Mental Health Commission of Canada | Commission de la santé mentale du Canada

Real-world examples of approaches that address mental illness- and substance use-related structural stigma in Canada's health-care system

Expression of Interest

Complete and submit your Expression of Interest form today.

Submission Deadline: 11:59 p.m. ET, September 15, 2020

Purpose

This Expression of Interest from the Mental Health Commission of Canada (MHCC) seeks to identify organizations that have implemented innovative models of care, quality improvement initiatives, interventions, programs, policies, or practices that show promise or effectiveness in reducing structural stigma for people with lived and living experience of mental health problems and illnesses and/or substance use.

Through this work, the MHCC will

- identify real-world examples of promising models and approaches to reducing mental illness- and substance use-related structural stigma in health-care environments
- support health-care organizations in gaining a better sense of structural stigma by offering comprehensive descriptions of specific promising or effective models and approaches
- facilitate knowledge sharing about impactful models and approaches within the Canadian health-care context.

The real-world examples chosen through this process will be described and highlighted in knowledge products related to addressing structural stigma in Canada's health-care system.

It is also our hope that the selected organizations, in addition to participating in this important project, will be interested in ongoing research and knowledge mobilization partnership opportunities with the MHCC — for example, further evaluation and measurement (if not yet being done) and possible scale up or replication.

If you have any questions about how your information will be used, please contact Veronique Joncas, Program Manager, Access to Quality Mental Health Services, at vjoncas@mentalhealthcommission.ca.

Background

Stigma reduction has been central to the MHCC's mandate. Opening Minds, the commission's first major initiative in this area, focused on identifying, evaluating, then sharing, promoting, and scaling up

effective interventions and approaches. This work has garnered international recognition in the fight to eliminate mental illness-related stigma. Since then, our mandate has expanded twice to include substance and opioid use-related stigma (2017) and structural stigma with particular focus on the health-care sector (2019).

Defining structural stigma

Stigma is a major barrier to timely and accessible quality care, recovery, and quality of life for people with lived experience. It is generally defined as a complex social process involving the interplay of many processes, such as labelling, stereotyping, separation, prejudice and status loss, and discrimination. Stigma also operates across multiple domains and levels, including individual or personal (e.g., self-stigma or internalized stigma), interpersonal or public (e.g., negative public attitudes, stereotypes, and behaviours), and institutional or structural (e.g., discriminatory practices, policies, or laws).

In addition, it is intersectional and compounding, meaning that stigmatization related to mental illness and substance use may be experienced even more severely by people who experience other forms of inequity (e.g., racism, transphobia, ableism, and colonialism).

Structural stigma refers to the accumulated activities of organizations that deliberately or inadvertently create and maintain social inequalities for people with lived experience. It is located in the formal and informal rules and practices of social institutions and is "reinforced in laws, the internal policies and procedures of private or public institutions and systems, and the practices of professionals and decision makers" (p. 4) [1].

Examples of structural stigma for people with lived experience:[1]

- the low availability of publicly insured services for mental health or substance use care and treatment in relation to population needs
- diagnostic and treatment overshadowing, i.e., when physical health symptoms are presumed to be a consequence of a person's mental health or substance use problem, leading to systemically poorer quality of physical care overall
- consistently lower client satisfaction compared to other health-care clients — or a failure to collect mental health- and substance use-specific client satisfaction data
- organizational health-care cultures that allow clients to encounter stigma when seeking or receiving help from the health-care system, i.e., feeling penalized, punished, diminished, demeaned, or treated as being less deserving of care
- institutional policies or practices that cause harm (e.g., policies that result in the denial of care, barriers to access, the inequitable availably of services, or overuse of coercion, compulsion, or punitive models of care)
- a relative lack of performance measures for assessing equity and quality of care for people with mental health or substance use problems;

[1] See additional examples in Appendix A and on the MHCC's Structural Stigma web page.

- offering people with lived experience little or no meaningful organizational involvement in policy or quality reviews, service delivery, needs assessments, research, etc.

Structural stigma is particularly dangerous and damaging because it represents an embedding of unfairness and inequity into the very fabric of social institutions, organizations, and our commonly held ways of thinking and acting toward people with lived and living experience of mental health problems and illnesses and/or substance use. It can lead otherwise well-intentioned people to act in discriminatory ways. Like other risks to health-care quality, structural stigma is often enacted through implicit cognitive biases that have influence outside our awareness, despite best intentions [2, 3].

The MHCC's structural stigma initiative

The MHCC's structural stigma initiative was launched in 2019 within the Access to Quality Mental Health Services[2] portfolio. Three main research projects were completed that year:

- a comprehensive literature review
- a qualitative research study based on focus groups consisting of people with lived and living experience of mental health problems and illnesses and/or substance use [5]
- an environmental scan to assess the need for tools that measure structural inequities in mental illness- and substance use-related care

This research brought into focus

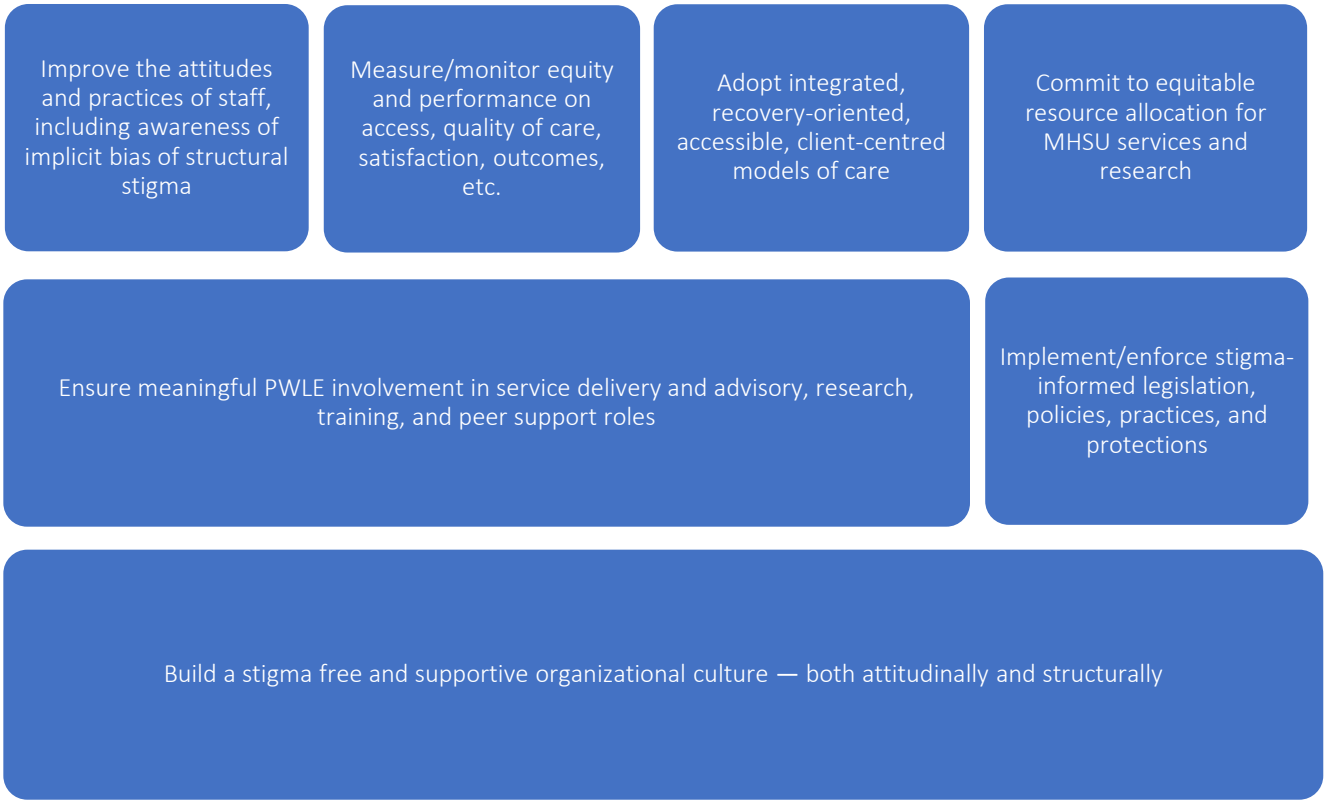
> a comprehensive picture of structural stigma in health-care environments: how it is experienced, how it impacts health and quality-of-life outcomes, and how we might reshape the way health service delivery and care are provided to persons with lived experience. The main findings were synthesized into the following seven priorities for dismantling and disrupting structural stigma.
>
> These findings were further summarized in an expanded version of the Action Framework for Building an Inclusive Health System fact sheet from *The Chief Public Health Officer's Report on the State of Public Health in Canada*. (p. 1) [4]

This expanded Action Framework[3] provides promising examples of interventions, approaches, and models of care for reducing mental illness- and substance use-related structural stigma identified through our research. As such, we hope it will be used to help guide "future research, interventions, and initiatives by organizations committed to improving access, the quality of service and care, and wellness outcomes for persons with lived experience" (p. 1) [4].

[2] Which includes substance use and addiction services.

[3] See Appendix A.

Figure 1. Key priorities for dismantling and disrupting mental illness- and addictions-related structural stigma in health-care environments[4,5]



Description of the Expression of Interest

Building on the research results from Year 1, a key activity for Year 2 is to identify, describe, and highlight real-world examples of approaches that address structural stigma in Canada's health-care system to help educate people about this problem.

To that end, we are seeking expressions of interest from organizations that have implemented innovative models of care, quality improvement initiatives, interventions, programs, policies, or practices that show promise or effectiveness in reducing structural stigma by improving access, quality of health care and/or outcomes for people with lived and living experience of mental health problems and illnesses and/or substance use.[6]

[4] Satisfaction from providing care.

[5] In the context of substance use, recovery-oriented care refers to models of care that incorporate harm reduction and quality of life as central pillars.

[6] See Appendix A for examples of the types of interventions we are seeking to learn more about.

The real-world examples chosen through this process will be described and highlighted in knowledge products related to addressing structural stigma in Canada's health-care system.

It is also our hope that the selected organizations, in addition to participating in this important project, will be interested in ongoing research and knowledge mobilization partnership opportunities with the MHCC — for example, further evaluation and measurement (if not yet being done) and possible scale up or replication.

If you have any questions about how your information will be used, please contact Veronique Joncas, Program Manager, Access to Quality Mental Health Services, at vjoncas@mentalhealthcommission.ca.

Scope

Those interested must be willing to share information about their organization and its initiative/ program/approach/model of care and provide a clear understanding of what these do to effectively reduce or address structural access or quality care barriers for patients with lived experience.

This may include

- providing relevant (non-confidential) program information
- participating in interviews or focus groups
- hosting a site visit (if circumstances permit)
- making other data collection activities available that will help generate a comprehensive picture of your organization's initiative/program/approach/model of care.

Supporting documentation

Other examples of the approaches we are interested in identifying and learning more about are available in the following reports:

- *Combating Mental Illness- and Substance Use-Related Structural Stigma in Health Care: A Framework for Action* [4]
- *Structural Stigma in Health-Care Contexts for People with Mental Health and Substance Use Issues: A Literature Review*
- *Structural Stigma in Health Care for Mental Health and Substance Use: Networking for the Design, Development, and Implementation of an Audit Tool*

Evaluation Criteria

Submissions will be reviewed and selected on the basis of

- the strength and clarity of their connection with structural stigma
- the extent to which they contribute an innovative and promising approach to addressing structural stigma

- whether the initiative/program/approach/model of care has demonstrated some effectiveness at reducing structural stigma (e.g., a shift in organizational culture, attitudes, or care practices; improved retention in care, client satisfaction, or client outcomes; enhanced performance monitoring).

Timelines

- Submission deadline: 11:59 p.m. ET, September 15, 2020
- The MHCC team will notify all applicants of our decisions by Monday, September 28.
- Data collection with followup interviews and document reviews will take place between October 1 and November 15.
- Completion of the draft report is expected by December 23 and the bilingual final report by March 31, 2021.

Expression of Interest Submission Form

Complete and submit your Expression of Interest form today.

References

1. Livingston, J. D. (2020). *Structural stigma in health-care contexts for people with mental health and substance use issues: A literature review*. Retrieved from https://www.mentalhealthcommission.ca/English/media/4348
2. Knaak, S., Patten, S., & Ungar, T. (2015). Mental illness stigma as a quality-of-care problem. *Lancet Psychiatry, 2*, 863-864. https://doi.org/10.1016/S2215-0366(15)00382-X
3. Ungar, T., & Knaak, S. (2013). The hidden medical logic of mental health stigma. *Australian and New Zealand Journal of Psychiatry* 47, 611-612. https://doi.org/10.1177/0004867413476758
4. Knaak, S., Livingston, J., Stuart, H., & Ungar, T. (2020). *Combating mental illness- and substance use-related structural stigma in health care*. Ottawa, Canada: Mental Health Commission of Canada.
5. Stuart, H., & Knaak, S. (2020). *Mental illness and structural stigma in Canadian health-care settings: Results of a focus group study*. Ottawa, Canada: Mental Health Commission of Canada.

Appendix A

Combating mental illness- and substance use-related structural stigma in health care: A framework for action

Level of Stigma	**Institutional:** health-system organizations, medical and health-care training schools, organizations in the community sector, social services, and those responsible for health policy, standards setting, and monitoring
How Stigma Operates	People with lived experience (PWLE) being made to feel "less than" (deprioritized, undertreated, denied; lack of empathy from staff)
	Physical environment not inclusive or conducive to quality care
	Institutional policies that cause harm (unnecessary interventions that humiliate, denigrate, or compromise dignity; overuse of coercion, compulsion, punitive approaches; policies that restrict access to best-evidence care; failure to implement wellness/recovery-oriented models of care [including harm reduction]; fragmentation of service)
	Diagnostic and treatment overshadowing
	Inequitable investment in services and underfunding of research
	Inadequate training of health-care professionals (mental health and substance use [MHSU] care; cultural safety/culturally responsible care and trauma- and violence-informed care; stigma-informed care)
	Failure to measure and track (quality indicators for MHSU; equity of care for people with MHSU; attitudes and practices at the level of organizational culture; client satisfaction and perspectives)
	Lack of enforcement on existing human rights protections
	MHSU stigma in the workplace (staff feel unable to disclose MHSU problems; inadequate policies and protections; culture is hostile to staff with MHSU issues; inadequate training and support; MHSU providers feel less respected and valued than physical health-care providers)
Interventions to Address Stigma	Ongoing training targeting conscious and implicit bias for all (clinical and non-clinical) health-care staff (build programs on evidence-based key ingredients and implementation guidelines, including ample use of social contact;[1] implementation and evaluation frameworks should focus on the possibility for cultural change)
	Implement cultural safety and humility models and provide training for staff.
	Workforce diversity initiatives
	Establish and adhere to resource equity for MHSU care and research.
	Institutional collaboration with the community; policies that support and fund meaningful engagement with PWLE (e.g., policy development, advisory, research, service delivery, peer support/navigation roles)
	Implement trauma- and violence-informed care models and training.
	Adopt and expand recovery-oriented models of care (e.g., integrated models of care, person-centred care, harm reduction models, meaningful involvement of PWLE, trauma- and violence-informed care).
	Implement accountability and monitoring frameworks that include structural stigma reduction indicators for MHSU (e.g., indicators for equity and quality, performance, patient satisfaction, culture change, accreditation standards).
	Conduct regular policy and practice reviews using a stigma-informed lens.
	Strengthen curricula and continuing education for all health-care providers in MHSU on social determinants of health, recovery-oriented care, harm reduction, and stigma-informed care.

Level of Stigma	**Institutional:** health-system organizations, medical and health-care training schools, organizations in the community sector, social services, and those responsible for health policy, standards setting, and monitoring
	Strengthen and enforce human rights protections and provide easy avenues for client complaints and resolutions.
	Strengthen policies, training, and support for staff to encourage help seeking, protect staff mental health, and improve workplace culture.
Potential Outcomes	An institutional environment that is inclusive, welcoming, diverse, and safe
	Organizations that can meet the needs of all populations, including PWLE
	A reduction in stigmatizing beliefs and attitudes among staff and across the organization
	Improved patient/client ratings of care, satisfaction, and trust
	Improved patient/client outcomes (physical and mental health for PWLE; quality of life for PWLE)
	Earlier engagement in care for PWLE due to earlier help seeking
	Better retention in care and treatment for PWLE
	More appropriate and best-evidence care provided to PWLE
	Greater compassion satisfaction among staff
	Improved mental health of health-care staff
	Less time off work; improved worker retention
	MHSU providers that feel valued and equitably compensated within the health-care system

Adapted from "Table 2 – Action Framework for Building an Inclusive Health System," by the Public Health Agency of Canada, *Addressing stigma: Towards a more inclusive health system,* The chief public health officer's report on the state of public health in Canada (p. 41), 2019, Ottawa, Canada: Copyright 2019 by Her Majesty the Queen in Right of Canada, as represented by the Minister of Health.