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I. Executive Summary

The Denver Department of Public Health & Environment (DDPHE) had three primary objectives for the Denver Anti-Stigma Campaign project. The first objective was to measure baselines of knowledge, attitudes, and beliefs that result in stigma associated with behavioral health conditions (i.e., substance use and mental health conditions) in Denver. The second objective was to increase empathetic responses and decrease adverse responses to behavioral health conditions in the general population. Reducing stigma as a barrier to accessing services for people with behavioral health conditions and their loved ones was DDPHE’s third objective. This report by the Analytics and Insights Matter (AIM) consulting team encapsulates the Formative Assessment / Phase 1 background, approach, findings and recommendations for a project designed to help DDPHE achieve its broader objectives as part of the Anti-Stigma Campaign (ASC) project.

Phase 1 of the ASC project took an incremental approach to designing the qualitative and quantitative data acquisition, analysis and campaign focus recommendations. Literature and background resources related to behavioral health and stigma were reviewed along with contextual understanding of existing campaigns and informational meetings with behavioral health experts. This context served as input into the design of the interviews and focus groups which, in turn, informed the design and approach to the quantitative stigma survey. Analysis of the stigma survey data and alignment with qualitative findings formed a solid foundation from which to make campaign focus recommendations using a structured decision-making framework established and used by the extended AIM consulting team in collaboration with DDPHE stakeholders.

It is recommended that the rest of the ASC project should design, execute and evaluate an anti-stigma campaign with the following attributes:

- **Focus on People with Personal Experiences:** There should be a focus on reducing levels of behavioral health stigma in people with personal experiences by targeting an anti-stigma campaign on people in the *general population* who are the primary sources of this stigma.

- **Focus on People with Serious Mental Health Conditions:** Focus on addressing the stigma associated with people who live with a serious mental health condition.

- **Focus on People with Specific Demographics:** Much information gathered during Phase 1 suggested that the anti-stigma campaign should focus on people with specific demographic profiles. Although the Phase 1 information gathered is not definitive on which demographic profiles should be targeted in the anti-stigma campaign, the data suggest that people from some groups (e.g., race, ethnicity, gender identity, housing status, and veteran status) may feel more stigmatized than other groups.
II. Introduction and Background

The Denver Department of Public Health & Environment (DPHHE) produced a Request for Proposal (RFP) in 2020 to create, execute and evaluate the effectiveness of an anti-stigma campaign in Denver related to behavioral health conditions. Stigma is known to be a barrier to early intervention and access to treatment and support for behavioral health concerns. In response to that RFP, this Anti-Stigma Campaign Project aims to engage with Denver community members to better understand the stigma associated with substance use and mental health conditions to ultimately reduce stigma. This report is the main deliverable for Phase 1 of this four-phase project, as described below.

Throughout this report, the phrase “behavioral health condition” is used to refer to any type of substance use or mental health condition unless otherwise described. Several specific types of behavioral health conditions are described in Phase 1 in the methods section of this report.

DDPHE is partnering with a team of organizations with expertise in all aspects needed for success. The lead organization is Analytics and Insights Matter (AIM), which brings research design, statistical analysis, and engagement management expertise. AIM is joined by the Arrow Performance Group (APG), which conducted informative interviews and focus groups, along with Circuit Media, the marketing and media campaign partner. Dr. Thomas Barrett is a retained behavioral health advisor for this project. Additionally, four interns from the University of Denver participated in the project for several months of the Phase 1 Formative Assessment. The extended AIM team is working closely with DDPHE to ensure that Denver’s diverse community voices are heard in the development and implementation of this project.

Project Objectives

The three overall project objectives are to:

- Measure baselines of knowledge, attitudes, and beliefs that result in stigma associated with behavioral health conditions in Denver,
- Increase empathetic responses and decrease adverse responses to behavioral health conditions in the general population, and
- Reduce stigma as a barrier to accessing services for people with behavioral health conditions and their loved ones.

Project Phases

Denver’s Anti-Stigma Campaign project activities fall into four phases:

- **Phase 1: Formative Assessment** – Study recent efforts, conduct focus groups and interviews with stakeholders, develop and conduct a survey of various populations to measure stigma (the scope of this report)
- **Phase 2: Message Development, Marketing/Advertising Plans** – Develop and test messages with different audiences based on formative assessment activities, assess language and cultural barriers, determine best channels for campaign
- **Phase 3: Campaign** – Disseminate messages, collect digital metrics regarding potential success, monitor reach, and conduct assessments for any needed adjustments
- **Phase 4: Evaluation** – Compile and analyze data to determine campaign awareness, understanding, and effectiveness, including a second dissemination of the survey to measure changes, followed by a summary report

Background

There is a national crisis around mental health and substance use issues. According to the Substance Abuse and Mental Health Services Administration’s National Survey on Drug Use and Health (NSDUH): “Among adults aged 18 or older in 2020, 21.0 percent (or 52.9 million people) had any mental illness (AMI), and 5.6 percent (or 14.2
Many People In Denver with Behavioral Health Conditions Not Getting Need Services

Unfortunately, there is equally compelling evidence that many individuals experiencing behavioral health issues in Denver are not receiving appropriate treatment. According to a 2014 Western Interstate Commission for Higher Education (WICHE) study contracted by the Colorado Department of Human Services, there were 8,728 children with serious emotional disturbance (SED) in Denver, and only 12% (1,067) were provided service through all of the state-funded programs within the Office of Behavioral Health (OBH). Similarly, only 11% of adolescents in Denver with the diagnosis of alcohol and other drug use or dependence (AOD) were provided services through OBH. The corresponding rates for adults with serious mental illness (SMI) and adults with alcohol or other drugs (AOD) issues were 17% and 48%, respectively.2 The current Behavioral Health Needs Assessment project that AIM is working on with DDPHE will provide an update for these figures.

The 2019 Colorado Health Access Survey (CHAS) reported that 16% of Denver residents needed mental health care and did not receive any care. And many of those reported that they were uncomfortable talking about personal issues and that was one of their reasons for not getting services.3

According to Mental Health America’s 2021 State of Mental Health in America Report, Colorado has a higher prevalence of mental health issues and lower rates of access to care. Colorado has an overall ranking of 47 out of 51, including all the states and the District of Columbia, derived from 15 measures of mental health and substance use prevalence scores among adults and youth. This measure also includes access to care.4

The Colorado Health Institute report states: “Many people who have died by suicide in Colorado were reported as having a current depressed mood or a diagnosed mental health problem like depression, anxiety, or other conditions such as schizophrenia. But less than a third were identified as currently receiving mental health care.”5

Youth Suicide Rate In Colorado Is Very High and Getting Worse

The youth suicide rates for Colorado are even more alarming. According to the Colorado Health Institute report noted above: “Over the past 10 years, the number and rate of suicide deaths among Colorado residents ages 15-19 have been increasing. Crisis Point, a project that examines youth suicide in Colorado, reports that the ongoing coronavirus pandemic, economic downturn, and racial injustice across the nation will negatively affect the mental health of youth and that increased anxiety, loss of social connection, and a potential rise in domestic violence will increase the risk for suicide and need to access mental health services. The 2019 healthy kids survey found that 42.0% of students who identify as gay, lesbian, or bisexual reported seriously considering attempting suicide during the past year.” 5

In addition, the suicide rate in Colorado is increasing and the rate is one of the highest of any state in the country. According to a 2021 report by the Colorado Health Institute: “Some 1,287 Coloradans lost their lives to suicide in 2019.5 This was not only an increase from the year before — it was also a higher number of suicides than has ever been recorded in the state.” Further, the report states, “The most recent data available from the Centers for Disease Control and Prevention (CDC) show that in 2018, Colorado had one of the 10 highest rates of age-adjusted suicide death rates in the nation, at 21.9 deaths per 100,000 people.”

Untreated Mental Health and Substance Use Issues are Devastating

The human toll of untreated mental illnesses and substance use is well documented. The 2001 World Health Organization (WHO) report indicates that neuropsychiatric disorders contribute more to the global burden of disease (12%) than any other single category of disease.6 This finding has led to the WHO recommendation that countries should be devoting at least 10% of their health care dollars to mental health and substance use conditions. The World Health Organization Mental Health Atlas for 2017 shows that the United States is far below this 10% level (less than 5%).7 Also, a 2018 Lancet article indicates that depressive disorders are the third highest disease contributing to Years Lived with Disabilities (YLD) for females in 2017.8 Years Lived with Disabilities (YLD) is one of the ways WHO measures the global burden of disease. The article reports that the YLD rate for depressive disorders increased by 14.1% from 2007 to 2017.8 The National Alliance on Mental Health

million people) had a serious mental illness (SMI) in the past year.” Also, the survey results showed that: “Among people aged 12 or older in 2020, 21.4 percent (or 59.3 million people) used illicit drugs in the past year.”1
suggests that there is a huge loss in productivity due to mental illness. “The National Alliance on Mental Health (NAMI) estimates that untreated mental illness costs the country up to $300 billion every year due to losses in productivity.”

**Stigma Is Major Barrier to Getting Appropriate Treatment**

Stigma is one of the primary reasons that people do not get the help they need. The American Psychiatric Association (APA) identifies stigma, prejudice, and discrimination as the first reason why people do not get help: “More than half of people with mental illness do not receive help for their disorders. Often, people avoid or delay seeking treatment due to concerns about being treated differently or fears of losing their jobs and livelihood. That’s because stigma, prejudice and discrimination against people with mental illness are still very much a problem. Stigma, prejudice and discrimination against people with mental illness can be subtle, or it can be obvious—but no matter the magnitude, they can lead to harm. People with mental illness are marginalized and discriminated against in various ways but understanding what that looks like and how to address and eradicate it can help.”

Also, according to the High Watch Recovery Center, stigma is the first listed reason why people do not get help: “Despite the progress in recent years of bringing to light the importance of mental health care, many people are afraid of being stigmatized if they admit they need help. It is great that Dwayne ‘The Rock’ Johnson, for example, spoke out about his struggles with depression to let people know it can happen to anyone and that depression is not a sign of weakness, but he didn’t have to risk much to do so. He’s a rich movie star who can push over a garbage truck. Most people struggling with mental illness are in a less secure position. Already unsure about themselves and their position in life, it’s hard to risk precious social and professional capital to seek help. Admitting your problem to your doctor, spouse, or even yourself can be difficult.”

Shatterproof is an organization founded by Gary Mendell, whose son, Brian, died after struggling with use of alcohol and other drugs. According to Shatterproof’s 2020 report on A Movement to End Addiction Stigma: “Stigma’s Impact on the Opioid Epidemic: Shatterproof identified nine commonly cited drivers of the epidemic: overprescribing, increased access to heroin and fentanyl, insufficient treatment capacity, gaps in evidence-based treatments, criminalization of SUD, insurance coverage disparities, social isolation, lack of help-seeking, and societal barriers to recovery. Seven of the nine drivers of the opioid epidemic are either partially or entirely driven by stigma.”

In summary, untreated mental health conditions and substance disorders have a huge personal, financial and emotional impact for citizens of Denver. Stigma is clearly one of the major reasons why Denverites do not receive needed services. Reduction in stigma levels has the potential of reducing unneeded suffering, improving health outcomes, and saving lives.
III. Method

1. Overall Approach

The overall Phase 1 approach was to become grounded in work already done related to anti-stigma efforts (described in the last section), determine an anti-stigma campaign method, collect and analyze stigma related information that fits within the campaign focus selection framework and recommend an anti-stigma campaign focus based on Phase 1 findings. The rest of the methods section describes this approach in more detail.

Target Populations – Information was gathered from three mutually exclusive populations living in the City and Country of Denver. Based on the background review, interviews and focus groups, three populations were defined. The survey differentiated the populations by asking respondents which of the following three statements best described them (see Appendix 5 for all survey questions):

1. I have had difficulties with my mental health in the past 12 months.
2. I know a friend or family member who has had difficulties with their mental health in the past 12 months.
3. Neither of these two statements describe me.

People were assigned to one of three populations based on their survey responses to this question:

- **Personal Experience** – People selecting option number 1 above were assigned to the Personal Experience population group, who are people that may be experiencing stigma because they have lived with a behavioral health condition within the past year.
- **Friends and Family** – People selecting option number 2 above were assigned to the Friends and Family population group, who are people that may be experiencing stigma by association with people they know who have had a behavioral health condition within the past year.
- **General Population** - People selecting option number 3 above were assigned to the General Population group, who are people that have no lived experiences with a behavioral health condition (personally or by association with a friend or family member) in the past year.

For all three populations, oversampling of historically unrepresented populations and groups disproportionately impacted by behavioral health conditions was used to ensure their adequate inclusion.

**Target Behavioral Health Conditions** – As updated by the AIM team and DDPHE stakeholders in June 2021, Phase 1 of the ASC Project gathered information on the stigma associated with five behavioral health conditions for the target populations noted above. For people with personal experience, these definitions applied to their self-reported condition. For friends and family, these definitions applied to the person that is their close friend or family member. For the general population, these definitions applied to the people for which they were asked to express their opinions.

Below are the definitions used for each of the behavioral health conditions for the purposes of the ASC Project. On the survey, after self-identifying into one of the three populations noted above, the personal experience and friends and family groups then self-selected which of the following five behavioral health condition groups best described them. People in the general population group were randomly assigned by an online survey platform program to one of the five behavioral health condition groups.

Below are the options people in the personal experience group on the survey could choose from when self-selecting into one of the five behavioral health condition groups. Similar statements referring to close friends and family members were used for the friends and family population group:

- **Non-Serious Mental Health Condition (NSMHC)** – “I have had a non-serious/general mental health condition like mild depression or anxiety that has interfered or limited major parts of my life.”
- **Serious Mental Health Condition (SMHC)** – “I have had a serious/severe mental health condition like schizophrenia or major depression that has interfered or limited major parts of my life.”
Anti-Stigma Campaign Project – Phase 1 / Formative Assessment Final Report

- **Substance Use (SUD)** – “I have struggled with substance use, like drugs or alcohol, which has caused problems with my health or my responsibilities at work, school, or home.”
- **Substance Use and Mental Health Condition (SUD+MHC)** – “I have struggled with substance use, like drugs or alcohol, and a mental health condition which have caused problems with my health or my responsibilities at work, school, or home.”
- **Suicide** – “I have had thoughts, plans or actions about harming or killing myself.”

**Campaign Focus Selection Framework** – The initial campaign selection framework included stigma levels, prevalence, and related anti-stigma campaigns and initiatives. This initial framework was refined and extended in January and February of 2022 through multiple meetings and framework document revisions that included representatives from AIM, APG, CM, and DDPHE. The final campaign focus selection framework, dimensions, and relative dimension importance are summarized in Figure 1 below that will be described in detail later in this report. The full campaign selection process, descriptions and definitions of the dimensions, measures, and criteria can be found in Appendix 2 of this report.

![Survey Findings by Campaign Selection Dimension](image)

<table>
<thead>
<tr>
<th>Dimension</th>
<th>NSMHC</th>
<th>SMHC</th>
<th>SUD</th>
<th>SUD + MHC</th>
<th>Suicide</th>
<th>Importance</th>
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</thead>
<tbody>
<tr>
<td>1  Stigma Scale Scores</td>
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<td></td>
<td></td>
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<td>Very High</td>
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<td>2  Stigma Barriers to BH Service</td>
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<td>High</td>
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<td>3  Stigma Impact on BH Services</td>
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<td>High</td>
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<td>5  Stigma Source</td>
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<td>Low</td>
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<tr>
<td>6  If MH Seen Like Physical Health</td>
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<td>Low</td>
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<tr>
<td>7  BH Condition Prevalence</td>
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<td>Information</td>
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<tr>
<td>8  BH Condition Lethality</td>
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<td></td>
<td>Information</td>
</tr>
<tr>
<td>9  Example Anti-Stigma Initiatives</td>
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<td></td>
<td></td>
<td>Information</td>
</tr>
</tbody>
</table>

**Figure 1**

**Collaborative Working Relationships** – Much of the data needed to “fill in” the campaign focus selection framework required the extended AIM team to collaborate extensively with many existing behavioral health providers and advocacy organizations serving Denver communities. Creating and nurturing these organizational relationships were essential to our ability to conduct relevant interviews and focus groups and to obtain completed surveys from diverse Denver community members who are typically underrepresented and disproportionately impacted by behavioral health conditions. These organizations were also very helpful in providing relevant stigma and behavioral health condition data for Denver communities.

**Design, Organize and Gather Information** – Once the appropriate information from the behavioral health providers and advocacy organizations was collected, arrangements were made to conduct 21 interviews and 10 focus groups. After gathering and comprehensively analyzing this rich qualitative information, a “core” quantitative survey was designed and “customized” to be relevant to 15 separate populations (N = 3) by behavioral health conditions (N = 5) respondent groups (See “Stigma Surveys” description in the methods section starting on page 13 for details). These 15 “customized” surveys were in both English and Spanish.
language versions for a total of 30 surveys which measured all planned stigma perspectives. A total of 957 valid completed surveys were gathered for analysis. The methods used for interviews, focus groups and quantitative surveys are described below in more detail.

**Analyze and Integrate Findings** – After all interview, focus group and quantitative survey data were analyzed, all findings were integrated into the campaign focus selection framework to enable a context and data-informed set of recommendations regarding the anti-stigma campaign focus.

## 2. Interviews and Focus Groups

An incremental approach to designing the qualitative and quantitative parts of the formative assessment phase was taken. The first step was to review background materials including over 20 pieces of literature related to mental health and mental health stigma. Additionally, contextual understanding of existing campaigns was conducted. The information and insights gained from this contextual information provided project direction and served as input into the design of interviews, focus groups, and ultimately the quantitative survey.

After reviewing background material, informational interviews were conducted with behavioral health providers to learn their perspectives around stigma associated with substance use, suicide, and mental health conditions. Working closely with DDPHE, several relevant organizations and leaders in the field were identified. In total, 21 interviews were conducted to explore each of the mental health focus areas like general depression and anxiety, serious mental health conditions like schizophrenia or severe depression, suicide and suicidal thoughts, and misuse of drugs and alcohol.

A structured interview process ensued. Several questions were asked to help gain an understanding of current and past efforts, available or needed data, stigma perceptions, access to treatment and services, focus group communities and considerations, and meaningful campaign engagement and approaches. See Appendix 3 for the list of interview session questions. Interviews with organizational representatives were conducted virtually with two APG team members, one person taking the lead on facilitation and the other taking notes. Additionally, interviews were recorded with the permission of the interviewee and transcribed for future reference. Using interview notes and transcription, interview findings were analyzed to identify early themes. Themes are listed below in order of prevalence mentioned out of 21 interviews:

- There is an interest in focusing on substance use (86%)
- There is a need for community support in crafting and delivering messages (76%)
- There is a lack of diversity and cultural competency within the system (71%)
- Perceptions that serious mental health conditions have greater stigma (57%)
- Providers are a source of stigma and there is mistrust of systems (57%)

The team intentionally designed focus groups to engage communities and provide a safe space to share personal stories and lived experiences. Focus groups were conducted via a mix of in-person and virtual group meetings, depending on what was most comfortable and accessible for a particular community. For example, the Hispanic/Latino and Indigenous/Native American community partners felt that their respective community members would feel most comfortable and more likely to attend an in-person focus group, while other communities like the Asian/Pacific Islander and LGBTQ+ communities felt more comfortable meeting virtually. The ten focus groups included: Hispanic/Latino, homeless/unhoused, Indigenous/Native American, youth, LGBTQ+, people with lived experience, friends and family of those with lived experience, providers, Black/African American, and Asian/Pacific Islander communities.

Focus groups followed a structured approach. All focus groups were facilitated by two team members with one taking the lead on discussion prompts and the other leading note taking. See Appendix 4 for focus group interview questions. Most focus group meetings were captured via recordings and notes. Some communities, like the Indigenous/Native American community, did not feel comfortable with recording, and only notes were used to capture that feedback. Analysis was conducted at the completion of all focus groups using notes and
transcription, when available, to identify primary findings. The list below includes the primary findings from focus group conversations. The percentage listed indicates the prevalence of that finding across all focus groups.

- There is an understanding that non-serious mental health condition such as depression and anxiety are easier to talk about: 100%
- The shame, or judgement placed on those with mental health conditions and the fear of other people’s response, was recognized: 80%
- There is a lack of education and awareness related to mental health: 80%
- There is a lack of provider diversity and the need for culturally and linguistically responsive care: 80%

Multiple team members reviewed the information collected during interviews and focus groups and consolidated the findings by theme for each dimension using a tally system/matrix. This information was then further refined across all community groups to extract consistent and repeated themes to provide credible qualitative findings representative of the community’s experiences enriched by their stories. The key findings from the interviews and focus groups were reviewed using thematic analysis. Key findings are organized into the most prevalent categories below:

**Interviews:**

- Themes: SUD (86%) and SMHC (57%) are of greatest concern, providers source of stigma (57%)
- Message: Empathic focus, and numerous avenues for messaging (48%)
- Delivery: From people “who look like me” (76%), targeting SUD and other MHC impactful
- Stigma is not the primary issue affecting access, rather it is systemic inequities, cost of care, and social determinants of health (38%), especially for populations of color

**Focus Groups:**

- Themes: Less stigma for general mental health conditions (100%), fear of others (80%), mistrust of systems and providers (50%), gender and generational differences (60%)
- Message: Positive and hopeful (50%), community-led & delivered by people "who look like me and speak my language"
- Delivery: Culturally responsive and reflective messaging needs to come from within a given community (60%). A variety of media distribution methods were identified as specific to subpopulation and age ranges.
- Barriers to access include a lack of education and accurate information (80%) about mental health high treatment costs (60%), and a lack of diversity / culturally responsive & reflective providers (80%).

The overall objective of the qualitative data collection was to discover primary causes of mental health stigma, severity related to conditions, and ways that an Anti-Stigma campaign might be most effective at reducing stigma for those needing mental health services. The outputs of qualitative data collection provided many of the topics to be explored further in the quantitative survey. The two-pronged approach of understanding community members’ lived experiences through listening sessions and measuring themes through the quantitative survey provided DDPHE with comprehensive data to inform the Anti-Stigma campaign focus for Denver.

### 3. Stigma Surveys

AIM’s plan was to obtain about 950 completed surveys from the general population and people with lived experiences of the five behavioral health conditions noted for this project – people with personal experiences along with their friends and family members. This number of surveys distributed across three populations and five behavioral health conditions (as noted in Table 1 below) allowed for adequate power to detect mean differences in stigma between groups while also providing adequate oversampling and reasonable confidence intervals when making point estimates within population or behavioral health condition.
The primary objectives of the quantitative survey were:

- Create a baseline of stigma level by population and behavioral health condition within the City and County of Denver.
- Determine if stigma levels differ by behavioral health condition and population.
- Obtain completed surveys from demographically representative subpopulations of the general population in Denver.
- Oversample historically unrepresented populations and groups disproportionately impacted by behavioral health conditions.

**Description of Stigma Scales** – Questions used to create measures for the stigma scales were adapted from existing stigma measures with the same names (see end notes below and Appendix 1 for scale question sources). These stigma scales were chosen because previous research (see end notes below) has shown them to be reliable measures of stigma that spans a variety of topics related to the stigma associated with people who have behavioral health issues.

Between 4 and 7 questions from each of the original scales were selected to keep the survey a reasonable length (target was 12 minutes for the entire survey) while also maintaining acceptable measurement reliability. Wording of stigma scale questions were modified to be relevant to each population and behavioral health condition as described in the methods section below. All stigma scale questions used a 5-point Likert rating scale format to obtain quantitative ratings to each question. Appendix 5 has a copy of the entire survey instrument with an explanation of how question wording was adapted to be relevant to each of the 15 subgroups surveyed in Phase 1. Appendix 6 identifies which questions were scored to be on each stigma scale.

All scale questions were scored so that higher scores are reflective of higher stigma levels. Scale scores are averages of all scale questions (1 to 5 ratings) for each respondent after scoring all questions in the same direction. An overall Stigma Composite score was created that was an average of all 23 stigma questions scored in the appropriate direction for each respondent. Below is a summary of the scales measured with the number of questions asked for each:

- **Social Distance** – 4 questions\(^\text{13}\)
- **Discriminatory Intent** – 4 questions\(^\text{14}\)
- **Accessing Treatment** – 4 questions\(^\text{15}\)
- **Willingness to Disclose** – 4 questions\(^\text{14}\)
- **General Stigma** – 7 questions\(^\text{15}\)
- **Stigma Composite Scale** – 23 questions

Below is an example question from each stigma scale to provide a sense of the meaning of each scale. The examples below are worded for people with personal experience living with a serious mental health condition. A copy of the entire set of stigma scale questions and which questions are associated with each scale can be found in Appendices 5 and 6. Recall that the exact wording for each subgroup survey question was adapted to be relevant to their specific situation. Appendix 5 provides a detailed description of how each survey question was adapted to be relevant to all 5 behavioral health condition groups within each of the 3 populations.

- **Social Distance** – “Most people would be willing to live with me if they knew I had a serious mental health condition.” (reverse scored)
- **Discriminatory Intent** – “Most people would believe that I cannot be trusted if they knew I had a serious mental health condition.”
- **Accessing Treatment** – “Most people would think less of me if they knew I had received mental health services.”
- **Willingness to Disclose** – “I feel that telling someone I have a serious mental health condition is risky.”
• General Stigma – “Most people would think I cannot handle responsibility if they knew I had a serious mental health condition.”

**Sampling Plan** – Given the quantitative survey objectives, below is the target number of completed surveys by population and behavioral health condition.

| Table 1: Target Completed Surveys by Population and Behavioral Health Condition |
|----------------------------------|------------------|----------------|------------------|------------------|
| Denver Population                | Behavioral   | Health    | Condition        |
| General Population               | NSMHC        | SMHC      | SUD              | SUD+MH C         | Suicide         | Total |
| People with Lived Experiences    | 65           | 65        | 65               | 65               | 65              | 325   |
| Personal Experiences             | 75           | 75        | 75               | 75               | 75              | 375   |
| Close Friends and Family         | 50           | 50        | 50               | 50               | 50              | 250   |
| **Total**                        | **190**      | **190**   | **190**          | **190**          | **190**         | **950** |

NSMHC: Non-Serious Mental Health Condition  
SMHC: Serious Mental Health Condition  
SUD: Substance Use  
SUD+MH C: People experiencing SUD and a SMHC or NSMHC  
Suicide: People with suicidal thoughts or actions

The following process and guidelines were used when planning and executing data collection for the quantitative survey.

1. **Meet People Where They Are** – The data collection process was designed to be as comfortable and convenient as possible for all respondents to complete the survey. A wide variety of survey completion methods were offered to respondents such as online surveys and interviews that could be conducted both remotely and in-person as well as in any language requested by respondents using interpreters.

2. **Recruiting and Survey Completion Methods** – There were two primary ways that participants were recruited to complete surveys for this project.
   - **Sample Providers** – An online survey sample provider (i.e., Alchemer) obtained completed surveys for this project. A part of Alchemer’s business is maintaining ongoing relationships with millions of people in the United States (including thousands of people living in Denver) who make up their “panel” of diverse participants who complete online and telephone surveys in exchange for a modest financial incentive for each survey they complete. This is a cost-effective way to obtain completed surveys for many of the people targeted in this project.
   - **Denver Service Provider and Advocacy Organizations** – Sample provider survey completions were supplemented by collaborating with behavioral health service providers and advocacy organizations in Denver to help recruit people to complete surveys online and in-person at planned events. Locally redeemable gift cards of between $5 (standard incentive) and $15 (for harder to reach people like those identifying as homeless or having unstable housing) were used when gathering completed online and in-person surveys when recruiting through these organizations.

3. **Demographics** – Using data available from Denver government agencies, the US Census and other online sources, demographic profiles of Denver citizens were established to use as a reference when recruiting
survey participants, which can be seen in Figures 5 and 6 in the Survey Respondent Demographics section starting on page 21 of this report.

4. **Oversampling of Select Subpopulations** – Oversampling of historically unrepresented populations and groups disproportionately impacted by behavioral health conditions was used. The plan included an oversampling of people in the following groups.

- People who are homeless or who have unstable housing
- People of color, including people who identify as Native Americans or Asian Pacific
- People from the LGBTQ+ community
- People who are veterans
IV. Findings

1. Integrated Findings Summary

An overview of results can be found in Figure 2 below, which summarizes Phase 1 findings within the anti-stigma campaign focus selection framework noted above. The description of the integrated findings in this section can be traced directly to Figure 2 below. Details supporting this summary can be found in the qualitative and stigma survey findings sections immediately following this section. The full campaign selection process, dimensions, measures, and criteria can be found in Appendix 2 of this report.

<table>
<thead>
<tr>
<th>Dimension</th>
<th>NSMHC</th>
<th>SMHC</th>
<th>SUD</th>
<th>SUD + MHC</th>
<th>Suicide</th>
<th>Importance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Stigma Scale Scores</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
<td>Very High</td>
</tr>
<tr>
<td>2 Stigma Barriers to BH Service</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td>High</td>
</tr>
<tr>
<td>3 Stigma Impact on BH Services</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td>High</td>
</tr>
<tr>
<td>4 Changeability SUD/MH Views</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>High</td>
</tr>
<tr>
<td>5 Stigma Source</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
<td>Low</td>
</tr>
<tr>
<td>6 If MH Seen Like Physical Health</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td>Low</td>
</tr>
<tr>
<td>7 BH Condition Prevalence</td>
<td>15%</td>
<td>5%</td>
<td>14%</td>
<td>7%</td>
<td>5%</td>
<td>Informational</td>
</tr>
<tr>
<td>8 BH Condition Lethality</td>
<td>Shorter Lives</td>
<td></td>
<td>Overdose Deaths</td>
<td>Overdose Deaths</td>
<td>Death by Suicide</td>
<td>Informational</td>
</tr>
<tr>
<td>9 Example Anti-Stigma Initiatives</td>
<td>Let’s Talk</td>
<td>Let’s Talk</td>
<td>Lift The Label, NYC Living Proof</td>
<td>Lift The Label, NYC Living Proof</td>
<td>SPCC, Second Wind</td>
<td>Informational</td>
</tr>
</tbody>
</table>

NSMHC: Non-Serious Mental Health Condition
SUD: Substance Use
SMHC: Serious Mental Health Condition
SUD + MHC: Substance Use and Mental Health Issues
SPCC: Suicide Prevention Coaliiton of Colorado
BH: Behavioral Health
MH: Mental Health

Notes: An "X" in a cell indicates the BH Condition metric(s) are significantly higher than some non-X row groups, but not significantly different from each other. A red "X" indicates the highest value of the X-row.

Figure 2

Personal Experience – As shown in the Figure 3 below, people with personal experience with behavioral health conditions have significantly higher levels of stigma than people in the friends and family and general population groups (sample sizes for each cell is presented in Figure 4 on page 20). This suggests that for people with lived experience (personal experience or friends and family members of people with personal experience), it is those with personal experience who experience significantly higher levels of stigma ($F(2,948) = 112.55$, $p < .001$, post-hoc comparisons significant $p < .05$).

People With a Serious Mental Health Condition – Within the 6 stigma survey dimensions assessed (see Figure 2, details explained in “People with Personal Experience: Stigma Related Scores by Behavioral Health Condition” section starting on page 23 of this report), people with a serious mental health condition (SMHC) had significantly higher scores on 4 stigma dimensions (i.e., dimensions 1, 3, 5 and 6 in Figure 2) compared to people with a non-serious mental health condition (NSMHC). Although people with other behavioral health conditions sometimes had significantly higher stigma dimension scores compared to people with an NSMHC, that happened less frequently than people living with an SMHC, and their stigma levels were always lower (though non-significantly so) than stigma dimension scores for the other groups. Furthermore, qualitative interview findings noted weeks before the survey results were finalized indicated that people with an SMHC would be a good group for the campaign focus along with other conditions.
2. Interview and Focus Groups

AIM's primary objective was to collect qualitative and quantitative data on the stigma surrounding behavioral and mental health conditions like general depression and anxiety, serious mental health conditions like schizophrenia or severe depression, suicide and suicidal thoughts, and misuse of drugs and alcohol. Early on, we heard that “behavioral health” was a term not used or understood by communities and so the term “mental health” was used to describe the above conditions, including those that have substance use issues. The team’s approach was to avoid duplication of efforts within Denver and identify areas of efficiency. The Phase 1 Formative Assessment began with 21 interviews with Denver-based mental health service providers and organizations. These interviews helped reveal existing anti-stigma efforts, barriers to accessing treatment, people's perceptions of common mental illnesses, and socio-cultural considerations to execute the campaign effectively and efficiently.

Building on the information gained during the interview process, 10 listening sessions with community-specific focus groups were held to capture diverse experiences and perspectives to better understand the impact of mental health stigma. These focus groups included 97 community members from the Asian/Pacific Islander, Black/African American, Hispanic/Latino, Indigenous/Native American, LGBTQ+, homeless/unhoused, providers, people with lived experience, friends and family of those with lived experience, and youth communities. Both interviews and focus groups helped inform existing efforts, data, stigma themes, access, and possible approaches for the campaign efforts and were followed-up with quantitative survey data collected.

**Existing efforts.** The interviews and focus groups revealed factors contributing to individual perceptions of mental health stigma in Denver, including social determinants of health and historical contexts of mental health treatment in the city. The findings highlighted the lack of diversity among providers relative to the communities needing care and the absence of culturally and linguistically appropriate care. Common findings reflected: a mistrust of providers and the system, a need for community mental health education, and those existing efforts have not been inclusive of diverse communities and languages.

**Data.** In line with the feedback on socio-economic and historical barriers to mental health services, a lack of data sources for Asian/Pacific Islander, Black/African American, Hispanic/Latino, Indigenous/Native American, and
LGBTQ+ populations was highlighted. The lack of data is reflective of the lower levels of resources and services tailored and accessible to these populations.

**Stigma themes.** Interviewees expressed greater concern for the stigma associated with suicide and with the conditions of substance use issues and serious mental health. Regarding sources of stigma, comments referencing providers as a source were so pervasive that a focus group specific to providers was deemed needed for the project. Focus group participants agreed that other mental health conditions, such as general anxiety and mild depression, are easier to talk about. It was noted that generational and gender differences impact the stigma associated with mental health conditions.

**Access.** It became apparent that stigma manifests differently by culture, thus requiring culturally and linguistically responsive messaging to come from trusted sources within a given community. Interviewees and focus group participants suggested that stigma is not the primary issue affecting access, but rather systemic inequities, cost of care, and social determinants of health. These barriers were identified as especially significant for populations of color who have suffered generational historic trauma. Additionally, the fear of others’ reactions keeps people from talking about mental health conditions and seeking treatment.

**Approach.** Considerations for the campaign include messaging that is positive, empathic, hopeful and community led. Additionally, there needs to be numerous avenues for messaging. All participants made clear that campaign messaging needs to come from people “who look like me and speak my language.” Interviewees suggested that targeting substance use issues and ‘other mental health conditions’ would be most impactful for the campaign. A significant consideration is that any campaign effort needs to have community support.

More detailed findings from interviews and focus groups can be found in Appendix 7 of this report.

### 3. Stigma Survey

Below provides more context and details around the stigma survey findings found in the integrated survey findings above.

**Survey Retention Criteria** – There was a total of 4,617 surveys submitted from December 17, 2021 to February 15, 2022. A total of 3,660 surveys were eliminated from the analysis for the reasons outlined below. Therefore, there were 957 surveys ultimately used for the analysis, with 853 (89%) coming from our sample provider while the remaining 104 (11%) came from recruiting through our Denver services providers and advocacy organizations.

- **Completed All Questions** – Respondents had to complete all stigma scale, demographic and media usage questions to be included for analysis.
- **Non-Automated Surveys** – There were three periods of high-volume survey completion (via recruiting through Denver provider and advocacy organizations) where several hundred surveys were submitted within a few hours that were attributed to “malicious intent” programmers. All surveys submitted during these “automated survey waves” were disqualified and not used for analysis. During these periods, all online surveys were “closed” for a few days while additional online survey countermeasures were put in place to reduce the chance of future automated survey events.
- **Live in Denver County** – All respondents had to affirm that they live in the City and County of Denver. People contacted through Denver services providers and advocacy groups also had to submit their residence zip code that was verified to be from the City and County of Denver. Only zip codes completely within the City and County of Denver borders were used for this screening step.
- **15+ Years Old** – All respondents entered their birth year that was used to confirm they were 15 years old or older.
- **Unique IP Address** – With some exceptions (e.g., in-person events), all online surveys were verified to be coming from one unique IP address. When multiple surveys came from the same IP address, the first survey was retained from that IP address (if it met all other survey retention criteria) and rejected all future surveys from the same IP address.
- 2+ Minutes to Complete Survey – The time taken to complete the survey was at least 2 minutes.
- No “Straight Line” Responses – For 19 of the core stigma scale questions, completed surveys could not have the same rating value for all 19 questions.

Completed Surveys by Population and Behavioral Health Condition – A total of 957 valid surveys were received (see Figure 4 below), which broke down to 412 from people with personal experience of a behavioral health condition (37 more than planned), 217 from friends and family of people with personal experiences (33 fewer than planned), and 328 from the general population (three more than planned). The behavioral health condition that fell most under target was for the Suicide category within the Friends & Family population group. This distribution of surveys across populations and behavioral health conditions provided a strong foundation from which to conduct a wide variety of planned and exploratory statistical analyses. Table 2 shows how many more or less surveys were obtained for analysis compared to the original plan outlined in Table 1 above.

![Completed Surveys](image)

**Figure 4**

Table 2: Number of Surveys More (+) or Less (-) Than Planned by Population and Behavioral Health Condition

<table>
<thead>
<tr>
<th>Behavioral Health Condition</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Denver Population</strong></td>
<td></td>
</tr>
<tr>
<td>NSMHC</td>
<td>+6</td>
</tr>
<tr>
<td>SMHC</td>
<td>+1</td>
</tr>
<tr>
<td>SUD</td>
<td>+5</td>
</tr>
<tr>
<td>SUD+MHC</td>
<td>-2</td>
</tr>
<tr>
<td>Suicide</td>
<td>-7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>+3</td>
</tr>
<tr>
<td><strong>General Population</strong></td>
<td></td>
</tr>
<tr>
<td>NSMHC</td>
<td>+27</td>
</tr>
<tr>
<td>SMHC</td>
<td>+21</td>
</tr>
<tr>
<td>SUD</td>
<td>-23</td>
</tr>
<tr>
<td>SUD+MHC</td>
<td>+25</td>
</tr>
<tr>
<td>Suicide</td>
<td>-13</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>+37</td>
</tr>
<tr>
<td><strong>People with Lived Experiences</strong></td>
<td></td>
</tr>
<tr>
<td>Personal Experiences</td>
<td>+5</td>
</tr>
<tr>
<td>Close Friends and Family</td>
<td>-8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>-33</td>
</tr>
</tbody>
</table>

Note: Total number of planned surveys was 950 and the actual number of retained surveys was 957
NSMHC: Non-Serious Mental Health Condition
SMHC: Serious Mental Health Condition
SUD: Substance Use
SUD+MHC: People experiencing SU and a SMHC or NSMHC
Suicide: People with suicidal thoughts or actions
Survey Respondent Demographics – The demographic profiles of the people responding to the surveys were well aligned with the demographic profile of the overall Denver population, including within each of the three populations examined in Phase 1 (i.e., General Population, Personal Experience, and Friends and Family). Figures 5 and 6 above show how each population (the colored bars) compared to the overall Denver population (numbers in parentheses above the colored bars) for race ethnicity, group identification, gender and age breakouts. These
findings show that a reasonable amount of planned oversampling was achieved for people who identified as Asian Pacific, Black/African American, Native or Indigenous American, Homeless/Unstable Housing, and LGBTQ+. (Note that “Person of Color” was a survey response category with no additional definition on the survey, so it does not have a Denver population value.) This oversampling was consistent for all three populations and was often strongest for people in the Personal Experience group. The sample appears to be more weighted to female and younger respondents compared to the Denver population.

**Stigma Scale Scores** – As shown in Figures 7 and 8, all stigma scale score averages across all respondents were between 2.56 (Access Treatment) and 3.22 (Willingness to Disclose), where 1.0 was the lowest possible stigma score and 5.0 was the highest possible score. It was also seen that people in the Personal Experiences group had significantly higher stigma levels on all stigma scales compared to people in both the Friends & Family and General Population groups (F(2,948)) = 112.55, p < .001). In this context (i.e., all populations and behavioral health conditions combined), higher stigma levels for any given scale means that respondents felt more stigmatized (for the Personal Experience and Friends and Family groups) or had more stigmatizing views of people who live with a behavioral health condition (for the General Population group).

Note 1: Ratings by 957 people
Note 2: Willingness to Disclose scale score significantly higher than Social Distance (t(947) = 13.100), Discriminatory Intent (t(948) = 17.761), Accessing Treatment (t(946) = 20.214) and General Stigma (t(947) = 18.029) with over 99% confidence (p < .001 for all).
People with Personal Experience: Stigma Related Scores by Behavioral Health Condition – As previously noted, people in the Personal Experience group had significantly higher levels of stigma than people in the Friends and Family and General Population groups (see Figure 8). Therefore, additional focus was given to stigma-related analyses on people with personal experiences to see how they are impacted across the five behavioral health conditions. In this way, it could be determined if people who experience a certain type of mental health condition have particularly high levels of stigma on the variety of dimensions mentioned in the campaign focus selection framework mentioned earlier.

As noted in the Integrated Findings Summary section above (and shown again in Figure 9 below), people with a Serious Mental Health Condition had significantly higher scores on 4 of 6 stigma dimensions compared to people with a non-serious mental health condition. Although people with other behavioral health conditions sometimes had significantly higher stigma dimension scores compared to people with an NSMHC, that happened less frequently than people living with an SMHC, and their estimated stigma scores were lower (although non-significantly so) than stigma dimension scores for the other groups. Each paragraph below describes findings for each row in Figure 9. Details of findings for each of these rows can be found in Appendix 8.
Summary of Personal Experience Group Stigma Survey Findings

<table>
<thead>
<tr>
<th>Stigma Dimension</th>
<th>NSMHC</th>
<th>SMHC</th>
<th>SUD</th>
<th>SUD + MHC</th>
<th>Suicide</th>
<th>Importance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Stigma Scale Scores</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>Very High</td>
</tr>
<tr>
<td>2 Stigma Barriers to BH Service</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Impact on Seeking BH Services</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td>High</td>
</tr>
<tr>
<td>4 Changeability SUD/MH Views</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 Stigma Source</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>Low</td>
</tr>
<tr>
<td>6 If Seen Like Physical Health</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Low</td>
</tr>
</tbody>
</table>

NSMHC: Non-Serious Mental Health Condition  
SUD: Substance Use  
Suicide: Suicidal Thoughts and Actions  
SMHC: Serious Mental Health Condition  
SUD/MHC: Substance Use and Mental Health Issues  
BH: Behavioral Health  
MH: Mental Health

Note: An “X” in a cell indicates the BH Condition metric(s) are significantly higher than some non-X row groups, but not significantly different from each other. A red “X” indicates the highest value of the X-row.

**Figure 9**

Row 1 summarizes the “stigma composite scale score” average differences between people with personal experiences of the five behavioral health conditions examined in Phase 1. People with personal experience of an SMHC had significantly higher stigma scores compared to people with a NSMHC. Although this was also true for other conditions (i.e., SUD, SUD+MHC, and Suicide), people in the SMHC group scored highest on the stigma composite score across all five conditions.

Row 2 summarizes the findings for three separate “stigma barriers to receiving substance use or mental health services” average differences between the five behavioral health condition groups. The survey asked “How large were / are these potential barriers when thinking about looking for services for your mental health condition over the past 12 months?” then listed 17 potential barriers to rate on a 5-point Likert scale from 1 (not a barrier at all) to 5 (extremely large barrier). Only three of these 17 barriers were related to stigma (e.g., scared to admit they may need help, fear what others may say, and might feel worse about self). It was found that people with personal experience of suicidal thoughts or actions had significantly higher ratings on all 3 separate “stigma-related barriers” compared to people in the NSMHC behavioral health conditions.

Row 3 summarizes the “stigma impact on seeking behavioral health services” average differences between the five behavioral health condition groups. The survey asked, “How big an impact does stigma about [SUD / mental health] have when you think about getting services for your [SUD / mental health condition]?” It was found that people with personal experience with a serious mental health condition had a significantly higher agreement with this statement compared to people with a non-serious mental health condition. Although this was also true for other conditions (i.e., SUD and SUD+MHC), people in the SMHC group scored highest on this measure across all five conditions.

Row 4 summarizes the “changeability of your substance use and mental health views” average differences between the five behavioral health condition groups. The survey asked, “Do you think you can change your views about [SUD / mental health]?”. It was encouraging to see that in people with personal experiences that the typical response was fairly positive with an average rating of 2.46, where 1 = No, 2 = Maybe, and 3 = Yes. This means that the typical response was about halfway between a “maybe” and a “yes”. However, no significant differences were found in responses to this question across the five behavioral health conditions.

Row 5 summarizes the “sources of stigma” average differences between the five behavioral health condition groups. The survey asked, “How stigmatized do you feel from the following people and sources about your [SUD /
mental health condition]?”; then listed nine different groups of people (e.g., friends, family, law enforcement) and media sources (e.g., social media) that were each rated on a 5-point Likert scale ranging from 1 (not stigmatizing at all) to 5 (extremely stigmatizing). A composite average of their ratings to all 9 sources was created (i.e., nine separate ratings for each respondent). It was found that people with personal experience with a serious mental health condition had significantly higher average ratings of these nine specific stigma sources compared to people with a non-serious mental health condition. Although this was also true for other conditions (i.e., SUD, SUD+MHC, and Suicide), people in the SMHC group scored highest on this measure across all five conditions.

Row 6 summarizes the “if substance use / mental health seen like physical health” average differences between the five behavioral health condition groups. The survey asked, “If [SUD / mental health] was seen and treated like physical health it would make it easier for you to get help for your [SUD / mental health condition]?” It was found that people with personal experience of a serious mental health condition had significantly higher agreement to this question compared to people with a non-serious mental health condition.

Stigma Perception Gaps Between People with Personal Experiences and the General Population – As noted previously, people with Personal Experiences were found to have significantly higher levels of overall stigma when compared to either the Friends and Family Group or the General Population group. When looking at the size of the stigma differences between people with Personal Experiences and General Population groups by behavioral health condition, people with personal experience perceive stigma much more harshly than the general population feels towards them. Although most of these “stigma gaps” between people with personal experience and the general population within behavioral health conditions were statistically significant, people with a serious mental health condition (SMHC) had the largest average difference as reflected by the gap score on the Stigma Composite scale (see Figure 10 below).

Personal Experience: Exploratory Stigma Key Drivers Model – An attempt was made to create a predictive model describing the key drivers of how stigmatized people regularly feel who personally experience living with a behavioral health condition. Data from the 412 completed surveys were used from people in the Personal Experiences group to create an exploratory model on this topic using a latent variable partial least squares structural equation modeling approach. Figure 11 summarizes an exploratory model that is described below.

---

**Stigma Gaps Between People with Personal Experiences and the General Population**

In most areas, people with personal experience perceive BH stigma much more harshly than the general population feels towards them, especially in the SMHC and Suicide groups regarding stigma around accessing treatment, general stigma and discriminatory intent.

*Note 1: Ratings by 740 total respondents in the Personal Experience and General Population Groups.  
Note 2: All stigma gap scores are significant (t-test p < .05) except for those noted by an “*”.*
On the survey, question 9 (Q9) asked respondents to rate the statement, “Most days, how stigmatized do you feel about your mental health condition?” on a 5-point Likert scale where 1 = “Not stigmatized at all” to 5 = “Extremely stigmatized”. For people with personal experience, the average rating was 3.12, which is slightly above the 3.0 label of “moderately stigmatized” on the 5-point rating scale. Q9 was used as the primary dependent variable in the overall model.

Next, four specific stigma scales were introduced into the model (i.e., Social Distance, Discriminatory Intent, Accessing Treatment, and Willingness to Disclose) as latent independent variables to see which of these scales was most related to explaining overall stigma – Q9. Dummy-coded variables for behavioral health condition (with NSMHC as the referent category) were also included as independent variables to Q9. Only two of the scales (i.e., Discriminatory Intent and Willingness to Disclose) had significant (p < .05) relationships with Q9. This initial model showed that Discriminatory Intent has roughly a two-thirds higher impact on reducing regular feelings of being stigmatized for their behavioral health condition compared to Willingness to Disclose (as assessed by comparing the relative values of the standardized path coefficients).

Then, ratings of how stigmatizing nine separate stigma sources were introduced into the model as independent variables explaining ratings of the two retained stigma scales (i.e., Discriminatory Intent and Willingness to Disclose). As done with Q9, dummy-coded variables for behavioral health condition were also included as independent variables for the two stigma scales. It was found that ratings of how stigmatized people feel from friends, strangers and family members, separately, were significant drivers of their ratings of feeling discriminatory intent from others. None of the other 6 stigma sources were found to be significant drivers of Discriminatory Intent beyond the three already noted. This suggests that some people “closest” to those with personal experiences (i.e., friends and family) have the biggest influence on how much they feel the stigma associated with intentions to discriminate against them because of their behavioral health condition. All three of these stigma sources are somewhat “personal” in that they are people who they know, or regularly encounter.

It was also found that ratings of how stigmatized people feel from social media, law enforcement, and traditional media, separately, were significant drivers of their ratings of willingness to disclose that they have a behavioral health condition. None of the other six stigma sources were found to be significant drivers of Willingness to Disclose beyond the three already noted. It appears that these three “institutions or platforms” have the biggest influence on how much people are willing to disclose to anyone about their behavioral health condition.
Information from this exploratory model can be used in at least a couple of ways when designing anti-stigma campaign messaging in Phase 2. One use is to tailor anti-stigma campaign messaging towards the core stigma dimensions of discrimination against people with a behavioral health condition and their willingness to talk about substance use and mental health. Reducing regular feelings of being stigmatized because of having a behavioral health condition is most heavily influenced by reducing feelings of discriminatory intent from others and reducing the stigma related to disclosing and talking to others about their substance use or mental health issues. It is noteworthy that an emphasis on increasing willingness to talk about behavioral health issues is a central theme of the ongoing Let’s Talk Colorado anti-stigma campaign that is currently being executed.

Another use of this model is to customize anti-stigma campaign messaging towards the six stigma sources noted in the model, with some emphasis on friends, family, and strangers. Reducing the level of stigma perceived to be coming from these three sources will have the largest impact on reducing feelings of Discriminatory Intent, which has been shown to have roughly a two-thirds higher impact on reducing regular feelings of being stigmatized for their behavioral health condition compared to Willingness to Disclose.
V. Recommendations

1. Campaign Focus Selection Process and Criteria

Below is an outline of the overall agreed-to campaign selection process that involved AIM, APG, Circuit Media (CM), and select DDPHE stakeholders in late January through the end of February 2022.

- Developed and agreed on the overall campaign selection process
- Developed and agreed on relevant dimensions, measures, and criteria for selecting a Phase 2 campaign focus
- AIM/APG team created draft Phase 1 final presentation with recommendations
- AIM, APG, CM, and select DDPHE stakeholders met to review Phase 1 final presentation and began discussing recommendations
- AIM, APG, CM, and select DDPHE stakeholders reconvened to review Phase 1 recommendations and finalize decision on Phase 2 campaign development focus

The full campaign selection process, dimensions, measures, and criteria can be found in Appendix 2 of this report.

1. Recommended Campaign Focus

After reviewing relevant background information and analyzing qualitative (i.e., interview and focus group) and quantitative (i.e., survey) information from Phase 1, the AIM / APG Anti-Stigma Campaign project team recommends that DDPHE support the development of a Phase 2 (Message Development) and Phase 3 (Campaign Execution) campaign focused on the following intersecting set of attributes:

- **Focus on People with Personal Experiences**: There should be a focus on reducing levels of behavioral health stigma in people with personal experiences by targeting an anti-stigma campaign on people in the *general population* who are the primary sources of this stigma.
- **Focus on People with Serious Mental Health Conditions**: Focus on addressing the stigma associated with people who live with a Serious Mental Health Condition (SMHC).
- **Focus on People with Specific Demographics**: Much information gathered during Phase 1 suggested that the anti-stigma campaign should focus on people with specific demographic profiles. Although the Phase 1 information gathered is not definitive on which demographic profiles should be targeted in the anti-stigma campaign, the data suggest that people from some groups (e.g., race, ethnicity, gender identity, housing status, and veteran status) may feel more stigmatized than other groups.

Below is a summary of the rationale for recommending these intersecting anti-stigma campaign focus areas:

**Campaign Target**: There should be a focus on reducing levels of behavioral health stigma in people with personal experiences by targeting an anti-stigma campaign on people in the general population who are the primary sources of this stigma.

- **People with Personal Experience** – The data shows that people with personal experience of living with serious mental health conditions experience the highest levels of stigma. People with Personal Experiences were found to have significantly higher levels of overall stigma (all individual stigma scales and the Stigma Composite score) when compared to the Friends and Family and General Population Groups.
- **General Population** – Addressing stigma should include an anti-stigma campaign focused on reducing stigmatizing views and behaviors from the primary sources of stigma – the General Population. Evidence from Phase 1 suggests that there are six primary sources of stigma towards people living with a behavioral health condition that have the highest impact on them feeling regularly stigmatized for the condition (see below). An anti-stigma campaign targeted at the general population should target the following six stigma sources noted in the exploratory key driver model noted in this report:
Anti-Stigma Campaign Project – Phase 1 / Formative Assessment Final Report

- Friends
- Family
- Strangers
- Law Enforcement
- Traditional Media
- Social Media

**Campaign Focus on Serious Mental Health Conditions:** It is recommended to focus on addressing the stigma associated with people who live with a Serious Mental Health Condition (SMHC).

Within the Personal Experience focus, there are a variety of stigma-related dimensions used to assess which behavioral health condition should be the target of an anti-stigma campaign. Taking the qualitative and quantitative findings as a whole and considering other factors (e.g., behavioral health condition prevalence and lethality), a pattern of findings suggest that people with a serious mental health condition (e.g., schizophrenia, major depression and/or bipolar depression) should further define the campaign focus. It is recommended to focus an anti-stigma campaign on reducing the stigmatizing views and behaviors people in the general population have towards people with a serious mental health condition based on the following information:

1. **High Stigma Levels** – On the survey respondents were asked 23 questions about the level of stigma they experienced personally in four specific SUD / mental health stigma domains (Social Distance, Discriminatory Intent, Accessing Treatment, and Willingness to Disclose) and on a “general” measure of stigma. When looking at the average of all 23 questions (with all scored for higher values reflecting higher levels of stigma experienced), it was found that people with personal experience of a serious mental health condition had significantly higher stigma levels compared to people with a non-serious mental health condition. Although this was also true for other conditions (i.e., SUD, SUD+MHC, and Suicide), people in the SMHC group scored highest on the stigma composite score across all five conditions. Additionally, people in the personal experience SMHC group scored significantly higher than the NSMHC group on the three stigma measures in a model predicting a single overall stigma rating.

2. **High Stigma Impact When Seeking Behavioral Health Services** – On the survey, respondents were asked, “How big an impact does stigma about [SUD / mental health] have when you think about getting services for your [SUD / mental health condition]?” It was found that people with personal experience of a serious mental health condition had a significantly higher agreement with this statement compared to people with a non-serious mental health condition. Although this was also true for other conditions (i.e., SUD and SUD+MHC), people in the SMHC group scored highest on this measure across all 5 conditions.

3. **Ability to Change Views in SUD/MH Views** – On the survey, respondents were asked, “Do you think you can change your views about [SUD / mental health]?”. We were encouraged to see that in people with personal experiences, the typical response was fairly positive with an average rating of 2.46, where 1 = No, 2 = Maybe and 3 = Yes. This means that the typical response was about halfway between a “maybe” and a “yes”. Furthermore, we did not find any significant differences in responses to this question across the five behavioral health conditions of people with personal experiences. This suggests that people with a serious mental health condition are just as likely to believe they can change their views about their condition as people from any of the other conditions, which was relatively positive.

4. **Specific Stigma Sources** – On the survey respondents were asked, “How stigmatized do you feel from the following people and sources about your [SUD / mental health condition]?”, then listed nine different groups of people (e.g., friends, family, law enforcement) and media sources (e.g., social media). A composite average was created of their ratings to all nine sources. It was found that people with personal experience of a serious mental health condition had significantly higher average ratings of these nine specific stigma sources compared to people with a non-serious mental health condition. Although this was also true for other conditions (i.e., SUD, SUD+MHC, and Suicide), people in the SMHC group scored highest on this measure across all five conditions.

5. **If Mental Health Seen and Treated Like Physical Health** – On the survey respondents were asked, “If [SUD / mental health] was seen and treated like physical health it would make it easier for you to get help for your [SUD / mental health condition]?” It was found that people with personal experience of a serious...
ment health condition had significantly higher agreement to this question compared to people with a non-serious mental health condition.

6. **Stigma Perception Differences with General Population** – As noted previously, people in the Personal Experiences group were found to have significantly higher levels of overall stigma when compared to either the Friends and Family group or the General Population group. When looking at the size of the stigma differences between people with Personal Experiences and General Population group by behavioral health condition, people with personal experience perceive stigma much more harshly than the general population feels towards them. Although most of these “stigma gaps” between people with personal experience and the general population within behavioral health condition were statistically significant, people with a serious mental health condition had the largest average difference as reflected by the gap score on the Stigma Composite scale.

7. **BH Condition Prevalence** – Data from the SAMHSA “National Survey on Drug Use and Health” report (2020) summarizes national and substate regional data on a wide variety of substance use and mental health conditions. The report’s substate maps suggest that about 5% of all the Denver metropolitan area residents aged 18 years and older have had a “serious mental illness” within the past 1 year. That is similar to the proportion of the same Denver metropolitan population that has seriously considered suicide (5%) or had a substance use disorder co-occurring with any mental health condition (7%), but is lower than Denver metropolitan residents who would be in the SUD (14%) or the NSMHC (15%) groups as defined in the project.1

8. **Qualitative Findings** – The surveys were designed and deployed in December of 2021 and were created within the context of the previously conducted 21 interviews and 10 focus groups. One of the primary themes identified weeks prior to deployment of the survey was that many interviewees suggested an anti-stigma campaign should focus efforts on people experiencing a serious mental health condition.

**Example Demographic Profiles** – Feedback heard in focus groups suggested that people respond better to messaging from people who look like, and sound like them. It is recommended that campaign messaging should be tailored to specific demographic profiles. Specific demographic targets are not recommended at this time based on Phase 1 findings.

The data suggests that people with personal experiences within each of the groups noted below (separately) have higher stigma levels who may have “greater room for improvement” in reducing stigma barriers that may be preventing them from seeking needed behavioral health services. Below is a summary of potential groups of people with personal experiences with a serious mental health condition based on the following information. To be clear, these examples are statistically relevant but not necessarily the recommended campaign focus, which will be determined early in Phase 2 of this project.

- **People Who are Veterans** – It was found that veterans with personal experiences of a serious mental health condition had significantly higher levels of stigma (Stigma Composite Score) compared to their non-veteran counterparts.

- **People 25 to 64 Years Old** – It was found people 25 to 64 years old with personal experiences with a serious mental health condition had significantly higher levels of stigma (Stigma Composite Score) compared to their 15- to 24-year-old counterparts.

- **People Who are Homeless / Have Unstable Housing** – Although no significant stigma differences were found for people with a serious mental health condition, it was found that people who have personal experiences (or friends or family members of those people) with homelessness or have unstable housing with any behavioral health condition have significantly higher levels of stigma (Stigma Composite Score) compared to their stably housed counterparts.

- **People in the LGBTQ+ Community** – Although no significant stigma differences were found for people with a serious mental health condition, it was found that people within the LGBTQ+ community (or friends or family members of those people) with any behavioral health condition have significantly higher levels of stigma (Stigma Composite Score) compared to their non-LGBTQ+ counterparts.
**Potential Campaign Collaboration** – To make the best use of the ASC project Phase 2 and Phase 3 resources, it is recommended that a collaborative approach be used to reach people from the general population. It is recommended that the campaign team collaborate with an anti-stigma campaign partner (e.g., Let’s Talk) to focus on adapting an ongoing anti-stigma campaign effort from another organization to align with reducing the stigma that the general population of Denver has about people with a serious mental health condition.
VI. Appendices
Appendix 1: End Notes


Appendix 2: Campaign Focus Selection Process, Dimensions, Measures and Criteria

Anti-Stigma Campaign Selection Process

I. Introduction / Overview – One of the primary objectives for the Formative Assessment (Phase 1) of the Anti-Stigma Campaign (ASC) Project is to recommend an anti-stigma campaign focus for Message Development (Phase 2) and Campaign Execution (Phase 3). In response to the Phase 1 recommendations by the AIM/APG team, DDPHE will provide feedback and approval for the target audience, behavioral health condition, communities and message features to be developed in Phase 2. A planned, thoughtful, and structured campaign selection process will help all to decide on the ASC Project campaign scope and focus more quickly and confidently.

II. Overall Campaign Selection Process – Below is an outline of the overall campaign selection process that involves AIM, APG, Circuit Media (CM) and select DDPHE stakeholders

1. Develop and agree on overall campaign selection process
2. Develop and agree on relevant dimensions, measures, and criteria for selecting a Phase 2 campaign focus
3. AIM/APG team create draft Phase 1 Final Report and presentation with recommendations
4. AIM, APG, CM and select DDPHE stakeholders meet to review Phase 1 final report and begin discussing recommendations
5. AIM, APG, CM and select DDPHE stakeholders reconvene to review Phase 1 recommendations and finalize decision on Phase 2 campaign development focus

III. Campaign Selection Dimensions and Weights – The ultimate, long-term objective of the selected campaign is increasing the number of people needing behavioral health services to getting the services they need. Although there are many factors beyond the scope of this project that can increase people getting the services they need (e.g., the capabilities and capacity of local behavioral health service organizations), stigma is a known barrier that can help if reduced. Therefore, our goal here is choose a campaign focus that will have the highest impact on reducing stigma as a barrier to receiving needed services. Given this perspective, we plan to select a campaign focused on a population and behavioral health condition where stigma levels can be changed the most, with the belief that will lead to more people receiving needed services.

Preliminary campaign selection dimensions were presented in AIM’s original proposal and discussed previously with DDPHE. During working sessions on February 2, 8, and 15, 2022, AIM, APG, CM and DDPHE agreed on the dimensions below that we plan to use when selecting a campaign focus for Phase 2 and beyond. By “campaign focus” we mean (1) a specific population [i.e., people with personal experience, friends and family members of people with personal experience, or the general population], (2) a specific behavioral health condition [i.e., non-serious mental health condition, serious mental health condition, substance use, substance use and mental health condition, suicide], and (3) specific communities [e.g., by age, race / ethnicity, LGBTQ+ status, veteran status]. For each of the dimensions below, a preliminary relative weight is noted in red text within brackets “[ ]” at the end of each description based on feedback during our most recent working session on 2/15/2022.

1. **Stigma Levels** (Q7.X, Q8.X and Q9) – There are 27 questions on the survey across Q7, Q8 and Q9 addressing 5 stigma dimensions (i.e., Willingness to Disclose, Social Distance, Discriminatory Intent, Accessing Treatment and General Stigma) and overall stigma. The “biggest impact” may be where stigma levels are currently the highest. [Very High Weight]
2. **Barriers to Services** (Q12.X) – There are 17 questions on the survey within Q12 addressing a wide variety of barriers to people receiving needed substance use and or mental health services, including stigma. It is possible that the “biggest impact” may be where the “stigma barrier” is rated high compared to other “non-stigma barriers”. [High Weight]

3. **Impact on Seeking Services** (Q14) – Similar to Q12.X above, Q14 on the survey directly asks the impact that stigma has on seeking substance use and or mental health services. Groups with the highest ratings on this question may have the most positive impact on seeking services if stigma were reduced. [High Weight]

4. **Changeability of Substance Use and or Mental Health Views** (Q22) – Q22 on the survey asks respondents if they think they can change their views about substance use and or mental health. Groups with the highest “openness to change” ratings on this question may have the greatest potential to changing their views and thus could have the highest impact of a campaign in lowering stigma. [High Weight]

5. **Stigma Population Source** (Q10) – Q10 on the survey asks how stigmatized respondents feel from 9 different sources of stigma, including friends, family, strangers and 4 different types of “professionals”, such as first responders, law enforcement and service providers. Stigma sources with the highest ratings may be relevant to selecting a population of interest for the campaign. [Low Weight]

6. **If Seen Like Physical Health** (Q15) – Q15 on the survey asks if getting help for substance use and or mental issues would be easier if those conditions were seen like a physical health condition. Groups with the highest ratings on this question may have the most positive impact on seeking services if stigma were reduced through a focus on “normalizing” discussing these conditions with people in their lives, including service providers. [Low Weight]

7. **Prevalence of Behavioral Health Condition** – Some behavioral health conditions have higher prevalence in the Denver County population than others. We will want a campaign focused on a behavioral health condition that has a relatively high prevalence. [Informational]

8. **Trend of Behavioral Health Condition** – Some behavioral health conditions in the Denver County population are increasing at higher rates than others. We will want a campaign focused on a behavioral health condition that is increasing faster than others. [Informational]

9. **Behavioral Health Condition Lethality** – People with some behavioral health conditions have a higher risk of death than others. We will want a campaign focused on a behavioral health condition that has a higher risk of death than others. [Informational]

IV. **Campaign Considerations** – In addition to the Campaign Selection Dimensions noted above, below are two additional anti-stigma campaign considerations. While these considerations are not part of the initial campaign selection criteria, there are potential advantages to combining and leveraging existing anti-stigma campaign knowledge and resources whenever possible.

1. **Alignment with Other Denver Behavioral Health Initiatives** – There are several existing strategic initiatives within Colorado and Denver already focused on addressing stigma related to one or more behavioral health conditions (e.g., Let’s Talk and Lift the Label). The ASC Project could align and collaborate with one or more of these existing initiatives to create an enhanced positive effect for the ASC Project campaign as well as the campaigns of the other initiative. Ideally, we will want a campaign focused on a population and behavioral health condition that can have its impact enhanced by aligning and collaborating with recent, existing or planned anti-stigma campaign efforts in Denver County. [Informational]

2. **Leveraging of Existing Anti-Stigma Campaign Knowledge and Resources** – In addition to Denver-specific behavioral health initiatives (see bullet 1 above), there are several recent or existing stigma reducing campaigns that we might be able to leverage (e.g., NYC Living Proof opioid awareness campaign) that could potentially have a high impact in Denver with fewer resources needed for message
development and campaign implementation. *Ideally, we will want a campaign focused on a population and behavioral health condition that can leverage recent or existing anti-stigma campaign design and execution efforts to reduce the cost and/or increase the effectiveness of an anti-stigma campaign focused on Denver County.* [Informational]
Appendix 3: Interview Questions

1. LEARNING FROM & BUILDING UPON PAST WORK
   - 1a. Do you have comments or guidance about these conditions or for these being the areas of focus for reducing stigma in Denver?
   - 1b. Would you prefer answering our next questions specific to one of these conditions or would you like to touch on all related to stigma?
   - 1c. Are you aware of existing or recent strategic initiatives within Denver already focused on a particular behavioral health condition or two that we could support or leverage?

2. OBJECTIVE #1 – DATA
   - 2a. Are you aware of recent surveys or data on stigma that might be helpful?
   - 2b. In thinking of the various subpopulations, race, ethnicity, veterans, homeless, LGBTQ, etc., what data sources might be available?
   - 2c. How important do you think it is to have accurate Denver baselines of stigma associated with attitudes and beliefs?
   - 2d. Would you be willing to allow us to survey your patients/clients/constituents if needed?

3. OBJECTIVE #2: STIGMA
   - 3a. Do you see differences in the stigma associated with the various conditions?
   - 3b. Are there considerations for stigma within any specific subpopulations? Cultural or religious considerations?
   - 3c. Which conditions inflect the most severe consequences to individuals & their families when present?

4. OBJECTIVE #3: ACCESSING TREATMENT/SERVICES
   - 4a. Given other barriers such as not enough providers, cost, etc., how significant is stigma as a barrier to accessing services?
   - 4b. How might we address the cultural stigma in asking for and accessing services in specific subpopulations?
   - 4c. Thinking about substance misuse, suicide, serious mental conditions and mental health conditions, what specific stigma issues would increase people accessing treatment?

5. FOCUS GROUPS
   - 5a. Generally speaking, who might we want to consider inviting to focus groups to understand the stigma in substance misuse, suicide, serious mental health conditions and mental health conditions.
   - 5b. Are there any subpopulations that you think we should specifically focus on (including race/ethnicity, age ranges, gender & nonbinary classifications, economic backgrounds, etc.)?
   - 5c. How can you help us reach “those with experience; their family, friends, loved ones”, subpopulations, providers?

6. MEDIA CAMPAIGN
   - 6a. What do you think are the preferred outreach methods for effectively engaging the communities in a meaningful way?
   - 6b. What type of campaign approach do you think would be most effective/beneficial?
   - 6c. Thinking about each of the behavioral conditions (substance misuse, suicide, mental health), where do you see having the most impact or potential for success?

7. CLOSING
   - In closing, how could this project be beneficial to you or your organization?
   - 7a. Is there anything that we didn’t ask you that we should know?
Appendix 4: Focus Group Questions

- In this section we want to focus on how people talk about mental health.
  a. What makes people uncomfortable (afraid) to talk about mental health? What would help?
  b. Is it harder for some groups of people (e.g., older vs. younger) rather than others to talk about mental health? Examples?
  c. Is it harder to talk about some mental health conditions and not others?
  d. We know that the words people use matter. What words do you want us to use (or NOT to use) when talking about mental health?

- In this next section we want to get a better idea about why people avoid those with mental health problems.
  a. Why do you think people keep away from those with mental health problems?
  b. How do people within your community support those with mental health problems? (Who are the helpers/what are the work arounds?)
  c. What messages might help those with mental health conditions in your community feel supported?
  d. What is the best way for those messages to reach your community?

- For our last section we want to have a conversation about accessing treatment for mental health problems.
  a. What keeps people from getting treatment/seeking help for mental health problems? Why?
  b. What would work in your community to lower stigma about mental health so that people can get the help they need?

- As we wrap up, is there anything else we should know about mental health stigma for your community?
Appendix 5: Stigma Survey Instrument – All Questions In Order

A total of 15 uniquely worded stigma surveys were created and used for Phase 1. Although all questions on the 15 surveys were “the same”, each survey used phrasing that was unique to the perspective of a specific population and behavioral health condition. The table below lists the 15 surveys / perspectives used:

<table>
<thead>
<tr>
<th>Stigma Surveys by Population and Behavioral Health Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Denver Population</strong></td>
</tr>
<tr>
<td>Friends &amp; Family</td>
</tr>
<tr>
<td>General Population</td>
</tr>
<tr>
<td>Personal Experiences</td>
</tr>
</tbody>
</table>

NSMHC: Non-Serious Mental Health Condition  
SMHC: Serious Mental Health Condition  
SUD: Substance Use  
SUD+MHC: People experiencing SUD and a SMHC or NSMHC  
Suicide: People with suicidal thoughts or actions

**Survey Perspectives** – Below is a description of the “perspectives” each survey took with wording for the stigma-related questions:

- **By Population**
  - *Personal Experience* – These surveys asked people to rate the degree to which they feel stigmatized because of their behavioral health condition. Even though they were asked to rate how stigmatized they feel, most questions were ambiguous as to the source of the stigma that they feel. No clear distinction was made between self-stigma and the stigmatizing beliefs and behaviors others have towards them.
  - *Friends & Family* – These surveys asked people to rate the degree to which they feel stigmatized because of being associated with a close friend or family member who has a behavioral health condition. Even though they were asked to rate how stigmatized they feel, most questions are ambiguous as to the source of the stigma that they feel. No clear distinction was made between self-stigma “be association” and the stigmatizing belief and behaviors others have towards them.
  - *General Population* – These surveys asked people to rate how they feel about other people who have a behavioral health condition. A notable exception to this is the Willingness to Disclose scale where people are asked to imagine they have a specific type of behavioral health condition and to rate the degree to which they would disclose this condition to others.

- **By Behavioral Health Condition**
  - *NSMHC* – Questions use the phrase “mental health condition” to refer to a non-serious mental health condition throughout the survey. A definition of a “mental health condition” was given just before that part of the survey and the phrase was given a “hover over” definition whenever used in the online version of the survey.
  - *SMHC* – Questions use the phrase “serious mental health condition” to refer to a serious mental health condition throughout the survey. A definition of a “serious mental health condition” was given just before that part of the survey and the phrase was given a “hover over” definition whenever used in the online version of the survey.
SUD – Questions use the phrase “substance use issues” to refer to the substance condition throughout the survey. A definition of “substance use” was given just before that part of the survey and the phrase was given a “hover over” definition whenever used in the online version of the survey.

SUD + MHC – Questions use the phrase “substance use and mental health issues” to refer to the substance use and mental health issues condition throughout the survey. A definition of “substance use and mental health issues” was given just before that part of the survey and the phrase was given a “hover over” definition whenever used in the online version of the survey.

Suicide – Questions use the phrase “suicidal thought or actions” to refer to the suicide condition throughout the survey. A definition of “suicidal thought or actions” was given just before that part of the survey and the phrase was given a “hover over” definition whenever used in the online version of the survey.

• Survey Questions

All questions below are for the “non-serious mental health condition” (NSMHC) survey for people with personal experiences. Given the description of survey perspectives above, the question phrasing for the other 14 surveys were changed to be directly relevant to the specific population and behavioral health condition.

[Questions to direct respondent to the appropriate survey language]
1) What is your preferred language?
   • English
   • Español [Spanish]
   • Tiếng Việt [Vietnamese]
   • العربية [Arabic]
   • Soomaali [Somali]
   • ኢማርኛ [Amharic]
   • Other [Arabic]

2) [question written in chosen language] Please enter your telephone number and first name only, and someone will call you to complete this survey with an interpreter.
   • Phone Number:

Additional Selection Questions

Introduction

Welcome! Thank you for participating in this survey about mental health in Denver for the Denver Department of Public Health and Environment (DDPHE). The purpose of this survey is to help DDPHE understand stigma and discrimination about mental health in Denver.

This survey will take about 15 minutes to complete. All your individual survey responses will be kept anonymous and will not be shared with anyone. Key words or phrases in the survey that appear in blue text will have a definition provided when you hover over the text in the online survey.

To show our appreciation for your time, you will have the option to receive a $5 online gift card from a variety of retailers after completing the survey.
If you need mental health support at any time, including while taking this survey, you can contact Colorado Crisis Services at 1-844-493-8255 or Text “TALK” to 38255.

Before we begin, we will ask you some questions to see if you will be able to continue with the survey. If you are not selected to continue, it is only because we have already received enough surveys from people like you.

[Questions to direct respondent to the appropriate survey]

1) Do you live in the City and County of Denver?
   - Yes
   - No
   - Not sure

In this survey we will be looking at substance use of drugs or alcohol, suicidal thoughts or actions, serious mental health conditions like schizophrenia, and other types of mental health conditions like mild depression or anxiety. For the next couple of questions, we will use the term “mental health” to describe all of these conditions.

2) Which statement best describes you? (select one)
   a. I have had difficulties with my mental health in the past 12 months.
   b. I know a friend or family member who has had difficulties with their mental health in the past 12 months.
   c. Neither of these two statements describe me.

3) [If 2a above] Which best describes your experience in the past 12 months? (select one)
   - I have struggled with substance use, like drugs or alcohol, and a mental health condition which have caused problems with my health or my responsibilities at work, school, or home.
   - I have struggled with substance use, like drugs or alcohol, which has caused problems with my health or my responsibilities at work, school, or home.
   - I have had a serious/severe mental health condition like schizophrenia that has interfered or limited major parts of my life.
   - I have had thoughts, plans or actions about harming or killing myself.
   - I have had a non-serious/general mental health condition like mild depression or anxiety that has interfered or limited major parts of my life.
   - None of the statements above describe me.

4) [If 2b above] Which best describes your experience with a friend or family member in the past 12 months? (select one)
   - Someone I know struggled with substance use like drugs or alcohol and a mental health condition that caused problems with their health or their responsibilities at work, school, or home.
   - Someone I know struggled with substance use like drugs or alcohol that caused problems with their health or their responsibilities at work, school, or home.
   - Someone I know had a serious/severe mental health condition that interfered with or limited major parts of their life.
   - Someone I know had thoughts, plans or actions about harming or killing themselves.
   - Someone I know had a non-serious/general mental health condition like mild depression or anxiety that interfered with or limited major parts of their life.
   - None of the statements above describe friends or family of mine.
[Main survey questions - NSMHC]

1) What year were you born? (please enter 4 digit year, such as 1985) You must be 15 years or older to participate in this survey.

2) What is your race or ethnicity? (select all that apply)
   - Asian Pacific
   - Black or African American
   - Hispanic or Latino
   - Native or Indigenous American
   - White
   - Other (please describe):

3) Do you identify with any of the following groups? (select all that apply)
   - Homeless / no stable housing
   - LGBTQ+
   - Person of color
   - Veteran
   - Other (Please describe): *
   - None of the above

4) Please indicate your gender identity (select one)
   - Male
   - Female
   - Non-binary
   - Other (Please describe):

5) How often do you worry about having enough to eat?
   - Most of the time
   - Sometimes
   - Never
   - Prefer not to answer

6) How often are you behind on paying bills?
   - Most of the time
   - Sometimes
   - Never
   - Prefer not to answer

For the rest of this survey, "mental health condition" refers to any non-serious / general mental health condition such as mild depression or anxiety that has interfered with or limited major parts of a person's life.

7) Please rate how much you agree or disagree with the following statements about others:
   1 - Strongly Disagree
   2 - Disagree
   3 - Neutral
   4 - Agree
5 - Strongly Agree
Not Applicable

a. Most people are willing to live with someone who has a mental health condition.
b. Most people are willing to work with someone who has a mental health condition.
c. Most people are willing to live near someone with a mental health condition.
d. Most people are willing to (begin or) continue a relationship with someone who has a mental health condition.
e. Most people believe that someone who has been treated for a mental health condition cannot be trusted.
f. Most people believe that a person who has a mental health condition is dangerous.
g. Most people look down on people who have a mental health condition.
h. Most people are afraid of someone who has a mental health condition.
i. Most people think less of others when they find out they are receiving mental health services.
j. Receiving mental health services results in discrimination.
k. Most people tend to dislike those who are receiving professional help for a mental health condition.
l. Most people think it is a good idea to hide from others who receive mental health services.
m. Most people think that I cannot care for myself because I have a mental health condition.
n. Most people think I cannot handle responsibility because I have a mental health condition.
o. Most people think I am not worth their time or resources because I have a mental health condition.
p. Most people think I am morally weak because I have a mental health condition.
q. Most people have told me that having a mental health condition is what I deserve from how I live my life.
r. Most people's attitudes about mental health conditions make me feel worse about myself.
s. Most people who know I have a mental health condition have grown more distant.

8) Please rate how much you agree or disagree with the following statements about yourself:

1 - Strongly Disagree
2 - Disagree
3 - Neutral
4 - Agree
5 - Strongly Agree
Not Applicable

a. I feel that telling someone I have a mental health condition is risky.
b. I keep my mental health condition private.
c. I worry that people may judge me if they find out I have a mental health condition.
d. There is no reason for me to hide my mental health condition.
e. I avoid new relationships because I worry about telling someone that I have a mental health condition.

Remember that "mental health condition" refers to any non-serious / general mental health condition such as mild depression or anxiety that has interfered with or limited major parts of a person's life.

9) Most days, how stigmatized do you feel about your mental health condition?

1 - Not stigmatized at all
2 - Slightly stigmatized
3 - Moderately stigmatized
4 - Highly stigmatized
5 - Extremely stigmatized
Not Applicable
10) How stigmatized do you feel from the following people and sources about your mental health condition?

1 - Not stigmatized at all
2 - Slightly stigmatized
3 - Moderately stigmatized
4 - Highly stigmatized
5 - Extremely stigmatized
Not Applicable

a. Family
b. Friends
c. Strangers
d. Mental health provider staff
e. Medical provider staff
f. First responders
g. Law enforcement
h. Social media (e.g., Facebook, Instagram, Twitter, Snapchat)
i. Traditional media (e.g., TV, Radio, newspapers)

Is there another source of stigma about your mental health condition that you would like to rate?
• Yes
• No

What is the "Other" source of stigma that you would like to rate?

How stigmatized do you feel from this "Other" source about your mental health condition?*

1 - Not stigmatized at all
2 - Slightly stigmatized
3 - Moderately stigmatized
4 - Highly stigmatized
5 - Extremely stigmatized

11) Which one best describes you? (select one)*

a. I have never looked for or received services for my mental health.
b. I am not sure if I need mental health services or not.
c. I have thought about getting services for my mental health but have never looked for help.
d. I have thought about getting mental health services, but I do not know where to go.
e. I have looked for services for my mental health but have never received services.
f. The last time I received services for my mental health was over 1 year ago.
g. I received services for my mental health within the past year, but not currently.
h. I am currently receiving services for my mental health.
i. Prefer not to answer.

12) How large were these potential barriers when thinking about looking for services for your mental health condition over the past 12 months?*

1 - Not a barrier at all
2 - Small barrier
3 - Medium barrier
4 - Large barrier
5 - Extremely large barrier
Not Applicable

a. I fear what others will think of me or say to me
b. I would feel worse about myself for receiving mental health services
c. I am scared to admit I need mental health services
d. The wait time to receive services is too long
e. I fear the services will be painful or uncomfortable
f. I am concerned about how long I would need to receive mental health services
g. There are no mental health providers who look like me
h. I do not believe receiving mental health services will be effective enough
i. Mental health services will cost too much
j. My insurance does not adequately cover mental health services costs
k. I do not like any of the mental health services options available
l. I have more important things to do than get mental health services
m. There are no mental health providers who would understand my experience
n. I fear that I will be forced into mental health services I do not want
o. I fear that I will be forced into an in-patient institution for mental health services
p. There are no mental health services providers who speak my language
q. COVID19 pandemic restrictions

13) How big an impact has the COVID19 pandemic had on your mental health?
1 - No impact at all
2 - Low impact
3 - Moderate impact
4 - High impact
5 - Extremely high impact
Not Applicable

14) How big an impact does stigma about mental health have when you think about getting services for your mental health condition?
1 - No impact at all
2 - Low impact
3 - Moderate impact
4 - High impact
5 - Extremely high impact
Not Applicable

15) If mental health was seen and treated like physical health it would make it easier for me to get help for my mental health condition
1 - Strongly disagree
2 – Disagree
3 – Neutral
4 – Agree
5 - Strongly agree
Not Applicable
Media Use and Impact
In the following section we would like to learn about your opinions and preferences.

16) Which of the following do you pay most attention to? (select all that apply)
   a. Broadcast TV Commercials
   b. Streaming TV Commercials
   c. Radio Commercials
   d. Newspaper ads
   e. Magazine ads
   f. Billboards
   g. “Junk mail”
   h. Bench / train / bus stop ads
   i. Internet ads
   j. Social media (please list all used):
   k. Other (please describe):
   l. None of the above

17) What social media platform do you use the most? (select one)
   a. Facebook
   b. Twitter
   c. Instagram
   d. Snapchat
   e. TikTok
   f. YouTube
   g. Discord
   h. Other (please describe):
   i. I do not use any social media platforms

18) How much time do you spend on social media each day?
   a. I do not use social media
   b. Less than 2 hours
   c. 2 to less than 4 hours
   d. 4 to less than 6 hours
   e. 6 hours or more

19) Which method of transportation do you use the most? (select one)
   a. Personal vehicle
   b. Walk/Bike
   c. Public transportation
   d. Carpool
   e. Other (please describe):

20) How would you like to receive information about mental health? (select all that apply)
   a. Social media
   b. Traditional media (e.g., TV, radio, billboards)
   c. Someone on the street handing out information
   d. Someone visiting my home
   e. Local community event
f. Local religious organization event

g. A friend

h. A family member

i. Other (please describe):

j. None of the above

21) How important are each of the following to you when hearing messages about mental health?

1. Low Importance
2. Medium Importance
3. High Importance
Not Applicable

a. Person delivering the message looks and sounds like me
b. Person delivering the message is from my community
c. Person delivering the message is someone I recognize
d. Person delivering the message is someone I respect
e. The message conveys hope and optimism
f. The message makes it OK to talk about mental health
g. The message is educational
h. The message gives me ideas on actions I can take for my mental health

Is there another important message feature about mental health messages that you would like to rate?
• Yes
• No

What is the "Other" type of important message information you would like to rate?

How important is this "Other" feature when hearing messages about mental health?
1. Low Importance
2. Medium Importance
3. High Importance

22) Do you think you can change your views about mental health?
• Yes
• No
• Maybe
Appendix 6: Stigma Survey Instrument – Questions on Each Scale

Survey Questions on Each Scale:

- All scales were scored so that higher scores reflected higher levels of stigma
- Reverse scored items are in red font and noted as “REV”

Social Distance (Alpha = .779)
- Q07a - Stigma - Willing to Live With (REV)
- Q07a - Stigma - Willing to Work With (REV)
- Q07c - Stigma - Willing to Live Near (REV)
- Q07d - Stigma - Willing to be In Relationship (REV)

Discriminatory Intent (Alpha = .858)
- Q07e - Stigma - Cannot Be Trusted
- Q07f - Stigma - Believe Dangerous
- Q07g - Stigma - Looked Down On
- Q07h - Stigma - Afraid

Accessing Treatment (Alpha = .885)
- Q07i - Stigma - Think Less Of
- Q07j - Stigma - Discrimination
- Q07k - Stigma - Dislike
- Q07l - Stigma - Avoid

Willingness to Disclose (Alpha = .748)
- Q08a - Stigma - Risky Telling Someone
- Q08b - Stigma - Keep Condition Private
- Q08c - Stigma - Might Be Judged
- Q08d - Stigma - No Reason to Hide Condition (REV)
- Q08e - Stigma - Avoid New Relationships

General Stigma (Alpha = .904)
- Q07m - Stigma - Cannot Care for Self
- Q07n - Stigma - Cannot Handle Responsibility
- Q07o - Stigma - Not Worth Time
- Q07p - Stigma - Morally Weak
- Q07q - Stigma - Deserve What Get
- Q07r - Stigma - Feel Worse
- Q07s - Stigma - Grown More Distant
Appendix 7: Qualitative Findings Detail

Environment and Existing Efforts

Interviewees (52%) and focus group participants (50%) agreed that the current environment for mental health systems in Denver is not working for many, particularly for communities of color. There was reference to the potential for leveraging some existing social support service organizations, including the Mental Health Center of Denver, DDPHE’s Wellness Winnie, and others. Several interviewees referenced the Support Team Assisted Response (STAR) program as an initiative to support and model in the development of “a menu of response options” for mental health needs in Denver. All participants identified more targeted approaches for specific subpopulations as effective and meaningful ways to reduce stigma and barriers to seeking mental health treatment, like Talking Circles for the Native communities, and peer support services. The focus group participants (60%) also noted a general lack of understanding of mental health within their communities.

“I always go back to the systems. I feel therapists are not being provided with the appropriate education to provide for our communities. You have to provide education that is meant for people. No one taught me how to give therapy in Spanish.”

Past or ongoing efforts like the ‘Let’s Talk Campaign’ and ‘Lift the Label’ were mentioned, and interviewees from organizations working on their own anti-stigma efforts expressed an interest in partnering to amplify existing campaign efforts. A key takeaway from all the interviews and focus groups was that communities of color do not see themselves reflected in campaign efforts, and therefore, view the efforts as ineffective; to make campaigns effective, they want to see people who “look like me and speak my language”.

Interviewees acknowledged that mental health has become a greater priority and received more funding in recent years. Some interviewees suggested the need to take a public health approach and participants from both interviews and focus groups agreed on the need to focus on upstream prevention efforts (25%) to better address factors affecting stigma. This includes social determinants of health, basic human needs, and the role of law enforcement in mental health interventions, particularly among communities of color. These issues are discussed in further detail throughout this report.

Data

There was consensus on the need to engage communities of color, who may be disproportionately affected by mental health stigma, have fewer resources available to them, and tend to be left out of these types of data collection efforts. Following these recommendations, the project conducted focus groups with the following communities: Hispanic/Latino, LGBTQ+, Asian/Pacific Islander, Indigenous/Native American, Black/African American, homeless/unhoused, youth, people with lived experience, as well as friends and family of those with lived experience. There was a great deal of diversity within each of these focus groups related to age, gender identification, and housing status.

The team attempted to identify data for subpopulations that may be underrepresented in existing data sources. Notably, there is a lack of mental health and stigma related data available for the LGBTQ+ community and communities of color.

“We don’t measure attitudes, knowledge, and beliefs enough to move the issues and to understand how to better communicate with community.”
especially the Indigenous/Native American and Asian/Pacific Islander communities. Most interviewees indicated that it was “important-to-extremely-important” to understand the current state of mental health stigma and to measure the impact of the campaign’s interventions. Stigma itself is generally difficult to quantify and lack of data sharing between agencies is a barrier. Some interviewees did not think baseline data collection was important because “we know it exists and the higher priority is to address systemic issues.” Focus group participants echoed this sentiment and felt that stigma played less of a role when compared to other barriers like cost of care (60%) and while interviewees acknowledged access to care (52%) as a barrier.

Stigma

Based on the qualitative data collected, the most stigmatized conditions include suicide (57% interviewees), substance use disorder (64% interviews and focus groups) and serious mental illness (57% interviews). General mental health conditions, like mild depression and anxiety, were considered less stigmatized by both interview and focus groups (51%). Co-occurring disorders were mentioned as an area of stigma, particularly within the homeless/unhoused community and those with disabilities. Additionally, the negative impact of law enforcement and incarceration on mental health stigma were mentioned. While there was a sense among interviewees that “you can’t just pick one [condition],” substance use disorder and serious mental health conditions were most frequently referenced as inflicting the most severe consequences to individuals and families. All focus group participants thought that anxiety and depression were easier to talk about and these might be a good avenue to start conversations about mental health.

“(Mental Health) organizations are largely white, English-speaking only, and do not have a curiosity or willingness to ask questions.”

One prevalent and consistent theme was stigma arising from providers including first responders, emergency room providers, mental health service providers, and staff that work within provider organizations. Fifty seven percent of interviewees mentioned the role that providers play in perpetuating stigma and the systems as well as 50% of focus groups which “are a failure to health”. The prevalence of this theme led to the inclusion of providers as a subpopulation for the focus groups. Participants shared that lack of provider diversity, poor or non-existent culturally and linguistically appropriate care (80% focus groups and 71% interviews), and noted the negative interactions with law enforcement, systemic inequities and historical trauma have resulted in distrust of systems and are particularly significant factors for communities of color. Providers were described as “not welcoming” by many focus group participants.

According to interviewees, subpopulations particularly impacted by stigma include the homeless/unhoused community; those with low-income, particularly people on Medicaid; people of color; and the LGBTQ+ community. Interviewees and focus group participants highlighted unique factors for the LGBTQ+ community. From the perspective of the interviewees, the LGBTQ+ community’s greatest mental health challenges included misuse of drugs and alcohol and suicide among youth and compounded challenges for the trans community. The LGBTQ+ focus groups shared concerns related to fear of other peoples’ reactions and lack of education and awareness about mental health.

Generational as well as gender differences (51%) were noted as factors where many perceived that youth were more open to talking about mental health and more receptive to messages they get from peers. Older generations also had specific considerations, such as the isolation that can come with aging and their fixed views of mental health, resulting in the older generation being more resistant to speaking about or receiving help for mental health conditions. Participants also referenced gender differences, COVID (38%), and religion as factors impacting people’s willingness to discuss mental health.
Access

All interviewees and focus group participants mentioned stigma as a barrier to accessing services. Perceptions of mental health conditions as a personal flaw or weakness, or self-stigma (61%), was considered significant, especially when compounded with other types of stigma. Interviewees recommended addressing stigma and discrimination from the providers; increasing the comfort in seeking help by having more staff and providers that “look like me” (i.e., increasing workforce diversity); and by having much more peer support. For focus group participants, barriers included the following: high costs, limited insurance coverage, long wait times due to provider shortages, poor experiences with providers and systems (i.e., microaggressions), lack of provider diversity, and a lack of trauma informed care – especially for communities of color. There was consensus between interviewees (62%) and focus groups (80%) that there is a general lack of awareness and understanding about mental health among all communities.

Though stigma acts as a barrier to accessing treatment, it is not the biggest issue for many communities. Rather, lack of treatment options, poor treatment by providers, long wait times, and high costs were some of the most significant barriers to accessing treatment and services. Despite the need for these services, there is a lack of capacity and of “people stepping up” to address those needs. Some interviewees emphasized the need to address upstream challenges like social determinants of health (38%), mental health, and health care and to recognize the impact that socio-economic hardships have on people accessing the system.

Lack of culturally and linguistically appropriate services was also noted as a major barrier to receiving mental health services for the Asian/Pacific Islander, Hispanic/Latino and Indigenous/Native American communities, where fear and major considerations among most (80%) focus group participants. The lack of culturally informed and responsive providers is seen as not only a training issue but also a workforce diversity issue.

Campaign Approach

Target conditions. There was consensus among interviewees that a campaign inclusive of all four mental health conditions would be too broad. Interviewees recommended we target our approach, with misuse of drugs and alcohol (86%) and general mental health conditions like depression and anxiety were noted as being easier to talk about among all focus groups as the top two areas on which to focus. Focus groups largely agreed that talking about general mental health may be a good place to start. Additionally, the campaign should raise awareness and educate the community about mental health according to both interviewees (62%) and focus groups (80%).
**Campaign audience.** A prevalent comment was that any campaign effort needs to be representative of the community they are hoping to impact. Storytelling was referenced as a powerful tool, especially when the messengers are part of that community. Participants agreed that campaign efforts needed to be audience specific.

Interviewees suggested (48%) that it was unlikely that the campaign with “a message that all of us will embrace” would meet the needs of the community. However, the majority (50%) of focus group participants were consistent in that a positive, educational, and encouraging message that normalized conversations about mental health is needed. Interviewees and focus groups mentioned providers as a source of stigma and as a good place to raise awareness. The provider focus group explained that they, providers, need the same messages of hope and encouragement that everyone else needs because they are “also at risk of these conditions”.

Cultural stigma plays a role in one’s ability to ask for and access services in specific subpopulations. Comments (70%) referred to the need for any anti-stigma campaign to be community led and community driven. Interviewees suggested that these types of campaigns need to “start with engaging communities to learn and better understand where they are coming from and what their perceptions are rather than make some assumptions” about what the community needs. Focus groups (60%) were also consistent in highlighting the crucial role meaningful community involvement plays and explaining that lack of community support would be detrimental to a successful campaign.

**Avenues for outreach.** The campaign not only needs to be reflective of diverse communities, but its messages also need to be delivered by trusted community members. Below are some of the recommendations for a more tailored approach by specific subpopulations:

<table>
<thead>
<tr>
<th>Population:</th>
<th>Suggested forms of outreach:</th>
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<tbody>
<tr>
<td>Hispanic/Latino</td>
<td>Radio, TV, WhatsApp</td>
</tr>
<tr>
<td>Black/African American</td>
<td>Churches and community centers</td>
</tr>
<tr>
<td>LGBTQ+</td>
<td>Bars, LGBTQ+ network</td>
</tr>
<tr>
<td>Indigenous/Native American</td>
<td>Existing family and culturally specific gatherings like talking circles</td>
</tr>
<tr>
<td>Providers</td>
<td>Professional networks</td>
</tr>
<tr>
<td>Youth</td>
<td>TikTok, Instagram</td>
</tr>
<tr>
<td>Any/all subpopulations, especially those without access to technology</td>
<td>Facebook, community leaders, documentaries or reality TV series, billboards, flyers, T-shirts, buses, light rail, newspapers, press releases, grocery stores, radio, community centers, other service providers, peer/support groups</td>
</tr>
</tbody>
</table>

There were a wide range of view and opinions on how to best reach different communities. For example, some interviewees believed that community fairs, billboards, and social media would be ineffective due to media overload. Other suggestions included use of quick response (QR) codes so that people can easily find resources. Focus groups suggestions revolved around more personal touch and community led approaches for any effort including those listed above.

Among both focus groups and interviewees using a more personalized approach (19%) and grassroots efforts to meet people where they are emerged as a theme. Grassroots suggested approaches ranged from word of mouth, face-to-face storytelling, to boots on the ground efforts, like door-to-door outreach in specific communities, as collaborative efforts to work with trusted community leaders and organizations. Interviewees and focus groups agreed on the need to reach people where they access other services, such as schools, pharmacies, medical clinics,
and pediatricians. Interviewees suggested building upon existing networks in Denver, such as support groups or peer groups (e.g., the Boulder SWAG teen peer group out of Boulder). It was suggested to use influencers that are reflective of the community, seen as credible, and perceived as genuine to deliver messaging.

**Empathic messaging.** Building empathy emerged as a common theme across interviews and focus groups. Participants (48%) emphasized that campaign messages should be positive in nature, realistic, and promote resilience. Messages should provide hope and communicate that there are solutions and chances for recovery and wellbeing, while recognizing that recovery is not the same as a cure. Suggestions also included messaging that helps people feel a sense of worthiness, being seen, supported, and not judged, encourages people to take that next step. Messaging should emphasize that people matter: “I hear you; I see you, You’re not alone”. It was suggested that the campaign be realistic – people relate more with honest messages and may benefit from the understanding that recovery and success look different for everyone. In addition, the campaign should provide information that is simple and easy to understand in a non-threatening format. It is important to raise awareness and educate our communities about mental health.

**Increasing education and help-seeking behaviors.** The campaign should focus on getting the conversation going about mental health (30%). Messaging could address damaging stereotypes often portrayed by the media, such as “people with mental illness are violent people”. People are also misinformed about what treatment looks like and what it means to ‘see a counselor.’ Participants of both interviews and focus group (67%) noted the importance of providing the community education and resources about mental health that are culturally and linguistically appropriate to combat the stigma that comes from lack of knowledge or understanding other people’s experience. Educational materials could weave in cultural considerations and help explain the difference between mental health conditions and other conditions, such as developmental disabilities and the western medical model. The campaign might want to compare mental health and physical health to help create the understanding that “everyone has mental health as we all have physical health” and both need care and attention. It may be effective to remind people that “you are not alone”.

**Other Considerations**

**Terminology considerations.** Participants referenced terminology that can be seen as stigmatizing. It was suggested that words like “stigma” and even “normalize” are not helpful because there is a tendency to only use this word when referencing mental health and that “discrimination” might be a more appropriate term. While there was a lot of feedback from focus group participants about terms that are not helpful such as “crazy/loco” there was an even greater focus on using more first-person language (50%). Suggestions included putting the individual at the center and not the condition. It was noted that “once we call something out and name something, it can be stigmatizing itself”. While more technical terms may have value and are commonly understood within the professional setting, they are usually not understood by the general public, like the term “behavioral health.” Participants recognized that different language and cultural perspectives are important factors for campaign messaging. Even when the terms used are technically correct, it may still be problematic.

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**“Keep it general. Keep it human, heartfelt, and hopeful.”**

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**“Be open with it. Normalize it. Teach it.”**

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**“The term ‘behavioral health’ means nothing to the rest of the world.”**
because different conditions are talked about in different ways, such as bi-polar disorder and schizophrenia, which can both be very charged terms.

**Accountability and intentionality.** Numerous comments highlighted the need for mindfulness around the campaign’s approach: “enough questions – do something; put the money into people, not things; be prepared to explain why you selected this condition or subpopulation; recognize the impact someone like Simon Biles can have on the topic; be considerate in how you frame the conversation and be intentional with your words – they have impact; be accountable to partner organizations, especially those that serve communities of color; and, give enough notice for good coordination.” Many interviewees requested access to the information and data obtained through this project, both in terms of reciprocity and to provide knowledge for use in working with their own clients. There is a general skepticism among focus group participants that these campaign efforts will really be reflective and responsive to them because communities feel they are frequently used for extraction of information with little, if any, follow-through.

**Systemic challenges.** Interviewees mentioned leveraging efforts at the state level and contracting with organizations that have shown success, hiring more providers, identifying gaps in the system, providing the right kind of support in moments of crisis, and addressing systemic racism as a root cause for so many of the inequities. Many focus group participants mentioned the importance of recognizing the role of historic racial trauma, such as forced assimilation through boarding schools, child separation of immigrant families, post-traumatic stress of refugees, and police violence that so many within diverse communities have had to endure over decades. These traumas have a cyclical impact on subsequent generations and their mental health. There is a need to address the harmful and hurtful stereotypes and preconceived biases that impact communities. It is also important to recognize that in the eyes of the community, especially communities of color, there is hesitation and distrust of proposed efforts when their communities have been negatively impacted by systems for generations. As one interviewee mentioned the “system is not ready for a Native American campaign. The Office of Behavioral Health (OBH) wanted to do a stigma campaign and asked the Black community and the Black community said, ‘you’re not ready, when you are ready to come back with an apology and explain why you waited so long to ask, then you can come back.’” These sentiments are based on prior experiences where campaigns were not designed with diverse communities in mind and the system embarking on these initiatives are not ready to effectively engage communities in meaningful ways. Even when communities of color are engaged in focus groups or interviews, the outcome, products, and services rarely serve or benefit diverse communities because they are geared toward the dominant culture. Lack of follow-up and follow through with the communities after their participation often leaves them feeling used.

**Benefits to Interviewees/Community Organizations.** Interview participants are eager to learn what the campaign uncovers to “provide us with a lot of insight and answer some missing pieces; help to build awareness of support from the city for people with mental health conditions; help us know how to reach the community; allow us to be able to identify policy changes and other things we can do internally to remove barriers that are acting as stigma barriers to services for folks”. The need for better data sharing efforts to avoid duplication of efforts was also mentioned. Interviewees hoped that campaign efforts can help recruit providers and improve the data gap that exists for communities of color. Interviewees hoped that these efforts could have an impact upstream so that people do not wait to reach out until there is a crisis. They would like to see material or tool sharing to increase outreach efforts, and to see a campaign message that could be used across the state (i.e., not too Denver specific). Generally, organizations want to see messages from this campaign that are hopeful and that will increase empathy and understanding for both those needing treatment and for their caregivers, so that people can connect with treatment. As repeatedly heard from focus groups these messages need to come from “people who look like me and speak my language” and that these efforts would be most successful with community led and community driven support. Organizations have offered to help craft messages specific to their communities and conduct outreach to help bring the message to their communities.
The information gathered in the qualitative assessment was used to inform the quantitative assessment and finding from both of these efforts will be analyzed and presented to DDPHE to help inform their decision on selecting a campaign focus area and approach for the campaign development phase of the project and then the later campaign assessment. Interviewees and focus group participants provided a reminder that stigma is formed and exists in the context of socio-cultural frameworks that have historically not worked or worked against certain subpopulations. Perceptions of stigma cannot be divorced from this context, and this history must be considered in the campaign’s approach.

The anti-stigma team is grateful for the partnership and support received from mental health organizations that helped guide these efforts. The contributions by Denver community members was also central in helping us understand and appreciate the stories and journeys of diverse community groups related to mental health and mental health stigma. The anti-stigma team is honored and humbled that so many welcomed us into their communities and opened their hearts to share their experiences. Thank you, Denver.
Appendix 8: Stigma Survey Findings Detail

Survey Findings - Stigma Scale Reliabilities

1. Social Distance - 4 Questions (Alpha = .779)
2. Discriminatory Intent - 4 Questions (Alpha = .858)
3. Accessing Treatment - 4 Questions (Alpha = .885)
4. Willingness to Disclose - 4 Questions (Alpha = .748)
5. General Stigma - 7 Questions (Alpha = .904)
6. Stigma Composite Scale - 23 Questions (Alpha = .943)

Note 1: Scales adapted from existing stigma scales with the same names - see reference section in Phase 1 Final Report
Note 2: Scale questions scored so that higher scores are reflective of higher stigma levels
Note 3: Scale scores are averages of all scale questions (1 to 5 ratings) after score all questions scored is stated in Note 2

Stigma Scale Intercorrelations

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<tbody>
<tr>
<td>2. Discriminatory Intent</td>
<td>.34</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Accessing Treatment</td>
<td>.32</td>
<td>.85</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Willingness to Disclose</td>
<td>.24</td>
<td>.55</td>
<td>.51</td>
<td></td>
</tr>
<tr>
<td>5. General Stigma</td>
<td>.31</td>
<td>.88</td>
<td>.87</td>
<td>.54</td>
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</table>

Note 1: Based on 957 surveys, pairwise correlations with minimum of 947 cases each.
Note 2: All correlations statistically significant with 95% confidence
Stigma Scores by Age Category: Friends & Family and Personal Experience

People 65 years and older score lower on the stigma composite score.

Stigma Composite Score
Social Distance
Accessing Treatment
Discriminatory Intent

15 to 24 Years
25 to 64 Years
65 Years and Older

Note 1: Ratings by 629 total respondents
Note 2: Stigma Composite scores significantly different across age groups (F(2,622) = 13.36, p < .001), 65 years and older significantly lower than others (p < .05)

Stigma Scores by Gender Identity: Friends & Family and Personal Experience

No significant differences in stigma composite score by gender identity.

Female (N = 384)
Male (N = 227)
Non-Binary / Other (N = 18)

Note 1: Ratings by 629 total respondents
Note 2: Stigma Composite scores not significantly different across gender identity (F(2,625) = 1.069, p = ns)
Stigma Scores by Group Identification: Friends & Family and Personal Experience

People who identify as Homeless / No Stable Housing or LGBTQ+ have higher levels of stigma compared to those not having those group identifications.

Note 1: Ratings by 629 total respondents
Note 2: Stigma Composite Scale significantly higher (p < .05) for Homeless or LGBTQ+ group identification compared to those not having those group identifications.

Campaign Focus Selection: Stigma Survey Findings
1. Overall Stigma by BH Condition: Personal Experience

People with a NSMHC experience have lower overall stigma levels

Note1: Ratings by 412 people with personal experience within the past 12 month
Note2: Stigma Composite scores significantly different across BH condition groups (F(4,404) = 19.63, p < .001), with NSMHC being significantly lower (p < .05) than all other groups

2. All Barriers to BH Service: Personal Experience

Cost, Insurance Coverage, Fear of Unwanted and Lengthy Services, and COVID restrictions top the list barriers to getting desired services for BH conditions. Stigma-related reasons (orange bars) are in the middle of the pack of reasons to not get needed BH

Note: Ratings by 412 people with personal experience within the past 12 month
2. Stigma Barriers to BH Services: Personal Experience

People with suicidal thoughts and actions have higher stigma barriers to getting needed BH services.

Note 1: Ratings by 412 people with personal experience within the past 12 months.
Note 2: All 3 stigma barrier scores significantly different across BH condition groups (Fs = 9.53(4,399), 7.50(4,394) and 5.85(4,400), all p < .001, for Fear What Others May Say, Feel Worse About Self and Scared to Admit Need Help, respectively)

3. Stigma Impact on Seeking BH Service: Personal Experience

People with SMHC, SUD and SUD + MHC experiences have significantly higher ratings of stigma impact related to seeking BH services compared to NSMHC group.

Note 1: Ratings by 412 people with personal experience within the past 12 months.
Note 2: Stigma Composite scores significantly different across BH condition groups overall (F(4,399) = 8.23, p < .001), with NSMHC being significantly lower (p < .05) than the SMHC, SUD and SUD.MHC groups.
4. Changeability of SUD/MH Views: Personal Experience

No significant differences across groups on changeability of SUD/MH views.

Note 1: Ratings by 412 people with personal experience within the past 12 month.
Note 2: No significant difference across all groups (F(4,407) = 0.958, p = ns)

5. Stigma Source Composite Score by BH Condition: Personal Experience

People with a NSMHC experience have lower overall stigma levels averaged across specific stigma sources.

Note: Ratings by 412 people with personal experience within the past 12 month.
Note 2: Stigma Composite scores significantly different across BH condition groups (F(4,404) = 19.63, p < .001), with NSMHC being significantly lower (p < .05) than all other groups.
6. If SUD/MH Seen Like Physical Health: Personal Experience

People with a SMHC have stronger beliefs that services would be easier to get if mental health was seen like physical health.

- NSMHC: Non-Serious Mental Health Condition
- SMHC: Serious Mental Health Condition
- SUD: Substance Use
- SUD.MHC: Substance Use and Mental Health Issues
- Suicide

Agreement (1 = Lowest, 5 = Highest)

3.75
4.19
3.84
4.02
3.92

Note: Ratings by 412 people with personal experience within the past 12 months.
Note 2: Scores not significantly different across condition groups overall (F(4,405) = 2.35, p = ns), but SMHC significantly higher than NSMHC (p = .04).

SMHC Deeper Dive: Serious Mental Health Condition
### Anti-Stigma Campaign Project – Phase 1 / Formative Assessment Final Report

**Stigma Scores by Race / Ethnicity: SMHC - Personal Experience**

No significant differences found between race / ethnicity categories

![Graph showing stigma scores by race/ethnicity]

Note 1: Ratings by 96 total respondents
Note 2: No significant differences found across race / ethnicity for any of the scales.
Note 3: SMHC: Serious Mental Health Condition

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**Stigma Scores by Group Identification: SMHC - Personal Experience**

People identifying as a veteran have higher Stigma Composite Scores than non-Veterans.

![Graph showing stigma scores by group identification]

Note 1: Ratings by 96 total respondents
Note 2: Stigma Composite Scale significantly higher ($t(94) = 2.963, p < .05$) for Veteran group identity compared to those not having Veteran group identity.
Note 3: SMHC: Serious Mental Health Condition
**Stigma Scores by Age Category:**
**SMHC - Personal Experience**

People 25 to 64 years older score higher on the stigma scales than younger people.

Note 1: Ratings by 96 total respondents
Note 2: Only 1 survey completed from someone age 65+ years with personal experience of a serious mental health condition - removed from this analysis.
Note 3: Stigma Composite Score significantly higher in 25 to 64 Years group (t(92) = 2.81, p = .003).
Note 4: SMHC: Serious Mental Health Condition

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**Stigma Scores by Gender Identity:**
**SMHC - Personal Experience**

No significant differences in Stigma Composite Score by gender identity.

Note 1: Ratings by 96 total respondents
Note 2: Stigma Composite Score not significantly different across group (F = 3.004, p = ns).
Note 3: SMHC: Serious Mental Health Condition
Stigma Source Ratings:
SMHC - Personal Experience

People with a serious mental health condition find traditional media, law enforcement, social media and strangers particularly stigmatizing.

Note 1: Ratings by 96 people with personal experience within the past 12 months
Note 2: SMHC: Serious Mental Health Condition

SUD Deeper Dive:
Substance Use Issue
**Stigma Scores by Group Identification: SUD - Personal Experience**

People identifying as a Person of Color have higher Stigma Composite Scores.

Note 1: Ratings by 52 total respondents
Note 2: No survey completed from someone age 65+ years with personal experience of a SUD - removed from this analysis.
Note 3: No significant differences in the Stigma Composite score by group (t = -1.18, p = ns).
Note 4: SUD: Substance Use Issues

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**Stigma Scores by Age Category: SUD - Personal Experience**

No significant differences in the Stigma Composite score by age group

Note 1: Ratings by 52 total respondents
Note 2: No survey completed from someone age 65+ years with personal experience of a SUD - removed from this analysis.
Note 3: No significant differences in the Stigma Composite score by group (t = -1.18, p = ns).
Note 4: SUD: Substance Use Issues
Stigma Scores by Gender Identity: 
*SUD - Personal Experience*

No significant differences in the Stigma Composite score by age group

<table>
<thead>
<tr>
<th>Gender</th>
<th>Stigma Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female (N = 21)</td>
<td>3.39, 3.54, 3.36, 3.59</td>
</tr>
<tr>
<td>Male (N = 30)</td>
<td>3.28, 3.08, 3.36, 3.16</td>
</tr>
</tbody>
</table>

Stigma Composite Score: 1 = Lowest, 5 = Highest

Social Distance
Accessing Treatment
Willingness to Disclose
Discriminatory Intent

Note 1: Ratings by 52 total respondents
Note 2: Stigma Composite Score not significantly different across age groups (t = .595, p = ns).
Note 3: SUD: Substance Use Issues

---

Stigma Source Ratings: 
*SUD - Personal Experience*

People with substance use issues find law enforcement, family and traditional media particularly stigmatizing.

<table>
<thead>
<tr>
<th>Source</th>
<th>Stigma Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Law Enforcement</td>
<td>3.73</td>
</tr>
<tr>
<td>Family</td>
<td>3.24</td>
</tr>
<tr>
<td>Traditional Media</td>
<td>3.20</td>
</tr>
<tr>
<td>First Responders</td>
<td>3.00</td>
</tr>
<tr>
<td>Social Media</td>
<td>2.96</td>
</tr>
<tr>
<td>Medical Providers</td>
<td>2.88</td>
</tr>
<tr>
<td>Friends</td>
<td>2.82</td>
</tr>
<tr>
<td>Strangers</td>
<td>2.78</td>
</tr>
<tr>
<td>SUD Providers</td>
<td>2.70</td>
</tr>
</tbody>
</table>

Note 1: Ratings by 52 people with personal experience within the past 12 month
Note 3: SUD: Substance Use Issues
SUD + MHC Deeper Dive:
Substance Use and Mental Health Issues

Stigma Scores by Race / Ethnicity:
SUD + MHC - Personal Experience

No significant differences found between race / ethnicity categories

- Black / African American (N = 20)
  - Stigma Composite Score: 3.38
  - Social Distance: 3.66
  - Discriminatory Intent: 3.45
  - Accessing Treatment: 3.38

- Hispanic or Latino (N = 10)
  - Stigma Composite Score: 3.49
  - Social Distance: 3.45
  - Discriminatory Intent: 3.80
  - Accessing Treatment: 3.65

- White (N = 60)
  - Stigma Composite Score: 3.41
  - Social Distance: 2.99
  - Discriminatory Intent: 3.34
  - Accessing Treatment: 3.75

Note 1: Ratings by 100 total respondents
Note 2: No significant differences found across race / ethnicity for any of the scales.
Note 3: SUD + MHC: Substance Use and Mental Health Issues
**Stigma Scores by Group Identification:**
**SUD + MHC - Personal Experience**

No significant differences found across these identity groupings on the Stigma Composite scale.

**Stigma Scores by Age Category:**
**SUD + MHC - Personal Experience**

No significant differences in the Stigma Composite score by age group.
**Stigma Scores by Gender Identity:**

**SUD + MHC - Personal Experience**

No significant differences in Stigma Composite Score by gender identity

<table>
<thead>
<tr>
<th></th>
<th>Female (N = 53)</th>
<th>Male (N = 43)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stigma Composite Score</td>
<td>3.41</td>
<td>3.37</td>
</tr>
<tr>
<td>Social Distance</td>
<td>3.69</td>
<td>3.50</td>
</tr>
<tr>
<td>Accessing Treatment</td>
<td>3.65</td>
<td>3.37</td>
</tr>
<tr>
<td>Willingness to Disclose</td>
<td>2.72</td>
<td>3.11</td>
</tr>
<tr>
<td>Discriminatory Intent</td>
<td>3.12</td>
<td>3.35</td>
</tr>
</tbody>
</table>

**Stigma Source Ratings:**

**SUD + MHC - Personal Experience**

People with substance use and mental health issues find law enforcement and family particularly stigmatizing.

<table>
<thead>
<tr>
<th>Source</th>
<th>Law Enforcement</th>
<th>Family</th>
<th>Traditional Media</th>
<th>Strangers</th>
<th>Social Media</th>
<th>First Responders</th>
<th>Friends</th>
<th>Medical Providers</th>
<th>MH / SUD Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rating</td>
<td>3.58</td>
<td>3.21</td>
<td>3.12</td>
<td>3.10</td>
<td>3.00</td>
<td>2.96</td>
<td>2.91</td>
<td>2.85</td>
<td>2.62</td>
</tr>
</tbody>
</table>

**Note 1:** Ratings by 100 people with personal experience within the past 12 month
**Note 2:** SUD + MHC: Substance Use and Mental Health Issues

**Note 3:** SUD + MHC: Substance Use and Mental Health Issues