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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

Thomas Ungar, MD, M.Ed.

Associate Professor, University of Toronto Department of Psychiatry,
Associate Scientist, Li Ka Shing Knowledge Institute,
Psychiatrist-in-Chief, St. Michael's Hospital, Unity Health Toronto

Nivatha Moothathamby, M.Ed.

Research Assistant, St. Michael's Hospital, Unity Health Toronto

Mental Health Commission of Canada
mentalhealthcommission.ca

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Background

From October 1, 2019 to March 19, 2020, the Mental Health Commission of Canada's (MHCC's) structural stigma research team explored the idea of developing an audit tool for mental health and substance use (MHSU).*

Our initial strategy evolved by reframing and contextualizing stigma within the health-care system's quality-of-care framework, specifically under the "E" pillar of equity.[1] Establishing stigma as a quality-of-care problem within existing monitoring and delivery processes requires new ways of thinking and the creation of a quality audit tool.[2]

Methodology

The research group used a human-centred design for its process of inquiry and the development of mental illness stigma interventions.[3] This methodology aligns with existing health-care quality improvement methods (related to human factors), root cause analysis, and process mapping.

Concurrent with the late stages of this project, Canada's chief public health officer released her 2019 annual report, entitled *Addressing Stigma: Towards a More Inclusive Health System*.

Serendipitously, this comprehensive document outlines the stigma pathways to health outcomes model† and describes the process and impact of stigma at various levels, including intrapersonal, interpersonal, institutional, and societal. We believe our work aligns well with this report, since it provides us with another organizing model for the various rapid prototypes and interventions that were stimulated by our networking activities. Our specific work on mental health and substance use may further advance the report's intentions: to design and develop interventions and "action solutions" to improve health outcomes.

Purpose

The research group set out to conduct a range of networking activities to identify promising partners for the design, development, and implementation of a structural stigma audit tool. The process involved inquiring, networking, and developing relationships with potential partners, key system influencers, and decision makers.

We contacted 13 agencies across a small sampling of the health regulatory and performance measurement field, locally, provincially, nationally, and (more selectively) internationally. With Nivatha Moothathamby having made the appropriate arrangements, Thomas Ungar interviewed each agency in person or by tele- or web conference. Stephanie Knaak also attended two of the meetings. Due to availability problems and a time zone difference, we collected information from one contact by email.‡

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* This use of "audit tool" is also meant to include similar items, e.g., quality dashboard and report card indicators or tools.

† According to the report, this model "provides a new way to think about stigma and how it undermines health for individuals and contributes to population health inequities" (p. 24).

‡ On the issue of co-design, only one agency (Children's Mental Health Ontario) represented patients or families. Further consultation and input for co-development and co-design, and for co-production with end users and persons with lived experience (PWLE) of mental illness and substance use, is still required. The proposed plan will continue this design and development phase through the MHCC's existing networks and advisory groups comprising PWLE.

Our semi-structured interview questions included the following:

1. What tools and measures do you currently use or know of that may be used to identify and address structural stigma?
2. What are the key gaps in metrics and monitoring in the health-care system that perpetuate or ignore the prevalence of structural stigma?
3. What is your level of interest in partnering with the MHCC to further develop and implement a new audit tool that can identify and address equity gaps in mental health and substance use care?

Synthesis of the results

1. Tools and measures: none currently in use

No agency is using or knows of any specific tool or measure to target structural stigma or mental health equity, although some groups have a mandate to develop and track quality in mental health care. Others have been developing mental health quality indicators that are somewhat related. These indicators may be grouped as follows:

- Cultural or organizational audit ─ Accreditation Canada has an in-depth list of criteria that peer reviewers can use when visiting an organization, some of which are ranked by importance, including required organizational practices (ROPs).
- Performance measurement ─ A quality dashboard or indicator that includes "restraint use" but little else specific to mental health. Ontario is looking at measuring adherence to quality-based procedures for three diagnoses.
- Equity measurement ─ Some organizations (e.g., CIHI, IHI) conceptualize gender, and socio-economic items as "stratifiers" for other outcome measures related to inequities or accommodations for persons with a "disability" (in keeping with, e.g., the *Ontarians with Disabilities Act*).
- Legal ─ The U.K. has a parity law for its *Mental Health Act,* and the U.S. has a *Mental Health Parity Act.* These laws enshrine the principle of parity for mental health care. In Canada, CMHA National has recently been calling for the same.

2. Key gaps in metrics and monitoring

- Funding of mental health services as a percentage of global health budgets in developed countries ─ the seven to nine per cent gap (much lower percentage in developing countries)
- Patient/client perceptions of care
- Policy and legislation gap in addressing structural inequity, parity, and quality rights
- The hidden, implicit, or noticeable absence of indicators (see potential indicators on page 3)
- Institutional external review or process and oversight monitoring gaps ─ minimal items for assessing structural stigma (e.g., ROPs)
- Narrative as a strategy for transformative learning and awareness and education on structural stigma for leaders

Potential indicators, measures, or audit items

- **Financial**
  - percentage of budget allocation for MHSU (with target)
  - equity of budgetary resource allocation (i.e., equity for MHSU programs compared to others in terms of increases, decreases, cuts, strategic investments, etc.)
- **Infrastructure**
  - relative time since last new build or renovation of physical space for MHSU treatment (often in the oldest, most decaying part of a hospital and among the last to be renovated)
- **Triage**
  - accuracy percentage of emergency department triage for MHSU, according to CTAS/CEDIS levels
- **Access**
  - equity of wait times to see an MHSU specialist (registered nurse, social worker, occupational therapist, or psychiatrist)
- **Patient/client satisfaction**
  - tool, measure, or score compared to medical-surgical services
  - emergency department medical stability protocol and standard referral pathway for MHSU and percentage of adherence (e.g., almost never, sometimes, almost always)
- **Followup care**
  - equity, availability, and wait times for urgent emergency department or inpatient followup (e.g., 30-day), compared to followup times for physical health acute care
- **Screening and assessment**
  - screening and assessment for physical health (weight, blood pressure, lipids, immunization status, etc.) in persons with mental health and substance use disorders (no standard assessment exists, and there is a lack of assessment and tools among high-risk populations)
- **Patient/client participation**
  - a tool that looks at access, engagement, and functional outcomes (i.e., patient/client quality of life, capacity, etc.)

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

Mental Health Commission of Canada

Suite 1210, 350 Albert Street
Ottawa, ON K1R 1A4

Tel: 613.683.3755
Fax: 613.798.2989

mhccinfo@mentalhealthcommission.ca
www.mentalhealthcommission.ca

@MHCC_ /theMHCC /1MHCC @theMHCC
/Mental Health Commission of Canada