for your own planning purposes. You can use SMART goals to ensure that you and your team are on-task with all of the moving pieces in the upcoming program planning process.

Sub-SMART Goal 1: Environmental Assessment

_____

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Sub-SMART Goal 2: Program Planning

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Sub-SMART Goal 3: Additional Programming

_____

_____

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Feel free to use the above fill-in-the-blank model for any additional SMART goal-making you would like to do.

Optional Slack Prompt

1. What questions do you have about SMART Goals? In what ways will this be a useful tool, and in what ways will it not be? In what ways can the exercise be clarified, or made more useful?
2. Discuss your project goals and respond to at least one other person's comment in Slack with praise, curiosity, and/or constructive criticism.

Notes: _____

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Chapter 5: Planning an Event

Diversity & Inclusion

Active Minds stands ardently for the health and well-being of all students. We advocate for universal inclusivity in program and event design and creating spaces in which the many individuals who constitute your diverse community feel actively included and welcomed. The following list is a guideline for how you may approach your program and event planning that takes into consideration many design elements that will foster a more welcoming environment. We encourage you to embrace these practices in your event planning. We also highly recommend that, to the best of your ability, you strive for cultural and social diversity within your planning team.

Diversity includes, and is not limited to, race and ethnicity, gender, language, age, ability, sexual orientation, mental health, religion, socioeconomic status, professional and academic background, and more.

Use this checklist as a guide. Add your own questions and reminders to help you as you plan your events.

This checklist draws heavily on resources from Meredith College Student Leadership and Service, Cornell University Student Disability Services Accessibility Checklist, and Student Government Association at Georgia Tech.

To Consider in Your Planning Stage

- Are people with various racial, ethnic, gender, sexual, religious, and cultural identities, disabilities, and ages included as part of planning this event?
- Does this event overlap or conflict with another major campus event, academic events, and/or significant religious holidays (i.e. Rosh Hashanah, Eid al Fatr, MLK Day, Veterans Day)?
- Have funds been allocated in the budget to cover the cost of accommodations?
- Check if your vendors, guest speakers, community partners, and co-sponsors have a positive history or stance on inclusion. Avoid doing business with those whose policies, values, marketing, and practices are discriminatory.
- Have presenters been asked if they need accommodations for equal access? Have they been informed of ways to make presentations accessible to various audiences?
- Consider providing a means for attendees to indicate their pronouns with their nametags if they are interested. You might provide pronoun ribbons or buttons or simply a written space on nametags to identify "Pronouns: _____"
- Develop a plan to have needed resources at your event based on the content you plan to cover. Do you need mental health professionals available for students in distress? Do you have educational materials and resources for the diverse audiences you expect at your event?
    - For example: information on the Lifeline, Crisis Text Line, TransLifeline, Trevor Hotline, services available for undocumented students, resources for PTSD)

To Consider in Your Promotion Stage

- Have you advertised this event to a diverse audience?
- Have you included a statement in your advertisement(s) that informs the audience about how and by when to request accommodations?
- Are you posting your promotion near where different populations of people spend their time and live? (International housing, transfer student housing, the Black student union, Muslim student union, Office of LGBTQ affairs, etc.
- Connect with representatives from various offices on campus (i.e. student life, disability services, office of the chaplain, veterans service coordinator, office for international students, multiethnic student affairs, counseling center) to include them in your event, invite their communities, and consult them on whether you've succeeded in making your event accessible to their community of students.
- Have you considered including a statement about your commitment to universal access and procedures for requesting disability-related accommodations? For example, "*Our goal is to make all services and materials accessible. Please contact (insert name) at (insert email/phone) by (insert date) to request accommodations that will make activities and information resources accessible to you.*"
- Does the information included on your advertisement and/or website include people with diverse characteristics with respect to race, gender, sexuality, age, religion, and disability? Do your photographs represent diverse characteristics?
- Include images and language that is representative of populations of people who have a particularly high presence on their campus
    - Include information on trigger and content warnings if appropriate in your promotion materials (e.g. this event will include a discussion of suicide, sexual assault, PTSD).

To Consider Regarding Your Facility and Environment

- Is the location and environment for this event inclusive of people with disabilities, racial/ethnicity minorities, genders, age and various cultural and religious groups?
- Are *all* areas of the facility considered accessible for people with physical disabilities – including parking, pathways, and entrances to the building, restrooms, and the room itself? Note: grassy or unpaved courtyards are not accessible.
- There should be accessible parking spaces near the accessible entrance that are clearly marked with the international symbol of accessibility. There should be an accessible route from the parking to the entrance (paved and level, recommended not to exceed 200 feet). The entrance door should have an opening of at least 32 inches of clear width. Non-accessible entrances should have signs giving directions to the accessible entrance. The event registration area should be accessible and free of protruding objects. The seating arrangement should allow room for a wheelchair.
- Are all gender bathrooms available?

- Are bathroom facilities wide enough to admit someone in a wheelchair, and do not require the opening of doors?
- Event materials as well as all bathroom doors should indicate the location of accessible and all gender bathrooms
- If food is being served at this event, are there options for those with dietary considerations (i.e. vegetarian, vegan, kosher foods, gluten-free, allergy-free)?
- If the event is scheduled during a time of religious fasting or is addressing the topic of eating disorders, consideration may need to be made regarding not serving food.
- Is the sound adequate for the purposes and attendance at this event?
- Is there a need for disability related assistive technology to be used for this event (e.g. enlarged print, screen readers, FM systems)?

To Consider During Your Program/Event

- Is all information presented at this event inclusive to diverse groups with respect to race, ethnicity, religion, gender, sexuality, culture, age, and disability? Do the speakers/presenters represent people of different genders, sexual orientation, race, age, ethnicity, and/or other characteristics? If you have students sharing their stories, do you have a diverse group?
- If doing introductions at the start of the meeting or event, include your pronouns. Invite others to do the same if they would like. Educate yourself about pronouns so that you can introduce others to this practice.
- Is all printed information presented at the event available (immediately and timely) in alternate formats such as large print, Braille, and electronic text?
- Is printed information available in languages other than English?
- Will the information presented at this event be done so using visual and auditory communication styles?
- Can your slideshows, movies, PowerPoint presentations, etc. include subtitles at the bottom of the screen for Deaf community members or those with hearing loss?
- Is there an anticipated need for interpreters or transliterators? (E.g. American Sign Language, foreign language). If so, have arrangements been made?
- Are exits accessible and is there an evacuation plan for persons with disabilities?
- Be prepared to challenge instances of racism, sexism, homophobia, transphobia, discrimination, or other micro-aggressions.
- Ask presenters to repeat questions asked by the audience or to pass around the microphone. In large groups, you may consider real-time vetting of the questions by chapter members to ensure that harmful language is omitted. Ex. Attendees write questions on an index card, chapter members (or staff, or other pre-determined people) sort through the questions and modify as needed.

Resources for More Inclusivity Information

The Historically Black Colleges and Universities Center for Excellence in Behavioral Health (www.hbcucfe.net)

The American Psychiatric Association (www.healthyminds.org)

National Asian American Pacific Islander Mental Health Association (www.naapimha.org)

The Trevor Project (www.thetrevorproject.org)

Student Veterans of America (www.studentveterans.org)

Substance Abuse and Mental Health Services Administration (www.samhsa.gov)

National Sexual Violence Resource Center (www.nsvrc.org)

Evaluating Your Success

You've thought through what your goals are. Now think about how you're going to evaluate success. Planning how you are going to evaluate the success of the project is a valuable step in the initial planning process. You'll recall that the overall goal of this project is to diversify and expand the reach of your mental health messaging on campus to be more inclusive of a historically underserved population.

In the next chapter, you will see samples of the surveys we can use to evaluate the success of the project.

In addition to that, we recommend that you think through how you are going to track the progress of the project on your own. Think about what kinds of tools do you need to track your progress towards those goals: a calendar? A Slack chat with National staff or a peer about your own school? A Google doc with your team?

What are the tools that you will use to ensure success?

_____

_____

_____

Optional Slack Prompt

What is your system for staying organized with your to-dos? How will you track your progress as you move through this project?

_____

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Chapter 6: Evaluation

Evaluating the Programs

Evaluation is an intrinsic step to successful programming. By evaluating our programs, we seek to learn who is accessing the information, what they are learning, what we did well, and what we can improve upon.

To ensure the forward movement of our work, and consistent improvement, we recommend that you conduct two levels of evaluation:

1) Progress evaluation (i.e. what you did, when you did each step, how it went, etc.)

2) Impact evaluation (i.e. disseminating and collecting surveys to each participant at your outreach events)

No matter the results, carefully tracking and evaluating our work is a critical step to our ongoing development and ensuring that we are on the right track to addressing the most pressing issues.

In the next pages, you will find two surveys.

The first is what you can hand out at your events to each attendee. You can use verbal encouragement and (if possible) incentives to collect a survey from each person who attends your event.

The second survey will be completed immediately following the event by each organizer. The purpose of this survey is to gather information about the event, and to allow you the space to reflect on how it went.

Attendee Questionnaire

Please take a moment to complete the following questions. Note that your responses are anonymous and solely for Active Minds, in an ongoing effort to improve our work. We appreciate your responses.

Please select your age range.

☐0-15 ☐16-25 ☐26-59 ☐60-84 ☐85+

How would you describe your race?

☐White

☐Black or African American

☐Asian or Indian or Middle Eastern

☐American Indian/Native American/Alaska Native

☐Native Hawaiian/Pacific Islander

☐Other

If other, please describe:

_____

How would you describe your gender?

☐Female ☐Transgender ☐Questioning/Unsure of gender identity

☐Male ☐Genderqueer ☐Another gender identity

Check any that apply to you:

☐LGBTQ ☐Veteran ☐Foster Youth

Have you ever been to a mental health event on your campus before today?

☐Yes ☐No

How would you rate the quality of this event?

☐Excellent ☐Good ☐Fair ☐Poor

How much did you learn about mental health at this event?

☐A lot ☐Some ☐A little ☐None

How valuable do you feel that mental health events like this are for students?

☐Very valuable ☐Somewhat valuable ☐Not very valuable ☐Not at all valuable

Where did you hear about this event?

_____

What do you think is the most important thing about mental health that students like you need to hear?

_____

_____

_____

_____

_____

What is the best way for a student group on your campus to reach you and your peers to let them know about mental health events on campus? (How did you learn about this event?)

_____

_____

_____

_____

_____

Thank you for attending this event and offering your feedback on this form!

Learn more and connect with Active Minds at www.activeminds.org

Organizer Event Wrap-Up Form

This form can be completed by the person who was primarily in charge of the organization of this event. This form will ideally be completed within 48 hours of the conclusion of the event so that your lessons learned through successes and challenges can be passed to future planners.

Name:

Active Minds at… [your school]

What was the title of this event?

What was the date of the event?

What organizations or individuals, if any, did you collaborate with to organize this event?

How many people attended the event?

Who was the primary target audience for this event?

Who was the secondary target audience, if any?

Please provide a reflection of the event using the following prompts.

- What stands out to you about the event?
- What challenges, if any, did you face in planning this event?
- In what ways, if any, do you feel that your chapter reached a population that wouldn't have otherwise been reached with these messages?
- In what ways, if any, has your chapter grown stronger as a result of this effort to reach wider audiences with Active Minds messaging?
- What else would you like to share about your planning and organization process?

In Conclusion

On behalf of Active Minds, we thank you. Your work contributes a movement that is working to be more inclusive and responsive with critical mental health messaging. Your hard work makes a profound difference in the lives of those it touches, and we appreciate you. Keep in mind, no matter what came of this endeavor, you and your work are enough. Every conversation that helps to shine a light on mental health and people's diverse experiences and stories is important.

Congratulations, and thank you.