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Structural Drivers of Stigma & Discrimination of Mental Health and Substance Use Disorders

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1. Structural drivers of stigma and discrimination - impact on equitable access to health care for marginalized populations.

2. How does structural stigma and discrimination manifest in service provision?

3. What practical steps can be taken to address this – for services and for the community?

ANZJP

Australian & New Zealand Journal of Psychiatry
00(0) 1–2
DOI: 10.1177/0004867413476758

The hidden medical logic of mental health stigma

Thomas Ungar[1] and Stephanie Knaak[2]

Reducing the stigma associated with mental illness has become an area of increased effort and attention (Abbey et al., 2012; Jorm and Kitchener, 2011; Stuart et al., 2012). What remains of primary concern is how and why health care providers, who are otherwise educated, kind and compassionate helpers, are amongst the most stigmatising when dealing with mental illness (Abbey et al., 2012; Lauber et al., 2006; Stuart et al., 2012).

While existing research suggests that emphasising biological aspects of mental illness does not reduce stigma and discrimination among the general public (Corrigan and Watson, 2004; Schomerus et al., 2004), we argue that the same cannot be assumed for health professionals. Health professionals are in the specific business of fixing, treating and otherwise controlling biologic disorder. As such, it is both logical and probable that health professionals apply a different set of cognitive interpretations and/or judgements to a medicalised framing of mental illness (Haslam et al., 2007) than does the general public.

Informing our argument is the consideration that stigma and discrimination among health care providers can be thought of as a logical by-product (and perhaps even a result) of mind-body dualism. Mind-body dualism refers to the philosophical split between the (non-physical) mind and the (physical) body. It is a problem that comes into play in the very way physicians think about illness and disease (Miresco and Kirmayer, 2006). When presented with a symptom or set of symptoms, for example, physicians will start by using the fundamental schematic categorisation of "Is it functional or is it organic?" If categorised as organic (i.e. in the body) it is assumed to be real, legitimate and material. From the physician's point of view, this means it is something that can be observed, studied, treated and corrected. Arguably, this reduces stigma and discrimination. However, if categorised as functional (i.e. a problem of the mind, with no physiological correlates), the physician will consider it less real and the patient may be more likely to be stigmatised and discriminated against.

Even though we 'know' this to be a false dichotomy, namely that mental illness (like most all illness) is inherently bio-psychosocial, this split between the material (body) and the immaterial (mind) nevertheless continues to structure our thinking. It permeates our language, explanatory models, attributions for illness, health care delivery structures and resulting

Anti-stigma efforts towards health care providers may be limited in their effectiveness if they ignore this basic schematic that underpins how physicians understand illness and disease.

Research indicates that a more biomedically dominated conception of mental illness does not seem to reduce stigma amongst the general public – mostly because it creates in the public's mind a perception that mental illness is less under a person's control, that people with mental illness are more unpredictable, more potentially dangerous, more fundamentally different, and less likely to recover (Corrigan and Watson, 2004; Schomerus et al., 2004; Stuart et al., 2012). However, extending this same conclusion to health care providers may be an error. And that's because physicians probably think about 'the biological' differently than the general public does.

For a physician, using biological information to emphasise the 'bio' components of a biopsychosocial illness helps to shift the conception of that illness from something 'merely' functional to something organic (and therefore real and treatable). From the physician's point of view, thinking of an illness in organic terms perhaps

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What is stigma

Stereotypes

Labels & language

Prejudice

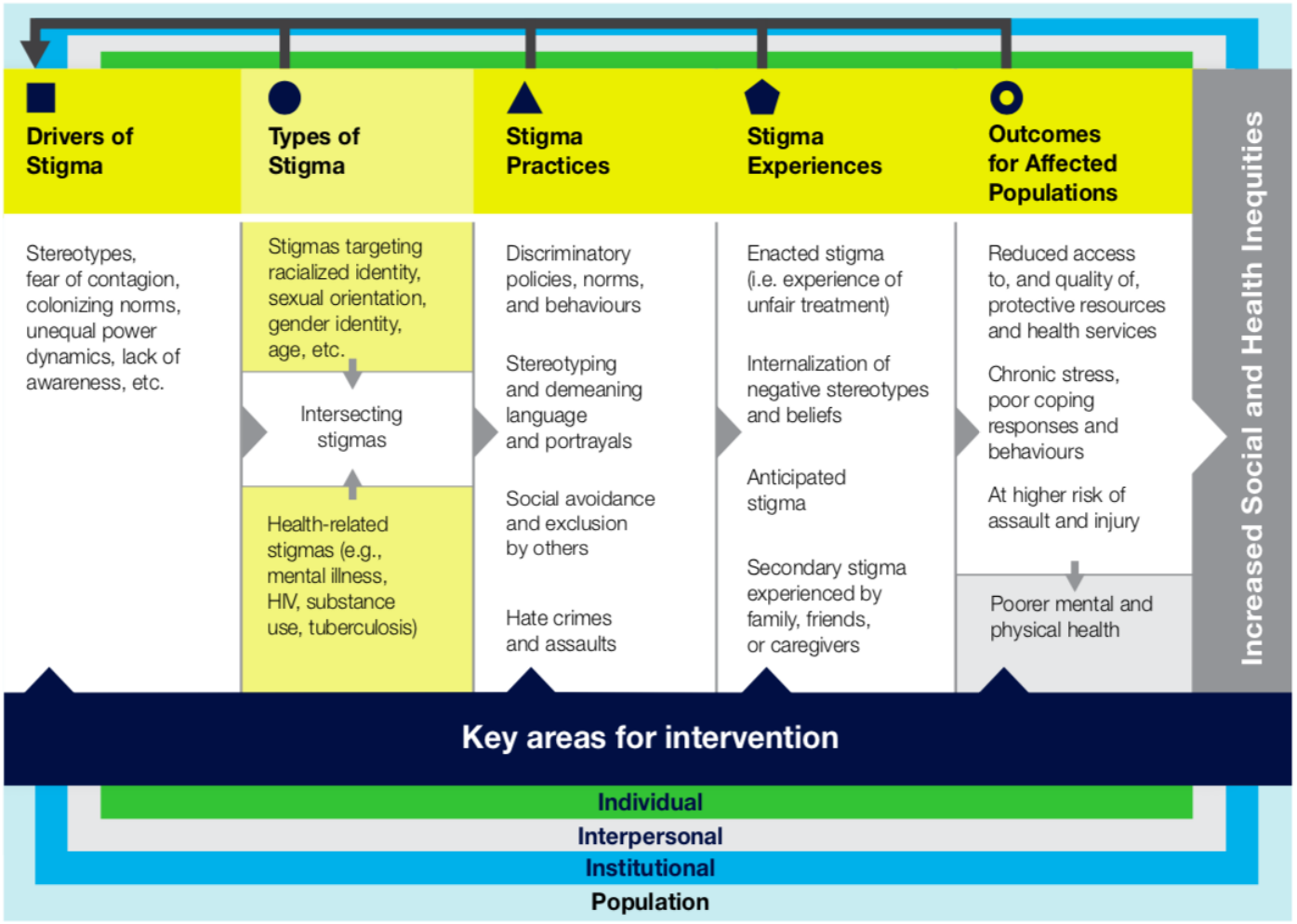
Discrimination

Negative attitudes

Unjust policies, laws, institutional practices

Seeing someone as 'less than'

FIGURE 7: Stigma Pathways to Health Outcomes Model



This model has been adapted from the novel *Health Stigma and Discrimination Framework* recently commissioned by the National Institutes of Health

CPHO 2019. Dr. Theresa Tam, Addressing Stigma: Towards a more inclusive health system

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STRUCTURAL STIGMA

Structural Stigma prevents persons living with mental health problems and illnesses and/or lived and living experience of substance use from receiving accessible, person-centred, high-quality health care

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Financial contribution from Health Canada | Santé Canada

Stigma is a key barrier to prevention, treatment, and recovery for people with lived and living experience

STIGMA'S multiple levels

Individual: Includes shame, fear of seeking help, and feeling less worthy.

Interpersonal: Endorsing negative stereotypes or prejudicial ideas, and speaking or acting in discriminatory ways.

Structural: Located in formal and informal rules, policies, procedures, laws and cultural norms.

Intersectional: The many ways stigma related to mental illness and substance use intersects with other forms of oppression (e.g., racism, transphobia, and colonization).

STRUCTURAL STIGMA in health care

Structural Stigma refers to the accumulated activities in health-care organizations that deliberately or inadvertently create and maintain social inequities for persons who are living with mental health problems and illnesses and/or lived and living experience of substance use.

SOLUTIONS

Addressing structural stigma in health-care settings requires a combination of approaches, such as

- enhancing the meaningful involvement of people with lived and living experience
- building a supportive and stigma-free workplace culture
- adopting integrated, recovery-oriented, holistic, accessible, client-centred models of care
- distributing resources for mental health and substance use care on par with physical health
- establishing mechanisms to monitor structural stigma

The Mental Health Commission of Canada assists in developing, implementing, and evaluating initiatives to reduce structural stigma within health-care organizations.

To learn more about these initiatives, visit Structural Stigma at **mentalhealthcommission.ca** or email us at access@mentalhealthcommission.ca.

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Structural Stigma

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2. How does structural stigma and discrimination manifest in service provision?

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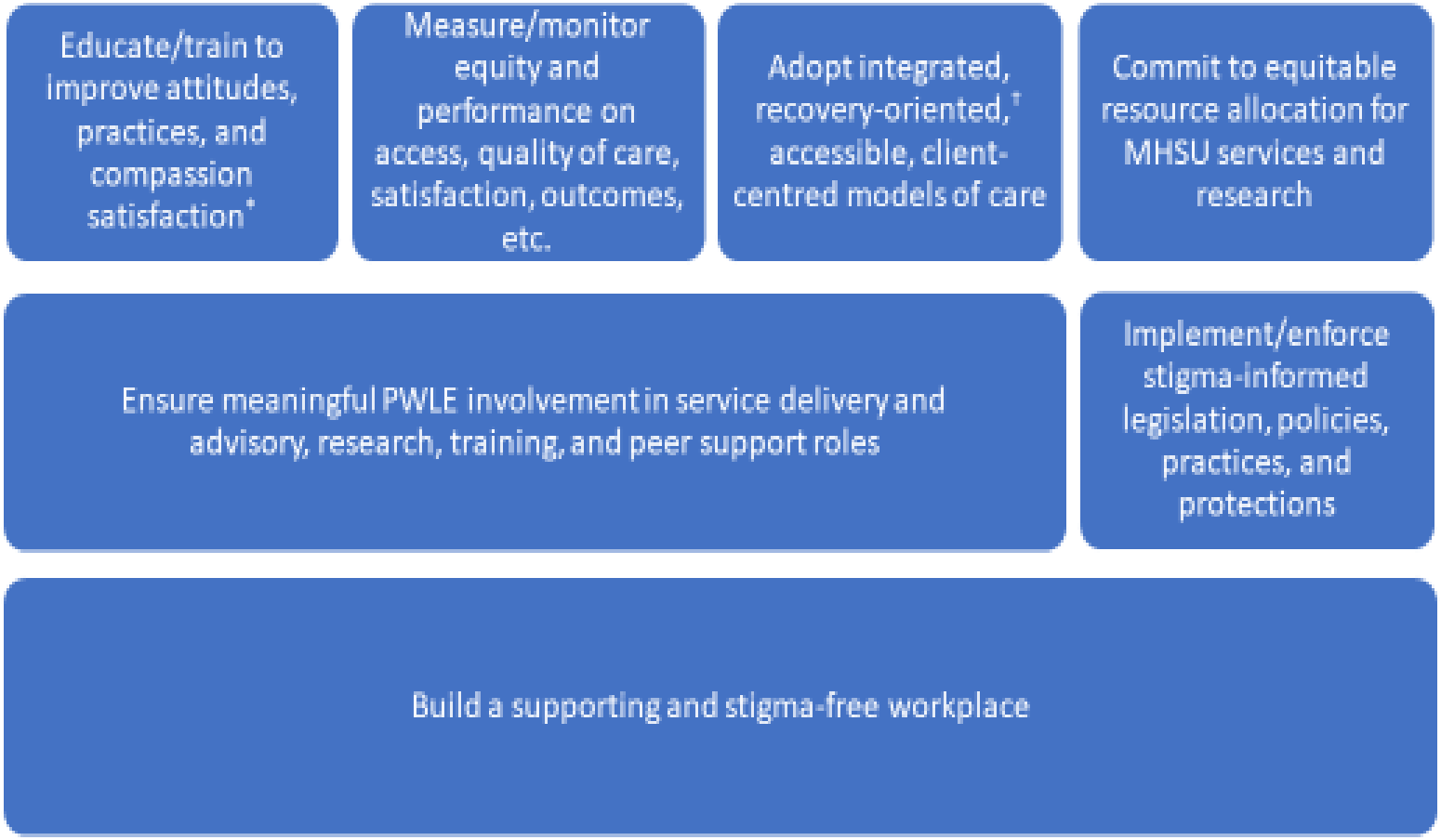
What practical steps can be taken to address this – for services and for community?

Key priorities for dismantling and disrupting mental illness- and addictions-related structural stigma in health-care environments



Dr. Stephanie Knaak

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Approach Structural Stigma as a Quality of Care/Equity Problem. Measure and Monitor it.

Focus on structural actions/behaviours/performance deficits as manifestations of structural stigma

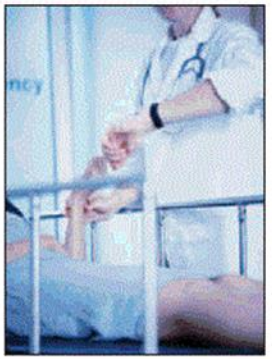
Mental illness stigma as a quality-of-care problem

Reducing the stigma associated with mental illnesses in health-care settings is becoming an increasingly important focus for research, programming, and intervention.[1-3] A systematic review[2] published in *The Lancet Psychiatry* in 2014 articulately described the growing body of evidence on mental-illness-related stigmatisation in health care and its consequences, including negative attitudes and stereotypes, prognostic negativity, diagnostic overshadowing, insufficient skills of health-care providers, discriminatory behaviours, and perceptions of unfair treatment among consumers of mental health services.[2] The stark mortality gap in high-income countries between people with severe mental illnesses and the general population—20 years for men and 15 years for women—has been argued to be at least partly related to the problem of stigmatisation.[2] These issues suggest that several important quality-of-care concerns exist for people with mental illnesses.

Opening Minds (OM), the anti-stigma initiative of the Mental Health Commission of Canada, identified health-care providers as one of four key target groups in its stigma reduction strategy.[1] OM's strategy involves seeking out existing anti-stigma programmes, identifying what works and why, then sharing this knowledge so that effective programmes, instruments, and best practices can be broadly implemented.[1] Thus far, OM's research has identified several effective programmes[4-5] and key

Quality of care is a structural priority, continually at the forefront of concern of health-care organisations and professions[7,8] and most have established quality-of-care standards and processes through which to assess, measure, and improve patient care. Instead of framing stigma as a problem in and of itself to be solved (ie, by focusing on stigma reduction as the primary outcome through the design and delivery of interventions explicitly marketed as being about stigma), we suggest greater traction could be gained through a view that understands the problem of stigmatisation in health-care settings, at least in part, as a core attitudinal and behavioural barrier to quality of care (panel).

Applying a quality improvement lens to the problem of stigmatisation in health care could also provide additional benefits. For one, viewing stigmatisation through a quality improvement lens would help ensure emphasis is placed on achieving higher level Kirkpatrick results,[9] such as behaviour and practice change and improved patient



***Panel:* Addressing stigma through quality of care—a hypothetical case example**

Scenario

Patients with a history of mental illness present to emergency departments with various complaints and symptoms, but are prematurely referred for psychiatric consultation and admission without full consideration, assessment, or treatment of physical symptoms or concurrent or pre-existing disorders.[2] Patients spend lengthy periods without care in the emergency room as providers disagree about which service should assume responsibility for the patients' care.

Towards a mental health inequity audit

Stephen Bartels and Peter DiMilia[1] presented a compelling argument in the *Lancet Psychiatry* for the consideration of serious mental illness as a health disparity. Recent evidence[2] in support of this change suggests that the greatest cause of excess morbidity and early mortality in people with serious mental illness compared with the general population is not suicide but common chronic health conditions, such as cardiovascular disease, respiratory disorders, diabetes, and tobacco-associated illness. Das-Munshi and colleagues[2] also reported that disparities in patient outcomes are not driven by increased risk associated with ethnicity or socioeconomic status.

Possible inclusion categories might include equity of continuing education in mental health (including anti-stigma training), equity of physical clinical space (quantity and condition), equity of diagnostic and treatment processes or procedures, equity of patient access, patient outcomes, equity of follow-up care, equity of critical incident reviews or risk assessment, equity of budget allocations, and human resources equity measures (eg, proportion of leadership roles held by mental health specialists).

Structural stigma is not easily recognised through existing quality processes, measures, and criteria for mental health care. The creation of an audit tool to assess equitable care would help ensure a fairer distribution of resources, and highlight differences in care that might contribute to

5 Smith PC, Mossialos E, Papanicolas I. Performance measurement for health system improvement: experiences, challenges and prospects. 2008. World Health Organization. http://www.who.int/management/district/performance/PerformanceMeasurementHealthSystemImprovement2.pdf (accessed June 5, 2017).

A call for parenting interventions for refugee mothers with children younger than 3 years

According to the United Nations Refugee Agency, more than 21 million people are refugees worldwide, over half of whom are younger than 18 years. Refugees experience severe stress, and stressors can have particularly

Ashley Cooper/Science Photo Library

For the **United Nations Refugee Agency figures** see http://www.unhcr.org/en-us/figures-at-a-glance.html

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Structural Stigma in Health Care for Mental Health and Substance Use

Networking for the Design, Development, and Implementation of an Audit Tool

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Gaps found in metrics and monitoring:

- funding of MHSU services, relative to budget percentage and need
- patient/client/PWLE perceptions of care
- policy and legislation gaps in addressing structural inequity, parity, and quality rights
- the hidden, implicit, or noticeable absence of indicators on quality dashboards
- institutional external reviews/processes and oversight of monitoring gaps for MHSU (e.g., ROPs)
- narrative as a strategy for transformative learning and awareness and implicit and/or unconscious bias
- education on structural stigma

Prototype indicators/measures may be grouped under the following categories:

- cultural or organizational audit — including ROPs
- performance measurement — a quality dashboard or indicator
- equity measurement — as “stratifiers” for other outcome measures related to inequities or disability
- legal — development of health legislation to enshrine the principle of parity for MHSU and disability/human rights

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Design Prototypes for Measuring Structural Stigma in Health-Care Settings

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Safe

MHSU health care that is safe must include

- the existence of and adherence to standard care pathways for MHSU presentations in emergency departments (EDs) (to combat diagnostic overshadowing and possibly for evidence-based medical/physical stability protocols)
- a standard pathway clinical algorithm in ED presentations for acute intoxications, overdoses, or confusion in clients who are elderly or who are experiencing psychosis, including the percentage of adherence rates
- ROP and dashboard monitoring to determine the documented percentage of ED physical exams for MHSU presentations
- dashboard monitoring to track the percentage of all admitted hospital MHSU inpatients who have a physical examination within 48 hours (or other benchmark to be determined)
- a process to document the accuracy of the CTAS/CEDIS triage assignment by relative percentage for MHSU in EDs compared to physical health and the use of the more accurate e-CTAS
- a workplace safety system to track and compare MHSU versus non-MHSU health-care providers with respect to disability, sick days, and illness leave or injury rates with a view to measuring anonymous occupational health and HR data against benchmarks on structural and infrastructure support for MHSU care delivery
- adequate care environment (ED, inpatient, ambulatory, community care) infrastructure and space to safely care for persons needing MHSU services (compared to what is provided for physical health care) with audits of physical care tools such as safe beds, modern restraints, locks, video monitoring equipment, safety alarms and personal buzzers, and adequate support for security staff
- MHSU care environments that are in keeping with the principles of design and location for triage, risk, acuity, and clinical care needs , ,
- a thorough initial medical/physical stability assessment for MHSU patients to combat the risk of implicit and cognitive bias in providers, which may lead them to prematurely refer and transfer patient responsibility to MHSU providers ,
- a requirement that code white (or behavioral) emergency policies and practices be led by a clinician, not security staff

Effective

MHSU health care that is effective must include

- a pharmacist team member to complete a medication reconciliation for MHSU patients in EDs and inpatient units, as is done for non-MHSU patients in medical-surgical units
- a rapid access addiction medicine (RAAM) clinic or low-barrier access to a walk-in addiction service
- a medically supported withdrawal management/detoxification service or clear pathway algorithm for responsibility for this clinical care service
- access to community-based psychotherapy
- a formal memorandum of understanding or partnership agreement for MHSU patients' physical health care, including a standard pathway algorithm or flow process between stand-alone MHSU hospitals or care facilities and non-MHSU physical health care hospitals or facilities
- an MHSU chief quality officer role to serve on organizational or hospital and board quality committees (exemplar item)
- MHSU most responsible service pathways that are equivalent to other non-MHSU services
- access to evidence-based treatments, such as ECT, r-TMS, clozapine clinics, and psychotherapies
- an embedded, integrated physical health-care provider for MHSU services in community mental health clinics (reversed co-location shared and integrated collaborative care), especially for PWLE with serious mental illness and MHSU concerns who face barriers or are unable to access timely primary physical health care or a family or general practitioner (e.g., assertive community treatment, early psychosis intervention, RAAM)
- continuing education on MHSU requirements among non-primary MHSU health-care services (e.g., rounds, topics in conference, in-services for interns, mandatory annual professional learning (benchmarks to be determined)
- access to peer support.

Patient Centred

MHSU health care that is patient centred must include

- measures of patient satisfaction and perception of care, enhanced by adding MHSU-specific care to generic score cards, which could be used to create a patient satisfaction tool and a scoring practice comparable to that of medical-surgical services (i.e., an MHSU satisfaction score greater than, say, 80 per cent)
- physical locations, waiting room areas, and care environments for MHSU services with conditions that are equivalent to those of non-MHSU services
- signage and service designations that use language in keeping with current MHSU standards (with PWLE-provided input and satisfaction)
- available or accessible MHSU information for the purpose of patient and family education
- the use of stand-alone provider engagement surveys (e.g., by Pulse) and satisfaction scores on clinical care-related items for MHSU staff, comparable to those for physical health-care providers (e.g., "I have the tools I require to meet the needs of my patients"), with a view to conducting a stratified assessment of care against the quadruple aim
- equitable access and provision of after-hours MHSU care with on-call rooms and reserved or dedicated parking access that is equivalent to allocations for non-MHSU providers
- the presence of patients and family members in mandatory terms of reference for boards and senior executive teams, with placements (including PWLE or MHSU patient- and family-centred care representatives) on organization boards, senior leadership teams, and senior committees (an equity, diversion, and inclusion [EDI] for MHSU implicit bias and an exemplar practice)
- access to outdoor space for MHSU patients, especially for those requiring involuntary admission, who are unable to leave inpatient units for safety reasons (Should minimum standards for the treatment of patients under such conditions be considered for health-care facilities as they have been for jails in the criminal justice system?)
- making recovery-oriented and trauma-informed care part of any policy or organization-wide mission, vision, or values, including MHSU services and beyond (e.g., trauma-informed care in EDs, as proposed by the Institute for Healthcare Improvement).

Timely (access to services)

MHSU health care that is timely must include

- MHSU wait time measures for services and assessments by registered nurses, social workers, occupational therapists, psychiatrists, psychologists, and addiction services, such as a 30-day wait time to see a specialist, an equivalent wait time for MHSU and non-MHSU patients between the ED presentation and a physician's initial assessment, and targets on the wait time for follow-up care after an ED visit or hospital discharge (e.g., 30 days, which would be akin to cancer care wait times)
- a ratio metric for MHSU services in number of days, linked to clinical outcomes (e.g., percentage of ED 30-day recidivism, inpatient average length of stay, percentage of overdose deaths in the area)
- continuity of care information, such as percentage discharge notes for MHSU (e.g., PWLE to follow up with service provider within seven days)
- information on access in relation to the availability of resources (e.g., percentage of MHSU providers per 100,000 persons and/or population in a geographic region).

Efficient

MHSU health care that is efficient must include

- funding for MHSU with a budget allocation as a percentage of the global health budget (by organization/hospital, system or region, province or territory, or country) including, e.g., percentage of gap targets (MHSU parity), the OECD international global comparators scorecard and ranking
- budget equity between MHSU and non-MHSU clinical programs over time in terms of increases, decreases, cuts, and discretionary "strategic investments" (e.g., changes to surgery budget versus MHSU budget)
- budget for and the number/ratio of acute ambulatory and urgent follow-up clinical staff and employees for MHSU compared to non-MHSU clinical services (medical-surgical) (e.g., staff number for fracture care or diabetes clinics versus the MHSU urgent clinic)
- tracking the ratio of allied health staff per inpatient bed for MHSU versus non-MHSU services (e.g., discharge planners, social workers)
- eligibility for a capital equipment budget that includes MHSU, following the same measures and financial percentage of the hospital/organizational global budget
- a measure to correlate health needs with resources (How does the MHSU population health burden and health system priority ranking align with the percentage of health budget allocation by the system or organization, and what is the degree of disconnect?)
- an understanding of the budgetary cost and percentage of MHSU hospital beds (MH and SU separate) per 100,000 people
- the integration of organizational MHSU and non-MHSU health performance data to enable the visualization of reporting and quality dashboard items on same document and prevent their segregation
- the adoption of the same integrated funding agreement template for MHSU and non-MHSU services (e.g., rather than having one health services accountability agreement for medical-surgical and one for MHSU)
- measuring and monitoring the funding percentage ratio between contributions by charitable foundations and those by the hospital (e.g., the dollar contribution coming from charitable foundations versus the hospital, organization, or system for new capital projects and new services) with a view to establishing an allocation for MHSU that is equitable to other clinical services.

Equitable

MHSU health care that is equitable must include

- a stand-alone and separate health disparity identifier for MHSU monitoring (along with those of gender, 2SLGBTQ+, race, disability, and others.) for all organizational EDI measurement or audit processes, implicit bias training requirements, and continuing education offerings (e.g., annual mandatory employee training or credentialing requirements for health-care providers, employees, managers, and executives)
- a measure of capital investment in MHSU treatment services and its relative ranking (e.g., how long it has been since the last new build or renovation of their physical space) compared to other health services (medical-surgical) • an assessment of the condition of physical MSHU care environments for ED, inpatient, and outpatient services, compared to rest of the organization or hospital (e.g., paint, furniture, cleanliness)
- an understanding of the relative remuneration (target to be determined within 10 per cent) of MHSU providers for equivalent work or roles compared to non-MHSU providers (e.g., MD specialty inequities)
- a determination of the charitable funding provided by foundations for MHSU versus non-MHSU as a percentage of the dedicated and discretionary charitable funds an organization allocates
- identifying funding amounts from agencies for research, scholarships, and innovation for MHSU versus non-MHSU as a percentage of the budget, with targets (to be determined)
- a comparison of policies and procedures for housekeeping services (Is the frequency of cleaning for MHSU clinical care [ED, inpatient, outpatient] the same as for non-MHSU environments?)
- an assessment of designations, categorizations, and language used for MHSU clinical spaces (Are outpatient MHSU clinical spaces designated as equivalent to clinical assessment or treatment rooms [as opposed to offices tantamount to administrative spaces]?)
- an evaluation of inpatient bed categories and their designation equivalencies (Are acute MHSU beds given the same acuity determinants as non-MHSU beds?; e.g. for MHSU, 1 = acute care unit, 2 = ward beds, whereas for medical-surgical beds, 1 = Intensive care unit, 2 = step-down unit, 3 = acute ward beds)
- an appraisal of whether the geographic locations of MHSU clinical facilities and services (ED, inpatient, outpatient) are integrated to the same extent as non-MHSU facilities and services, using a patient-centred, quality-of-care rationale for what is best for the patient (i.e., the principles of form follows function and low barrier access)
- having equitable employee/provider recruitment and hiring policies to require equivalent police background checks for all staff, including those in MHSU care (e.g., via health professional credentialing and licensing or HR processes)
- knowledge of the percentage of MHSU health-care providers or PWLE who are in leadership roles for the hospital/organization and on senior leadership teams or governance boards
- integrating MHSU into the same parts and sections of workplace leave insurance forms (disability, illness) as is medical illness, instead of segregating MHSU diagnoses (i.e., medical versus psychological/non-medical)
- an acknowledgment on organizational/licensing body self-attestations and in HR forms and policies that every health concern and illness may impair a person's ability to perform and function in a given role, rather than using a separate category and reporting/questions section for MHSU.

Other frameworks and processes to consider for new prototype development

Legislative policy

- Create an MHSU Parity Act for Canada.

Equity measurement outside of direct health-care contexts

- Make MHSU a separate, stand-alone disability, disparity, health equity category in Health Equity Impact Assessments
- (e.g., in the Ontario Ministry of Health and Long-Term Care template) instead of a broad category of disability.
- Add MHSU as a separate category or stratifier item to the Statistics Canada General Social Survey.

Why Structural Stigma Matters

Important to the needs and mandate of health care leaders and decision makers

How Structural Stigma is Manifested in Clinical Operations

Impacts on quality of care

How Structural Stigma can be Transformed

Awareness of implicit systemic cognitive bias

Dr. Thomas Ungar

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Merci and Thank You

Looking Forward to a better future!

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