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Case Study:
Education, Resources, Empowerment and Skills (Project ERES)

The Challenge of Overcoming Stigma

The California Endowment’s Mental Health Initiative

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An estimated 22 percent of the U.S. population experiences a mental disorder in any given year, but almost half of these individuals do not seek treatment.¹ People in need of mental health services often fear the stigma associated with accessing such services. Stigma is defined as the use of negative labels to identify a person living with mental illness.² As such, this fear of being labeled as “crazy” prevents many from seeking the mental health services they need. Individuals often fear that their relationships with family, friends and coworkers may be negatively affected if their mental health problems are disclosed. Socio-cultural norms and beliefs also contribute to apprehension about seeking counseling services. This fear of potential discrimination often prevents individuals from seeking treatment at an early stage, which can result in further destabilization or an escalation of issues.

Mental Health Initiative (MHI) grantees used innovative strategies such as community education and culturally responsive service delivery to address stigma, resulting in increased access to, and utilization of, mental health services, and increased knowledge and awareness among community-based organizations (CBOs), local providers and families of behavioral health and cultural issues. One organization that was successful in decreasing the stigma associated with accessing and receiving mental health services was Family Health Centers of San Diego.

Building on the “Hablando Claro” (Plain Talk) model of community empowerment and engagement development, Family Health Centers of San Diego (FHCSD) staff, working with the Barrio Logan/Logan Heights community, created a model to change social norms relating to mental health, mental illness and mental health services access. The MHI-funded program, Project “Education, Resources, Empowerment and Skills” (ERES), primarily served the Logan Heights neighborhood, a predominantly recent-immigrant, monolingual Spanish-speaking Latino community. Project ERES used a promotores model of mental health support and intervention in order to increase access to mental health services. The “Vecino a Vecino” (Neighbor to Neighbor) model was used to train community residents as promotores (volunteer peer educators). The Program also created the Community Core Group (CCG), a representative community leadership body that participated in the development of the community empowerment model.

² U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, National Mental Health Information Center.
In 2001, The California Endowment (The Endowment) launched the Mental Health Initiative (MHI), a three-year initiative aimed at identifying and breaking down the barriers limiting access to mental health services in California. The Endowment awarded grants to 43 community-based organizations—large, small, established and emerging—and three county agencies in 15 counties. The grants enabled these organizations to develop new mental health prevention and intervention approaches for the most at-risk, vulnerable and underserved individuals and communities. Programs varied in their focus from direct services and provider training to community outreach and education. Grants ranged from $250,000 to $500,000 for single organizations and $500,000 to $1 million for collaboratives.
Project ERES’ Strategies for Reducing Stigma

Project ERES used a variety of strategies to reduce the stigma associated with accessing and receiving mental health services in the community. The program’s efforts to reduce stigma spanned the service continuum from community outreach and education to culturally responsive mental health service delivery.

1. Community Outreach and Education
To educate the community about mental health, the program used the community engagement aspects of the “Hablando Claro” model, which provided linkages among mental health education, services and resources. Community residents were educated through contact with promotores, the program’s Advisory Group, CCG members and staff members in individual and group settings. The program also held community picnics, presentations and CCG meetings, during which mental health issues, services and resources were discussed. The program’s mental health education was structured to help community residents understand the meaning of mental illness, the nature of psychiatric conditions and treatments, and the available resources for accessing mental health services.

2. Culturally Responsive Service Delivery
   a. Use of Culturally Appropriate Curriculum and Terms
   Program staff created a curriculum that was culturally and linguistically sensitive to the community. The curriculum was field-tested with community residents to ensure appropriateness. The names of different parts of the curriculum reflected the language of community residents (e.g., Como Manejar Las Emociones de Nuestros Hijos - “Speaking Clearly About the Emotions of Our Children”). In response to feedback from the community residents, the program changed the term for “support groups” to “platicas” (which mean “conversations” or “group sharing”) to be more culturally appropriate. Because men and women experience different forms of stigma and stressors, separate support groups were held for men and women. The women’s support group was entitled “Platicas de Mujeres” (Talking Groups for Women), and support groups for men were called “Con Voz de Hombres” (The Male Voice). The names of these groups were suggested by the community residents, which helped to empower them and give them ownership of the groups. The names also helped to promote the groups and encourage attendance by other residents.
Rather than using clinical terms, the program used culturally acceptable words to describe the content and intent of the mental health curriculum (e.g., Asi Somos, Asi Cambiamos - “This Is How We Are, This Is How We Change”). Project ERES also created parenting programs with a mental health focus on children (e.g., Como Manejar Las Emociones de Nuestros Hijos - “How to Deal with the Emotions of Your Children”) because parents would be more inclined to attend sessions that were focused on helping their children and strengthening the family rather than on themselves. Program staff addressed nuances within the language in order to prevent confusion from imprecise translation from English to Spanish. For example, staff used pictures, metaphors and storytelling to reinforce ideas and concepts that were difficult to explain through direct translation.

b. Home Visits

Project ERES also ensured that provision of care was conducted in a culturally appropriate manner. Instead of taking community residents away from their daily activities, the promotores took the mental health curriculum into community residents’ homes. By integrating mental health education and support groups into a residential venue, the promotores reduced the stigma of going to a dedicated “mental health facility.” Community residents did not see the promotores as mental health professionals who were imposing on their homes, but rather, as fellow community members who were trying to help them ease their tension, stress and social isolation.

The in-home curriculum was structured to allow community residents to gather with family members and friends in a natural setting to learn about mental health issues and support each other. The members of the support system helped and encouraged each other to use the new behaviors they were learning in the home visits. After the home visits, community residents were encouraged to participate in platicas, and if necessary, were made aware of counseling services. This circle of care allowed the community residents to access education and services in multiple ways.

c. Role of Belief Systems in Treatment

When promotores discussed mental health issues, they did not use complicated jargon or concepts that were unfamiliar to the community residents. They discussed ways for community residents to relax and reduce stress and anxiety by performing activities that were familiar to the client (e.g., taking a walk, showering, deep breathing, listening to music). The promotores also engaged the community residents in games and activities, such as Stress Bingo (“Loteria de Emociones”), to teach mental health terminology (e.g., emotional, physical, mental, spiritual stress). The program created games to
reinforce the education sessions. For example, games such as the health and well-being circle helped residents to describe the balance of physical, emotional, spiritual and mental health, while other activities such as the “Popsicle” game helped participants to identify people in their lives who provided social support and comfort. When encouraging community residents’ to receive services from the program’s therapist, the promotores told the community residents that the therapist was “just like us” and “speaks Spanish,” which helped the client to relate to the therapist. When the therapist treated community residents, he acknowledged the uses of herbs, prayer and the laying on of the hands. He also asked community residents about the types of beliefs or practices that would help them feel better.

3. Community-centered
To help reduce the stigma associated with accessing and receiving mental health services, Project ERES brought the services to the community. The program held support groups at sites within the community and in close proximity to where the majority of community residents lived (e.g., elementary schools, churches, recreation centers). These sites were not only convenient to community residents, but also places where they felt comfortable and safe. In order to reach men, the program went to auto shops, barber shops and other community venues frequented by men and offered services on-site at these locations.

4. Culturally Competent Staff
The program trained residents of the community to become promotores, who conducted outreach and presented the “Hablando Claro” (Plain Talk) mental health curriculum to other community residents. As members of the community, the promotores had strong existing relationships with community residents, spoke the same language, and could relate to the specific issues affecting the community. These factors facilitated community residents’ acceptance of services provided by the promotores because they were not considered “outsiders.”

Program staff also took interest in learning about the culture of the community residents, who were mostly from Southern Mexico. Staff learned what was important to the community residents and what their home life was like because these issues affected community residents’ stress and anxiety levels. Moreover, one of the program’s group counselors/therapists attended the Community Core Group meetings to establish relationships with community residents outside of the clinical setting. The clinical therapist also provided education sessions, which allowed residents to meet him and be comfortable approaching him with concerns. As a visible presence in the community, the clinical therapist was trusted by the community residents.
5. Responsive to Community Residents’ Needs
Program staff engaged community residents in Project ERES by making it the community’s program. Residents were involved in program planning and helped to shape the program to meet the needs of the community. For example, community members participated in Community Core Group (CCG) meetings, where they contributed to the creation and development of a mental health curriculum appropriate to the community’s needs. This resulted in a sense of ownership, belonging and empowerment for community residents. Staff constantly engaged residents in dialogue about how the program was evolving and used feedback from the community to shape the program. For example, the program responded to the specific needs of parents by creating a special session on “Discipline without Punishment.” Program hours were realistic and helped to facilitate participation. For example, groups were not scheduled from 10 to 11 a.m. on Wednesdays because parents and children were at work and at school, respectively. This was in direct response to community members’ input and feedback on the program design.

Outcomes

Project ERES’ efforts to reduce the stigma were successful as evidenced by the community’s increased access to and utilization of mental health services and increased knowledge and awareness among CBOs, local providers and families of behavioral health and cultural issues.

- Increased access to and utilization of mental health services
As a result of the program’s outreach and engagement strategies, community residents realized that it was acceptable for them to attend “platicas” and that they were not alone in suffering from depression and anxiety. They realized that they could ask for help and didn’t need to hide their problems from the community. After attending the program’s “platicas,” community residents were more willing to receive individual therapy.

Four support groups met regularly at community sites. The women’s group, with approximately 12 women, met weekly, and approximately five to eight men attended the men’s group on a weekly basis. The boys’ and girls’ youth groups met at a school site every week. In addition, 827 community residents participated in the in-home education, and the agency received 769 referrals for counseling services at Logan Heights Family Counseling Center from community residents who attended the in-home mental health program. As a result of the program, intake at the Logan Heights Family Counseling Center increased by 114 percent. The program’s mental health therapist was booked and had waiting lists of approximately three weeks.
• Increased knowledge and awareness among CBOs, local providers and families of behavioral health and cultural issues
Through its in-home education curriculum, CCG meetings, promotora training, and other community forums and meetings, Project ERES increased mental health and cultural competency knowledge and awareness among CBOs, local providers and families. With the use of pre-/posttests, the program documented a 95 percent increase in knowledge about mental health problems, relaxation techniques, mental health services, and various treatment and resource options among community residents who received the in-home mental health curriculum. One hundred forty-four community residents were provided with training and project orientation through the Community Core Group (CCG), which held meetings bimonthly. In addition, 30 community residents completed promotora training. Through CCG meetings, community events and community door-to-door contacts, Project ERES contacted 10,416 community residents and educated them on available mental health services and resources in the community.

Program Impact
The impact of Project ERES’ efforts to reduce stigma was far-reaching and went beyond those outcomes the program planned to achieve. As a result of the program, additional partnerships were developed, as well as new agency programs.

• Additional partnership opportunities
As the impact and value of Project ERES became public knowledge, community agencies began viewing FHCSD as a credible organization with expertise in serving linguistically and culturally diverse community residents. Agencies that had never before been interested in partnering with FHCSD began contacting the agency for collaborative opportunities. For example, Step Forward contacted Project ERES to request workshops and support groups on depression. They were interested in finding a community mental health intervention and support group program for people referred by the court or probation with a history of mental health problems. The agency chose Project ERES because it was community-based and culturally and linguistically appropriate for their members.

• Development of new agency programs
As the agency observed the impact Project ERES was having on the health and well-being of the community, it realized the importance of providing community residents with a
continuation of services. Specifically, FHCSD observed the successful coordination between two departments, Logan Heights Family Counseling Center and Project ERES (e.g., establishing a triage system for the increase in phone calls from community residents requesting information and services from the counseling center). As a result, FHCSD developed several other programs at the agency (e.g., Alcohol and Depression Screening and Family Strengthening Program), which built upon the strengths of Project ERES and provided community residents with access points to the range of services offered by the agency.

Lessons for the Field

Project ERES’ efforts to reduce the stigma associated with mental illness have implications for the mental health field and policymakers.

• **Community engagement is key to reducing stigma**
  In communities where mental health is not openly discussed and residents feel stigmatized when accessing services, community engagement is critical. Community engagement can involve the use of residents as *promotoras* to educate the community about mental health issues, as well as the convening of various community forums and meetings to discuss the nature of mental illness and how and where to access services and mental health resources. Community forums and advisory groups also provide a means for community residents to advocate for services. By engaging community residents and linking them to mental health education, services and resources, stigma associated with accessing and receiving mental health services can be greatly reduced.

• **Collaboration among agency departments facilitates service provision**
  Project ERES involved various departments within FHCSD pooling their resources and coordinating program activities and staff to complement services provided to residents. Collaboration can decrease duplication of agency services and can also facilitate higher quality service provision for clients.

• **Placing staff within the community increases access**
  By locating staff in community settings (e.g., local counseling center, schools), community residents can become acquainted with staff outside of a clinical setting. Rather than view them as outside professional staff, residents see them as community members. This serves to demystify mental health services because residents are already familiar with the staff person and are more willing to access services.
Multiple access points bring people through the door

By creating tiers of mental health access opportunities for potential clients, programs can reach people and bring them into care. For example, programs can provide wraparound care by using a variety of methods (e.g., mental health services, community education, outreach, lay peer educators), which allow clients to first utilize the services that are of interest to them (e.g., education sessions, parenting classes). Once people are familiar with a program and aware of other services provided, they are more willing and interested in using more critical services, such as counseling.