Stigma, Discrimination, and Well-Being Among California Adults Experiencing Mental Health Challenges

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The California Mental Health Services Authority (CalMHSA) oversees one of the broadest and most comprehensive efforts in the United States to provide strategically targeted prevention and early intervention (PEI) programs to improve the mental health of residents. With funds from the Mental Health Services Act (Proposition 63), a 1-percent tax on incomes over $1 million to expand mental health services, CalMHSA developed and implemented three statewide PEI initiatives in California that focus on mental illness stigma and discrimination reduction (SDR), suicide prevention, and student mental health. CalMHSA selected RAND to evaluate these efforts.

As part of this evaluation, RAND developed the California Well-Being Survey (CWBS), a surveillance tool designed to track exposure to PEI activities and the critical outcomes they target. Conducted with a representative sample of California adults who are experiencing psychological distress, the CWBS enables the tracking of the population-level impact of PEI on a population that is a key target of PEI efforts. **The CWBS is the first population-based survey of individuals who are at risk for or are experiencing mental health problems but who may or may not have obtained treatment or even recognized that they may have a mental health problem.** In contrast, previous efforts to examine the effects of antistigma campaigns or the experiences of mental illness stigma and discrimination have largely been conducted with individuals recruited from mental health service or advocacy organizations (Brohan et al., 2011; Henderson, Corker, Lewis-Holmes, et al., 2014). Although these studies have generated valuable findings, a major goal of stigma reduction is to increase individuals' recognition of their own mental health problems and their enrollment in treatment—goals already accomplished by the groups sampled for prior studies. By enrolling a broader population of individuals, the CWBS provides an unprecedented picture of the experiences of individuals who are at different points on the continua of risk, self-awareness, and engagement in treatment. Thus, the CWBS also provides the first opportunity to gauge the impact of PEI and antistigma programs on this broader group.

According to *Mental Health: A Report of the Surgeon General*, stigma exerts deleterious effects by causing people to avoid "socializing or working with, renting to, or employing" individuals with mental health challenges, which results in decreased opportunities and resources and, ultimately, low self-esteem, isolation, and hopelessness (U.S. Department of Health and Human Services, 1999). The CWBS assesses a wide variety of factors considered vital to influencing how individuals respond to potential mental health challenges. These include perceptions of public stigma, treatment and recovery beliefs, experiences of self-stigma and discrimination, and exposure to antistigma activities and messages. The CWBS also assesses several dimensions of well-being that may be adversely affected by mental health–related stigma. Well-being indicators include life satisfaction, social well-being, goal directedness, and personal confidence and hope. Life satisfaction and social well-being have been applied more broadly at the population level as indicators of well-being (Kobau, Bann, et al., 2013). In contrast, goal directedness and personal confidence and hope have been assessed in the context of recovery from a mental health challenge (Corrigan, Salzer, et al., 2004).

This paper reports results for each of these domains. The picture that emerges is one of individuals substantially burdened by mental illness stigma and discrimination, but who are responding with resiliency. Most have a positive outlook on treatment and recovery and are leading lives filled with hope, confidence, drive, and satisfaction. The purpose of this report is to present initial findings from the CWBS, which represents a landmark effort to systematically investigate the effects of stigma and related PEI efforts on the full spectrum of individuals affected by psychological distress.

Methodology

The CWBS is a follow-up survey of participants in the California Health Interview Survey (CHIS) 2013 (Nooney and Duffy, 2014). The CHIS is a random-dial telephone survey conducted with a representative sample of Californian adults (ages 18 years or older) focusing on health issues, including mental health. All individu-

Table 1. 2014 California Well-Being Survey Respondent Characteristics

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
Hispanic/Latino		
Hispanic/Latino	257	42
Not Hispanic/Latino	803	58
Race[a]		
American Indian	12	1
Asian	29	7
Black/African American	48	6
Hispanic/Latino (volunteered)	171	31
Multiracial	96	8
Other Pacific Islander	4	1
White/Caucasian	689	46
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: As a follow-up to the CHIS 2013, the CWBS used CHIS 2013 weights adjusted for undercoverage, subsample selection, nonresponse, and ineligibility when the CHIS sample was recontacted. 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.

[a] With the exception of Hispanic/Latino respondents, other racial/ethnic minority groups make up only a small proportion of the CWBS sample. This is reflective of the sociodemographic profile of eligible CHIS 2013 respondents.

[b] Respondents could select more than one response.

als completing the CHIS 2013 (N = 20,724) who were willing to be recontacted, were English- or Spanish-speaking, and had a mild to moderate or serious level of psychological distress—as measured by the Kessler-6 (K-6), a screening scale for clinically significant mental health problems (Kessler, Barker, et al., 2003)—were eligible to participate in the CWBS (N = 2,395). A K-6 score ranging from 8 to 12 is indicative of mild to moderate psychological distress; scores greater than 12 are indicative of probable serious mental illness. The CWBS was administered in English or Spanish between May and August 2014. The final response rate was 45.2 percent, with a total of 1,066 respondents completing the CWBS. Fifty-four percent (N = 578) had CHIS K-6 scores in the mild-to-moderate range and 46 percent (N = 488) in the serious distress range. Sociodemographic information on respondents is provided in Table 1. The characteristics of the sample are slightly different (e.g., disproportionately female, younger, and Hispanic) from those responding to another CalMHSA-supported surveillance tool, the 2013 California Statewide Survey, which was conducted with a representative sample of the general California adult population (Burnam et al., 2014). Differences are presumably due to the CWBS' sampling of those experiencing distress.

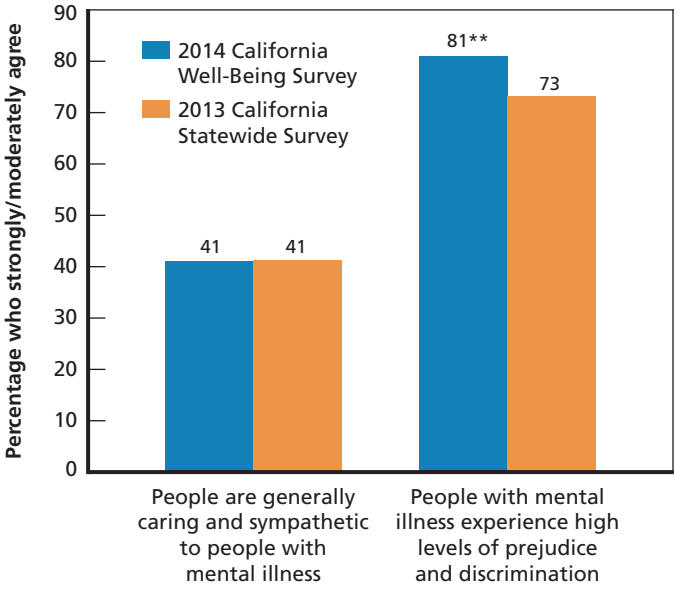
This report presents findings from the CWBS. When possible, we compare findings from the 2014 CWBS to data from the general California population (e.g., 2013 California Statewide Survey), as well as other key populations. Such comparisons can help us better understand how Californians who are at risk for or are experiencing mental health problems are faring.

Results

Perceptions of the Environment for Treatment and Recovery

The extent to which individuals who are experiencing mental health challenges reach out for help likely depends, in part, on their perceptions of public support for individuals with mental illness and their beliefs about the efficacy of mental health treatment and recovery. Our results indicate that **most CWBS respondents do not perceive the public to be supportive of people with mental health challenges but instead perceive high levels of stigma and discrimination** (see Figure 1). Only 41 percent of respondents believe that people are caring and sympathetic to people with mental illness. This is comparable to responses to the same question by members of the California general population (Burnam et al., 2014), but lower than one national estimate of 60 percent (Kobau and Zack, 2013). However, among the subset of the nation with serious psychological distress, levels of perceived support are much closer, at 44 percent (Kobau and Zack, 2013). Correspondingly, a large majority of CWBS respondents (81 percent) believe that people with mental illness experience high levels of prejudice and discrimination. This is significantly higher than rates observed among the California general population (73 percent) and higher

Figure 1. Perceptions of Public Stigma and Support



NOTES: * $p < 0.05$; ** $p < 0.01$.

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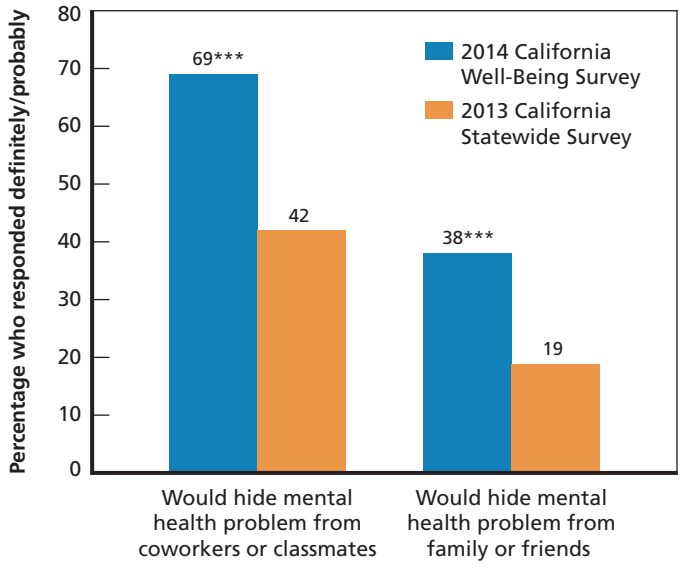
Figure 2. Concealment of Mental Health Problems



NOTES: * $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$.

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than rates in Ireland at the start of its national stigma-reduction campaign (See Change, 2012). Overall, this suggests that a significant proportion of Californians perceive an unsupportive climate for individuals with mental health problems, irrespective of personal experiences of psychological distress. CWBS respondents may perceive higher levels of prejudice and discrimination due to actual personal experiences of being discriminated against because of a mental illness. In a subsequent section, we present findings on reported experiences of mental health–related discrimination.

Consistent with their perceptions of public stigma, more than two in three respondents would definitely or probably hide a mental health problem from coworkers or classmates, and more than one in three would do so from family or friends (see Figure 2). These rates are significantly higher than those found in the general Californian population and are consistent with the high rates of perceived stigma and lack of support in this group of respondents. The lack of safety or comfort with disclosure raises concerns about the degree to which individuals are able to obtain sufficient support in school or in the workplace, as well as from those with whom they may be closest. Disclosure can be associated with both positive (e.g., empowerment, enhanced support) and negative (e.g., discrimination, isolation) consequences (Corrigan, Kosyluk, and Rusch, 2013). Interventions aimed at assisting individuals with the complex decision of whether to disclose their own mental illness have been associated with decreases in disclosure-related distress (Henderson, Brohan, et al., 2013; Rusch et al., 2014).

In spite of these concerns, **nearly all respondents said they would obtain professional help if they had a serious emotional problem, but one in five indicated that they might delay treatment out of fear of letting others know about their mental health problem** (see Figure 3). This is consistent with our findings regarding likely concealment of a mental health problem. It also corroborates previous findings, in which the large majority of individuals with mental health problems eventually obtain treatment but with significant delays to first contact. Putting off needed mental health treatment is a pervasive problem in the United States, with treatment delays ranging from six to eight years for mood disorders and nine to 23 years for anxiety disorders (Wang et al., 2005). On a more optimistic note, among CWBS respondents who reported having ever experienced a mental health problem, 88 percent had sought treatment.[1] Findings are in line with predicted lifetime probabilities of mental health treatment contact, which is approximately 90 percent for a major depressive episode, dysthymia, a panic disorder, or bipolar disorder but lower for generalized anxiety disorder (86 percent), posttraumatic stress disorder (65 percent), or social phobia (50 percent) (Wang et al., 2005). Delays in treatment contact for CWBS respondents were not assessed. With respect to service use in the past 12 months, 59 percent of CWBS respondents with serious psychological distress had obtained mental health treatment. This is slightly higher than in a national survey that employed slightly different methods to establish mental health status and service utilization, in which 45 percent of U.S. adults with mental illness reported receiving mental health services in the past year (Substance Abuse and Mental Health Services Administration, 2014). Although a high percentage of Californians with self-recognized need appear to be seeking treatment, findings suggest the need for continued efforts to address barriers to treatment, given that nearly one in ten report they would not

Figure 3. Treatment Attitudes and Utilization

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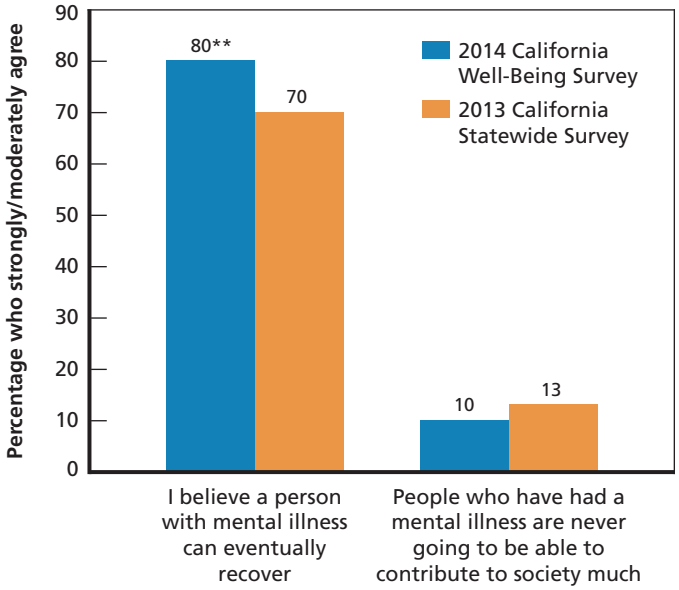
Figure 4. Recovery Beliefs



NOTES: * $p < 0.05$; ** $p < 0.01$.

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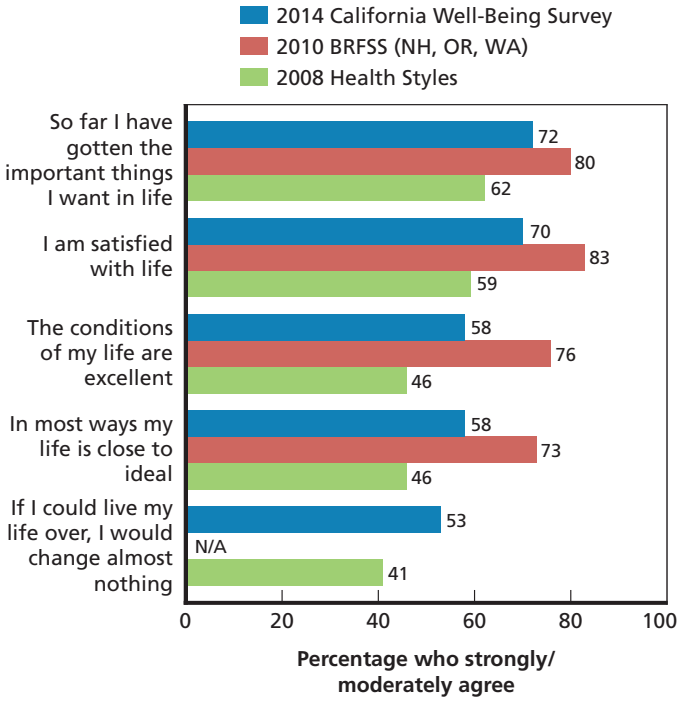
obtain treatment if needed and and that a substantial proportion indicate they would delay treatment due to stigma.

Willingness to seek professional help for a serious emotional problem may be so high because of respondents' strong beliefs in recovery. Four out of five CWBS respondents agree that a person with a mental illness will eventually recover, and only one in ten believe such a person will never be able to contribute to society much. Belief in recovery among our respondents is significantly greater than in California's general population (see Figure 4). It is important to note that belief in recovery is substantially higher in the California population to begin with, compared to national estimates of 29 percent (Kobau, DiIorio, et al., 2010). These relatively strong beliefs in recovery may undergird the high rates of treatment seeking in our sample.

Well-Being

The CWBS monitors several dimensions of well-being that may be adversely affected by mental health problems or by mental illness stigma. These include *life satisfaction*, *social well-being*, *goal directedness*, and *personal confidence and hope*. Compared to other available population-based studies, **life satisfaction among respondents was greater than in the nation overall but somewhat lower than the general population residing in a few select states.** Approximately 70 percent of CWBS respondents strongly or moderately agree that they have gotten the important things they want in life and that they are satisfied with life (see Figure 5). A lower proportion (58 percent) view their life conditions as "excellent" or "close to ideal." About one-half of respondents reported that they would change almost nothing if they could live their life over. Compared to the 2010 Behavioral Risk Factor Surveillance Survey (BRFSS), which was conducted with a

Figure 5. Life Satisfaction



NOTE: N/A = not applicable, given that this item was not assessed in the 2010 BRFSS.

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representative sample of U.S. adults in New Hampshire, Oregon, and Washington (Kobau, Bann, et al., 2013), CWBS respondents reported relatively lower levels of life satisfaction. In contrast, they were doing better than a representative sample of the United States in 2008 responding to the HealthStyles survey (Kobau,

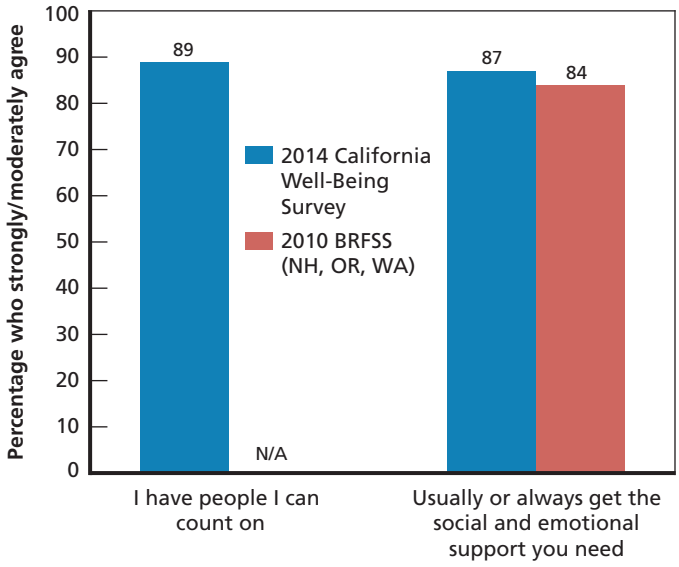
Sniezek, et al., 2010). If life satisfaction in California is more like the states in the BRFSS study, it may be that the burden of mental illness or stigma has driven down satisfaction among those experiencing emotional distress. If this is the case, these individuals are nonetheless faring better than the average American.

CWBS respondents report high levels of social support. Close to 90 percent agree that they have people they can count on and that they usually or always get the social and emotional support that they need (see Figure 6). These rates are comparable to the three-state 2010 BRFSS survey (Kobau, Bann, et al., 2013). Individuals experiencing psychological distress do not appear to be impeded in establishing supportive relationships relative to the U.S. general population. Though findings appear to contradict theories about the adverse effects of stigma on social support (Link et al., 1989), they are consistent with a longitudinal study in which individuals with serious mental illness experienced increased social support over time, and no significant associations were observed between stigma and social support (Mueller et al., 2006). It is possible that, in the course of experiencing mental health challenges, individuals maintain and form new supportive social ties while parting with less-supportive ones (Mueller et al., 2006).

A key component of well-being is goal directedness—the perception that one can determine the course of one's life and an active effort to do so (Corrigan, Larson, and Rusch, 2009; Deci and Ryan, 2000).

CWBS respondents express high levels of goal directedness compared to others with serious mental illness. As seen in Figure 7, virtually all respondents have goals in life that they want to reach (95 percent) and have a desire to succeed (95 percent). The large majority of respondents also have a plan for how to stay or become well (86 percent) and believe that they can meet their current personal goals (83 percent). The latter two indicators had the lowest rates of positive endorsement, indicating potential room for improvement in assisting individuals who experience distress to have a plan for wellness and for meeting personal goals. Total scores for the Goal and Success Orientation Scale can range from 5 to 25, with higher scores representing greater levels of goal and success orientation. CWBS respondents had a mean total score of 22.20, which is higher than individuals from community mental health settings with serious mental illness who had a mean total score of 19.30 (Cook et al., 2012).[2] The factors underlying the higher levels of goal and success orientation observed for CWBS respondents are unknown but could be related to their (on average) lower level of distress, sociodemographic differences, or other unknown variations between the two samples.

Figure 6. Social Well-Being



NOTE: N/A = Not applicable, given that no population-based comparative data are available.

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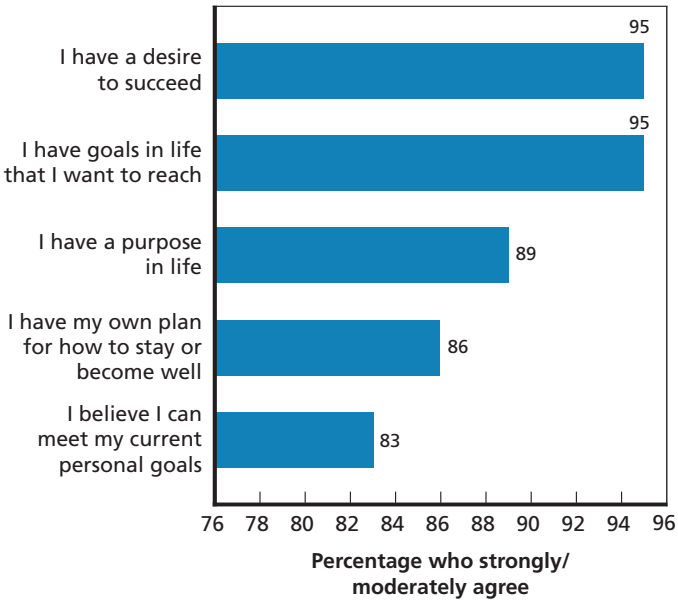
Figure 7. Goal Directedness



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Levels of personal confidence and hope are lower among Californians with psychological distress than others affected by serious mental illness but are still in the positive range (see Figure 8). As shown by items in the Personal Confidence and Hope Scale (Corrigan, Salzer, et al., 2004), 85 percent of respondents strongly or moderately agree that they can handle what happens in life, while the same proportion strongly or moderately agree with the statement: "I like myself." Eighty-three percent are hopeful about their future, while a lower proportion feels that they are able to handle stress (70 percent) or that fear does not stop them from living the way they want to (68 percent). On the Personal Confidence and Hope Scale, CWBS respondents had an overall mean item score of 3.98. This is lower than estimates found with individuals with serious mental illness from community mental health settings (mean = 4.57) (Cook et al., 2012).[3]

Figure 8. Personal Confidence and Hope

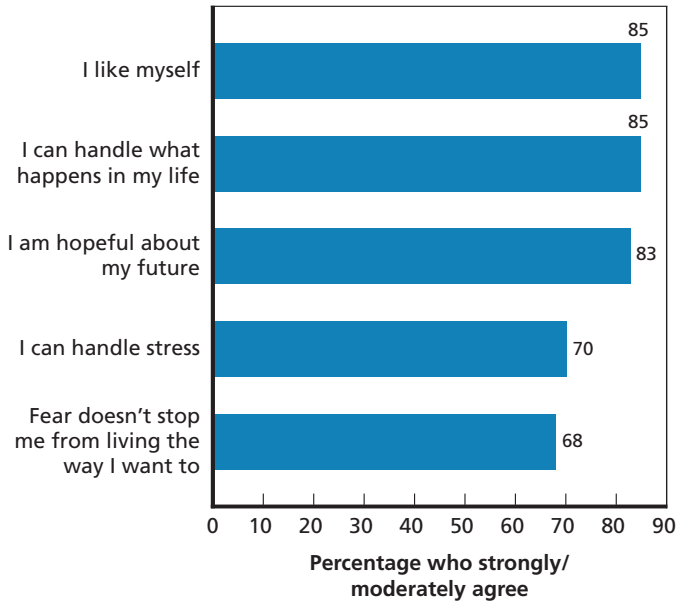

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Figure 9. Self-Stigma

NOTE: Self-stigma items administered only to respondents who indicated having experienced a mental health problem (unweighted *N* = 608).

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Self-Labeling and Recognition

A key issue in unmet mental health needs is whether low rates of treatment seeking stem from a failure to recognize symptoms as signs of mental illness and/or a desire to avoid labeling oneself or one's symptoms as mental illness due to stigma. We asked respondents to the CWBS: "Have you (yourself) ever had a mental health problem?" Overall, 53 percent of respondents indicated having experienced a mental health problem. Of those with mild to moderate levels of psychological distress, 37 percent indicated that they have experienced a mental health problem. Of those with serious levels of psychological distress, 74 percent acknowledged having experienced a mental health problem.

Self-Stigma Among Those with a Self-Acknowledged Mental Health Problem

Although CWBS respondents fared well according to most of the well-being indicators, many reported experiences of self-stigma. Of those who indicated having experienced a mental health problem, **more than 60 percent believed that they could not possibly be understood by people who have not had a mental health problem, and 40 percent reported feeling out of place in the world** because of their mental health problem (see Figure 9). Approximately one in three harbored feelings of shame, inferiority, and disappointment in themselves because of their mental health problem. Although the CWBS assesses only one aspect of self-stigma, alienation, this has been documented as the most-frequently endorsed type of self-stigma in studies conducted in other countries (Brohan et al., 2011).

Discrimination

Individuals who reported experiencing a mental health problem in the past 12 months were also asked about experiences of discrimination (being treated unfairly because of their mental health problem). **Nearly all of those with a self-acknowledged past-year mental health problem (about 90 percent) reported an experience with discrimination during that year. Respondents experienced discrimination in an average of about six life domains** (mean = 5.81; standard error = 0.43). These rates of discrimination in California are comparable to those recently observed in a survey of mental health service users in England. In that study, 91 percent experienced at least one instance of discrimination and discrimination was experienced in an average of 5.40 applicable life domains (Henderson, Corker, Hamilton, et al., 2014). The English study assessed for discrimination in 22 life domains, compared with 14 domains in the CWBS. It is possible that California rates would be higher if more domains had been assessed—the CWBS assessed fewer because we felt many from the English study were not relevant to our study (e.g., treated unfairly in levels of privacy in hospital and community settings).

In Figure 10, we list the domains assessed in order from those most to least frequently endorsed as areas in which discrimination occurred. Findings clearly show that discrimination was experienced most often within the realm of intimate social relationships (e.g., family, romantic relationships, friends). However, a substantial proportion (more than 40 percent) also encountered discrimination in other spheres of life, such as in work, school, and social activities. Though not as frequently endorsed, more than one-third of respondents reported being discriminated against by

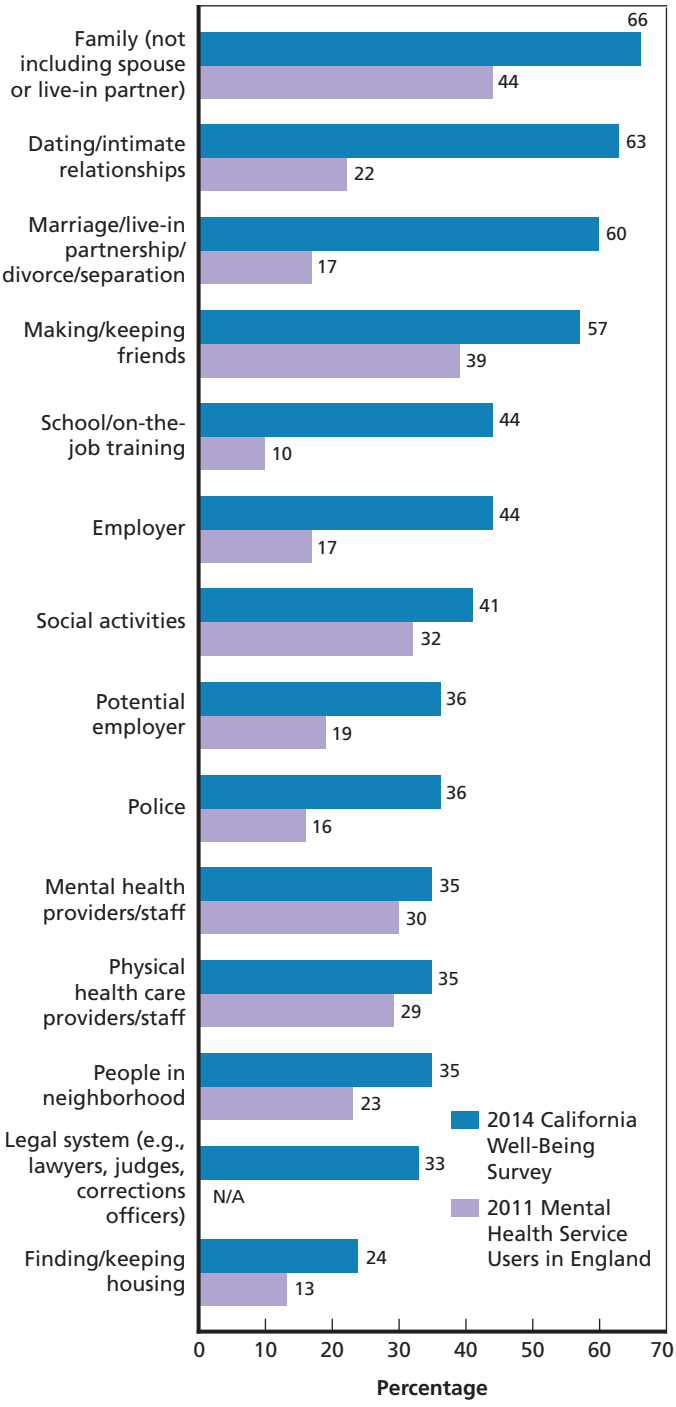
those in the service sector (e.g., police, physical and mental health providers). Disability Rights California, a CalMHSA program partner, provides legal education and advocacy targeted at reducing discrimination against individuals affected by mental health problems in many of the life domains assessed (e.g., health care, housing, employment). Akin to the work of Disability Rights California, efforts to reduce discrimination often focus on the adoption or enforcement of institutional or legal policies that safeguard the rights of those affected by mental illness. Findings underscore the importance of this work while also highlighting the significant attention that needs to be paid to reducing discrimination from those who may be closest to individuals affected by mental health challenges, such as family members, friends, romantic partners, and spouses. **Rates of being discriminated against in social intimate relationships were much higher for respondents to the CWBS than estimates from a 2011 survey of mental health service users in England** (Corker et al., 2013). Reports of discrimination were also markedly higher in domains involving employers, educational settings, and law enforcement than in England.

Exposure to CalMHSA and Other SDR 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. CWBS respondents were asked about their exposure to these activities during the 12 months prior to their survey interview. Exposure to activities that were clearly "branded," such as those from the social marketing campaigns, could be specifically attributed to CalMHSA. Other CalMHSA-funded activities, such as the wide variety of educational presentations and materials, occurred under a variety of organizations, labels, and counties, and other entities in the state were simultaneously conducting similar activities. Thus, it is difficult to determine whether those exposed to these activities were reached by CalMHSA or one of these other organizations. We categorized activities that could be directly linked to CalMHSA efforts as "CalMHSA Reach," and the others as "Other Reach." Using this method, we found that **35 percent of CWBS respondents were reached by CalMHSA in the 12 months prior to survey**, and 89 percent were reached in a manner that *might* have been attributable to CalMHSA. Importantly, even if the efforts that were involved in "other reach" were not part of CalMHSA, **this indicates the potential for the CalMHSA SDR initiative to reach nearly nine in ten Californians in distress given the methods it is currently using.** Below, we present findings on potential exposure to CalMHSA SDR efforts by each specific activity.

CalMHSA Reach. The CalMHSA social marketing campaign included the distribution of a documentary called *A New State of Mind: Ending the Stigma of Mental Illness* that showcases the lives of individuals who have experienced mental health challenges and recovery (Each Mind Matters, 2015). The documentary's

Figure 10. Percentage Who Reported Discrimination in Past 12 Months



NOTES: Discrimination items administered only to individuals indicating having experienced a mental health problem in the past 12 months (unweighted *N* = 436). Percentage reporting discrimination was calculated as respondents who endorsed *often*, *sometimes*, or *rarely* response options to correspond with estimates from Corker et al. (2013), which reported on the percentage that endorsed *a lot*, *moderately*, or a *little* response options. N/A = not applicable, given that this item was not assessed in Corker et al. (2013).

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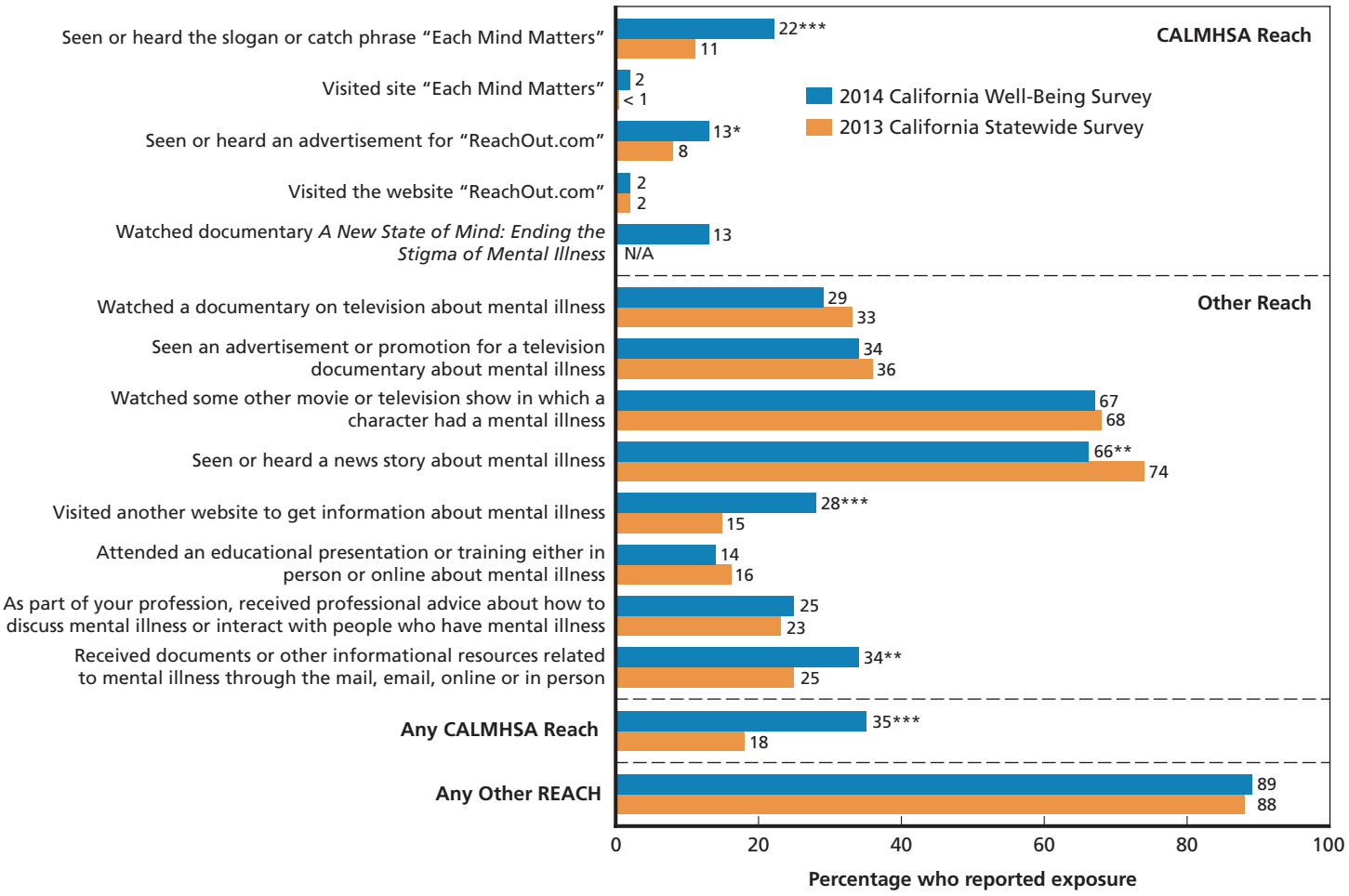
primetime debut on California Public Television was followed by showings on various CPT stations at different times and days. It was also distributed through planned community events through September 2013 and through EachMindMatters.org, which also houses a variety of other SDR materials that are part of the social marketing campaign. The site has more recently become a hub for CalMHSA PEI resources more broadly, and the brand "Each Mind Matters" now accompanies all CalMHSA resources and activities. As seen in Figure 11, 13 percent of CWBS respondents had viewed the CalMHSA-sponsored documentary. **Slightly more than one in five CWBS respondents were aware of the "Each Mind Matters" slogan**, which is double the rate of those in the California general population (Burnam et al., 2014). However, rates of actual visits to the Each Mind Matters website were much lower; approximately 2 percent of CWBS respondents had accessed the site, about the same as the rate for the California general population. A second part of the social marketing campaign—targeted at younger persons (ages 14–24 years)—was the creation of an online discussion forum linked to an existing website targeting mental health information to youth: ReachOut.com. The ReachOut forums allow youth to seek and provide support for emotional, school, relationship, and work problems and are monitored and moderated. The marketing campaign included radio, online, and some cable TV spots promoting the web forums, as well as posters and other supporting materials that contained campaign messages. Thirteen percent of CWBS respondents had seen or heard an ad for ReachOut.com, which is significantly higher than the California general population. Only 2 percent of CWBS respondents had accessed the ReachOut.com website.

It is unclear why CWBS respondents were more likely to be reached or to be aware of both the Each Mind Matters and Reach Out campaigns relative to the California general population. It may be that the reach of CalMHSA activities is stronger to those with psychological distress or that these individuals better remember the material, since it is more relevant to their lives. However, the two surveys on which estimates are based each reference the past 12 months but were administered a year apart.

Figure 11. Potential Exposure to CalMHSA SDR Activities



NOTES: * $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$. N/A = not applicable, given that the documentary aired when the administration of the 2013 California Statewide Survey was already under way.

Respondents could have been differentially exposed to SDR activities because they tap different phases of the campaign. For example, the Each Mind Matters campaign was not fully implemented, and the slogan "Each Mind Matters" had only been recently applied during the administration of the 2013 California Statewide Survey.

Other Reach. Approximately one-third of respondents had watched a documentary on television about mental illness, and twice as many had watched a movie or television show that featured a character with a mental illness (67 percent) or had seen or heard a news story about mental illness (66 percent). These individuals may have been exposed to stories influenced by CalMHSA media efforts. At the very least, these high rates of exposure to media portrayals of mental illness indicate that these are appropriate venues for CalMHSA to target. Nearly one-third of CWBS respondents (28 percent) had accessed websites other than Each Mind Matters or Reach Out for mental health information, which is almost double the rate of the California general population. This indicates that a substantial proportion of individuals who are at risk for mental health problems are turning to online resources for information. In addition, a sizable segment of the population obtained information through more-intensive educational experiences, such as presentations or trainings (16 percent) or receipt of information within the context of their profession (25 percent). Finally, more than one-third of CWBS respondents had received informational resources about mental illness via mail, email, online, or in person. Relative to the California general population, CWBS respondents were significantly more likely to access information about mental illness via websites, mail, email, or in person.

Conclusions

Californians who experienced mild to serious psychological distress exhibited signs of resiliency as indicated by a number of well-being indicators. CWBS respondents possess high levels of goal directedness, personal confidence and hope, and social support. In addition, CWBS respondents held favorable attitudes toward recovery and mental health treatment. The large majority of respondents believed that recovery is possible and would seek treatment for a mental health problem if needed. Of those experiencing serious psychological distress in the past 12 months, 59 percent had sought treatment; although this is slightly higher than rates found in the U.S. general population, substantial levels of unmet need remain.

Prior research suggests that many individuals can adapt and achieve satisfaction in life in the face of adversity (Diener, Lucas, and Scollon, 2006). Nonetheless, even though a substantial proportion of individuals who experience challenging life events often report high levels of well-being (Diener, Lucas, and Scollon, 2006), certain subgroups (e.g., those with chronic health conditions, disability status) have been shown to exhibit lower levels of well-being relative to their counterparts (Kobau, Bann, et al., 2013). This study focused on individuals along the broad continuum of prevention, including those with mild to serious distress. It is possible that lower levels of well-being might have been observed among the subset of CWBS respondents with more severe levels of distress and impairment.

CWBS respondents possess high levels of drive, social support, confidence, and hope

- 95 percent have goals in life and a desire to succeed
- 89 percent have people they can count on
- 80 percent believe in recovery
- 70 percent are satisfied with life.

Although these findings suggest that CWBS respondents are coping well with their distress, several areas of concern should be noted. Respondents who indicated having experienced a mental health problem reported substantial levels of self-stigma and discrimination. More than one-half felt a sense of alienation, and approximately one in three harbored feelings of inferiority, shame, and disappointment in themselves because of their mental health problem. Nearly nine out of ten reported experiencing mental health–related discrimination in the past 12 months. Disconcertingly, discrimination occurred most frequently within the realm of intimate social relationships (e.g., family, friends), where individuals with mental health problems may be the most likely to turn for support. Still, high levels of discrimination occurred in other arenas as well, such as at school, in the workplace, and by health care providers and law enforcement. Perhaps as a consequence of these experiences, most of those with mental distress viewed the public as being unsympathetic, prejudiced, and discriminatory toward people with a mental illness, indicating high levels of perceived stigma. Distressed individuals were also significantly more likely to conceal a mental health problem from coworkers, classmates, family, and friends and were more likely to believe they would delay treatment out of fear of stigma relative to the California general population. Such a delay could undermine treatment and recovery (McGorry et al., 1996; Wang et al., 2005).

Our findings indicate the clear need for stigma and discrimination reduction efforts in the state of California. For a sub-

Of CWBS respondents who acknowledged experiencing a mental health challenge

- nearly nine in ten were discriminated against because of their illness
- more than half felt a sense of alienation
- one in three harbored feelings of inferiority, shame, and disappointment in themselves because of their mental health challenge
- discrimination occurred most frequently in the realm of intimate social relationships.

stantial proportion of individuals facing psychological distress, social inclusion and full integration into society have not yet been completely realized (New Freedom Commission on Mental Health, 2002). Attention to reducing discrimination in intimate social relationships is particularly warranted, along with continued efforts that focus on other sources of discrimination (e.g., employers, health care providers). Efforts are also needed to stem the potential negative effects that can result from self-stigma. Though the evidence base for effective strategies for reducing self-stigma is still emerging, targeting high-risk groups to avert self-stigma has been identified as a promising area for future research (Griffiths et al., 2014; Mittal et al., 2012). Moreover, self-stigma has been shown to be associated with perceived stigmatization by the general public (Brohan et al., 2011), which suggests that increasing public support for individuals with mental health challenges may also help reduce self-stigma. CalMHSA is conducting some of these activities, particularly efforts to reduce public stigma and to reduce discrimination among employers and healthcare providers. Our findings indicate that some specific CalMHSA activities reached more than one-third of people experiencing mental distress, and other activities that could be related to CalMHSA efforts reached nearly 90 percent of this group.

Although beyond the scope of this report, future analyses will examine the theorized relationships between public stigma and self-stigma and how self-stigma relates to goal directedness, personal confidence and hope, well-being, and treatment seeking (Corrigan et al., 2009; Corrigan et al., 2004). Further, our findings do not account for potential cultural variations, and plans are under way to test for racial/ethnic and language differences across targeted outcomes, which will be presented in a future report. Findings should also be considered in light of certain study limitations. The study relied on the K-6, a nonspecific psychological distress screener, which has been demonstrated to be a valid screener for serious mental illness (Kessler et al., 2010), though it has been shown to be more strongly correlated with anxiety and depression than other mental disorders (e.g., psychosis) (Andrews and Slade, 2001). Finally, although our analyses incorporated weights to account for nonresponse, unobserved influences may not have been factored in. Moreover, our study did not include individuals residing in psychiatric institutions affecting the representativeness of our findings. Nonetheless, given that prior studies have mainly relied on treatment-seeking samples, this is one of the most rigorously conducted studies focused on a representative sample of individuals who were selected based on their experiences of psychological distress.

Because it relies on self-report, the CWBS necessarily measures only direct exposure to CalMHSA activities. CalMHSA efforts are also designed to influence the lives of those experiencing mental health challenges through changes to institutions and social interactions. To detect whether such changes are affecting the lives of those in distress, continued monitoring of this population will be required. Such an effort would allow researchers to determine whether shifts in the domains examined in this report occur over time as CalMHSA and other PEI efforts continue. This would also enable an examination of the impact of PEI efforts that extend beyond process measures, such as the reach of CalMHSA activities, which are necessary but not sufficient to understanding whether PEI is making a difference. The baseline findings presented in this report provide an important benchmark that will be vital to this tracking and assessment of the impact of California's unprecedented attempt to improve the well-being of its residents through prevention and early intervention.

Notes

[1] Treatment seeking was assessed by asking respondents the following question: "Have you ever sought treatment for a mental health problem?" Treatment seeking was assessed only among respondents who answered "yes" to the question: "Have you ever had a mental health problem?"

[2] The Goal and Success Orientation Scale contains a 5-point scale ranging from 1 (strongly disagree) to 5 (strongly agree) (Corrigan, Salzer, et al., 2004).

[3] The CWBS included only five of the seven original items that comprise the Personal Confidence and Hope Scale. Thus, instead of using the total scale score, we calculated the mean of individual item scores to facilitate comparison with other studies.

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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.

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