Changing the Systems and Norms that Drive Stigmatization of Behavioral Health Disorders

A Complete Guide to Developing and Delivering a Two-Day Convening and Preparing for Follow-Up

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Development Supported by

Northwest Addiction Technology Transfer Center

Northwest Prevention Technology Transfer Center

Northwest Mental Health Technology Transfer Center

Contents

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Disclaimer

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I. Introduction to the Guide

A. Purpose and Goals of the Learning Collaborative

This learning collaborative is designed for prevention, mental health and substance use disorder service leaders and funders to come together and address the intractable problem of stigma and discrimination that many individuals with behavioral health disorders experience. It was initially created to be a cross-discipline learning collaborative hosted by the prevention, mental health, and addiction technology transfer centers (TTCs) in a region. However, it can be easily adapted for delivery by a single technology transfer center or other training and technical assistance center.

The overall goal of the learning collaborative is to enhance the knowledge and skills of a group of leaders in prevention, mental health, and substance use disorder services in using a system change lens to implement strategies to reduce stigma and enhance collaboration across the continuum of care. The Six Conditions of System Change framework[1] is used to promote understanding of the conditions that hold mental health and substance use stigma and inequities in place. Shifts in system conditions are more likely to be sustained when working at the three different levels of system change, explicit (policies, practices, & resources), semi-explicit (relationships & power dynamics) and implicit (mental models). The learning collaborative provides the space for participants to apply this model towards reducing stigma and health inequities at the individual, organization, and system level.

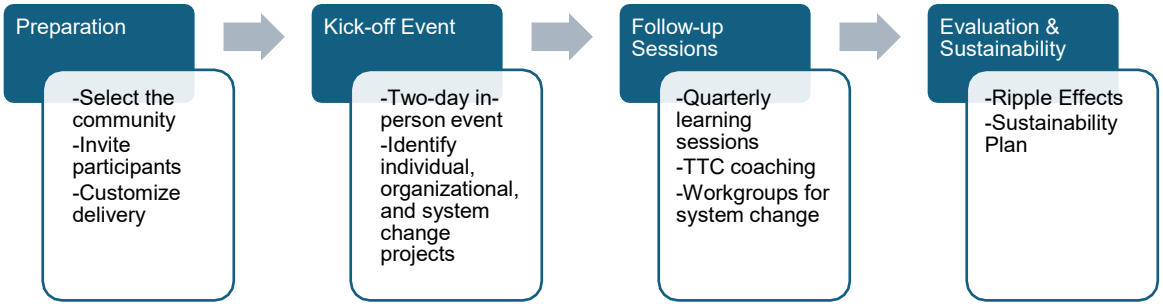
The learning objectives include:

- Examine stigma through a system change lens and identify the six conditions of system change.
- Describe subjective and shared beliefs, attitudes, actions, and structures that produce and sustain behavioral health stigma.
- Identify root causes and multiple forms and levels of stigma.
- Examine mental models and how they shape how we act and address the issue of BH stigma.
- Discuss the research on evidence-based strategies to reduce and dismantle stigma.
- Identify and apply strategies to promote change at the implicit and semi-implicit levels.
- Create teams and develop an action plan to implement a system change initiative.

B. Design of the Learning Collaborative

The learning collaborative includes several components aimed at achieving the goals and objectives identified in the previous section. The main components of the Learning Collaborative include a two-day in-person community event, quarterly follow-up learning sessions, individual coaching and consultation for workgroups, and a final evaluation and development of a sustainability plan.

System change requires long-term investment and often takes several years to affect change. This project is designed to last approximately 8-12 months and should be viewed as a jump start to longer term system change initiatives. This guide is geared towards primarily providing TTCs with the guidance and content for the two-day kickoff event; however, we also include some general guidance for the full learning collaborative structure and content.



C. Who is the Intended audience for this Guide?

The Intended audience for this guide includes TTC leadership and facilitators interested in hosting a learning collaborative that's directed at changing the systems and norms that drive the stigmatization of behavioralhealth disorders. This guide outlines the steps for hosting a similar learning collaborative and includes training and facilitation materials for the in-person and follow-up sessions. This guide assumes the facilitators and trainers delivering the content for the learning collaborative have some basic expertise in the research and practice of destigmatizing behavioral health conditions and system change methodologies.

II. Preparing for the Learning Collaborative

A. Identify the community (city, county, state, region) and Intended audience

This learning collaborative is designed for a multi-stakeholder group of behavioral health and prevention providers and leaders. One of the first steps in delivering this collaborative learning is identifying the community where it will be offered. A key consideration in selecting the community is to assess the likelihood of the participants working together to conduct a system change initiative. In the pilot project, the community selected was Skagit County, Washington, a semi-rural community in the Puget Sound Region. The selected community could also be a city, state, or region.

B. Find your partners (TTCs, Others)

The recommended hosting partners for this learning collaborative are regional prevention, mental health, and addiction technology transfer centers. It is also important to identify key local partners, such as public health departments, behavioral health leadership organizations, county health departments, and/or other local entities that play a key role in prevention and behavioral health services.

C. Identify your Participants

Identifying the participants will depend on the partners hosting this learning collaborative.The suggested number of participants is thirty to forty, which accounts for some attrition common in these intensive technical assistance projects. In the Skagit County pilot, we partneredwith Skagit Public Health and worked with its staff to identify ten leaders each in the areas of prevention, mental health, and addiction services. We then added ten more leaders from other domains (behavioral health, policy, philanthropy, health care, and law enforcement).

D. Invitation and Event Logistics

Facilitators/Trainers/Coordinator

The recommended staffing for the learning collaborative is a coordinator/project manager to coordinate all the events and logistics and communication with learning collaborative participants, two trainers/facilitators who have expertise in behavioral health and stigma, and system change. At the kick-off event, you will need one to two additional staff people to attend to the logistics of the event (i.e., registration table, audio-visual, food,

Invitations

Once the participants for the learning collaborative are identified, we suggest sending each a personal email inviting them to participate in the learning collaborative. Invitations should be sent out by the individualTTCs and/or local community partners who have connections with each participant. Section VI includes a sample of the invitation email used in the Skagit County delivery.

Registration

A registration link is included in the invitation letter and includes a full description of the project, goals and objectives, timelines, and participant expectations.

Timeline

Although much of this guide is devoted to the kickoff event, the learning collaborative is designed toextend for at least one year. The two-day kick-off is followed by quarterly learning sessions and individual work-group meetings and activities that are devoted to implementing system-change efforts.

Facility & Equipment

The facility for the kick-off event needs to comfortably hold 40-50 people with round tables that can seat 6-8 people. There should be enough space to allow for the formation of two large groups toward the end of day two. To promote cross-discipline conversations, it's best to assign the seating at each table.

Easels and flip charts are needed for every table to be used during the group discussions, as well as the typical audio/visual equipment (projector, screen, microphones, speakers).

III. Learning Collaborative Modules

1. Introduction

See Section 1 of the included PowerPoint File

1a. Overview of the Content

This module aims to create a welcoming and safe environment and establish a culture of sharing and active participation.

During this module, you will welcome the participant, review the goals and objectives of the learning collaborative, establish working agreements, and facilitate an exercise to engage participants and encourage them to think about their *reasons* for agreeing to be part of this learning community.

1b. Comments

The TTC introduction slides are included in the slide deck; however, they can be replaced if another entity hosts the learning collaborative.

1c. Discussion Exercise

The discussion exercise allows participants to start getting to know each other and talk about why addressing the issue of stigma and health equity is important to them. The slide with Simon Sinek leads the discussion and emphasizes the importance of starting with our personal "why." We suggest using the **1-2-4-All** liberating structure approach for this discussion.

1- Ask participants to silently spend one minute writing down their response to the question, "*Why does this issue matter to you?"*

2- Ask them to find a partner at their table to share what they wrote about their "why". Let them know they will have two minutes for this discussion.

4- Have the entire table discuss their "whys" with each other and let them know they will have four minutes for this discussion and to listen for common themes.

All- Facilitate a large group discussion and ask each table what themes surfaced in their discussions.

The total amount of time allocated for this discussion should be around 20 minutes.

1d. References

Simon Sinek (2011) *Start with Why: How Great Leaders Inspire Everyone to Take Action* Penguin Group, NY, NY.

Simon Sinek (2010) How great leaders inspire action TED Bing Videos

2. Thinking About Stigma

See Section 2 of the included PowerPoint File

2a. Overview of the Content

This session aims to accomplish the following:

This section reviews what stigma is (and isn't) and creates a shared understanding of how it operates in society and why it is important to implement strategies to reduce stigma. Specific objectives for this module include:

- Define behavioral health stigma and the multi-step process that drives stigma
- Explore the types of stigmas and three levels at which they operate and discuss how stigma negatively affects people and their use of health care services.
- Discuss the specific social functions of SUD stigma as a precursor to understanding the mental models and relationship dynamics that drive stigma.
- Create a shared understanding of the commonly studied dimensions of stigma.

2b. Comments

The assumption is that participants are already familiar with the fundamental concepts and don't need to be convinced. However, it's possible that there may be slightly different perspectives, so it's important to ground everyone in a shared understanding at the outset.

If necessary, acknowledge that there may be disagreement on some of the finer points related to stigma but affirm that there's agreement on the core principles.

2c. Discussion Exercises

- Share the definition of stigma and then ask the group what they would add to the definition. Record the answers on a whiteboard or flipchart.

- The second discussion activity involves asking the group to spend time on these two questions: 1) What do you think the specific social function of SUD stigma is? and 2) What do you think is the specific social function of mental illness stigma? To facilitate this discussion, use 1,2,4, All format; or you could just have them discuss the questions at their tables. The full instructions for the 1,2,4 and All discussion formats are in the notes section of the slide.

2d. References

Kimmetat, et al. (2022) Understanding the Association between Alcohol Stigma and Alcohol Consumption within Europe: A Cross-Sectional Exploratory Study. European Addiction Research 28(6): 446-454.

National Academies of Sciences, Engineering, and Medicine. 2016. Ending Discrimination Against People with Mental and Substance Use Disorders: The Evidence for Stigma Change. Washington, DC: The National Academies Press. https://doi.org/10.17226/23442

Northwest Addiction Technology Transfer Center (2021) Attitudes and Stigma Webinar https://attcnetwork.org/products_and_resources/attitudes-stigma-around-addiction-webinar/

Schomerus, G. & Corrigan, P.W ed (2022) *The Stigma of Substance Use Disorders* Cambridge University Press. DOI: 10.1017/9781108936972.

Stigma and Discrimination Research Toolkit - National Institute of Mental Health (NIMH) (nih.gov) https://www.nimh.nih.gov/about/organization/dar/stigma-and-discrimination-research-toolkit

3. The Vital Conditions & System Change

See Section 3 of the included PowerPoint File

3a. Overview of the Content

- This session introduces Vital Conditions, an organizing framework for taking action on the social determinants of health.
- It also introduces systems thinking and provides a way of understanding the elements that are at play in any effort to transform an entrenched system.

3b. Comments

- There are several benefits to introducing the Vital Conditions framework:
    - It provides a shared, positively oriented language for discussing the landscape that affects stigma. Without a common vocabulary, discussions can easily bog down.
    - The Vital Conditions Framework is focused on the community-level conditions that enable everyone to thrive. As such, it provides a helpful balance to individual-level crisis conditions and the urgent services that tend to dominate discussions.
    - The central vital condition, Belonging and Civic Muscle, is very helpful for understanding the work that's necessary for reducing stigma. Communities need to build the civic muscle that enables them to solve problems together. And they need to dedicate themselves to the principle that *everyone* in a community should feel that they belong and that they're valued for who they are and what they bring.

- The exploration of system dynamics is meant convey the following key points:
    - Stigma is held in place by complex systems that evolved over decades
    - To shift that system, we need to pay attention to structural reforms (policies, practices, and resource flows) *and also* hidden, implicit factors (relationships, power dynamics, and mental models).
    - Our relationships are interdependent, but it's easy to lose sight of that. Success in reducing stigma will depend on building up positive interdependence.

3c. Discussion Exercise

- Gallery Walk: Stigma & System Change Activity: The group exercise for this section provides an opportunity for participants to apply levels 1 and 2 (power dynamics, relationships, practices, resources, policies) of the system change conditions to the issue of stigma. To set up for this activity, you will need five separate areas with a flip chart notepad, a sturdy easel, and markers. Set the stations up so there is as much distance between stations as possible because simultaneous discussion will occur. Divide the participants into five groups and ask each group to go to one of the stations with a flip chart. Ask the entire group to think about people experiencing MH andSUD stigma and their friends, families, and professionals who are trying to help them and answer the questions on the flip chart. There will be separate questions at each of the flip chart stations. You will want to prepare flipcharts with the following questions before the training.
    - Station 1: Write the following questions at the top of the flip chart: What are the power dynamics that affect stigma? How does stigma affect power dynamics?
    - Station 2: Write the following questions at the top of the flip chart. How do people's relationships affect stigma? How does stigma affect people's relationships?
    - Station 3: Write the following questions at the top of the flip chart. How do policies (local, state, national, business, etc.) affect stigma? How does stigma affect policies?
    - Station 4: Write the following questions at the top of the flip chart. How do practices (professional, legal, personal, etc.) affect stigma? How does stigma affect our practices?
    - Station 5: Write the following questions at the top of the flip chart. How does the allocation and distribution of resources/funding affect stigma? How does stigma affect the allocation anddistribution of resources/funding?

  Ask each group to spend 5 minutes discussing the questions at their stations and recording a summary of their responses on the sheet. Then each group will rotate to the next station in a clockwise direction and spend 5 minutes discussing that set of questions and adding their responses to the first group notes.

  Continue rotating until all five groups have had a chance to discuss the questions at all five stations. Then, the facilitator will ask the entire group to gather around station 1, and the facilitator will provide a quick summary of the responses to the questions and move the full group around toeach station as the facilitator provides a summary.

4. Host a Panel and Discuss Aspirational Outcomes

See Section 4 of the included PowerPoint File

4a. Overview of the Content

- Hear from a panel of individuals who have experienced substance use and mental health challenges to share with the group their own experiences with stigma and what promoted equity and recovery in their lives.
- Spend time identifying the aspiration outcomes of the work of the Learning Collaborative. Where do they want to be in five years? using the "Headlines from the Future" exercise.

4b. Comments

- The panel discussion provides the participants with an opportunity to hear the direct impact of stigma and discrimination and what behaviors promote belonging and equity. The suggested composition of the panel is 4-5 individuals with lived experience of substance use and mental health challenges. Preparation for the panel includes having individual conversations with each of the panel members to prepare them for the panel discussion, to include sharing the questions you will be asking them during the discussion. It also is helpful to pull the participants together for a group preparation call, as well. Identify a moderator to pose the questions to the panel members and provide some brief summaries during the panel presentation discussion and then elicit questions from the audience.
- The Headlines from the Future activity is an opportunity for participants to envision a future with less stigma and discrimination in their community. Reviewing the headlines on Day 2 also is a great way to set the stage for the second half of the kick-off event.

4c. Discussion Exercise

- The Headlines from the Future exercise helps to create alignment on aspirational outcomes for the work of the learning collaborative. Have everyone close their eyes and imagine it is five years in the future and the work of the learning collaborative has been a resounding success. *After some initial challenge, your reducing system change initiative is having a huge impact on the world in ways you'd never imagined.* Ask everyone to take a few minutes to think about this and then to jot down some of their thoughts about how things would look different. Then ask each table to share their thoughts and begin to draft a newspaper headline on the poster board paper at their table. What does the world look like? How has your project evolved? What is it famous for? Ask them to use the markers to create the headline for a local newspaper that captures their collective discussion. Allow approximately 15- 20 minutes for this exercise.
- Have each table share their newspaper headline with the larger group and post it on the wall.

5. Explore Mental Models

See Section 5 of the included PowerPoint File

5a. Overview of the Content

- Explore the evolution of attitudes related to stigma, particularly as they relate to the respective fields of Mental Health, Substance Use Disorder, and Prevention.
- Identify specific mental models that are still influencing our present-day disciplines.
- Identify the mental models that are driving stigma and holding it in place and those that are helping to promote equity and dismantle stigma.

5b. Comments

- The content for this module is mainly based on participants' individual review of the handouts on each of their profession's history and a discussion with other participants who are also a part of their discipline.

5c. Discussion Exercise

- Before setting up the group discussion, ask all the participants to identify their primary professional background. Many may identify with two or all three professions; however, askthem to select their primary professional background. Then ask them to find the handout corresponding to their primary profession in their packet and the corresponding history and give them 5 minutes to silently review the handout.
- Have three group discussion stations set up in various parts of the room or in separate rooms (if available), with each station having a flipchart and markers. Identify each station as being either mental health, substance use disorder, or prevention professionals. And pre-write the following questions at the top of the flipchart paper: 1) Based on the history of our profession, what are some of the mental models that are still very much in play? 2) What are some new mental models that are emerging? 3) Identify which of the mental models either hold stigma in place (identity by placing a P by the mental model) and which ones are helping to reduce stigma and discrimination and promote health equity (identity by placing an RS by the mental model).
- Ask the participants to self-select the group they identify as their primary profession and to identify a note-taker for the group. You might assign a facilitator to each group or allow them to facilitate themselves. Allow 20-30 minutes for the group discussion. Ask each group to select a person to summarize the discussion and report to the large group.
- Bring the group back together and ask each group to provide a 5-minute report out of the key mental models they identified as both holding stigma in place and helping to reduce stigma.

6. How to Shift Norms and Mental Models

See Section 6 of the included PowerPoint File

6a. Overview of the Content

- This section begins by exploring the factors that made it difficult to shift norms and mental models, emphasizing the importance of providing social confirmation
- Relying on research from the social scientist Damon Centolla (University of Pennsylvania), the section examines the power of strong-tie networking, including . . .
    - How strong-tie networks differ from weak-tie networks
    - Why strong ties are crucial for providing social confirmation
    - The dangers of "awareness backfire"
- The section concludes by discussing how tipping points can be achieved

6b. Comments

- Many attempts to reduce stigma focus on mass messaging that is of questionable value because it relies on weak-tie networking and doesn't provide social confirmation
- There is risk that, in the absence of social confirmation, promoting change can actually backfire
- The most effective methods involve creating snowball effects in which people hear change messages from multiple people they trust
- The good news is that norms can shift rapidly once a tipping point is reached (usually about 25% adoption of a new norm).

6c. Discussion Exercise

- Participants have a brief breakout exercise in which they partner up with one other person to think about an existing strong tie that they could leverage to start shifting mental models or practices around reducing stigma and promoting health equity.
- The goal of the exercise is to have everyone apply the concept of strong ties to their own lives.
    - It's important not to think about strong-tie networking (or any other aspect of system change) as someone else's problem.
    - Every person has strong ties that they can leverage.

7. Taking Action Together: Evidence-Based Strategies

See Section 7 of the included PowerPoint File

7a. Overview of the Content

- This section provides an overview of the evidence-based strategies for reducing stigma associated with mental and substance use disorders.
- The purpose of this section is to provide participants with a knowledge base of the most effective strategies for addressing stigma.
- The strategies outlined in this section have been pulled from both SUD and MH research sources.

7b. Comments

- This section starts with a brief discussion of how beliefs about the cause and controllability of behavioral health conditions are key to understanding effective strategies for reducing stigma.
- There is considerable overlap between strategies across the three levels of stigma. However, there are nuances and so the strategies are outlined separately for each of the three levels.
- The slides in this section have detailed notes in note section of the PowerPoint to provide guidance around delivery of each slide.

7c. Discussion Exercise

- There is not a structured discussion session for this module; however, the facilitator might start by asking the group about their knowledge of evidence-based strategies for reducing stigma and then fill in the gaps in knowledge with a review of the slides.

7d. References

Corrigan, P. (2011) Best Practices: Strategic Stigma Change (SSC): Five Principles for Social Marketing Campaigns to Reduce Stigma. Psychiatric Services. Washington, D.C.

Kelly, J. F., & Westerhoff, C. M. (2010). Does it matter how we refer to individuals with substance-related conditions? A randomized study of two commonly used terms. International Journal of Drug Policy, 21(3), 202–207. doi: 10.1016/j.drugpo.2009.10.010

Kvaale, E. P., Haslam, N., & Gottdiener, W. H. (2013). The 'side effects' of medicalization: a meta-analytic review of how biogenetic explanations affect stigma. Clinical Psychology Review, 33(6), 782-794. doi: 10.1016/j.cpr.2013.06.002

Loughman, A. & Haslam, N. (2018). Neuroscientific explanations and the stigma of mental disorders: a meta-analytic study. Cognitive Research: Principles and Implications, 43. doi: 10.1186/s41235-018-0136-1

McGinty E, Pescosolido B, Kennedy-Hendricks A, Barry CL. Communication Strategies to Counter Stigma and Improve Mental Illness and Substance Use Disorder Policy. Psychiatr Serv. 2018 Feb 1;69(2):136-146. doi: 10.1176/appi.ps.201700076. Epub 2017 Oct 2. PMID: 28967320; PMCID: PMC5794622.

National Academies of Sciences, Engineering, and Medicine. 2016. Ending Discrimination Against People with Mental and Substance Use Disorders: The Evidence for Stigma Change. Washington, DC: The National Academies Press. https://doi.org/10.17226/23442

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Schomerus, G. & Corrigan, P.W ed (2022) The Stigma of Substance Use Disorders Cambridge University Press. DOI: 10.1017/9781108936972.

Stigma and Discrimination Research Toolkit - National Institute of Mental Health (NIMH) (nih.gov) https://www.nimh.nih.gov/about/organization/dar/stigma-and-discrimination-research-toolkit

8. Taking Action Together: Stewardship

See Section 8 of the included PowerPoint File

8a. Overview of the Content

- This section culminates the preceding content about Vital Conditions, system change,and methods for changing norms.
- Stewardship brings together the ways of thinking and working that allow us to shift the forces that hold stigma in place.
    - Stewards are people who form working relationships with others to strengthen the systems that enable everyone to thrive

    - The work can't be rushed: progress moves at the speed of trust
- The section paints a picture of what a stewardship orientation looks like by contrasting it with usual ways of thinking and working – and sets the stage for making a plan in the final section.

8b. Comments

- By tying together all of the preceding concepts, this section allows everyone to rallyaround a single comprehensive goal: adopting a stewardship orientation
- The emphasis on working relationships is crucial for facilitating progress after the end of the meeting. The plan-making in the final section only makes sense in the context of shared work to leverage strong ties and build momentum for changing the systems and norms that hold stigma in place.

8c. Discussion Exercise

- There is no discussion exercise in this section.

9. Plan

See Section 9 of the included PowerPoint File

8a. Overview of the Content

- The introduction of this section refers to the introductory slide regarding the big picture and highlights where you are in the process. The goal of this section is for participants to begin applying what they have learned to guide plans for individual, organizational, and system change.
- Making plans for individual and organizational changes uses the 15% solution liberating structure to guide the development of plans; followed by group consultations for individuals to receive feedback on their ideas for change.
- In the system change brainstorm session, participants break into two parallel groups that are charged with brainstorming potential collaboration opportunities.
    - Each group should have a large piece of paper that has a blank quadrant chart drawn on it (see the slides for an example).
    - Rather than writing directly on the paper, it is best to use post-it notes that can later be repositioned
    - Each group should have a designated facilitator.
    - It is also helpful to have at least one circulating facilitator who can track progress and consistency of approach across the two groups.
- The goal is to identify "projects" that meet a few crucial tests . . .
    - It can be started soon and doesn't require additional resources, special permission, etc.
    - People in the group are personally enthusiastic about the idea and are willing devote their time to moving it forward

    - The project would have an impact on the practices and mental models that hold stigma in place, including creating a snowball effect that brings us closer to a tipping point
    - Members of the group feel that they have sufficient leverage to achieve success
- As the discussion goes on, people's standards of "high impact" and "high leverage" may evolve. In that case, it may make sense to change where different ideas appear on the chart.

8b. Comments

- It is important to create a preliminary plan for action before the meeting concludes. Otherwise, there is a risk that momentum created during the meeting will simply fade.
    - It isn't necessary to reach agreement on a single project. The objective, rather, is to leave with a set of strong candidates that can be narrowed down later, after people have had an opportunity to think.
- There is a risk of choosing a goal that is too vague and/or too hard to achieve. To avoid that risk, the discussion is designed to evaluate every idea in terms of its feasibility and potential impact.

8c. Discussion Exercise

- The first exercise involves individuals silently writing out their 15% solution ideas for either individual or organizational changes they want to implement to address reducing stigma. Once they have completed writing out their ideas, they will form groups of 3-4 people to discuss their ideas with each other and receive feedback.
- After the separate groups wrap up, everyone should come back together.
- The discussion should concentrate on the ideas that fall in the "magic quadrant" or close to it – potential projects that would have high impact and for which there's strong leverage.
- The discussion should conclude with agreement to have a follow-up call in a couple of weeks. The goal of that call will be to settle on a shared project.

10. Additional Content

See Section 10 of the included PowerPoint File

Day 1 Wrap-up

- Articulate a new narrative and shared aspirations; check in about the first day and identify any needed changes for Day 2

Day 2 Into

- Review progress from the first day and you may want to start with sharing again the Newspaper headlines created at the end of day one. Provide a preview the second day's agenda

Day 2 Wrap-up

- Summarize the two days; identify next steps; adjourn on a positive, hopeful note for what is possible.

- Closing Activity (if time and space allows) is designed to demonstrate interconnectedness between the learning collaborative participants. Ask the group to stand in a large circle and as the facilitator you will be holding a ball of yarn or string. You will start the activity by sharing with the group one key pearl of wisdom you are taking with you from your experience over the last two days. Then you will toss the ball to someone across the circle from you and ask them to state their pearl of wisdom and toss the ball of yarn to someone across from them, and so on, until everyone has spoken and is connected by a web of yarn.

IV. Follow-Up

Quarterly Learning Sessions (purpose/goals)

The quarterly learning sessions are designed to support the on-going learning of participants and development of system change initiatives. We recommend the first follow-up learning session focus on a deeper dive into application of system change principles and the selection of 1-2 system change initiatives. Facilitators will need to coalesce the ideas from the final brainstorm session of the kick-off event and present these ideas back to the group and facilitate a conversation to prioritize and select the system change initiative the group wants to implement. This is also an important time to assess the overall motivation of the group to move forward with a co-joint system change initiative.

Subsequent learning sessions may be used to provide additional training on system change and implementation of change initiatives.

Sample agendas for the learning sessions

Sample agendas from the Skagit LC delivery are included in Section VI. The content for the quarterly learning sessions is dependent on the individual needs of your learning collaborative. The learning sessions may be delivered virtually or in-person. The Skagit LC held virtual learning sessions.

Providing coaching to the workgroups

Coaching is provided by the TTCs to support the on-going work of the selected system change initiative. The coaching may take the form of helping to organize the workgroups and providing both administrative support (scheduling, zoom meetings, setting agendas) and coaching around developing a plan and facilitating the change process. In the pilot, coaching involved assisting the work group with strategic planning and implementing the agreed upon plan for change. The coach may also identify TTC resources to help with execution of the plan.

A coach should be assigned to each system workgroup that emerges after the first learning session.

Evaluation Process (GPRAs, Ripple Effects)

The GPRA evaluation per TTC requirements can be used to assess basic participant satisfaction with the kick-off event and then it can be administered again at the end of the learning collaborative. A pre and post kick-off event survey was administered during the initial two-day event to assess knowledge and attitudes regarding stigma and system change. The pre and post event assessment is included in the attachments.

One option for evaluating the overall impact of the learning collaborative is to use a participatory evaluation method called Ripple Effects.

V. Recommended Module Sequence

Modules	Topic	Time
Day 1		
I. Introduction, Agenda, Expectations	Welcome & introductions - Review of goals and objectives for the Learning Collaborative - **Small Group Activity:** Why is this topic important? What is your "Why" around addressing stigma to promote health equity and increase belonging in the community? (1,2,4, all) - Agreements for working together - Review of Day 1 Agenda	9:00 – 10:00
II.	Stigma (What is it and Why do we Care) - Define behavioral health stigma - Explore the types and levels of stigma and how they negatively impact people suffering from BH challenges - Discuss the specific functions of SUD - Review commonly studied dimensions of stigma	10:00-11:00-
	Break	11:00-11:15
III.	Vital Conditions and System Change - Vital Conditions Framework (All people and places thriving together) - Introduce the inverted pyramid and explain the underlying theory. - Touch on mental models, power dynamics, and relationships - Power Dynamics Example: Tension between the disciplines - Relationships Example: Negative interdependence	11:15 – 12:00
	Lunch	12:00 – 1:00
III.	Group Activity - Gallery Walk *Think about people experiencing stigma, their friends and family, and professionals like those of us in the room* The groups will each have a flipchart at their table and take notes, draw pictures during the discussion. One person will be identified to provide a short report back to the larger group on the discussion. Report Outs – 3-4 minutes per table.	1:00-2:00

	Facilitator of the exercise provides a brief overall summary at the end pulling together common themes.	
IV.	Panel of Individuals with Lived Experience	2:00 - 3:00
	Afternoon Break	3:00 - 3:15
IV.	Aspirational Outcomes (Where do we want to be in 5 years?) Future State Headline Activity Close Day 1	3:15-4:00

Day 2		
Module	Topic	Time
Welcome Back	Review of key takeaways from Day 1	9:00-9:15
V.	Exploring Mental Models - Exploring the History of our Disciplines - Reviewing Handouts - Group Discussions	9:15-10:00
VI.	How to Shift Norms and Mental Models	10:00-10:30
	Morning Break	10:30-10:45
VI.	Taking Action Together - Evidence-Based Strategies for reducing stigma - Stewardship	10:45-12:00
	Lunch	12:00-1:00
VI.	Making a Plan - Planning Individual/Organizational Change - Brainstorming System Change Initiatives	1:00-3:30
VII.	Evaluation & Closing Activity	3:30-4:00

VI. Supporting Materials

Sample invitation Email Sent to Invitees

We are excited to invite you to an important gathering of key leaders in Skagit County to explore strategies to collectively rethink behavioral health to reduce stigma, its effects on community members and learn evidence-based strategies to reduce and dismantle stigma to promote wellbeing. This learning opportunity will involve a deep dive into understanding the complexity of reducing stigma and how viewing it through the lens of systems change can help your community to develop a multi-component stigma reduction initiative to promote health equity.

The *Northwest Addiction, Mental Health, and Prevention Technology Transfer Centers* and *Skagit County Public Health* are offering this cross-discipline leadership learning collaborative for prevention, mental health, and substance use disorder service leaders in Skagit County. *Coming Together to Rethink Behavioral Health – integrating practice, reducing stigma, and achieving outcomes. A Leadership Learning Collaborative* will explore stigma attitudes and behaviors that perpetuate stigma across our disciplines. The focus will be on identifying ways to braid our three disciplines to strengthen our mutual impact on reducing stigma and advocating for health equity and community well-being. We will look at stigma through systems change lens to examine the mental models, relationship and power dynamics that may be contributing to health disparities and inequities.

Skagit County was selected as a community to pilot this learning collaborative, as reducing stigma, and improving health equity aligns with several of the county's current initiatives led by North Star, the Population Health Trust, and North Sound Accountable Community of Health are all aimed at improving services for individuals struggling with behavioral health issues and creating an environment where people can thrive.

The learning collaborative will start with a two-day in-person meeting scheduled for July 11-12, 9:00-4:00 at McIntyre Hall Conference and Performing Arts Center in Mount Vernon. During day two of the initial learning session participants will identify 1-2 system-level stigma reduction initiatives to collaborate on over the next several months. On-going coaching and support will be provided to teams to support the identified initiative(s). A learning session will be held in the fall to share lessons learned and discuss future directions.

To learn more about the full details of this project and register to attend please click here. We really hope you can join us in this important work.

Please let us know if you are planning to attend by replying to this email and completing the registration.

Pre- and Post-Evaluation Questions

Pre-test

1. **Please create an anonymized personal code. Your personal code consists of the first letter in your mother's first name, the first letter in your mother's maiden name, the first digit of your social security number, and the last digit of your social security number. For example, if your mother's maiden name was Jane Doe and your social security number is 123-45-6789, your personal code is JD19.** *Open-ended*
2. **How would you define stigma?** *Open-ended*
3. **How confident are you that you can describe stigma?** *Likert*: 0-10, Not at all confident - Completely Confident)
4. **How confident are you that you can describe the impacts of stigma?** *Likert*: 0-10, Not at all confident -Completely Confident)
5. **How would you describe your level of competence in combatting stigma at the individual level?** *Likert*: 0-10, Complete beginner- Fully Expert
6. **How would you describe your level of competence in combatting stigma at the organizational level?** *Likert*: 0-10, Complete beginner- Fully Expert
7. **How would you describe your level of competence in combatting stigma at the systemic level?** *Likert*: 0-10, Complete beginner- Fully Expert

Post-test

1. **Please create an anonymized personal code. Your personal code consists of the first letter in your mother's first name, the first letter in your mother's maiden name, the first digit of your social security number, and the last digit of your social security number. For example, if your mother's maiden name was Jane Doe and your social security number is 123-45-6789, your personal code is JD19.** *Open-ended*
2. **How would you define stigma?** *Open-ended*
3. **How confident are you that you can describe stigma?** *Likert*: 0-10, Not at all confident - Completely Confident)
4. **How confident are you that you can describe the impacts of stigma?** *Likert*: 0-10, Not at all confident -Completely Confident)
5. **How would you describe your level of competence in combatting stigma at the individual level?** *Likert 0-10:* Complete beginner- Fully Expert
6. **How would you describe your level of competence in combatting stigma at the organizational level?** *Likert 0-10*: Complete beginner- Fully Expert
7. **How would you describe your level of competence in combatting stigma at the systemic level?** *Likert 0-10*: Complete beginner- Fully Expert
8. **Do you feel like you had enough training to implement the plan you developed**? *Likert 1-5:* Not at all- To a very great extent
9. **Please indicate your level of interest in implementing what you learned at this workshop in your workplace.** *Likert 1-5*: Not Interested-Have been using with efforts in place to maintain it
10. **To what extent do you expect to be able to incorporate the concepts and techniques you learned into your daily work activities**? *Likert 1-5:* Not at all-Extremely

History of Alcohol and Drug Addiction Treatment & Prevailing Beliefs

1750-Early 1800s (Alcohol History)

- ❑ Alcohol was an integral part of early colonial culture.
- ❑ Alcohol Mutual Aid Societies & Sobriety Circles (Native Americans)
- ❑ Washingtonians Program (1800-1840)
- ❑ Addiction Medicine Emerges (Drs. Benjamin Rush & Samuel Woodward)
- ❑ Early Institutional Care (Jails, Mental Illness Asylums)
- ❑ Temperance Movement emerges in 1808.

Prevailing Views

- Mutual aid and sharing are an important means of recovery
- Alcohol problems are due to weak character and are seen as a moral affliction
- Temperance movement starts with the idea of moderation and then moves to abstinence

1850s – 1900 (Alcohol History)

- ❑ Lodging Homes and Homes for the Fallen (inebriate homes) open (1850s)
- ❑ New York State Inebriate Asylum opens (1864)
- ❑ Keeley Alcoholism cures spread (1870s) Home Cures (tonics & syrups)
- ❑ Freud recommends Cocaine to treat alcoholism and morphine addiction
- ❑ Addiction treatment starts to collapse in 1890 and by 1920 asylums and inebriate homes close

Prevailing Views

- Important to isolate the individual from society to remove temptation
- Looking for quick "*miracle cures"*
- Psychoactive drugs used to treat addiction
- Medical treatment is available to the wealthy
- Alcohol and other drugs begin to be thought of as a great social evil

1900 – 1950s (Alcohol and Drug Treatment History)

- ❑ Prohibition limits access to alcohol
- ❑ Alcohol use increases and treatment options disappear
- ❑ Criminalization of Drugs began with the Harrison Act of 1914
- ❑ Narcotic Farms for "drug offenders"

Prevailing Views

- Important to isolate the individual from society to remove temptation
- Looking for quick "*miracle cures"*
- Psychoactive drugs used to treat addiction
- Medical treatment is available to the wealthy
- Alcohol and other drugs begin to be thought of as a great social evil

Modern Alcoholism Movement (1933-1955)

- ❑ 21st Amendment ended prohibition (1933)
- ❑ Medical profession takes a renewed interest in treating addiction
- ❑ Professional Groups Established
- ❑ AMA officially defines addiction as disease in 1952
- ❑ Alcoholics Anonymous established by Bill W. and Dr. Bob in 1935

Prevailing Views

- Alcoholism is once again reconceptualized as a disease that is treatable
- Resources and funding for the treatment and research are allocated
- Idea of mutual support being an important part of recovery re-emerges

1955-2000 (Alcohol and Drug History)

- ❑ Minnesota Model of Treatment (1940s)
- ❑ American Medical Association (AMA) defines "Alcoholism"
- ❑ Resurgence of Drug Treatment (Separate from Alcohol Treatment)
- ❑ Therapeutic Communities (mid-1958) – Synanon (moral treatment)
- ❑ Civil Commitments & Criminal Justice Mandated Treatment (early 1960s)
- ❑ Methadone Treatment (1960s)
- ❑ Expansion of mutual aid support groups (NA, SMART Recovery)
- ❑ Substance Use Treatment is paid for by insurance and public funds

Prevailing Views

- Focus on abstinence for all individuals with substance use disorders
- Addiction treatment is steeped in the 12-Steps and confrontation
- Growing public belief that "treatment doesn't work"
- Addiction counselors defined as "paraprofessionals"
- Mental Health and Substance Use Disorder treatment is very bifurcated

2000- Present (Alcohol & Drug Treatment History)

- ❑ Neurobiology of Addiction (*"Addiction is a Brain Disease and It Matters")*
- ❑ Addiction viewed as a "chronic disease" needing long-term support
- ❑ Motivational Interviewing and Stages of Change wide-spread adoption
- ❑ Medications for treating Addictions (Buprenorphine, Naltrexone, Methadone)
- ❑ "Treatment Works" – SAMHSA messaging
- ❑ Recovery Revolution (Recovery Oriented Systems of Care)
- ❑ Significant shift from inpatient treatment to outpatient/community-based treatment
- ❑ Harm Reduction resurgence

Prevailing Views

- SUD is a brain disease with bio-psycho-social factors (use of medications)
- General public view of treatment "not working"
- Meet clients where they are at

History of Treatment Services for Individuals with Serious Mental Illness

19th Century

- Asylum system grows in the U.S.
- Moral treatment rehabilitation through exposure to normal habits.
- As the institutions grew there was a shift from therapy to caretaking.
- Chronic sufferers were cared for at home.
- Jails served as the Mental Health system for individuals with serious mental health issues.

Prevailing Beliefs and Mental Models

1) Moral treatment rehabilitation – treat them how to act right.
2) Custodial institution – warehouse people and keep them away from society.
3) No one wants to pay for treatment.

Early 20th Century

- Growth of eugenics and forced sterilization emerges (usually Intendeding specific populations, such as immigrants, people of color, the poor, unmarried mothers and individuals with disabilities).
- Experimental treatments (ECT, Insulin shock therapy, lobotomization)
- Albert Deutsch releases a book called *"The Shame of the States."*
- The Great Depression and World Wars place further strain on the institutions and hospitals.
- The National Mental Health Act passed in 1946.

Prevailing Beliefs and Mental Models

1) People with MH problems must be taken care of and should not have the right to marry or reproduce.
2) They don't deserve quality care – the conditions of the state hospitals were inhuman.

1950s

- National Institute of MH calls for community care versus hospitalization.
- Thorazine (first anti-psychotic)
- Deinstitutionalization begins around 1955 and continues to the present day.
- States refuse to pay for networks of community clinics as a part of the original vision for deinstitutionalization.

1960s

- The Federal government's role around caring for individuals with MH issues is expanded.
- Mental Retardation Facilities and Community MH Center Construction Act (1963) signed by John F. Kennedy.
- Community Mental Health Centers were the vision for the future; however, funding did not follow.
- Medicare provided funds for the elderly to be treated in nursing homes instead of hospitals.
- Medicaid was also designed to encourage states to move people out of hospitals and into small facilities.

1970s

- Medicare/Medicaid rules govern the mental health treatment system.
- States "get out of the MH business" – state funds diverted to general funds.
- Supreme Court decision O'Connor v Donaldson (1975) held that people not deemed to be a threat to themselves could not be hospitalized against their will.

1980s to present

- 1981 Omnibus Budget Reconciliation Act repealed funding for the Community Mental Health Centers.
- Deinstitutionalization, while beneficial for some, resulted in others being housed in the Criminal Justice System.
- State Hospitals have become primarily forensic institutions.
- The Affordable Care Act expands MH and SUD coverage.

Common themes and assumptions in the history of MH treatment for individuals with Mental Illness

1) Optimistic belief in quick fixes for Mental Illness to avoid the need for long-term care.
2) Determination to make the system work as cheaply as possible. Shifting responsibility back and forth between the State and Federal System.
3) Assumption that people with MI are undeserving of compassionate care, either because they should be "curable" and not under long-term care or because of genetic defects.
4) Jails and prisons have become the mental health system of last resort, due to a lack of community mental health and hospitalization options.

Sources:

Larson, Z. America's Long-Suffering Mental Health System available on-line at: America's Long-Suffering Mental Health System | Origins (osu.edu) Ohio State University

Bertolote J. The roots of the concept of mental health. World Psychiatry. 2008;7(2):113-6. doi: 10.1002/j.2051-5545.2008.tb00172.x. PMID: 18560478; PMCID: PMC2408392.

Follow-up Leaning Session – Sample Agendas

First Follow-Up Learning Session

Topic	Time	Facilitator(s)
Learning Session – September 20, 2023 – 9:00-11:00		
I. Review of the Agenda and Discussion of Goals - **Welcome and review of agenda and goals for this session**	9:00 – 9:15	

II. Sharing Progress with Individual and Organizational Change Efforts
- **Share a 1–2-minute report on their progress (including a self-rating on your personal stage of change and your organization's stage of change)**
  ○ **Precontemplation**
  ○ **Contemplation**
  ○ **Preparation**
  ○ **Action**
  ○ **Maintenance**
	9:15-10:00	

III. Prioritizing and Selecting a Collective System Change Project
- **Review and clarify the top 6-8 system change initiative ideas**
- **Vote on the candidates**
  ○ **I am strongly committed to this project (would help to drive it)**
  ○ **I wouldn't want to *drive* this project, but I *would* like to help**
  ○ **I would not want to commit myself to helping with this project**
	10:00-10:50	

IV. Next Steps - **Poll to determine types of support needed during the next phase** - **Identify concrete next steps relative to the system change initiatives.**	10:50-11:00	

Second Follow-Up Learning Session

Topic
Learning Session – December 13, 2023 – 11:00-12:00
I. Review of the Agenda and Discussion of Goals - **Welcome and review of agenda and goals for this session**
II. Putting System Change into Practice Discussion - **Six Conditions of System Change (Identifying which one's we are seeking to address with our system change initiatives)** - **Common barriers to systems change (are you facing any these?)** - **Strong-tie networks**
III. Updates from Workgroup Leads - **Peers as Stewards of the Community (Sarah/David)** - **Community Education Initiative (April)**
IV. Next Steps - **Poll to determine types of support needed going forward.** - **Identify concrete next steps relative to the system change initiatives.**
V. Evaluation

Substance Abuse Prevention Skills Training (SAPST)

SESSION 1

INFORMATION SHEET 1.3

Timeline of Alcohol and Drug Abuse Prevention

DATE	NATIONAL SITUATION	PREVENTION STRATEGY
1950s	Drug use intensifies. Heroin addiction alone hits an all-time high, particularly in urban areas.	Scare tactics through films and speakers
1960s	People begin using drugs to have psychedelic experiences. Drug use is associated with the counter culture or racial/ethnic minorities. By the end of the decade drug use is considered a national epidemic.	Scare tactics through films and speakers; information about substance abuse through films and speakers
1970s	Alcohol and drug abuse are recognized as major public health problems. War on Drugs campaign is developed to reduce illegal drug trade. Throughout the decade, society grows more tolerant of drug use.	Drug education using curricula based on factual information; effective education using curricula based on communication, decision making, values clarification, and self-esteem
1980s	"Just Say No" campaign, part of the War on Drugs effort, encourages youth to resist peer pressure by saying "no." Partnerships develop as the public becomes increasingly involved in addressing the problems of substance abuse.	Parent-formed organizations to combat drug abuse; social skills curricula; refusal skill training; and parenting education
1990s	Research examines the factors that protect people or put them at risk for a variety of problems, including alcohol and drug abuse. The value of professionalism and training in this area grows. Community collaborations receive funding to address alcohol and drug problems.	Community-based approaches to prevention; environmental approaches; media campaigns; culturally sensitive programs; evaluation of prevention programs; professional training programs
2000–2010	Understanding of the connections between substance abuse and mental illness/health evolves. "Behavioral health" encompasses both substance use and mental health problems.	Application of evidence-based models; comprehensive programs targeting many contexts (family, school, community); data-driven decision making through a strategic planning process
2010–present	Greater emphasis is placed on prevention and treatment for everyone. Behavioral health is integrated with primary care under the Affordable Care Act of 2010.	Use of evidence-based practices; strategic planning process; improved access to health insurance with better benefits for mental health and substance abuse services and support

The Vital Conditions

THRIVING NATURAL WORLD

Sustainable resources, contact with nature, freedom from hazards
Clean air, water, soil; healthy ecosystems able to sustainably provide necessary resources; accessible natural spaces; freedom from the extreme heat, flooding, wind, radiation, earthquakes, pathogens

BASIC NEEDS FOR HEALTH + SAFETY

Basic requirements for health and safety
Nutritious food, safe drinking water; fresh air; sufficient sleep; routine physical activity; safe, satisfying sexuality and reproduction; freedom from trauma, violence, addiction and crime; routine care for physical and behavioral health

HUMANE HOUSING

Humane, consistent housing
Adequate space per person; safe structures; affordable costs; diverse neighborhoods (without gentrification, segregation, concentrated poverty); close to work, school, food, recreation, and nature

MEANINGFUL WORK + WEALTH

Rewarding work, careers, and standards of living
Job training/retraining; good-paying and fulfilling jobs; family and community wealth; savings and limited debt

LIFELONG LEARNING

Continuous learning, education, and literacy
Continuous development of cognitive, social, emotional abilities; early childhood experiences; elementary, high school, and higher education; career and adult education

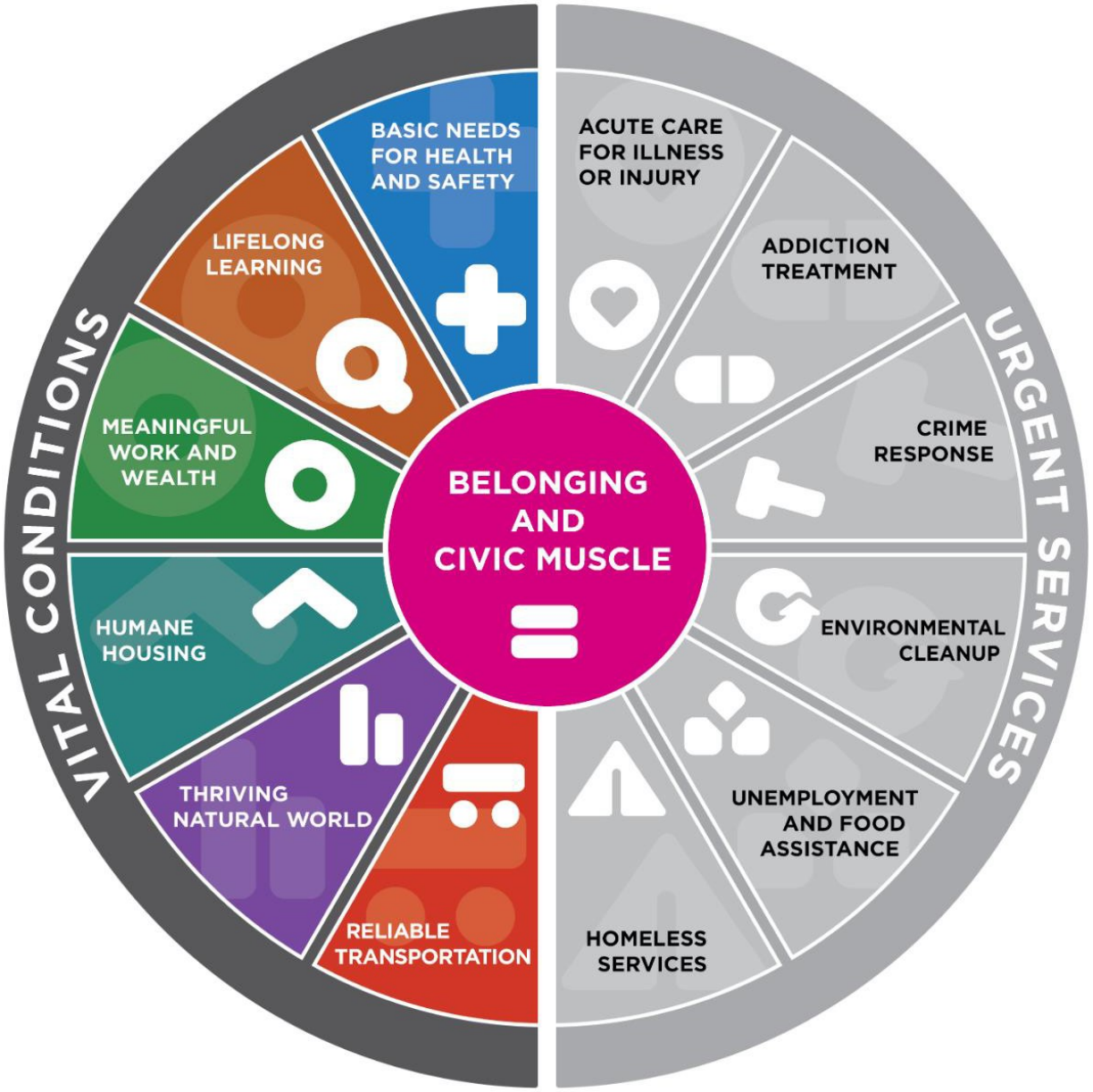
RELIABLE TRANSPORTATION

Reliable, safe, and accessible transportation
Close to work, school, food, leisure; safe transport; active transport; efficient energy use; few environmental hazards

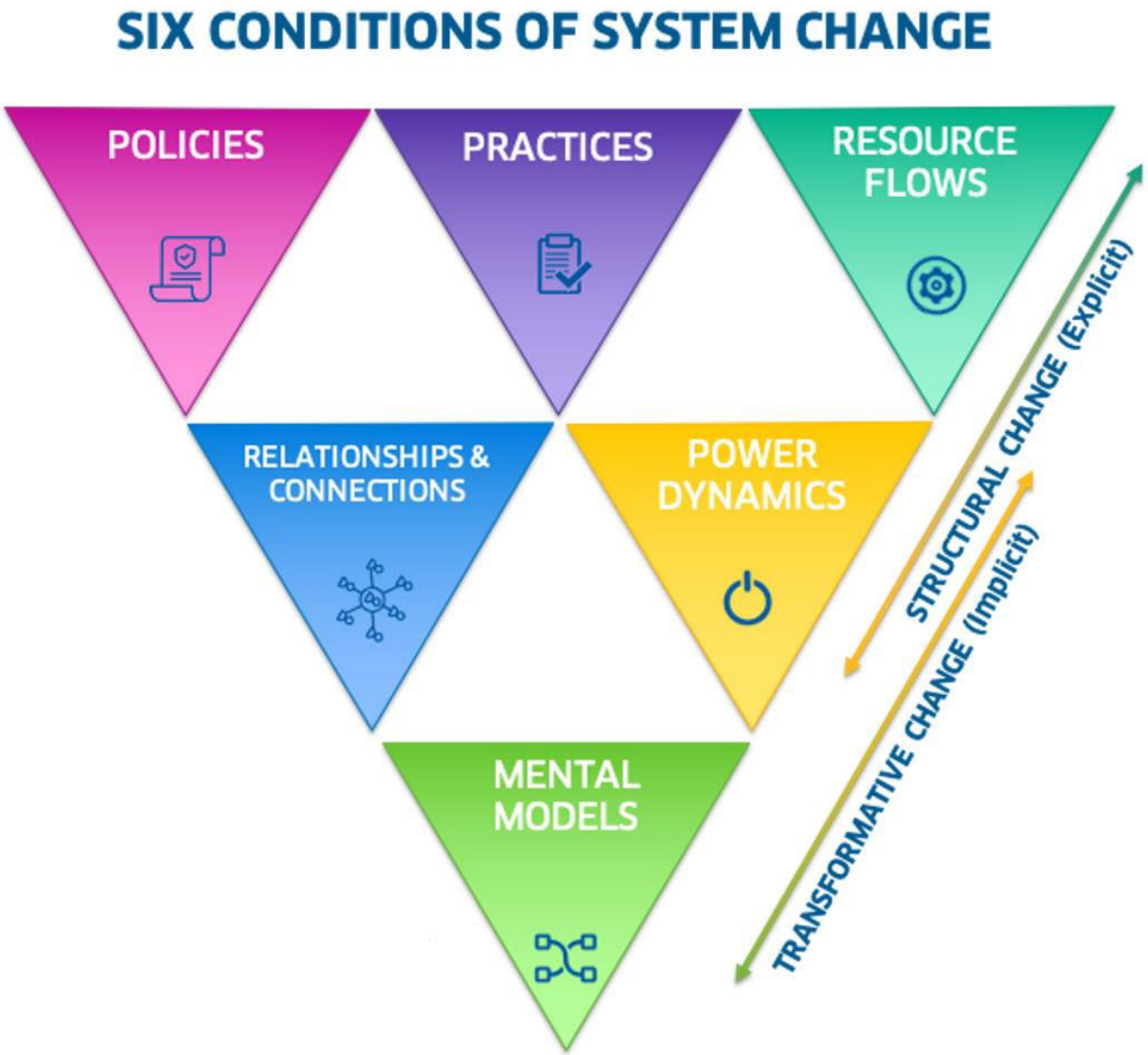
BELONGING + CIVIC MUSCLE

Sense of belonging and power to shape a common world
Social support; civic association; freedom from stigma, discrimination, oppression; support for civil rights, human rights; civic agency; collective efficacy; vibrant arts, culture, and spiritual life; equitable access to information; many opportunities for civic engagement (voting, volunteering, public work)

Graphic developed by The Rippel Foundation



Graphic developed by The Rippel Foundation



Graphic adapted from *Kramer, Mark R., John Kania, and Peter Senge. "The Water of Systems Change." Report, FSG, May 2018*