EXECUTIVE SUMMARY

Champions & Changemakers:

Real-World Examples of Approaches that Address Mental Illness– and Substance Use-Related Structural Stigma in Canada's Health-Care System

mentalhealthcommission.ca

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Structural stigma refers to the accumulated activities of organizations that create and maintain social inequalities for people with lived and living experience of mental heath and substance use problems.

Structural stigma is also embedded within the formal and informal rules and practices of organizations and society at large. Mental illness- and substance use-related structural stigma remains a significant problem that adversely impacts the quality of Canadian health care.

In August 2020, the Mental Health Commission of Canada (MHCC) distributed a public call for expressions of interest to identify examples of innovative models of care, quality improvement initiatives, interventions, programs, policies, or practices related to reducing structural stigma — specifically, those that showed promise or effectiveness by improving access and the quality of health care and/or outcomes for people with lived and living experience of mental health problems or illnesses and/or substance use. The MHCC was seeking to identify case studies to help raise awareness and illustrate the problem of mental illness- and substance use-related structural stigma in Canada's health-care system. The aim was to leverage what was learned from these real-world examples to inform key ingredients, features, strategies, and considerations and assist other organizations, departments, or work units who have an interest in combating and addressing such structural stigma.

Of the **62 submissions** received, the following **six were selected**:

1. **The Addiction Recovery and Community Health (ARCH)** initiative, which tackles structural stigma by providing a patient-centred, trauma-informed, recovery-oriented model of care for people with substance use problems within a hospital setting. It offers services such as peer support, reproductive health, ID procurement, an in-hospital safe consumption site, pain management, as well as treatment and referral services.

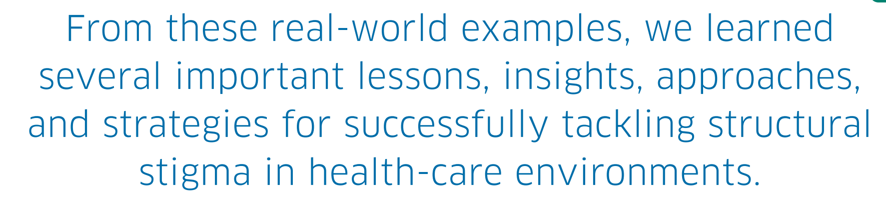
2. **Health Justice**, a non-profit human rights organization whose mandate is to research, educate, and advocate to improve the laws and policies that govern coercive health care in British Columbia.

3. **Biigajiiskaan: Indigenous Pathways to Mental Wellness (bee-GAH-jees-khan)**, a partnership between Atlohsa Family Healing Services and St. Joseph's Health Care London. The program provides culturally safe, specialized care for Indigenous people with serious mental illness, addiction, and concurrent disorders by combining traditional healing medicine, Indigenous elder-guided care, and ceremony with hospital-based health-care practices and psychiatric treatment in a hospital setting.

4. **The Canadian Resident Matching Service (CaRMS)**, a Service User Committee initiative, which gives a concretized role to people with lived experience of a mental illness or substance use problem in recruiting and selecting candidates for psychiatry postgraduate training in Canada's largest psychiatric residency program.

5. **Centering Madness: Building Capacities for Community Engagement**, a mandatory, embedded, and graded educational module for first year University of Toronto psychiatry residents. The course applies a social justice-informed critical lens to dominant paradigms and understandings of mental health and illness and is fully designed and delivered by service users.

6. **Adult Neurodevelopmental Stabilization Unit (ANSU)** dual diagnosis restructuring, an initiative in which a nine-bed unit at a Nova Scotia hospital (which provides in-patient care and community transition support to patients living with a dual diagnosis of intellectual disability and mental illness) underwent a wholesale transformation of its model of care, moving from a (primarily) custodial approach to one that prioritizes recovery-oriented principles and positive behavioural care.



From these real-world examples, we learned several important lessons, insights, approaches, and strategies for successfully tackling structural stigma in health-care environments.

1

CENTRE the voices of people with lived experience.

2

EMBED change for sustainable results.

3

MODEL change from within the organization to spread influence.

4

ANCHOR results to structural solutions like legislative or policy change.

5

ACKNOWLEDGE the intersectional nature of structural stigma and other inequities.

6

ENSURE explicit leadership support.

7

GROW through tension and dissonance.

8

EVALUATE outcomes with monitoring and measures.

The initiatives illustrate how combating mental illness-and substance use-related structural stigma in healthcare is a complex and multilayered endeavour, which can be targeted through multiple intersecting avenues and approaches. These include:

1. **Prioritize** the **meaningful participation** of service users and community members/stakeholders in the design, delivery, and/or governance of any initiative for change and to formalize any established models of co-design and shared leadership.

2. **Focus on embedded and ongoing education and training** approaches that prioritize the voices and perspectives of people with lived experience.

3. **Implement models that provide high-quality, evidence-based, holistic, culturally safe, client-centred, and recovery-oriented care**, which are guided by the perspectives and input of people with lived and living experience of mental health and/or substance use problems, and which incorporate ongoing education, training, and engagement – as well as role modelling and leading by example – to help facilitate and support wider cultural buy-in.

4. **Work to change inequitable and unjust laws and policies** that negatively impact the experiences of care for people with mental health and substance use problems and (in many cases) violate their human rights. Advocacy efforts can be enhanced through service user-led outreach, engagement, and education activities.

5. **Focus on the intersecting nature of structural stigma** by addressing the needs of population groups that face multiple levels of stigma and experiences of marginalization.

6. **Ensure** the success and sustainability of any initiative for change by drawing on **supportive leadership and passionate champions**.

7. **Commit to** making **collaborative and creative problem solving** part of the structural change process to meet administrative and other system-level challenges that will occur along the way.

8. **Be aware that concerns about long-term sustainability**, especially with respect to funding, **are common** and can pose real threats to long-lasting structural change.

9. **Know the importance of undertaking evaluation and research**, setting targets or goals, and monitoring progress. The design of evaluation and other research should involve input and direction from people with lived experience.

For more information on these initiatives, please contact access@mentalhealthcommission.ca.