

Reducing the Stigma of Mental Illnesses in Georgia



Twelfth Annual Rosalynn Carter Georgia Mental Health Forum
May 18, 2007

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Planning Committee

Special thanks to the planning committee:

Nora Haynes, President, NAMI Georgia

Ellyn Jeager, Interim Executive Director, MHA Georgia

Carol Coussons de Reyes, Director, DHR - Consumer Relations and Recovery Section

Anna McLaughlin, Co-Executive Director, Georgia Parent Support Network, Inc.

Sue Smith, Executive Director, Georgia Parent Support Network, Inc.

Sherry Jenkins Tucker, Executive Director, Georgia Mental Health Consumer Network

Denise McClain, DHR, Case Expediter Coordinator, Division of Georgia MHDDAD

Joetta Prost, Director, DHR - Policy and Training

Thomas Bornemann, Ed.D., Director, The Carter Center Mental Health Program

Lei Ellingson, Assistant Director, Carter Center Mental Health Program

Deborah Leiter, Vice President, Campaign Director, The Advertising Council, Inc.

Publication Design: Madison Graphics, Inc.

Editorial Services: Sarah Fedota, Scripsit

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OPENING REMARKS

Rosalynn Carter

Chair, The Carter Center Mental Health Task Force

We are pleased to focus this year's Rosalynn Carter Georgia Mental Health Forum on reducing the stigma of mental illnesses around our state. There is nothing more important we can do for those who have mental illnesses. Stigma affects everything we do in the mental health field. It runs through every issue. The planning committee chose this topic because of the obstacle stigma presents in accessing quality care and treatment.

The Atlanta Journal-Constitution's ongoing series, "A Hidden Shame," has brought to our attention many cases of horrible injustice for people receiving treatment, or lack thereof, in Georgia's state psychiatric facilities. I think it is safe to say that stigma is at least partially why the Legislature reacted—or rather didn't react—with any meaningful legislation. After working in the mental health field for more than 35 years, I had begun to think for the first time that stigma might be lifting a little. Hopefully the stories about our state hospitals and the General Assembly's inadequate response as well as the Virginia Tech incident aren't indicators that we're backsliding. We must use them to demonstrate the critical need for quality mental health services in our state and in our country. If we can achieve that then maybe we can make some good come of these horrible situations.

The Carter Center Mental Health Program is pleased to be taking part in the National Anti-Stigma Campaign. It is spearheaded by the Ad Council and the Substance Abuse and Mental Health Services Administration (SAMHSA) and is an expansion of an earlier program begun in eight states. It is a three-phase project, the first of which is targeted at 18- to 25-year-olds and was launched last December. The next two phases are going to be launched later targeting different groups.

The campaign is based on the belief that if we can reduce the stigma and mental disorders become more socially acceptable, the disability of the illnesses can be minimized. I think we all know that mental illnesses are highly treatable and that the earlier they are treated, the better off those with the illnesses will be — and the less they will suffer.

According to SAMHSA, 18.6 percent of 18- to 25-year-olds experience psychological distress, compared with 11.3 percent in adults over 18. Furthermore, the 18- to 25-years age group has the lowest rates of help-seeking behavior. This surprised me because I thought younger people were beginning to be more open-minded about mental illnesses and more accepting of treatment. So, we really have to work on this group.

Today, you will be asked to commit to undertaking an anti-stigma activity that you and your organization can implement. We all have to work together if we are going to be successful in our state in overcoming stigma. We know how hard it is and if we can all come together, I am hopeful that we can achieve success. The end result of stigma is discrimination. All of us need to do whatever we can to make sure that all children and adults in Georgia have the best quality of life possible.

Rosalynn Carter

Reducing Stigma and Discrimination

Otto Wahl, Ph.D.

Director, Graduate Institute of Professional Psychology and Professor of Psychology, University of Hartford; Advisory Board, The Rosalynn Carter Fellowships for Mental Health Journalism

I have been asked to talk about stigma, to remind us about the nature and impact of stigma and its manifestations. I also want to talk about some of the organized efforts to reduce mental illness stigma and to give you a few ideas about what each of us, as individuals, can do to combat stigma.

Like any good academician, I have to start with definitions of “stigma.” “Stigma” is a mark or a label imposed on an individual or a group. It is important to note that the stigma does not reside within the individual – it is imposed upon them by others – and leads to devaluation and discrimination. I started with a Greek spelling of “stigma” because “stigma” is believed to come from the Greek and comes from the practices of the ancient Greeks of marking their slaves with a physical brand so there would be a visible sign that this person who was so

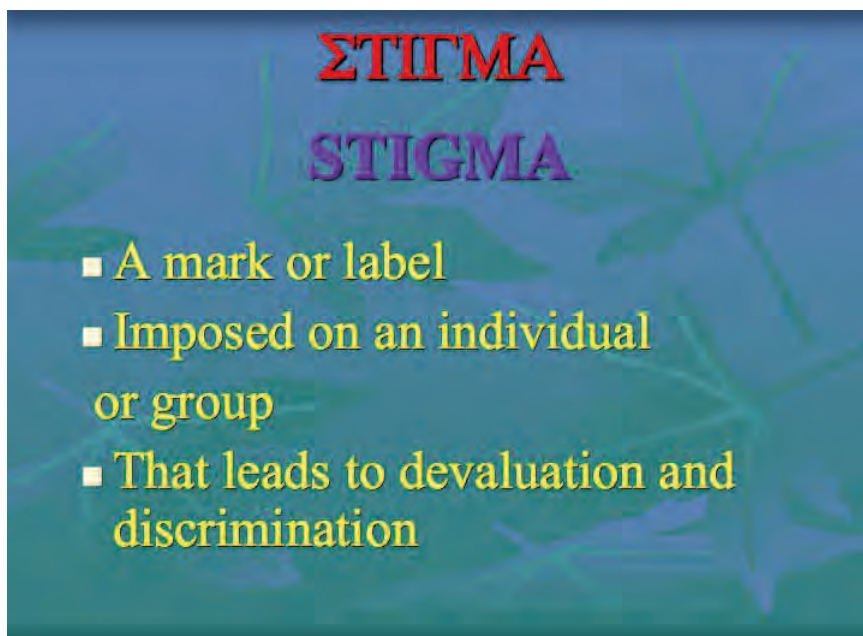
marked was not a full and participating member of their society and was not entitled to the privileges of others. That brand, that stigma, signified that these people were to be treated differently, to be treated as inferiors.

We no longer physically brand people, but we do brand them with labels – labels that lead to devaluation and discrimination. Unfortunately, mental illnesses and psychiatric diagnoses are some of those brands.

We know that negative attitudes about mental illnesses exist. The 1996 General Social Survey, which is a survey given to a representative sample of the U.S. population about a wide variety of topics, included questions related to mental health. Of those responding to the survey, 14 percent indicated they believed that schizophrenia is caused by bad character.

Almost half, or 48.6 percent, indicated they would be unwilling to work closely on a job with a person with depression – which is all the more remarkable because those folks probably are working closely on the job with someone who has experienced depression.

Even more telling is what happens in the lives of people who have mental illnesses. A number of years ago, we surveyed mental health consumers concerning their experiences of stigma and discrimination, the results of which are described in some detail in “Telling Is Risky Business.” It is noteworthy that the title of this book comes from one of the things that a





mental health consumer wrote. She wrote that “telling is risky business,” meaning that disclosure of the fact that one has a psychiatric disorder or one is in psychiatric treatment risks many negative things.

I have to say that even I, who had been studying this for a long time, was amazed by the variety of manifestations of stigma and discrimination people told us about. Hearing from people about the specific instances of stigma and discrimination they have experienced brought home that experience more than numbers and data.

People told us they encountered fear and avoidance. When people hear that someone has had psychiatric treatment or has a mental illness, one of their first responses is to be frightened – fueled by a media that emphasizes danger and violence among people with mental illnesses from fictional icons like Hannibal “the cannibal” Lecter to the selective news coverage of tragic events involving people with mental illnesses. While the vast majority of people living with psychiatric disorders are neither violent nor dangerous, but good citizens like the rest of us, a person with a psychiatric disorder who commits a serious or violent

crime is far more likely to get in the headlines than if a similar crime is committed by someone without a mental illness. It makes it seem to the public like this is something characteristic of people with mental illnesses, which causes them to fear and avoid people whom they know to have been in psychiatric treatment.

People in our survey told us that those around them seemed to shy away once they found out they had a mental illness. One person described a co-worker who would take a long route around their

desk rather than come close to the person with a mental illness. People told us how, after a hospitalization for depression, neighbors would no longer allow children to play at their houses because they were frightened of what might occur.

I once attended a community hearing preliminary to setting up a group home for people with mental illnesses in the community. I watched as community resident after community resident stood up and said things such as, “I think we shouldn’t have this home in this neighborhood because we have lots of children and elderly people here, and they would not be able to defend themselves well when attacked.” Such is the great fear that people have of those with mental illnesses.

Not surprisingly, people also experienced rejection. When someone goes into a hospital for surgery, people send flowers, stop by and visit, and send get-well cards. When someone gets admitted to a psychiatric hospital, the same thing does not occur. When people leave the hospital after surgery, people stop by their houses and bring them food and good wishes. When people return home from a psychiatric

hospital, they do not get any phone calls. In fact, many people told us that those who used to call and stop by and have lunch on

People turn to us and say, “Have you had your medication today?” as if our opinions and our passions were due only to a mental illness we have.

a regular basis no longer did so. When people return to work after surgery, co-workers say, “It’s good to see you back, how are things, hope you are doing well.” When people return

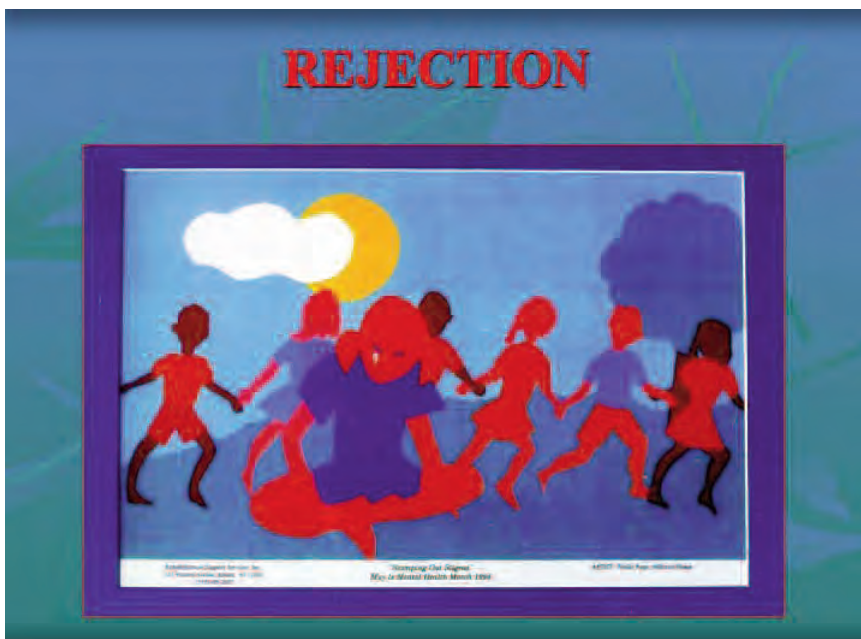
to work after a psychiatric hospitalization, everyone nervously avoids them.

Sometimes rejection is even more severe. People talked about experiencing harassment. One young man in college who had had a psychiatric hospitalization – and apparently others in his dormitory learned about it – reported that every time he got out of an elevator, there was a crowd around who would begin to chant, “Norman, Norman” as in Norman Bates from “Psycho.” And just to remind us of the intensity of the rejection that people with mental illnesses sometimes can experience, I brought an e-mail that was received by a mental health consumer group in Virginia following the Virginia Tech incident. It says, “CNN, ABC, CBS, and Fox News have made it

abundantly clear that the people we should fear the most live right next door to us . . . Mentally ill people are a threat to themselves and everyone else. There should be a law that allows us to haul them all off to American concentration camps so that we can save society from these psycho, lunatic crazies. Then we can all breathe a sigh of relief knowing that violence has finally been eradicated.”

When we spend our time in circles with people who care about those with psychiatric disorders, we sometimes lose touch with how intense the fear and rejection of people with mental illnesses can be. This picture was produced by a mental health consumer for a May Is Mental Health Month campaign in a particular program in New York. Every year they have a contest for people to submit ideas for posters, and this poster captures the experience of stigma. As you see, a person in the foreground sits by herself while other children play in the background, and that person is tearful and sad. That is the isolation experience that occurs as a result of stigma. You have people who perhaps have the greatest need they have ever had for support and understanding who end up experiencing just the opposite: isolation and alienation.

People also told us that they experience ridicule. Seventy-seven percent of our respondents said they had encountered unfavorable media depictions of mental illnesses – in advertising that shows wild-eyed folks in straightjackets with messed-up hair – that provide the public with a false image of people with mental illnesses. They reported experiencing disrespect. Seventy-eight percent heard others say offensive or hurtful things about mental illnesses, using slang and offensive terms for mental illnesses, and talking about



EMPLOYMENT DISCRIMINATION

31% TURNED DOWN FOR A JOB FOR WHICH THEY WERE QUALIFIED



people as their disorders – as schizophrenics, manic depressives, or obsessive compulsives – rather than recognizing that a mental illness is only a small part of what a human being is. They experienced condescension. They said, “People talk down to us as if we are children. When we have ideas, people devalue them, and heaven forbid we should show passion for something and express ourselves in assertive ways. People turn to us and say, “Have you had your medication today?” as if our opinions and our passions were due only to a mental illness we have.

This also is translated into discrimination in housing. All of us have seen headlines like these, “Home for the Mentally Ill Is Opposed: Not in My Backyard,” where people are resistant to having those identified as having a mental illness live in their neighborhoods. Thirty-one percent of the people in our survey reported they had experienced discrimination in housing. Some reported that they had, for example, rented an apartment, begun to have serious mental health difficulties, gone to a hospital, and a month later when they got out of the hospital, found they

had been evicted from their apartments even though they had paid their rent three months in advance.

People also experienced discrimination in employment. Thirty-one percent said they had been turned down for a job for which they were qualified when it was discovered they had a psychiatric treatment history. One man talked about doing an experiment, unintentionally. He was an engineer, had a degree in engineering, had worked as an engineer, and applied for a job after he had completed a psychiatric hospitalization. He wrote in his job application that he had been ill but was now recovered and ready to return to work. He was offered the job contingent on getting a letter from his doctor saying that he was ready to return to work. He got such a letter from his psychiatrist saying that he had been ill – had a psychiatric disorder, had received treatment, and was now recovered and ready to return to work. When the company saw that the letter came from a psychiatrist, the funds for that position dried up, and they told the man they were no longer able to offer him the position. When they did not know that he had a psychiatric illness, he was fine for the job, and when they found out he had a psychiatric illness, the job disappeared.

If you think that 31 percent being turned down for a job is not much (less than a third), the number is that low only because more than 70 percent of the people we talked to said they avoided disclosing their psychiatric history when they applied for a job. They felt that they were forced not to disclose or they would not be compatible for employment.

The cartoon that you see appeared in a Virginia newspaper when the Equal Employment Opportunity Commission

attempted to articulate some of the rules about discrimination related to employment of people with mental illnesses. The newspaper chose to depict the law by saying you would be forced to hire hockey-masked maniacs with hatchets who would endanger your employees. Where, apart from Hollywood films, have you heard about someone with a mental illness and a hockey mask and a hatchet killing somebody? Yet that has become the image used to represent someone with a mental illness of whom you are afraid.

People experience other forms of discrimination as well. There is discrimination in education. Even today, people who disclose on their applications (particularly to higher-level, graduate-level medical schools) that they have had psychiatric treatment in the past are less likely to be admitted – even, I’m sorry to say, to medical schools that train psychiatrists and to graduate schools that train clinical psychologists.

There is legal discrimination. Woe be the person with a mental illness who gets involved in a child custody dispute. It

I have seen in the last five years more efforts to focus on and reduce stigma than I have in the 25 years prior to that.

will be much more difficult for them to retain custody of their children. Some of the people we talked to said that they were discouraged from even reporting crimes against them. People who had been mugged, for example, often were advised by their lawyers not to press charges, because they would not be credible witnesses in a court of law. So people with mental illnesses would be denied basic protections.

There also are a number of subtle things in laws, codes, and procedures that some people have talked about as structural discrimination. There are states in which questions on driver’s license applications

include whether or not you have a psychiatric disorder, where questions on voter registration forms ask whether you have a psychiatric disorder, and for which you may be denied the right to vote or the right to a driver’s license. Passports have similar questions. There were some important cases where people with a history of a psychiatric disorder were not allowed to sit for the law boards. Fortunately, that has been overturned in those states. But there are policies and procedures that we need to take a careful look at to see whether institutions are supporting stigma and discrimination.

And, of course, there is insurance discrimination. People are denied coverage, or they are provided with insufficient coverage. We had people talk to us about how it was necessary for them to budget their mental health treatment so that their insurance did not run out. They would say, “I have to wait until I am really, really sick, because my insurance might run out.” By then, it was much more difficult for them to be treated because their mental health had deteriorated.

All of this also leads to secrecy and worry. Seventy-five percent of the people we talked to said they avoided telling other people that they were consumers of mental health services for fear of the consequences. Even if they did not tell, 56 percent said they worried about how others might respond to them if it were discovered that they had a psychiatric disorder. They live with constant anxiety and worry and a sense of guilty secrecy, a sense of “I can’t tell this because it is shameful or blameworthy.”

I do not want to focus only on that bleak picture. I think it is important to recognize the enormity of the issue; however, I am pleased to say there is a lot going on to try to reduce stigma and discrimination. In fact, I have been working on this for about 30

years, and I would say that I have seen in the last five years more efforts to focus on and reduce stigma than I have in the 25 years prior to that. I am hopeful that things are going to happen.

Among those techniques are public education campaigns, national and international, to educate the public about mental illness, with the belief that the more people know about mental illnesses, the less likely they will be to subscribe to misconceptions about mental illness. For example, the National Alliance on Mental Illness (NAMI) had a campaign a few years ago called the Campaign To End Discrimination, in which they tried to educate numerous segments of the public. (By the way, part of that campaign funded the research I just told you about, surveying mental health consumers about their experiences.) There was a national campaign called the Elimination of Barriers Initiative,

It is important that we train our future mental health professionals to be sensitive to issues of stigma, language, and respect.

which was taken to eight states to try to help those states develop anti-stigma programs. Each state did something a little different, depending upon what resources were available to them and what they felt the most important issues in their

state were. The result was a document called Developing a Stigma Reduction Initiative, which provides guidelines for how someone can set up a stigma reduction initiative in one's own state.

There are things happening on the world level as well. The World Psychiatric Association has the Global Programme Against Stigma and Discrimination Because of Schizophrenia. Although it specifies schizophrenia, it is not just about schizophrenia. It really is about mental illnesses in general. The association has gone to many countries to help set up anti-stigma

programs. The results are contained in the book called Reducing the Stigma of Mental Illness that describes programs in Mexico, Bolivia, Budapest, Spain, Morocco, and a variety of other places. It provides both a guide for how to set up a program – steps, procedures, infrastructure, etc. – and also talks about what each country has done.

Many programs target specific rather than general populations. For example, the National Mental Health Awareness Campaign is another campaign involving a partnership between the American Psychological Association, the National Mental Health Association (now Mental Health America), and MTV targeting adolescents, encouraging them to change [their minds] about mental health. The campaign has public service announcements and teenage speakers who go to schools and other places to talk about experiences with mental illness and encourage people to accept that mental illness occurs even among adolescents and that they should welcome help with it.

The Mpower initiative has tried to get prominent musicians to include discussions of mental health and mental health issues as part of their concerts. The Brain Dance Awards, sponsored by the Institute of Living in Hartford, are given every year through a contest in the school systems in which children are invited to submit essays, artwork, and photography that represent something they have learned about mental illnesses – schizophrenia, in particular. Kids who win the awards and their schools are recognized in a public way as a way to encourage schools and schoolchildren to think and learn about mental health issues.

The Break the Silence Program is a curriculum – three different curricula, actually, for elementary schools, middle



schools, and high schools – about mental illnesses and stigma that was developed by NAMI. It is given to school systems, and teachers deliver this curriculum that includes games, videos, and activities. A Stigma Buster game gives players points for doing things that will reduce stigma, and they lose points for things that might increase stigma. The curriculum has been widely used in New York state, but it is spreading to schools all across the country.

And, of course, there is the National Anti-Stigma Campaign, which also targets youth, and there are campaigns that, wisely, target future mental health professionals. Unfortunately, we learned in our survey of mental health consumers that many of the things they expressed concerns about came from mental health professionals. Disparaging language, condescension, and devaluing were things they experienced at

the hands of mental health professionals. So it is important that we train our future mental health professionals to be sensitive to issues of stigma, language, and respect. Ken Duckworth, who is a psychiatrist, has developed a training module, the centerpiece of which is a video, “The Stigma of Mental Illness.” Viewing the video is followed by discussion, including a pre- and post-test. It is available, I think, at minimal or no cost.

There are also media watch programs, programs that monitor the media and respond to reduce the number of stigmatizing portrayals. And there are programs that work with and within the mass media to improve the depiction of mental illnesses. For example, Lichtenstein Creative Media has produced a number of radio shows that involve mental health consumers talking about their experiences. There are films

being produced, such as “People Say I’m Crazy,” a film directed and produced about John Cadigan, a young artist with schizophrenia. His sister, Katie Cadigan, is a more experienced film producer, but John was largely responsible for the film.

There is the Workman Theater Project that supports plays about and by people with mental illnesses. The Entertainment Industries Council involves both well-known producers and directors in Hollywood as well as mental health advocates, and they have developed guidelines for people in the Hollywood industry to learn how to better depict people with mental illnesses. And, of course, there are the Rosalynn Carter Fellowships for Mental Health Journalism that help journalists to do a better job in covering mental health.

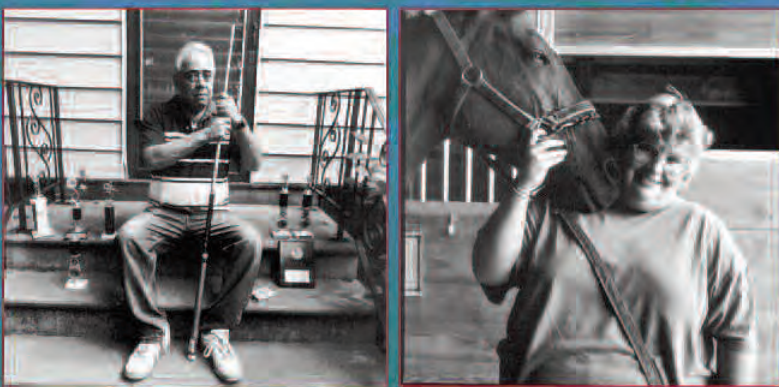
I also want to mention things individuals can do. It is one thing to rely on organizations; it is another to do something yourself. As individuals, we need to avoid contributing to stigma. We need to watch our own language and behavior. Like many other forms of prejudice and discrimination, we all hold some. As much as we may feel

enlightened, there are things we do that forward stigma. We need to take a careful look within ourselves and avoid, in our language and behavior, contributing to stigma.

We need to raise our expectations about recovery. We need to recognize that it is not 50 years ago, when people with mental illnesses were not recovering and becoming productive members of society. Now they are. We need to increase consumer involvement. We need to learn from people with mental illnesses about their perspectives and experiences. They will help us be more sensitive. They will have more ideas for us as to how we can reduce stigma. We need to speak out against stigma. When we hear people saying or doing stigmatizing things, we need to say something in tactful and appropriate ways. We need to write to people. We need to talk to people about our concerns about stigma. And we need to contribute to those organizations that challenge stigma either with our time or with our funds.

Finally, there is one important thing that encompasses all of this. In our survey of mental health consumers, we asked people, “If there were one thing you could tell people, what would it be?” Although the ideas varied a bit, they all centered around one theme: Treat mental health consumers with dignity and respect. If we can accomplish that and get the rest of the public to accomplish that, we will have done a great deal to reduce stigma.

Treat mental health consumers with dignity and respect!



Anti-Stigma Campaign Materials

Deborah Leiter

Vice President and Campaign Director for the Ad Council's Health Campaigns

The Ad Council was founded in 1942 as the War Advertising Council, and you may be familiar with some of our messages like “Loose Lips Sink Ships” and “Rosy the Riveter.” Those campaigns used communications and advertising to get a social message out there, and when the war ended, it was clear to everybody that advertising was a great vehicle to spread social messages; it was not just a good vehicle for selling a product. Thus, the Advertising Council was born. Today we focus our campaigns on the most important public issues of the day, including mental health. We want to stimulate action on those issues through communications programs beyond traditional advertising and make a measurable difference in our society. We do not just send out these campaigns and hope that they run and make a difference. We hold ourselves accountable and track them and measure the results that we get. We, ourselves, are a nonprofit organization, and we partner with other nonprofit and government agencies such as SAMHSA to sponsor campaigns. Then we rely on industry partners, the ad industry, and media companies to donate time and services. The ad agencies that we work with donate their time pro bono, to the tune of about \$200,000 or more in services, and then the media donate the air time. In every Ad Council campaign that runs, not a penny is spent on media. We do truly integrative campaigns. It’s not about a 30-second commercial; it’s about how we can reach people through public relations, through podcasting. We want to make sure people can get their messages anywhere they are.

In 2006, almost \$2 million was donated in media on behalf of our approximately 50 campaigns.

We have secured that media through a number of approaches. First, popular media companies such as Clear Channel or Time Warner commit to a dollar amount (such as \$40 million or \$100 million) up front in support of Ad Council campaigns. It is a top-down approach. The other approach is through community outreach. We have 10 regional directors, including one based in Atlanta, who knock on the doors of public service announcement (PSA) directors to explain the importance of our issues and get the directors to run them.

The National Anti-Stigma Campaign has been in development for the past two years. The most important thing to do is figure out what you want to say, because the issue of mental health is so broad, and we begin with a 30-second commercial. Do you want to create awareness of the issue? Do you want to educate the public about something? Are you changing attitudes? Do you want to instill a direct behavior? It is important to get a sense of what is going on around the issue in order to define our objectives.

Today, 21.4 million Americans are suffering from a serious psychological disorder. Other statistics say that one in four people will experience a mental health issue in their lives, and if you compare that to other diseases, you see just how much more common mental illnesses are than the other diseases that get so much more attention.



Prevalence among younger adults is so much higher than the 26- to 49-year-olds, and the rate of self-help-seeking behavior among that group is the lowest. That was the crux of the problem and a true opportunity. We also learned that peer social support networks have been declining over the past 20 years. One in four people has no clear confidant, and having somebody who you can turn to relates strongly to mental health.

These thoughts culminated in a PSA among 18- to 24-year-old consumers that targets their friends and peers. We did not target consumers directly. We targeted their peers – to make sure they understand how important their role is in recovery. There are two benefits to this approach. First, it addresses stigma by giving the peer a role in the issue of mental health, and it helps the consumers by giving them the support they need to seek help or to recover. It is telling that only a quarter of people believe that a person with a mental illness can recover. When you understand just how high the recovery rates are, the fact that only 25 percent of people believe that is astonishing.

To create the ad, we asked respondents to cut clippings from magazines to review thoughts about mental illnesses and pictures that demonstrated their feelings. On the positive side is compassion, which shows that people have this true sense of goodness in them, and they want to help people with a mental illness. They just do not know how.

[Mental health] is not an issue that people think about all the time unless they are forced to deal with it. We want to give them the tools to do the right thing when they are forced to deal with it – to do the thing they know they should be doing even though they may be uncomfortable because of fear, uncertainty, or doubt. Certainly, there is fear of unpredictability and violence, and there is lack of knowledge.

Our campaign objective is to inspire 18- to 24-year-olds to step up and support friends they know are experiencing a mental health problem. It is not a diagnosis campaign. It is not, again, targeting consumers to get them help. It is getting friends to be the friends they want to be. It is that moment in time they are defining who they are, and we want

to give them the sense of pride to be that friend. So the message is, "Be the first step in a friend's recovery."

We have a number of traditional elements, including TV, print, radio, outdoor, Web banners, and the host of traditional media. At the same time, we are seeking out more unique opportunities that get to our target audience, such as podcasting, text messaging, or blogging. Also, we are on You-Tube and My Space, which are affordable and are where our target is.

The Web site www.whatadifference.org is a terrific resource that includes a video that shows role modeling. I liken it to the choose-your-own-adventure books that I grew up with. It teaches the user the appropriate and supportive thing to do. The site also includes a host of information on the facts about mental illnesses.

A quick overview of our results: We launched very successfully on Dec. 4, 2006, at the National Press Club. We received about \$2 million in public relations support, including articles in USA Today and on MSNBC.com. We sent packages to local outlets and did 110 interviews and airings, reaching 8 million people.

We have gotten support from industry leaders to run our campaigns from the United Association of Broadcasters and the Radio Advertising Bureau. We're looking into a college campus

outreach program. Our online and outdoor print materials will be distributed [in June 2007], Spanish TV and radio are being launched with Univision [in May 2007], and the community toolkits have been produced.

Your role is to put a face on the issue. I do not think that PSA directors have a full understanding of the prevalence and impact of mental illnesses and stigma. They are not issues such as obesity that are in the news every day. It is up to individuals to show PSA directors how important this issue is and why they need to run it. Our hope is that we can harness the interest in this issue from the Virginia Tech tragedy and that something positive can come out of this. Our fear at the Ad Council, shared by you, is that stigma will be perpetuated because of the violence, but on the flip side, there is more attention on the issue showing the need for support and for proper mental health services. Secondly, the 18- to 25-year-old viewers and consumers who are on these campuses are going to want to learn the facts, and they are going to be interested in learning about this issue. We would like to harness that interest and harness this moment in time.

To see video or hear audio ads, visit www.adcouncil.org. Click on Health and Safety; National Mental Health Anti-Stigma. Also see video and learn more at www.whatadifference.org.



'jumping off bridges'

The film "jumping off bridges," written and directed by Kat Candler and produced by Candler and others, is the subject of the following panel discussion and question-and-answer section. The film follows a carefree, adventurous group of four best friends deep in the trenches of adolescence. It is a story about the struggle of grief, about friendship, and about strength and finding hope. For more information, visit www.jumpingoffbridges.com. Click on "Press" to see scenes from the movie.

PANEL I: DISCUSSION OF ‘JUMPING OFF BRIDGES’

Deborah Leiter

Vice President and Campaign Director, Ad Council

I was struck by how similar the messaging in the film is to the PSA campaign we developed. And they were developed in complete isolation. It is amazing to see how tapping into a true human insight

transcends the media you are in. To me, that is the power of communications: taking an idea and getting it out in messaging in a number of ways.

Emily McKee

Intern

Mental Health Program, The Carter Center

I have particular interest in this film because I suffer from obsessive compulsive disorder (OCD) and depression. I have [suffered] my whole life, and I was diagnosed in seventh grade.

I can feel from the movie the pain that Zach, the main character, went through. There were times when I would stay in my room or avoid going outside for weeks to avoid contact with people. It was physically painful. I think stigma is such a part of that suffering that many people with mental illnesses go through. I never told anyone except my mom, because I was afraid of what people would think. I was ashamed, and I did not feel I could confide in anyone, basically because of the stigma. I did not know what to expect of my friends. I did not know what they would think. I did not even know if they knew what OCD was, which most of them did not. And it manifested itself in other ways in my life. When I would get a massage and would be asked, “What kind of medications are you on?” I was

reluctant to say that I was on an anti-depressant. I was scared of what my massage therapist might think, which was not what I should have been considering. When I would go to the pharmacy and pick up my medications, I was concerned with what the pharmacist would think. When I would announce to friends or co-workers that I was going to a doctor’s appointment, and they would say, “Is everything OK?,” I did not know how to respond. You commonly do not say, “I am going to my psychiatrist.” It is not like you have diabetes and are going to get your blood levels checked. It is a different kind of response that people give.

I think people in my generation are much more tolerant in many ways. I feel like there is room for improvement with stigma, and I hope that things like the Ad Council campaign and the SAMHSA initiative and other initiatives will help educate people. I think education is so important. Jokes about mental illnesses are funny because people fear it and do not know what to make of it.

Leslie Langee
Associate Producer/Actress, Storie Productions

I started this project as an actress. I knew a little, but not a lot, about the film. At the first full reading of the script, all the actors gathered, and that really was when I read the script through. It struck me at that time – in a very personal way, not just as an actress – because when I was in high school, a brother of one of my good friends had committed suicide. At that first script reading, I tried very hard not to tear up,

because I can relate so well to the kids in the film, their characters, and what they were going through. It felt like it was me. My dad was a psychiatrist, and I thought I knew a lot about mental health issues. I joined the production team because I thought this was a great way to promote these topics. The film itself snowballed and developed its own path and ended up being drawn into the mental health community.

Kat Candler
Writer/Director, Storie Productions

I never intended for this film to take the path it has taken. It was just a simple story about friendship and this group of kids, that sort of youthful innocence and how something so tragic can shake their world, and how grief affects all of us in such completely different, strange, and upsetting ways. When we started screening the film, I thought it was going to be embraced by the film community and the film critics, but those were not the people coming up to us after the screenings. The people talking to us were counselors, therapists, and others who had been affected by suicide or mental

illnesses. That is when we realized that the film was telling us what it is and where it needed to go and the people who were going to take it there.

It has been a truly life-changing experience for us and for so many of the people involved in the film. One of the teenagers in the film, on her own with another friend of hers, started making PSAs for suicide prevention and is going to a conference in Austin [in June 2007]. That speaks volumes to me. I am thankful for all that you are doing because we just make movies; you go out and talk to the people and make change.

QUESTIONS AND ANSWERS

- Q:** The power of symbolism in this movie struck me. What was, for you, the most powerful symbol that was yours and that you wanted to leave with those who saw this film?
- A:** Kat Candler: I was working on the script a long time ago, and I would take long walks to try and figure out the different layers to it. I remember walking in my neighborhood and seeing a father trying to repair the roof of his house. And I thought about trying to fix everything and trying to be the strength for a family when things are crumbling beneath you and falling apart. And I thought about not having to do it alone – not having to be the one who always puts things together – and being the complete, absolute strength of something, but relying on friends and family to join forces and be a strength beyond ourselves. That is what I think you are doing. We hope that this film will help us join forces with other people and bring a voice to something that has been so quiet and so repressed for such a long time, sadly.
- Q:** What inspired you to make the film?
- A:** Kat Candler: I had a group of friends from high school who had an incredible bond. When you are in high school and you are a teenager, you have friends who are your everything, and you spend every waking moment with them. They are like your limbs; they are a part of who you are. I was interested in the tragedy and how it affected that group and that cord – the ripple effect of something and how far-reaching it is and how it goes beyond the core group of friends – how it affects the teachers, the other students, the family members, the friends, the girlfriends, the mothers, the siblings. It is so widespread. So the friendship idea is a play on my friends from high school, and, yes, I continue to maintain those relationships and love those guys with all my heart.
- Q:** What single, perceptual, or tangible focus about mental illnesses can we give to our legislators or the public to begin to improve our mental health system? How can we get others to realize that education materials are out there? How do we change people so that they will begin to understand?
- A:** Deborah Leiter: Many of our Ad Council campaigns serve as the beginning of a movement. Think about our drunk driving campaign, “Friends Don’t Let Friends Drive Drunk.” When that campaign began, it was socially acceptable to “have one for the road,” and now that is just not done. That came out of years of staying the course with the same message and getting advocacy behind that in order to change laws. What the Ad Council does not do is lobby or legislate change, but we change the thinking of Americans and put issues on people’s radar screens so they can influence legislation. Legislators want to do what their constituents want them to do.
- A:** Emily McKee: I have worked on Capitol Hill and at the Texas Capitol as well. They are two very different beasts, but I feel that if you really lobby your congressperson – if you go up there and ask to speak to your representative or senator at the state level or in D.C. and keep hounding them, send letters, call, ask how they are voting on an issue – it eventually gets in. It penetrates the surface, and then they figure out that people really do care about this, and they actually do need to pay attention. Say that you will be watching closely to see how they do. I encourage everyone to be persistent.
- Q:** I was profoundly moved by the writing of the film and what I felt was really flawless dialogue. Your ability to have a perspective on the father’s struggle as well as the son’s, Zach’s struggle was really moving to me. How were you able to be so insightful? As a writer, where were you?

A: Kat Candler: The film does have situations that were in my life. There are situations that I have had or tragedies that I have had to deal with that were not necessarily accurate in the film. I think all of us have gone through something huge that has rocked our world and rocked the world of all the people who are close to us. So it really did not matter whether it was suicide or what exactly it was that shook who family. It was the fact that something so tragic and so awful would happen and how they dealt with it. How do people go about their days dealing with the blame of something that they have carried with them, no matter what it was? We all deal with grief in such strange ways. For me, it was a matter of looking around and seeing how my friends dealt with the loss of a loved one or how my husband deals with whatever he is going through. It was opening my eyes and listening to people and watching our everyday struggles, because it is every day and all of us. We are all going through something. It was me listening and watching and taking it in and trying to be as respectful and honest and accurate as I could, because the last thing I wanted to do was screen the film and have people say, "People don't do that." I wanted to show something that people related to and could be affected by and that people knew that people experienced.

A: Leslie Langee: People have related to different characters and experiences and have come up to us and said, "Thank you for making an honest film about this. Thank you for not putting the Hollywood spin on it that is always the glorified version of something bad." We have had a very honest response to it.

A: Kat Candler: The film is full of pieces from my life, from other people's lives, from things I have seen or heard. It is just all of us.

Q: What is your next project? What can you do to top what you have already achieved?

A: Kat Candler: I am working on a comedy. I am hoping to start a family soon. I got married about a year ago, and I have focused on family comedies because when I have kids, I want to take them to films that I am proud of and that they can relate to. It is a backward reality film about a group of junior high students who go to a school where all of the nerds and geeks are the superpopular, worshipped elite, and the academic competition team called Brain Brawl (which is an actual Florida competition team) are like football stars; they are worshipped. It is about kids embracing their intelligence and realizing that being smart is cool.

Q: Has the film been shown in high schools or other places?

A: Kat Candler: We have kind of run the gamut now, and we have had screenings in a community on a Native American reservation last fall. We have screened at a number of universities and in different community centers, and a lot of suicide prevention groups have used it for suicide prevention week. We have developed a study guide to go with the film, because we would love for it to be used as a tool to open conversation.

PANEL II: YOUTH AND ADULT PEER SUPPORT PROGRAMS

Thomas Bornemann

Director, The Carter Center Mental Health Program

The work that has been pioneered so well here in Georgia and is penetrating around the country around peer and family supports serves as a bridge between what we think of as the formal mental health system, which are programs and institutions and service delivery and provider groups. But they are only part of the system. We often forget that people live the rest of their lives elsewhere. What are those natural supports that exist around all of us: our families, friends, and communities? One of our colleagues asked if we could remind you that the Georgia Department of Human Resources' Division of Mental Health and Division of Aging

Services, along with the Fuqua Center for Late-Life Depression, have launched a new peer support program for older adults with mental illnesses. The first older adult peer support training took place in February 2007. Fifteen volunteers from around the state completed the three-day training. These peer support specialists were providing services to people in the Community Care Services Provider Program. The Community Care Services Provider Program provides medically frail older adults an alternative to nursing home placement. That is an exciting new program.

Youth Peer Support Programs

Barbara Sample

Director, Family Support Network

I was one of the first family support networks in the country 25 years ago. At that time, my son was beginning his recovery from a serious time of depression. I was teaching in the university system, and I was appalled at the difference in how we were treated as parents. When we worked with his cardiologist earlier, we were partnered. That cardiologist has become a good friend of my husband and me. When my son became depressed (because he thought he would be in the NBA but his chances did not look good because of his heart problems), we went to a psychiatrist.

On the first visit, the psychiatrist called my husband and me the "unidentified patients." We were somehow responsible because my son was so depressed that he would not make the NBA.

We started Family Support Network, and I would like to use a metaphor for you for what our experience is with working with families. Think of a baseball team. The team is the professional community who are out there to help families and children. The system is the pitcher. The kid or parent comes up to bat. In the field, we have medicine and residential treatment and

hospitalization. All those players are in the field, although I must say, recently the number of players is shrinking for services for kids. Nonetheless, a child or his family comes up to bat. The first strike is that he has a mental illness. The second strike we see is stigma. There is nobody there that wants to be on his or the family's team. And the third strike, which I think is prevalent in our community, is poverty. You really are in trouble if you are poor.

Sometimes kids get walks, they get on base, they get services, but very often they are sent back to the dugout. They struck out. It is not until they become seriously ill that they can get onto the field and really begin to experience baseball mental health. I think that the family, if that child does get on base, is sent away. They are not needed anymore. Our experience, and the

experience of many of the families with whom I work, is that those very people who are not needed anymore when the professionals take over are the people to whom that child is returned, and then when they do not have the support systems they need to maintain their children safely at home, they, again, are blamed. I want to change that.

Why not quit playing major league baseball? Why don't we – all of us, the team on the field, the families – why don't we play T-ball and use those natural supports that families need? Let's have people up there doing pitches 2 inches from the tee. Let's put the ball on the tee. We can do that. Those are natural supports that are there to make a family a part of the solution rather than the reason or the blamed cause of a child's mental illness.

Sara Johnson
Youth Advisory Council, Kidsnet

I recently started out in advocacy, and I already have three strikes against me. I am only 17 years old. I have bipolar disorder, and I also have attention deficit/hyperactivity disorder. In the world, I am condemned to sitting back and watching other people advocate for me. When I was 15, I was diagnosed with bipolar, and I decided I was not going to sit back and watch other people do my work for me. If you are capable of doing something, that is an important step, because not only are people hearing people with bipolar or depression or schizophrenia, they are seeing them do something. And by seeing, they can say, "Maybe they are worth my time. Maybe this is worth funding." You build up that support. Also, people who have bipolar, depression, or schizophrenia that are not

doing it see that they are capable of doing it. They live by example, and that, I think, is one of the most important things. It is not just the stigma that keeps us back. That is a big part of it. But it is also the "can't do" attitude we've heard a million times. When you do not believe you can do something, you cannot. By seeing other people do it, it becomes a possibility. You can become capable of doing it; not always, but a good percent of the time.

It seems ridiculous to me that, once we are diagnosed with whatever the array of medical or mental disabilities, we resign ourselves to the sidelines; we just sit back and say, "Somebody will do it for me." That is not true. I did not start getting actual care until I found my support team through the

Gwinnett-Rockdale-Newton Community Service Board , and there the person I worked closely with, Amanda, pushed me to start doing things on my own. So I started doing conferences and speaking for myself, and people are actually listening to me! You start talking and people eventually listen. Either that, or they will tune you out, but often they listen.

Barbara Sample: One of the things I have told Sara – because it certainly has been our experience, and I know it will be hers – is that my son who wanted to play for the NBA has been a producer for all NBA games for a number of years. He is in the NBA, and all those other people were wrong, and he proved to us that he could do it. She will too!

Adult Peer Support Programs

Larry Fricks

Director, Appalachian Consulting Group

Beliefs are hard to change. In peer support training, we help consumers understand what creates beliefs, how hard they are to change, and how to try to change them. A peer work force attacks stigma right at its heart. I want to give credit to the consumers of Georgia who, starting 16 years ago, voted employment their top priority and kept pushing the state. Usually, in a social setting in the Western culture, the first thing you say is your name, and the next thing somebody wants to know is what you do. Out of that leadership, when we had the chance to be the first state in the country to bill Medicaid for peer support, it was leadership that stepped forward and said, “This is another way, another career opportunity.” It is a unique career opportunity to attack stigma, because one of the things that happens is that our culture respects people who are caregivers, who support other people. We have moved from the role of someone who has always been helped to someone who is helping someone else self-direct his or her own recovery and

be successful at getting a meaningful life in the community. That is one of the powerful pieces of this.

The Atlanta Journal-Constitution did a story on how race relations had improved in the South. What I remember from that story was that in some places, relations had not improved, but there was one place that race relations absolutely improved, and that was when people worked alongside each other. There were a tremendous sharing and a different opportunity to relate to each other in such a way that people’s beliefs changed, and you had some real improvements in stigma and beliefs.

Now we are being seen as competent. To be a peer support specialist, you have to pass and demonstrate a set of competencies. I can assure you that in the mid-1980s and with my three hospitalizations, no one was seeing me as competent. In fact, when the deputy sheriff from the Appalachian Mountains was driving me to the hospital, and he could not find the hospital, he would not let me tell



cars. Driven like the rest of society – by debt! Is that not great?

I have a window into what I think is going to happen with the peer movement. Now, Michigan is no different from Georgia. They are cutting Medicaid 6 percent this year. The advocates are all railing at the Legislature.

him how to get there! We probably wasted an hour and a half because he would not listen to me.

I think that at the core of stigma is a person's belief that our thought process is so broken that we cannot be trusted. I think that is part of what we saw going on at Virginia Tech – that we are a group of people who can never be trusted. We do not have strengths or insights. And what a waste! The whole peer movement is blowing up those disbeliefs. And it gets us out of poverty. I will never forget the doctor saying, "You know, Larry, this bipolar thing is pretty serious, and you may not be able to work." He kept talking about stress. Well, let me ask you something. Have you ever tried poverty for stress? That will shake you at your roots when you cannot have any choice because you do not have any money and are locked down economically. It has given people a chance to buy homes, buy

The state office has cut all travel. It is the same thing in a number of states. Because of the cut in human services federally, everybody is struggling. But I will say they have a great waiver called a 1915 B-3 waiver. We have been able to experiment with this peer work force and try things that are not done in any other state.

The waiver focuses on people and their planning. It focuses on natural supports in the community, and it focuses on self determination. So, the peer work force is able to do person-centered planning, and then, literally, you can get control of your money in Michigan through a fiscal intermediary. When money goes straight to the consumer to control, consumers are choosing peer specialists instead of professionals for their services. Almost all of them have decided that they did not want more time with the doctor. They wanted a great person-centered

plan that was about a quality life in the community and a peer to help them achieve that. I foresee that as being huge.

Another thing coming down the pike that is going to be huge for the peer movement is the Open Minds report that came out in October 2006 about us dying 25 years prematurely because of “metabolic factors.” This is an opportunity for us to start looking at recovery more holistically.

We have some new best friends: Ben Druss, M.D.; Greg Fricchione, M.D.; and a cardiologist named Herbert Benson, M.D. What do those men have in common? Dr. Druss has received a National Institute of Mental Health grant to study peer-led health self-management, and we are already seeing outcomes from that. In other words, based on Kate Lorig’s study from Stanford, we are looking at peers learning how to help peers change their health habits. Dr. Fricchione is now at Massachusetts General Hospital and is the new director of the

Benson-Henry Institute for Mind Body Medicine. That was at Harvard, and they’ve just moved to Mass General. Dr. Benson is 72 years old, and he’s famous for a book that went to number one in the country: “Relaxation Response” (1975).

Dr. Bornemann used to use relaxation response in his practice. They have decided that the peer work force is perfect to train in the relaxation response, which counters the “flight or fight” response and all the things that get released into your bloodstream. Stuff like glucose gets released, which is sugar, and it bombs your insulin system. All of these things are leading to or contributing to type 2 diabetes. Their data shows that the relaxation response can counter that almost immediately. So we are now changing our training modules nationally, and Georgia will be the first state in which we introduce this work from Harvard. We also will be looking at diet and exercise.

Bob Patterson
Certified Peer Support Specialist

In my experience working as a certified peer specialist, I have found that many consumers with whom I work sometimes are not aware that they are stigmatized or that they are perpetrating their own stigma. When a consumer says something like, “I am schizophrenic,” or when a person says, “I suffer with,” they are self-stigmatizing themselves. It is one of my personal soap boxes to get them to transform how they express this and to say, “I am a person living with a diagnosis of mental illness,” to say, “I am a person who has experienced suffering due to a mental illness,” rather than quantifying it in such terms.

I was working with a young man, and we were discussing a problem he was having. I was trying to get him to talk and discover some of the steps he could take toward solving this problem. He looked at me and said, “Bob, you have to understand; I have a mental illness.” And I looked at him and said, “You have to understand; I am a person living with a diagnosis of a mental illness, too, and I do not use it as an excuse to keep from doing what I need to do.” He said, “Is that what I am doing? You are right. That is what I am doing.”

I was a temporary receptionist at the Community Service Board (CSB) in Georgia, and [in May 2007], I was invited to the peer support graduation at a CSB. Ten of the consumers I knew were graduating. I had been the person who took their co-payments and made their appointments. After they had finished a large part of the program, Doris Mims and Audrey Brown introduced me and asked me if I would like to speak. I looked at the group and said, “I see many faces I recognize. I see many faces that are dear to me. You know me mostly as the funny, smart-aleck guy behind the counter who took your copayments and made your appointments or who listened to you. Afterwards several of them came up and said, “I had no idea you were one of our peers, that you were somebody with a mental illness.” I said, “I am somebody living with a diagnosis of a mental illness.”

Recently my father passed away, and I went home to West Virginia for the funeral. I saw my aunts and uncles, my father’s brothers and sisters, for the first time in many years. They said, “Are you still doing plays? Are you still doing that theater stuff?” I said, “No, I am doing something different now. I

am the project director for the Georgia Certified Peer Specialist Project.” And they said, “What is that?” My uncle said, “‘Peer specialist’? You mean you help build docks?” I said, “No, Uncle Eugene,” and I explained to them what I did. My two aunts were nodding, and my Uncle Gene was sitting back and looking at me. I said, “What’s the matter, Uncle Gene?” He said, “You mean you have to have recovered from a mental illness to be one of these?” I said, “Are you implying that I have not recovered?”

One of the most important things I find when I am working in the field is the ability to instill hope by being an example – the ability to tell your recovery story to someone who is in deep despair and hopelessness, and when you are finished, to suddenly see a light break over their face. These have been some of the most meaningful moments of my life. Becoming a peer specialist and helping people transform their own lives and live the lives they wish in the communities of their choosing have been absolute life-changing experiences for me. I would not change a second of the path that it took to get me here.



QUESTIONS AND ANSWERS

Thomas Bornemann: The main message that I take from all of you is one of empowerment: taking charge of your life. How do we begin to translate that to the big audience where stigma lives or maybe more narrowly to a professional audience where stigma does live, unfortunately?

Sara Johnson: I think it starts with understanding that we are capable. We are not “stupid,” I guess is the best word for that. Because of what we have been through, we are more passionate about it, we have more at stake, and it is a force to be reckoned with when someone with a mental illness decides “I am going to do something.” The first thing you have to understand is that we can do it.

Barbara Sample: I think we have to recognize that none of us lives in a vacuum and as we live in a community, we need the community to support us. What we saw in the movie, what the Ad Council’s ads demonstrate, and what our life experience is show us that if the people surrounding us support us, we can do anything. Each of us has to choose to support the person sitting across from us, behind us, or near us when we realize that there is a mental illness either in that particular individual’s life or in the life of one of their family members. I think we often focus on the patient and forget that there is a family, and we must remember to reach out to the whole community in which anyone with a mental illness lives.

Larry Fricks: I would concur with Bob [Patterson] that if you were to say, “Larry, we are going to take away your bipolar illness, your hospitalizations, the loss of your first wife, your bankruptcy, your suicide attempts,” I would say, “This journey has brought me to a place.” I often use a quote from Dr. King that we are all woven into a mutual garment of destiny. I am not all I can be until you are all you can be. And you are not all you can be until I am all I can be. I think he was giving us a blueprint for a community that I want to live in. Unfortunately, before I went through what I went through, I was headed toward a different community. It was more about, “I am going to get mine, and I will see you down the road.” In some ways, this whole movement of mutuality and supporting each other is a blueprint for a healthy community that we need to grow quickly.

Bob Patterson: I am back on my language soap box again. I have become extremely sensitized to the word “crazy.” If I see an ad for a business saying, “These prices are so low they are crazy,” I will not shop there. If I ask someone how their day is going, and they say, “Oh, gosh, my day has been so crazy,” I say, “Your day has been diagnosed with a mental illness?” I probably would say the biggest weapon in my arsenal, fortunately, or in some cases, unfortunately, is humor, and I try to find ways to use humor to defuse stigma.

Q: I have a question about the holistic peer-led health self-management project that I think you [Larry Fricks] said you are trying to get in Georgia. I have been working as a peer specialist for about seven years in the field for a CSB, and I see a lot of different types of physical health problems. One of the problems that I hope the peer specialist can help address is smoking. Anyone who has worked in the field knows there is a high level of smokers; I have heard 88 percent. My heart breaks when I walk out into the smoking area and see tons of the people with mental illnesses smoking.

A: Larry Fricks: When Kate Lorig came to Emory, she said, “You have to get in touch with what the person is passionate about starting with.” That is very similar to what we say about strength-based recovery: You start where the person is and with what they want to change in their life, and then the peer is trained to bring oxygen to that as quickly as possible.

Yes, smoking is huge. I saw a statistic that 44.3 percent of all cigarettes are smoked by people in recovery from a mental illness. But if we listen to Lorig, in some 400 sites around the world, she says you get in touch with what the person wants to change, and then the peers support that quickly. You do not say, “You have to stop smoking.” You start out with something small like walking two blocks, and then build from there. Then, of course, you have the investment in Mary Ellen Copeland’s Wellness Recovery Action Plan, which it fits nicely with too. I am hopeful that peer-led health self management is going to start with the person’s passion and use the same principles that we have learned in self-directed recovery: that you bring oxygen to what that person wants to change in their life. (By the way, we are going to introduce the training in three states – Iowa, Michigan, and Georgia – in the summer of 2007.)

Q: I am a certified peer specialist, and I have wondered if trauma is going to be brought into this program. I see in my peers a number of problems with trauma, and that is not a part of our training. That is not a part of what we can do now, and I feel they are not able to recover because of trauma.

A: Larry Fricks: Trauma has impacted so many people in the mental health system and the public system. I have heard numbers of well over 50 percent. When someone is a trauma survivor, you shouldn’t be saying, “What’s wrong with you?” You should be saying, “What happened to you?” You address it from that perspective.

Q: I understand that our services are covered by Medicaid, but what about the people who have Medicare? Can we bill for Medicare services? Is that being addressed?

A: Larry Fricks: We have a former assistant surgeon general of the United States, Dr. Bornemann, at the table, and he probably knows more about Medicare than I do. But the history has been that Medicaid has been the primary funder for us.

Q: And Medicare still does not have parity. Why does Medicare not have parity? Medicaid drives the public mental health system. I think that is a public policy hole in the safety net at which people ought to take a hard look.

Comment: And it is not being addressed as yet.

Thomas Bornemann: It is being addressed. There are a number of groups that have gone after it. It just has not been addressed successfully yet.

Q: Is there an organization we should know about that we could support?

Thomas Bornemann: I think all of the major national organizations have it somewhere on their radar. So whatever organizations you belong to, make sure they get it a little higher on their radar. Certainly now with an aging demographic, it is going to have increased importance. There will be many reasons for increased political impetus. We have an election coming up. I think Medicare and Medicaid are going to be back on the table again politically. So, first and foremost, watch your gains, because they could get lost. But, secondly, look at those holes in the system that do exist such as the problem we have with Medicare.

Q: I am thinking of going through the certification training, and I am teaching classes because I have some knowledge. But I am seeing that we cannot take someone in our car, cannot take them to a meeting, pick them up, or take them grocery shopping because they are too afraid to get out of their home. Are we getting away from actual peers helping peers at the level they are at to bring them up to a higher level?

A: Larry Fricks: The medical necessity part of Medicaid creates a real challenge. That is my point about Michigan. By having the 1915 B-3 waiver (and it is managed care), they are able to do almost anything they want. Ultimately, peers are going to be able to hang their own shingle, and a person can contact the peer directly and not have to run through a mental health center. I hate to say it, but that is going to have a huge impact when you change financing that fundamentally.

I have run into a psychiatrist I just love. His name is Dr. Mark Reagan, and he is at the Village in Los Angeles. He and I have co-presented at national events recently. He said he had to tear up everything he learned in medical school. He said helping motivate somebody to recovery requires relationships. You cannot put in a distance barrier. The Village is probably the most famous psycho-social rehab program in the country. Proposition 63, with \$1 billion coming in, has to go to programs like the Village that Mark Reagan and Richard VanHorn started.

Q: Could you tell us more about the youth peer support model? Is it based on the adult model, and who trains the youth?

A: Barbara Sample: In our program, we train the youth. We have a psychologist who works with us in the development of the training, but the youth end up training. Initially, we trained family members who are part of our network, but the psychologist was concerned that we were (I think he used Bob [Patterson's] favorite word) "crazy." He was concerned about what we might say or do and that we might have pejoratives said in the group about providers. Now he has become one of our advocates and insists that every peer, every child in his entire practice, gets a peer support person, a youth support person. Now the youth are training. There are 21 at this point. I had the privilege of hiring one of the youth to become one of our parent advocates. It has been an extraordinary experience.

Comment: I am the president of our local youth organization, and we decided that we did not need the adults anymore – that we have learned from them and from our own experiences. It starts with the adults, and it takes adults with forward thinking, believing that you can do something. But we do believe that eventually youth should take over the youth organization.

Bob Patterson: I am part of a pilot program set up by the state to work with the hardest of the hard. We work with the top, say 100, people who are in and out of Georgia Regional the most. Most of the people do not have private insurance. Many of them are homeless. It has amazed me what we have been able to do with case management and certified peer specialist day treatment. The people that everybody said could not move forward are moving forward every day. The gains are just phenomenal.

Barbara Sample: Our state did a case audit because we were getting state monies. I was terrified, because after we were no longer involved with a family for five years, they went back and looked through their records to see whether those families appeared in any residential treatment program or hospitalization. Eighty-three percent of those families had not reappeared. It works.

Town Hall

Cynthia Wainscott, *Moderator*
Board Member, Mental Health America

I would like to begin with two words that floated to the surface in the group I was in: “normalization” and “confronting discrimination.” If we do those two things, we will move forward.

Two things going on nationally fit in the “normalization” category. They are both with an organization that I have worked with for many years: Mental Health America. You may know it as the National Mental Health Association. One of the initiatives is called Real Lives. You have an opportunity to be part of this and to encourage people to be part of it. If you go to the Web site, www.mentalhealthamerica.net, you can tell your story. The more people we get to do that, the more normalized having mental illnesses will be.

The second initiative at the national level and Mental Health America is Mpower, Musician’s Power and Mental Health Power. It has been a successful attempt to get rock, country, and all kinds of musicians talking about their own battles with mental illnesses or those of someone they love.

Here in Georgia, the Atlanta Business Leaders Initiative is getting kicked off. At this point, the initiative is composed of men, and I hope women soon will be willing to go into their businesses, look at their benefits, and see if they are making good business decisions. We know that if people get treatment, there is more money for the business at the end of the year. There is less absenteeism. People are healthier. Then we can work on how to accommodate in a work place when someone has depression.

Welcome them back. Send them flowers. Tell them you care about them as they are battling the illness. That, also, is going to be normalizing.

The last thing I will tell you is a personal story. I am so proud of my oldest granddaughter, who has three diagnoses. She has been treated since she was 8 years old. She graduates from high school in two weeks. She is one spectacular young woman, although I admit that I could be somewhat prejudiced. She has flaming red hair, which is important in the story. I heard her stand in front of about 250 people in Washington last summer and receive an award for her own openness and advocacy on this issue. She said, “Did you know that it is more normal to have a mental illness than it is to have red hair, and I am not going to be ashamed of either one.” The kind of testimony we heard this morning will move us forward with normalization. When you meet someone and you like them and then you find out they are battling OCD, it makes it normal. So to each of you who have gone public, thank you. We have a lot more “going public” to do.

Comment: It might be possible to introduce ‘jumping off bridges’ in a mission setting or to a pastoral counseling group or in churches or to do something monumental on World Mental Health Day. I personally commit myself to those two things.

Deborah Leiter: In my group, I expanded on the notion of what you, as local advocates for this issue and for the campaign, can do and how you can get many of the resources for free or at nominal cost.



There are many tools we can give you. First is a PSA kit that is a CD-ROM of all of our campaign materials. It includes fact sheets, talking points, and background information about the campaign and the issue.

Secondly, you can order brochures for free from www.samhsa.gov. They also are going to be available in Spanish, so feel free to log onto the Web site and order as many as you want to distribute to your partners in your communities. There is a localization form on the list, which means you take our

materials and put your own local information on it: your logos, your phone numbers, whatever you want. All you have to do is fill out the form. There is low cost involved if the Ad Council does it. Our hope is that you can take this message, whether it is just the message or the brochure or if it is the campaign materials, and get it out to your communities through your own community networks or through mass media by pitching this campaign to your PSA directors to get them to run it.

Discussion

Cynthia Wainscott: Once you get the PSAs in your hand, what is the best strategy for using them?

Deborah Leiter: In our packets is a list of all of the local media in Georgia. Do not be afraid to ask. Pick up the phone, be

persistent, call your local media, set up an appointment, or send them the material with a letter. And put that local face on the issue to explain how important it is and why their support is needed to help address this issue. If you can position yourselves as a partner to them, they are always looking for

local resources. So position yourselves as somebody who is an expert who can answer any questions they want.

Cynthia Wainscott: If you have an opportunity to do a media interview and you don't know who to send, get in touch with Nora Haynes at NAMI Georgia, Ellen Yeager at Mental Health America, Sue Smith or Anna McLaughlin at the Georgia Parent Support Network, or Sara Jenkins Tucker at the Consumer Network.

Comment: I want to challenge the young people here. There is a My Space page that includes links about mental health. If people click on the link because they are curious, it is an amazing opportunity for them to learn about mental health, how to talk about it, and how to interrelate with people who have or are experiencing mental illness.

Mark Safran: Since The Carter Center helped the Centers for Disease Control form the Mental Health Work Group seven years ago and broke down some of the stigma that prevented the Centers for Disease Control and Prevention from addressing mental health in that way, we have been making gradual progress each year. It is a pleasure to come back and to get more support for pushing for more and better work so that mental health can be treated like all other diseases not accepting second-rate status.

Blue Group: We decided some of the action steps would be to discuss language related to stigma or perpetuating or reducing stigma at the corporate and board levels. Continue to self-identify as an individual in recovery. Contact TV and radio stations regarding all the PSAs available to individuals in different geographic areas, and reach out to friends and neighbors. "What a difference a friend makes" means that you extend a hand of friendship when your neighbors or others may experience an event that could result in stigmatization.

Black Group: My name is Emily Wells, and I commit to training for minority families who have stayed away from disclosing a mental illness. My husband and I were in a class sponsored by NAMI in Cobb County to teach family members how they could help a family member who was a client or user of the services provided for mental health clients. I plan to establish the training in the African-American or the minority, underrepresented community.

Red Group: I am Sherry Alvie. My group talked about educating teachers and principals and schools and universities. Also, we talked about having a mental health professional in the schools. It is important that we get the message out in the school systems and get professionals or peers in these systems.

Debbie Warren: I work with Magellan Health Services as its director of quality. Magellan could put links to the anti-stigma campaign on its Web site. Additionally, we write articles both for our practitioners and our members, and we do medical behavioral integration with different health plans with which we work. We can put information out to them that they can then distribute to their membership.

Ruby Moore: On behalf of our organization (the Georgia Mental Health Consumer Network) and our collaborators, I have made a commitment to bring home all of the children in Georgia who are institutionalized. Children's mental health parity issues are so huge that there continues to be much work to do about giving children permanent homes and loving families.

Another commitment I will make on behalf of our organization is Employment First Georgia. We have been working with cross-disability, including people with mental illnesses, to have the first dollars for day services go to employment. The Mental

Health Division is showing some initiative around public sector jobs. We primarily work with the private sector to ensure that those jobs do not become “slots” limited to stereotypic things that people are perceived as capable of doing. The idea is to imagine that any job in a public or private sector environment could be held by a person who has a mental illness.

Gary Henschen: I am the medical director at Magellan. Debbie Warren mentioned that we work with our partner health plans on medical integration activities. Part of this is educating primary care physicians about mental illnesses, about the treatment of mental illnesses. I think we have all experienced the issue of stigma and prejudice in the primary care environment against people who have a mental illness: patients who go to emergency rooms, for example, not getting the best care because of their histories; patients going to primary care offices and not getting the best care; office staff gossiping about them; being shunted to the back. The Georgia Academy of Family Physicians has been working with Magellan over the past year to develop a curriculum to teach about mental illnesses to their group. And because of this meeting today, we are going to be talking about stigma.

Carol Strajas: I am director of consumer relations and recovery with the Georgia Division of Mental Health, Developmental Disabilities and Addictive Diseases. We are working on several videos highlighting success stories about consumers as well as other mental health system successes.

Harriett Steele: I am a Fayette County representative to the MHDDAD Board, and one of my focuses is mobilizing young people. People who are now 18 to 24 are going to face a large group of returning veterans with a post traumatic stress disorder dynamic that is going to be different from

what we saw in Vietnam. We need to start training our young people to deal with a society that has another group of PTSD individuals and a Veterans Affairs system that is horribly overworked. I would like to structure a group that could develop a podcast that focuses on mental health issues for young people.

Yellow Group: Kimberly Fluellen: I work with Simpatico Behavioral Health, and I represent the Yellow Group. We came up with 19 commitments personally and/or from our organizations.

Cynthia Wainscott: Another theme from our group was confronting discrimination. A few years ago I heard Mrs. Carter say, “When the insurers pay for it, it will be all right to have a mental illness.” That describes the imperative for us to combat insurance discrimination, but there are other kinds of discrimination that result from stigma. I heard about one that I had not heard of before, and it is happening in our city. If you go to the Fulton County Jail and you are designated as someone who has a mental illness, you wear a red jumpsuit, while everybody else wears another color jumpsuit.

In our session, we did a lot of finger pointing at other people such as the media. The media talk about people with mental illnesses killing somebody, but you never see a headline that says “Perfectly Sane Man Kills Wife.” That, in fact, is the norm. The norm is that people without a mental illness commit most crimes. The minority of crimes are committed by people with a mental illness.

We did a lot of saying, “It’s their fault,” but we have to recognize that we do things intentionally and by policy that are discriminating. For example, if you have a heart attack, a policeman [probably] does



not take you to the hospital, but we act as if it is normal for someone with a mental illness to be driven by a policeman to the hospital. There are many ways that we say we are willing to accept second class status. I think we need to examine those and act on them. If anybody can do it, the people in this room can.

Postscript

Cynthia Wainscott
Board Member, Mental Health America

Thomas Bornemann, Ed.D.
Director, The Carter Center Mental Health Program

In 1971, when Rosalynn Carter became an outspoken advocate for mental health issues, few people even spoke the words “mental health.” Mental health referred only to mental illnesses, and mental illnesses were shrouded in such shame that many people avoided the issue completely. Today, much has changed. Research has given us tremendous knowledge about the brain and new medications, and other mental health treatments have improved significantly. Despite this progress, society continues to stigmatize mental illnesses, and far too many people do not receive the services they need. The Carter Center Mental Health Program was founded in 1991 to promote policies and practices that lead to improved mental health and social functioning, to advance the prevention of mental illnesses, and to ultimately help reduce stigma and discrimination against mental illnesses.

Substance Abuse and Mental Health Services Administration and the Ad Council. The campaign is the direct result of the recommendations from the President’s New Freedom Commission on Mental Health that was launched at the 2003 Rosalynn Carter Symposium on Mental Health Policy. The prominent role that the Carter Center Mental Health Program had with the release of the commission’s report and its goal to reduce stigma and discrimination led to participation in the anti-stigma campaign efforts.

The National Anti-Stigma Campaign will release in three phases, with the first phase released in December 2006. States are encouraged to develop local plans for reducing stigma. Through the Rosalynn Carter Georgia Mental Health Forum, the Carter Center Mental Health Program provided leadership for the campaign launch in Georgia along with the Georgia state government and advocacy organizations. The participants at the forum were asked to commit to a stigma reduction strategy, and the Mental Health Program will ask participants to participate in a follow-up survey to determine if they were able to implement their plans and if not, to describe the barriers they encountered.

Cynthia Wainscott moderated the Town Hall portion of the forum, reviewing the activities of the work groups and collecting some of the commitments made by the participants.

The 12th Annual Rosalynn Carter Georgia Mental Health Forum, Reducing the Stigma of Mental Illnesses in Georgia, was held in May 2007. The topic was selected in response to a national anti-stigma campaign sponsored by the



Closing Remarks

Rosalynn Carter
Chair, The Carter Center Mental Health Task Force

The complex and continuous fight against stigma has provided for a day of fruitful discussion, and the family that has developed among us as we listened and learned will serve as a powerful force against stigma in the coming years.

It is exciting to hear all the ideas and plans that have been developed for advancing the national anti-stigma campaign. Today's forum will be followed up with an online survey that will assess the extent to which you, the participants, have been able to implement the activities you committed to today. Hopefully, all of you will have been able to get something started. We will also see if you had to modify your plans, and the barriers you have come up against as you began implementation.

I appreciate everyone's efforts today because although the stigma surrounding mental illnesses seems to have improved at least a little bit, it remains prevalent in our society. Situations like the tragedy at Virginia Tech show us that although more and more young people with mental illnesses are able to stay in school these days, we continue to struggle with how to sufficiently meet these students' needs. This is at least partly due to the persistence of stigma in the young adult age group, as Emily told us.

Not only are young adults struggling with mental illnesses, but younger children are increasingly being diagnosed as well. The benefit of this is that juvenile diagnoses allow for early treatment. However, society remains largely unaware of treatment advances and continues to put negative labels on these ill children and their families. The families themselves may even be paralyzed by stigma, and as a result may wait too long to get their children the help they need.

As we have learned, the end result of stigma is discrimination, whether it is loss of a job, denial of housing, or lack of parity for insurance coverage for mental health conditions.

We can have a real impact in Georgia if we all actively participate in the national anti-stigma campaign. First, it is important that we truly commit to implementing the anti-stigma efforts outlined here. Also, we must closely monitor the legislative commission that Georgia's mental health advocates worked so hard to get passed this year. Let's all work together and stay consistently updated on mental health legislation regarding parity and other mental health issues.

Rosalynn Carter

Biographies



Kat Candler

Candler graduated from Florida State University with a degree in creative writing and a love for storytelling. In 2000, she debuted her first feature film, “cicadas,” at the Austin Heart of Film Festival. In 2002, she was one of 50 finalists in the Chesterfield Fellowship Competition, a semi-finalist in the 2002 Sundance Screenwriter’s Lab, and a participant in the 2002 IFP Market’s Emerging Narrative Section for her second feature script, “jumping off bridges.” In 2004, Candler’s short film, “Roberta Wells,” premiered at the 2004 Slamdance Film Festival. Her latest script, “Brain Brawl,” was selected for the 2004 IFP Market’s Emerging Narrative Section, was a quarter-finalist in the 2004 Slamdance Screenplay Competition, and won the grand prize at the 2005 Rhode Island International Film Festival Screenplay Competition.



Larry Fricks

Fricks currently serves as director of the Appalachian Consulting Group Inc. For nearly 13 years, Larry was Georgia’s director of the Office of Consumer Relations and Recovery in the Division of Mental Health, Developmental Disabilities and Addictive Diseases. He is a founder of the Georgia Mental Health Consumer Network Inc., the Georgia Consumer Council, Georgia’s Peer Specialist Training and Certification, and the Georgia Peer Support Institute. He served on the planning board for the Surgeon General’s Report on Mental Health and currently serves on the board of directors of the Depression and Bipolar Support Alliance and Mental Health America. He also is on the advisory board of the Rosalynn Carter Fellowships for Mental Health Journalism. Larry has a journalism degree from the University of Georgia.

Sara Johnson

Johnson attends Salem High School in Rockdale County, Ga. She has been a Youth Advisory Council member for the past two years with Kidsnet, a program of the Georgia Parent Support Network, where she mentors peers in the program.



Leslie Langee

After attending the University of Florida’s postgraduate studies in theater, Langee worked as a theater, film, commercial, and voice-over actress; singer; radio personality; and, more recently, behind the camera as a publicist and an associate producer. Among others, she has appeared in “Friday Night Lights” (NBC), Steve Martin’s “Leap of Faith” (Paramount), Storie Productions’ “jumping off bridges,” and Kimberly Peirce’s “Stop Loss” (postproduction). Langee currently is an associate producer with Storie Productions and a teaching assistant to Kat Candler’s Script to Screen workshop series. When she was in her teens and 20s, she worked in the office of her father’s psychiatric private practice (the late Dr. H.R. Langee, M.D., P.A.) and assisted him with research.



Deborah Leiter

Leiter is vice president and campaign director of the Ad Council, having joined the Ad Council in June 2000 to lead the development of campaigns such as Crime Prevention, Childhood Asthma, Environmental Defense, and Global AIDS awareness. Leiter is responsible for the Ad Council’s health campaigns and provides strategic insight and learning across these efforts. She works closely on the strategic development, production, and distribution of specific campaigns, including SAMHSA’s Mental Health Anti-Stigma Campaign, Blood Donation, Autism

Awareness, Disease Prevention, and Diabetes Management. Prior to working at the Ad Council, Leiter worked in advertising account management at BBDO and at Grey Advertising. She graduated from the University of Pennsylvania with a bachelor of arts in communications.



Emily McKee

Emily McKee is a recent graduate of the University of Texas at Austin, where she majored in government and communication studies. Her proudest accomplishments include helping raise more than \$12,000 to save the sexual/physical abuse victims' service on campus from deletion; starting a college mentoring program at her former high school, where nearly 90 percent of the students live under the poverty level; and surviving her own bout with mental illness while supporting others in similar situations. In addition, she was a member of Orange Jackets, the top women's organization at Texas; Mortar Board; and Phi Beta Kappa. Other interests include

Vince Young, college football, road trips to the far ends of the country, and encountering new people and experiences that challenge her.

Bob Patterson

Patterson is the project director of the Georgia Certified Peer Specialist Project. Patterson spent more than 30 years as an actor and director in live theater. While employed as a receptionist at a Community Service Board, the clinical director overheard him talking to a consumer who was experiencing a severe panic attack. Knowing that Patterson had a diagnosis of a mental illness and impressed with the insight Patterson showed in his conversation with the person, the clinical director suggested that he apply to the Georgia Certified Peer Specialist training. Bob received his certification in 2006 and began work as a CPS with an Assertive Community Support Team soon thereafter. He began as project director for the Georgia CPS Project in March 2007.



Barbara Sample

Sample is the founder and executive director of Family Support Network in Billings, Mont. Sample holds a master's degree in special education with a concentration in children with serious emotional disturbance. For her work in creating the Partnership To Strengthen Families project in Montana, Sample received the Governor's Celebration of Children Award. She has served on the board of directors and is past president of the Federation of Families for Children's Mental Health. She also has received the Outstanding Mental Health Professional Award from the Montana Mental Health Association and is recognized for her collaborative efforts

in Yellowstone County to create programs that enhance the ability of families to maintain their children at home. As retired foster parents, the Samples worked with many children and their families. She serves on the Drug Court Advisory Council.



Otto Wahl

Wahl is director of the Graduate Institute of Professional Psychology and professor of psychology at the University of Hartford. Wahl's work includes numerous research articles related to stigma and to media depictions of mental illnesses. He is the author of "Media Madness: Public Images of Mental Illness" and "Telling Is Risky Business: Mental Health Consumers Confront Stigma." Wahl serves as an adviser to several organizations involved in public education about mental illnesses, including the National Stigma Clearinghouse and Mental Health America. He also works with the Rosalynn Carter Fellowships for Mental Health Journalism to select and mentor

journalists in their coverage of mental health issues. Wahl has been the recipient of numerous awards for his efforts to combat the stigma of mental illness, including the Patient Advocacy Award from the American Psychiatric Association and the Eli Lilly Welcome Back Award for Destigmatization.



Cynthia Wainscott

Wainscott is the immediate past chair of the board of Mental Health America. She was acting president and CEO of Mental Health America in 2006. She served as a member of the Institute of Medicine committee that released the 2005 landmark report, Improving the Quality of Health Care for Mental and Substance-Use Conditions. She is a founding board member of the Campaign for America's Mental Health. Wainscott has been appointed to the Center for Mental Health Services' National Mental Health Advisory Council and has been elected vice president for North America and the Caribbean of the World Federation for Mental Health. In Georgia, Wainscott

is a member of the Governor's Mental Health, Mental Retardation and Substance Abuse Advisory Council and the Department of Community Health's Drug Utilization Review Board. She holds a B.A. in communications from Metropolitan State University.

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