A Workshop Dedicated to:

ENDING STIGMA AND ACHIEVING PARITY IN MENTAL HEALTH:

A Physician Perspective

SUMMARY OF PRESENTATIONS
AND KEY EMERGING THEMES AND RECOMMENDATIONS

September 23, 2010
Toronto, Ontario

The Canadian Medical Association
The Canadian Psychiatric Association
The Canadian Paediatric Society
The College of Family Physicians of Canada

Prepared by: Chenier Consulting Canada

TABLE OF CONTENTS

EXECUTIVE SUMMARY 3
INTRODUCTION 6
PRESENTATIONS & DISCUSSIONS 7
The Patient Experience: Mr. Michael Creek 7
Physicians and Stigma: Dr. Heather Stuart 8
Stigma towards colleagues, including psychiatrists: Dr. Mamta Gautam 10
Shunned: Evidence for improving stigma and discrimination: Dr. Graham Thornicroft 11
Homeless and marginalized populations: Dr. Jeffrey Turnbull 12
Children and Youth: Dr. Miriam Kaufman 13
Engagement through practice changes: Dr. Garey Mazowita 14
KEY RESULTS, THEMES AND RECOMMENDATIONS FROM BREAK-OUT GROUPS 15
Improve physician education and training at all stages 15
We're all in this together—normalize the experience of mental health problems and share responsibility 16
Make it easier for physicians with mental health issues to reach out and seek help 16
Put the patient at the centre 17
Advocate for parity of resources 19
Conduct relevant research 19
Promote the mental health and wellbeing of physicians 19
Develop a capacity for advocacy and use it 20
Promote innovative and effective models of care 20
Build support for generalists and for matching specialty outputs to needs 21
NEXT STEPS: DR. MAURA RICKETTS 21
APPENDIX A Biographies of Presenters 22

EXECUTIVE SUMMARY

Setting:
The Canadian Medical Association, the Canadian Psychiatric Association, the Canadian Paediatric Society and the College of Family Physicians of Canada held a workshop in Toronto, September 23, 2010 to build a shared understanding among physicians about the sources of stigma in the health care system experienced by persons with a mental illness and to develop recommendations for action to end stigma and discrimination and achieve parity in health care.

A number of guest speakers shared research findings and discussed various perspectives pertaining to stigma and discrimination. Each presentation was followed by a question and answer session. In the afternoon, four working groups were formed:

- Physicians' personal experience of stigma
- Physicians and their patients
- Physicians as a profession
- Physicians and the health care system

Questions for the working group

1. What are the best policies and practices that should be promulgated?
2. What are the educational needs for physicians, addressing both knowledge and behavior?
3. What can individual physicians and the medical profession do to affect/cause change?

Summary:
Stigma is an overarching term that includes problems of knowledge (ignorance), problems of attitudes (prejudice), and problems of behavior (discrimination). Research and personal testimonials from people with mental illness show clear evidence that stigma and discrimination towards people with mental illness are real and have a powerful negative impact.

Stigmatization and discrimination within the health care system are not confined to mental illness. There is a substantial body of stigmatization research on epilepsy, HIV/AIDS and leprosy. In all three, stigma and discrimination have been reduced for many of these groups for different reasons. Reducing stigma in mental illness can, and should, become a success story.

Through the sharing of his personal story, Mr. Michael Creek set the stage by providing witness to the pain and isolation that is suffered by those who've experienced mental illness. When stigma is pervasive in society, people with mental illness cannot break free from the notion that they might be the cause of their own problems.

The harm of stigma is more than skin deep. People with mental illnesses do not live as long as those without mental illness, even after accounting for suicide. Stigmatization leads to lower rates of employment; usually only 10-15% of people with severe mental illness are working, although many would like to. Many find themselves trapped in that role –mentally ill, unemployed and relegated to low levels of choice for accommodation. Consider this: 1% of Canadians are homeless. The life expectancy of homeless people is lower than the average – the age adjusted mortality rate in shelters is 4-7 times that of the housed population. People with HIV/AIDS living in shelters have a 21% mortality rate, equivalent to that of sub-Saharan Africa.

Many people do not believe that children can have serious mental illness, but they can and do. When a child has a mental illness, their parents are not spared from the accompanying stigma - they fear being portrayed as bad parents and may become very secretive or deny the problem. However, it goes both ways - physicians can sometimes be dismissive about mental health problems in adolescents as well, attributing important mental health problems to 'hormones'. Indeed, adolescence is a turbulent time in a person's life, but certain symptoms or behaviors need to be confronted and this is not necessarily stigmatizing or discriminatory.

So, while the social determinants of health are particularly relevant for many of those with severe mental illnesses, they do not explain all the differences. Treatment disparities account for at least some of the differences. Physicians and health care providers must be attentive to the impact of stigma because it can result in poorer quality services, inequitable access to care and failure to treat physical illnesses with the same vigor as in those without mental illnesses. In fact, it has been shown that when people with mental illness have heart attacks, they receive less invasive treatments, fewer investigations and have worse outcomes and higher mortality rates. This effect is called diagnostic overshadowing – the health issues of people with mental illnesses tend to be viewed as part of the mental illness.

Research about stigma and its impact through discrimination is fundamental. For example, there are important cultural issues – discrimination is significant in the workplace in Europe, but in Southeast Asia discrimination affects the chances of marriage and impacts on marital relationships. Reducing and removing stigma is important and it is notable that there is a proliferation of multi-year anti-stigma campaigns (international and national). Unfortunately, there is little in the way of an evidence base to demonstrate that this type of campaign can make a difference. National level interventions are being implemented in a number of countries, including Australia, New Zealand, Scotland, Canada, England, Sweden and Denmark, and they have demonstrated some positive effects. A major campaign in England has received political endorsement and has shown a consistent pattern of moderate and positive change, of knowledge, attitudes and sometimes, behavior. Funding for more and better research about how to counter stigma caused by mental illness is essential. However, major funders in Canada tend to place greater emphasis on other research endeavors.

Physicians have a responsibility to become involved. There is growing evidence that interventions, at local and national levels, can reduce stigma and discrimination. By working within three spheres of action (structural and organizational action, group/practice action, and personal action on the part of a patient), stigma can be fought.

There is a fundamental lack of understanding and coordination of the complex health care needs of people with mental illness – systems are too difficult to navigate and there seems to be a limited capacity or willingness of health care systems to make the changes that could improve access to care. A paradigm change is required, with a focus on the patient and their family, targeting the stigmatizing behavior of particular groups of people, developing long term initiatives that fundamentally change the health care workplace, and maximizing best practices and research.

Organizations can play a major role. For example, there are intrinsic barriers to providing health care to vulnerable populations. The Ottawa Inner City Health project has exceeded targets for national standards for health indices and saves the health care system $3.5 million each year. It has done so through initiatives such as personal support workers to accompany homeless people to the hospital; later appointment times; ongoing socialization; and advocating for privileges – medications, supportive equipment, devices, etc.

Adopting a chronic disease model paradigm of care within clinical settings has done a great deal to reduce stigma for other health conditions, such as HIV and erectile dysfunction. A key element of a chronic disease model paradigm of care is that physicians work together, across specialties. In British Columbia, family doctors working with psychiatrists, psychologists and school educators are set to launch a prototype of a child and adolescent mental health module. If chronic disease model attributes such as patient flow can be properly handled, patient satisfaction improves enormously, wait lists go down and there are other positive outcomes. Access to cognitive behavior therapy (CBT) is a predictor of recovery. Among other options to improve access to CBT, family physician training could be enhanced to improve care through provision of different treatment modalities by, for example, embedding CBT into the training of family physicians.

Stigmatizing environments can be changed by incorporating direct contact with consumers of mental illness care*, outside of the clinical environment*, as part of the training for health professionals. It is a profoundly important way for physicians and other health care providers to learn how to view each patient as a unique individual, within the context of a life lived, rather than simply as a diagnosis. Social contact theory, which involves direct contact between stigmatized persons and a target group, has been used to improve professional training and reduce stigmatizing behaviors.

Stigma in the health care setting isn't confined to our patients. Physicians have misconceptions about colleagues who have a mental illness, viewing them as weak, flawed, or somehow at fault for becoming ill. In turn, physicians self-stigmatize – feeling shame and fearing judgment from their colleagues, they delay help-seeking and self-medicate. The role of stigma in disciplinary actions taken by regulatory authorities adds another dimension to the discussion. There is a 'professional' stigma toward the profession of psychiatry and psychiatric research leading to difficulties recruiting medical students and residents, and in unequal access to research dollars.

Finally, we can't forget that people with mental illness often carry with them many of the attributes of mental *wellness* – strength, resilience and adaptability – and we can help physicians to recognize ways to work *with* their patients as they travel down the road to recovery.

Engaging physicians in ending stigma and discrimination is essential because of their role within the health care system. The goal of the workshop was to engage physicians in the discourse. However, the Workshop participants went a step further: they made 10 recommendations based on a vision of a health care system that puts the patient in the centre, pulls mental health care out of its second tier status within the Canadian health care system, and leads to the implementation of innovative and effective models of care.

INTRODUCTION

The Canadian Medical Association, the Canadian Psychiatric Association, the Canadian Paediatric Society and the College of Family Physicians of Canada held a workshop in Toronto, September 23, 2010 to build a shared understanding among physicians about the sources of stigma in the health care system experienced by persons with a mental illness and to develop recommendations for action to end stigma and discrimination and achieve parity in health care.

A number of guest speakers made presentations about stigma and discrimination from various perspectives, and specific research findings pertaining to stigma and discrimination were also shared with the participants. Each presentation was followed by a question and answer sessions. The participants then joined break-out workshops to address the following issues:

- Physicians' personal experience of stigma
- Physicians and their patients
- Physicians as a profession
- Physicians and the health care system

Each break-out group discussed the following questions within the context of the workshop topic:

1. What are the best policies and practices that should be promulgated?
2. What are the educational needs for physicians, addressing both knowledge and behaviour?
3. What can individual physicians and the medical profession do to affect/cause change?

When the break-out groups concluded their discussions, each group reported back to plenary and the workshop was then adjourned.

The following report represents a summary/synthesis of the seven presentations along with the identification of ten major themes emerging from the breakout groups. A full copy of the Workshop Proceedings is available upon request. Biographies of the Workshop Presenters are enclosed as Appendix "A".

PRESENTATIONS & DISCUSSIONS

THE PATIENT EXPERIENCE: MR. MICHAEL CREEK

Recovery is a personal and life-long journey. To begin, Mr. Creek talked to us about his experience of abuse and how his shame prevented him from seeking the help he needed. Mr. Creek spent many years in the street, addicted to drugs and trying to live with the memories of his abuse as a young child. There is such a need to get help to young people; Mr. Creek will always wonder how different his life might have been if he had received help for the abuse he suffered as a child. Funding for the support for youth and children is particularly important. Most of the youth Mr. Creek works with have both mental illness and addictions. Mr Creek is a survivor of cancer, physical and mental abuse, homelessness and poverty, and he is a mental health consumer. Today, he is a champion for people living on the street in Toronto.

Lingering and suppressed trauma can lead to ongoing struggles with depression and mental health crisis. Shame and self-stigma can become internalized. Mental health consumers experience shame, stigma and discrimination from family members, friends, co-workers, supervisors and health care providers. Even vocabulary, such as the word 'survivor', is potentially stigmatizing. Young people probably think of themselves as surviving the system rather than the illness itself. So, why is it used? Mr. Creek explained that he uses the term in part because he's a cancer survivor and in part because he thinks people should take pride in having survived serious health challenges of any sort. At the same time, he experienced a dramatic difference in how he was treated as a cancer survivor compared with how he was treated as a person with a mental illness.

Mr. Creek wanted to emphasize the healing power of disclosure, because healthy disclosure is one of the most important ways to reclaim your sense of self and to reject stereotyping and stigma. In the past, he would advise people with mental illness not to disclose, but he now advises people to disclose because disclosure is needed, both to heal oneself and to help reduce stigma. There is a cost to disclosure and people who do so are taking a risk. It takes tremendous courage to disclose traumatic abuse and it is critically important for service providers to encourage disclosure by creating a non-judgmental and open atmosphere. A key part of the journey of recovery for consumers is in sharing their experiences with others, including physicians. For Mr. Creek, the need for physicians to meet with mental health consumers as equals in non-therapeutic settings is essential. It is a profoundly important way for physicians and other health care providers to learn how to view each patient as a unique individual, within the context of a life lived, rather than simply as a diagnosis. Mr. Creek had advice for those who teach medical students: students need direct contact with consumers so that they can have conversations, and hear their stories. Stories about how they feel as patients, perhaps talking about more than what would be disclosed in an office. "It is important for psychiatrists to be able to hear how we, the people who use the service, see things differently than they do", for example, talking openly about patient versus psychiatrist perspectives on shock treatment. In closing, he suggested that individuals who suffer from a mental health issues should disclose the fact that they have a mental illness.

PHYSICIANS AND STIGMA: DR. HEATHER STUART

Dr. Stuart began by noting that those with mental illnesses do not seem to get the same treatment for their non-mental illnesses as others who do not have mental illnesses. Treatment disparities are known to impact mental health care in many ways: poor system outcomes, human rights abuses, poor quality services, and inequitable access to care. One of the greatest concerns in psychiatry is that a patient with an undiagnosed health issue is under-treated because it is thought to be somatisation. Dr. Stuart felt that a meeting in which physicians were looking at their own prejudices and attitudes was an excellent step forward. Furthermore, she noted that the difficulties attracting high quality professionals, lack of funding for research and the consequent slowing of the production of new knowledge is a consequent of stigma toward those with mental illnesses and those who treat them.

An important dimension of stigma management in the health care system comes from the power imbalance between patients and health care providers; it allows discrimination to arise. Stigma within the health care system is confirmed by patient reports of disrespect and condescension. Yet, empowerment is important in the recovery process – it is part of a personal journey – so, it is essential to empower patients within the context of a power imbalance. Unfortunately, there is little knowledge and experience to inform us about how to support patients in that context. It is centrally important and Dr. Stuart recommended a lot more thinking about how to develop recovery oriented care. Dr. Stuart encouraged an approach of managing and coping with stigma rather than fight it. Her opinion is that fighting stigma will take a long time and that today's need is to help people manage and cope with stigma.

Reducing and removing stigma is important and it is notable that there is a proliferation of multi-year anti-stigma campaigns (international and national). Unfortunately, there is little in the way of an evidence base to demonstrate that this type of campaign can make a difference. There is a need for more research on stigma and discrimination, but we can't wait for definitive answers: researchers have to consider "promising" practices rather than best practices, as research evidence on best practices is limited. For example, the Opening Minds campaign of the Mental Health Commission of Canada is looking at a number of issues: literacy, prejudice (stereotypes and attribution, devaluation), discrimination (social distance and social exclusion), recovery (recovery knowledge, empowerment) and engagement (motivation to learn, social responsibility). However, there are few tools for measuring these outcomes.

There are three spheres of action to reduce stigma:

1) Structural action (health systems and organizations) to address inequitable or unfair policies and practices and inadequate or outdated facilities. For example, structural change can be employed to improve equity and social justice – not just changes to the law but changes to policies in health systems and organizations. In some ways, structural reform appears to be a fringe issue while at the same time, organizational reforms are not uncommon. Recommendations or advice describing successful structural reform are few and far between. Dr. Stuart noted that in Calgary, they were able to influence the construction and design of the new emergency rooms by simply asking clients and family members which structural issues bothered them the most. They said "surroundings in the ER, no time out room, too busy and noisy". Even existing facilities can be changed piecemeal if clients and families are asked what bothers them the most.

2) Group action (clinical practice) can address clinical stereotypes involving inaccurate estimates of disease risk, diagnostic overshadowing and pejorative interactions with patients and or families. Promising strategies here include contact-based education, which has been shown to improve attitudes and behaviours.

3) Personal action (patient behaviour) can address help-seeking avoidance and rejection or poor adherence to treatment. Questions posed included: Is there a place for us to help people to work through being exposed to stigma? Can we help them to find ways to handle it? People with lived experience, who've been able to manage stigma successfully, have an important role in documenting their experience and teaching their skills to others in similar situations. It is best that people are prepared and have a plan to address stigma when it occurs.

Opportunities arise through a whole new set of paradigms for thinking about mental illness and stigma reduction:

- Focus on patient and families by providing knowledge and concrete help to increase self-esteem;
- Provide accessible and comprehensive care;
- Focus programs on sharply defined groups of people;
- Focus on specific diseases rather than developing broad-based campaigns;
- Develop coordinated long-term initiatives that also become part of routine work and that address changing behaviours rather than just attitudes;
- Address structural inequities that create and maintain stigma;
- Increase best practice knowledge through research and evaluation; and
- Involve families and patients as active members in these processes.

Barriers arise when there is:

- Failure to recognize that stigma is primarily a problem of behaviors;
- Politicization of anti-stigma activities;
- Focus on visibility versus meaning;
- Implementation of grand gestures instead of locally sustainable initiatives;
- Glitzy campaign launches instead of long-term programs;
- Adoption of the "big bang" theory of social change;
- Misplaced faith in conventional education and social marketing approaches.

There are too many psychiatric patients in the criminal justice system, some of whom are a danger to other people and themselves, as happened recently in Toronto where a man with a mental illness pushed people on the subway. Media coverage was sensational and contributed greatly to prejudices against those with severe mental illness. Apparently, although he was well known within the legal system, he was not provided with the mental health care he needed. The relationship between mental illness and the law is a complicated one that needs to be tackled.

Faith communities are compassionate and provide tangible support in the form of housing, meals, and social support, yet they are not always fully engaged in anti-stigma campaigns. Clients and families have expressed their hope that their church and the congregation would be provided with the

same support as is offered for someone who's had a heart attack - a prayer or to be invited for lunch, for mental illness to be seen in the same light as physical illnesses. In Dr. Stuart's experience, it is difficult to engage the faith community in anti-stigma work because there are so many different communities and no central body to approach.

STIGMA TOWARDS COLLEAGUES, INCLUDING PSYCHIATRISTS: DR. MAMTA GAUTAM

Nowhere is stigma greater than within medicine. Doctors view their colleagues with mental illness differently. This stigma is due, at least in part, to the culture of medicine, which strives for perfection, encourages self-denial, sets high expectations of self and others and promotes hard work, conscientiousness, compulsiveness and thoroughness. Physicians are expected to be always responsible, to be tough, in control and to be able to handle everything. As a result, physicians have misconceptions about colleagues who have a mental illness, viewing them as weak, flawed, or somehow at fault for becoming ill. Many physicians are unsure how, and sometimes found to be unable, to provide support and understanding to a mentally ill colleague. A mental illness is viewed much more negatively than a physical illness.

These expectations, misconceptions and the stigma of mental illness become internalized, with significant consequences. Stigma reinforces intellectual defenses, i.e. reaction formation, denial, minimization, rationalization. It creates fear of shame, judgment and reprisals from colleagues. It leads people to self-treat and self-medicate. It causes delays in help-seeking. If physicians seek help, they prefer to be seen outside the workplace and they are more likely to accept psychotherapy than medication, as the latter is seen as an indication that they are really ill. Dr. Gautam undertook a study of her own practice seven or eight years ago. Eighty-two of 100 physicians in her practice had already started themselves on an anti-depressant. In her opinion, this is the tip of the iceberg and that it is also likely that they do well enough that they don't seek further help. Unfortunately, self-medication can lead to further denial, incomplete treatment, and more serious mental illness which can even lead to suicide.

Stigma is also directed from physicians towards psychiatric colleagues. Psychiatrists may be seen by other physicians as "less than", and the choice of psychiatry viewed as unscientific and a waste of medical training. Many physicians consider psychiatrists to be "weird", "crazy" or incompetent. Stigma has led to discrimination: the needs and requests of psychiatrists are devalued or dismissed by other physicians. A 2008 survey of CPA members supports these conclusions: 75% had experienced stigma and discrimination towards psychiatry as a profession and 53% had personal experience of stigma and discrimination.

The harm from stigma and discrimination extends beyond interpersonal relationships. Indeed, the Alberta Medical Association and Family Support Program, which offers a helpline and a case coordination service for physicians, has experienced a decrease in calls. In 2009, they had over 1000 calls to their line: 8.5% of the physician population in Alberta. About 40% of the calls related to addiction and mental health issues. For the first time this year, their calls are decreasing, which may be attributed to the increasingly intrusive questions they are obliged to answer in order to satisfy the regulators. The result is stigma at the level of a medical regulator and the consequence is a reduction in help-seeking behaviour.

Medical residents are concerned about seeking help because of their fears about confidentiality, because of the potential impact on licensing and concerns about getting insurance. For example, a

resident working in a Canadian hospital disclosed depression and senior staff discouraged him, for fear it would impact his career.

In order to reduce and eliminate these misperceptions and stigma, several steps are required:

1) Self-reflection on personal stigmatizing beliefs and attitudes

2) Sharing stories about positive treatment, recovery, hope, competency

3) Fostering awareness of physicians as patients, and that stress is inherent and the norm

4) Fostering collegiality within medicine, educating physicians about how to identify, support and reach out to colleagues at risk, and demystifying psychiatry to improve awareness between non-psychiatrists and psychiatrists.

SHUNNED: EVIDENCE FOR IMPROVING STIGMA AND DISCRIMINATION: DR. GRAHAM THORNICROFT

Stigma is an overarching term that includes problems of knowledge (ignorance), problems of attitudes (prejudice), and problems of behaviour (discrimination). Research and personal testimonials from people with mental illness show clear evidence that stigma and discrimination towards people with mental illness are real and have a powerful negative impact. Often, the effect is to reduce help-seeking and treatment – 70% of diagnosable cases of mental illness are untreated. Stigmatization and discrimination may be seen in other areas of medicine. For example, there is stigmatization research on epilepsy, HIV/AIDS and leprosy. In all three, stigma and discrimination have been reduced for many of these groups for different reasons. However, there has been very little work done to compare the degree of stigma and discrimination between groups.

Family members, neighbours, friends and co-workers/supervisors may react adversely to and make negative judgements about people with mental illness, which can lead to loss of intimate relationships, discrimination in terms of housing, hiring, pay rates and promotion prospects.

The media perpetuates discrimination – up to 2/3 of items in print and broadcast show violence, unpredictability or risk associated with mental illness. While 85% of children's animation includes characters with mental illness, the portrayals are usually negative. The media provides few direct accounts from those with mental illness; this choice has clear negative effects on popular views.

Discrimination happens in the physical health care system, mainly in the form of diagnostic shadowing. Diagnostic shadowing is what happens when people with mental health problems report physical health issues: the health issues tend to be viewed as part of the mental illness and are undertreated. For example, people with mental illness who have heart attacks receive less invasive treatments, fewer investigations and have worse outcomes and higher mortality rates. Structural discrimination occurs through systematic ways in which mental health service users and services are given less value e.g. less investment for new buildings, lower staffing levels, budget cuts. As a category, people with mental illness are treated as having less value compared to people with other health problems.

Comparisons of countries around the world show very consistent patterns in the experience of discrimination, with some differences. For example, discrimination is a significant issue in the workplace in Europe, while in Southeast Asia discrimination affects the chances of marriage and impacts on marital relationships. Anticipated discrimination is also an issue: due to self-stigma and self-discrimination people will avoid important actions such as seeking a job or seeking relationships. Poverty plays a role in keeping people mentally ill for longer than necessary – stigmatization leads to lower rates of employment; usually only 10-15% of people with severe mental illness are working, although many would like to. Many find themselves trapped in that role –mentally ill, unemployed and relegated to low levels of choice for accommodation.

There is growing evidence that interventions, at local and national levels, can reduce stigma and discrimination. With respect to local level interventions, the most powerful research support is for social contact theory, which involves direct contact between stigmatized persons and a target group. This intervention would have a consumer talk about what it is like to have a mental illness, the experience of treatment, and experiences with friends or neighbours (the wider world). Research shows that professionals hold the personal experiences of consumers in their memories longer, for at least four weeks after the workshops, than they do presentations of specific facts about mental illness. Overall, the strongest predictor of more positive attitudes is social contact.

National level interventions are being implemented in a number of countries, including Australia, New Zealand, Scotland, Canada, England, Sweden and Denmark, and they have demonstrated some positive effects. In England, there has been disclosure by well-known people, the use of all sorts of media advertisements and the implementation of innovative ways to prime social contact, for example, in a shopping mall and through a living library, where you can "borrow" a person with mental illness, sit down in a safe environment and have a discussion to improve understanding. The campaign has received political endorsement and overall, has shown a consistent pattern of moderate and positive change, of knowledge, attitudes and sometimes, behaviour.

Engaging physicians in ending stigma and discrimination is of key importance because of their role within the health care system.

HOMELESS AND MARGINALIZED POPULATIONS: DR. JEFFREY TURNBULL

There are significant inequities in health care for vulnerable people, and homeless persons are among our most vulnerable. Approximately 1% of Canadians are homeless, but this estimate is an under-representation: many homeless are "couch-surfing" or otherwise under-housed. Many have a drug and alcohol problem, and many have a mental illness. There are homeless elderly, families and young people, children and youth who are growing up in and going to school from homeless shelters. First Nations and immigrant people represent a larger proportion of the homeless. For many, shelters are no longer temporary residences; they have become their permanent residences.

Homeless persons have poor health. Their life expectancy is lower than the average – the age adjusted mortality rate in shelters is 4-7 times that of the housed population. People with HIV/AIDS living in shelters have a 21% mortality rate, equivalent to that of sub-Saharan Africa. The homeless are deprived of meaningful access to health services and this has a direct effect on their health. As well, they are socially isolated, which further increases the risk for poor health outcomes. They lack all of the essential elements of resilience.

There are intrinsic barriers to providing health care to vulnerable populations. For example, the homeless often have impaired executive functioning and judgement. They live in constant crisis mode, hour by hour, and either do not or cannot plan beyond their immediate needs. This makes health promotion strategies very difficult. In addition, it is more common for a homeless person to have difficulties interacting with health care providers – many have suffered abuse from institutions, giving them an understandable distrust of institutions, authorities and health care providers.

There are also extrinsic barriers to providing care such as unrealistic treatment goals, the lack of understanding and coordination of the complex health care needs of marginalized people, systems that are too difficult to navigate, and the limited capacity or willingness of health care providers to make changes that could improve access to care (e.g. scheduling later appointment times, providing transportation).

It is our responsibility to become involved and the solutions are not always that difficult or complicated, yet they can have a very beneficial effect. The health needs of the homeless can be treated adequately with the right models of service provision. The Ottawa Inner City Health project, for example, has exceeded targets for national standards for health indices and saves the health care system $3.5 million each year. Successful strategies applied by the project include: having Personal Support Workers accompany homeless people to the hospital; providing later appointment times; supporting ongoing socialization into a meaningful life; and advocating for privileges – medications, supportive equipment, devices, etc.

CHILDREN AND YOUTH: DR. MIRIAM KAUFMAN

Many people do not believe that children can have serious mental illness, but they can and do. When a child has a mental illness, their parents are not spared from the accompanying stigma - they may be portrayed as bad parents. All in all, when a child has a mental illness, their parents can become very secretive.

For youth with mental health problems, stigma is a serious issue. In fact, adolescents are often a stigmatized group just by virtue of their age – adults quickly make assumptions that adolescents are more likely to commit crimes. If youth are obese or gay, they will experience additional stigma. The harm that can be predicted from stigma can cause parents to be reluctant to acknowledge that their child has a mental disorder and this can hinder access to treatment. However, it goes both ways - physicians can sometimes be dismissive about mental health problems in adolescents as well, attributing important mental health problems to 'hormones'. Indeed, adolescence is a turbulent time in a person's life, but certain symptoms or behaviours need to be confronted and this is not necessarily stigmatizing or discriminatory.

Strategies that would reduce the stigma of mental illness for children and youth include the following:

- Provide comfortable, friendly, non-judgmental environments;
- Develop policies that are "adolescent friendly" such as being flexible and non-punitive if youth are late for appointments;
- Talk to colleagues about how to support and include adolescents;
- Include adolescents in developing and managing programs;
- Develop inclusive informational materials at appropriate literacy levels;

- Advocate for a full spectrum of services and supports; training teachers in basic cognitive-behavioral therapy (CBT) techniques;
- Ally with stigmatized groups and encouraging them to link with each other.

ENGAGEMENT THROUGH PRACTICE CHANGES: DR. GAREY MAZOWITA

Adopting a chronic disease model paradigm of care has done a great deal to reduce stigma for other health conditions, such as HIV and erectile dysfunction. This model of care could do the same for mental illness.

A key element of a chronic disease model paradigm of care is having physicians work together, across specialties. A "generalist" model of care, with a holistic approach, can help to reduce stigma, while stand-alone services such as "niche" specialty clinics can actually increase stigma if they are not fully integrated with primary care. In British Columbia, for example, family doctors working with psychiatrists, psychologists and school educators are set to launch a prototype of a child and adolescent mental health module. This is a good example of multiple stakeholders working together to transform the system, a powerful tool to reduce stigma. If chronic disease model attributes such as patient flow can be properly handled, patient satisfaction improves enormously, wait lists go down and there are other positive outcomes.

Organizations such as Institute for Health Improvement (IHI) can be of help. The IHI "Triple Aim" ensures that everything is viewed in the context of 1) population health perspective; 2) per capita cost; and 3) patient and provider satisfaction.

People with mental illness often carry with them many of the attributes of mental *wellness* – strength, resilience, adaptability – and we can help physicians to recognize and build on these. Organizations can play a major role in supporting health care professionals. For example, family physician training could be enhanced to improve care through provision of different treatment modalities by, for example, embedding CBT into the training of family physicians.

KEY RESULTS, THEMES AND RECOMMENDATIONS FROM BREAK-OUT GROUPS

Improve physician education and training at all stages

THIS THEME EMERGED ACROSS ALL OF THE BREAK-OUT GROUPS

- Incorporate direct contact with consumers into physician training – medical school through residency and practicing physicians
- Develop educational module to deliver for teachers to stress importance of it to students
- Institute basic competencies regarding mental illness and mental health and revisit these periodically to ensure adequacy
- Develop mental health continuing medical education for physicians in practice
- Include more psychiatric training in medical schools and residency training
- Residency training needs to implement good modeling such as specialists working collaboratively with family physicians
- Develop and use tools and approaches to training that foster awareness through self-reflection

One of the most frequently cited recommendations was to incorporate direct contact with consumers into physician training. Direct contact, as a means of educating physicians about the lived experience of consumers, should be a component of all stages of training—from medical school, through residency and for practicing physicians—and it should involve all physicians, not just those training in psychiatry. It should, in fact, be incorporated in the medical curricula as early as possible in training. It could be made part of accreditation. Clearly, training tools, including modules for teachers, would be needed so that teachers could successfully communicate the full importance of consumer contact to students. The goal of the training is to create mutual understanding, and because personal stories are more powerful than written documentation, the focus of the direct contact strategy should be on sharing positive stories of hope and recovery.

More attention should be paid to psychiatric training in medical school and in residency training. Currently, medical schools offer only two weeks of psychiatry, even though many family physicians are managing mental illnesses in their practices and have questions, for example, about how to manage antidepressants. Residency training needs to implement good modeling, such as specialists working collaboratively with family physicians.

Developing and using tools and approaches to training that foster awareness through self-reflection would help to improve physician training. There are self-assessment measures that can be used to identify inherent biases and discriminatory attitudes, such as implicit association testing, and these could be included in medical school training and other physician education programs. Physicians may develop stigmatizing attitudes as they go through training, and they need safe spaces in medical school to explore these. The use of these tools should also be encouraged with other health professionals such as nurses, by approaching their professional bodies. Collaborative care training

needs to begin as early as possible (in medical school), include shared care mentorship opportunities and training in how to work within and lead collaborative initiatives.

More mental health continuing medical education (CME) for physicians in practice is needed, including re-entry one-month rotations for physicians already in practice. Of concern is the focus of currently available training on a narrow sub-set of mental health concerns that are mainly related to pharmacological interventions. Training needs to be broadened and enhanced to include non-pharmacological tools such as CBT and consumer contact.

Physician training could also be improved by instituting basic competencies for mental illness and mental health. Competencies for all physicians need to be revisited and revised to include competencies related to mental disorders, stigma and discrimination. It was additionally recommended that hospital accreditation have mandated competencies in the management of mental illness.

We're all in this together—normalize the experience of mental health problems and share responsibility

THIS THEME EMERGED FROM THREE BREAKOUT GROUP DISCUSSIONS.

- Encourage and support disclosure by leaders and celebrities
- Have leaders in various specialties, including those who are living with the experience, talk to physician groups
- Adopt a chronic disease paradigm of mental illness similar to those on HIV

There appeared to be general agreement that the experience of mental illness needs to be normalized, as it is a common part of the human experience, for physicians and non-physicians alike. "Us" versus "them" thinking needs to be challenged, as it assumes that one cannot be a patient and also a physician. When leaders in various specialties, including those who are living the experience, talk to physician groups, the impact will be broadly felt. Furthermore, physicians need to see that stigma and discrimination are everyone's problem and not simply the responsibility of psychiatry alone.

Make it easier for physicians with mental health issues to reach out and seek help

THIS THEME EMERGED FROM THREE BREAKOUT GROUP DISCUSSIONS.

- Provide access to primary care practitioners
- Encourage disclosure from other physicians and health care providers who have had a mental health problem, with the focus on how they have recovered to full function
- Provide an environment where physicians feel safe disclosing a mental illness
- Provide safe venue for physicians to disclose mental illness
- Provide safe places for physicians to seek help and support (e.g., help lines, support groups)

- Provide clarity regarding the consequences of answering questions on licensing, privileges and applications related to mental health
- Address barriers in terms of remuneration and limits to private insurance to foster help seeking.

The trend toward structured discrimination of physicians who've experienced mental health problems is not acceptable. It must become easier, not more difficult for physicians who need help to disclose a mental health problem and seek treatment. One of the first steps is to ensure that physicians have access to care, particularly primary care. Access to timely care would enable more of a focus on early identification and treatment.

Physicians need to feel safe disclosing a mental illness. This means that they must be free of the fear of censure from colleagues or professional colleges. Clarity is required, for example, regarding the consequences for licensing, privileges and applications when physicians answer questions related to mental health. Compulsory approaches are more likely to cause physicians to ignore their health and not seek treatment. As with others, physicians need to be able to access safe places for help and support, such as confidential help lines and support groups. Barriers in terms of remuneration and limits to private insurance also must be addressed to foster help seeking.

The consultants felt that as more physicians disclose their experience, stigma will begin to disappear and physicians will be enabled to reach out for help when needed. This suggestion was tempered by caution: disclosure from individual physicians in a piecemeal fashion is unlikely to benefit all of physicians and their patients. In fact, the opposite may be more realistic. The consensus was that a mass coming out of physicians (preferably leaders) who have had mental health problems, with a focus on how they have recovered full function, would be a powerful message to physicians, and prevent isolation, marginalization and harm to the more vulnerable physicians.

Finally, all physicians must confront and challenge negative stereotypes and demeaning language about mental illness, a phenomenon that is, unfortunately, not uncommon in health care settings. The culture of physicians in medicine works against help seeking, and when colleagues use demeaning language, it is a powerful deterrent to those who need to seek help. The role of language in the workplace and public arena has been proven as a means for changing society, with the women's movement serving as a good example of success. The same result could and should be achieved in medicine with respect to mental illness.

Put the patient at the centre

THIS THEME EMERGED FROM THREE BREAKOUT GROUP DISCUSSIONS.

- Make health care environments more patient-friendly
- Engage staff and teams to support a patient-centered approach to care
- View the patient holistically in the context of his/her life
- Maintain an awareness of power imbalances between physicians and patients
- Improve communications with patient and engage them in care decisions
- Include patient involvement in service planning and review

- Develop mental health literacy for consumers
- Use peer support workers in emergency rooms and train lay volunteers to contribute to patient-centered model of care
- Confront and challenge negative stereotypes and demeaning language about mental illness

Health care environments must move quickly to become more patient-friendly. There are many options, many of which are relatively simple to implement: inviting office spaces, ensure that appointment times are convenient for patients with mental illness, engage staff and teams in a broader sense, such as receptionist training at the CMHA Mental Health First Aid course. All of these would support a patient-centered approach to care and help to reduce stigma and discrimination.

However, a critical component of patient-centred care comes with learning to view your patient holistically, to look at your patient in the context of his or her life. Simple changes in approach, such as consideration of poverty or homelessness, two of the more relevant social determinants of mental health, could have important and meaningful impacts on the lives of our patients.

Patient involvement in service planning and review is also needed. On consideration, it is notable that consumers are rarely involved in developing programs, services or even in the design of facilities. The consumers of mental illness care need to be directly involved in evaluations, asked how they experienced their care and to identify the barriers to care, to answer the question, "is the system working for you?". Cultural safety is a key consideration that needs to be taken into account when asking consumers for their help in developing and reviewing services, as consumers are also patients with the attendant issues of power discrepancy, possible fears of repercussions and their inexperience in participating in similar processes, at least in part due to the traditional management of health care systems without the point of view of consumers.

The power imbalance between doctors and their patients is insufficiently well addressed in training and in the culture of medicine. Physicians have particular obligations to redress the harms from perceived power imbalances and their patient's sense of control or lack of control. Addressing and redressing power imbalances could be achieved, at least in part, by changing one's point of view of a 'patient' as someone who receives advice and, instead, engage your patient in care decisions. For example, doctors can normalize the "difficult" questions by finding different ways of asking, "who do you feel comfortable seeing?" rather than "do you need to see someone for your problem", or by asking, "where would you feel comfortable going?" rather than "you will go to the psychiatric outpatient clinic for your treatment."

Improving the mental health literacy of consumers through patient education would foster the meaningful engagement of consumers in their own plans of care as well as in system assessment and planning. For example, consumers should be educated about mental illness and mental health, including mental health terminology. This should be done in a way that is inclusive of patients with low levels of general literacy.

Finally, the use of peer support workers in emergency rooms and the training of lay volunteers was seen as a means to rapidly contribute to a patient-centred model of care that would support empowerment and recovery for consumers.

Advocate for parity of resources

THIS THEME EMERGED FROM THREE BREAKOUT GROUP DISCUSSIONS.

- Address the inequity of resources allocated to mental health care and advocate for change
- Advocate for funding parity of ancillary professionals so that patients can access treatments such as psychotherapy and cognitive-behavioral therapy

When compared to those dedicated to physical health care, there is an inequity of resources allocated to mental illness research and mental health care. Mental health care is chronically under-funded, yet system capacity cannot be created and nurtured in the absence of adequate resources. Any and all work that is done to normalize mental illness and mental health care would help in this regard.

Another issue that needs to be addressed is that of unfunded ancillary professionals. In most cases, consumers cannot access psychotherapy, including cognitive-behavioral therapy, unless they are able to pay for it out of pocket. There are some exceptions, such as community health clinics and family health teams, who have ancillary professionals but again, this speaks to a lack of funding parity. Physicians and unions should be advocating for changes to policies that limit access to ancillary mental illness professionals.

Conduct relevant research

THIS THEME EMERGED FROM THREE BREAKOUT GROUP DISCUSSIONS.

- Advocate for research initiatives on effective methods to reduce stigma and discrimination related to mental illness

Research initiatives to find out what actually works to reduce stigma and discrimination are sadly lacking. Research is needed to identify effective physician education; linkages (closing the loop) between stigma and discrimination and health outcomes; and the case for change using a business model, i.e. evidence that change is an investment that generates a good return.

Promote the mental health and wellbeing of physicians

THIS THEME EMERGED FROM TWO BREAKOUT GROUP DISCUSSIONS.

- Implement faculty wellness programs
- Develop policies that support healthy workplaces

The importance of promoting and supporting the mental health of physicians was recognized. Physicians themselves need to be healthy and well in order to work and because they are role models for their colleagues and their patients. They lead by example, model healthy self-care. To do so, they must maintain an awareness of their own attitudes and biases.

A key element of mental health promotion is ensuring that physicians have access to primary care, as noted earlier. In addition, faculty wellness programs should also be implemented, as should policies that support healthy workplaces. Continuing medical education for physicians should include a support on health promotion for physicians.

Develop a capacity for advocacy and use it

THIS THEME EMERGED FROM TWO BREAKOUT GROUP DISCUSSIONS.

- Develop common messages and deliver as one voice
- Work towards an evidence-based business case for change (demonstrate that stigma and discrimination reduction activities are cost-effective)
- Speak publicly about stigma and discrimination

Shared capacity for advocacy involves working together as physicians to develop common messages, delivered as one voice. Psychiatrists and family physicians working together would be a powerful force for advocacy.

Advocacy is most likely to succeed if there is an evidence-based business case for change, principally because it is needed to gain political support for change; it is a message that resonates with politicians. Sharing best practices and clear, concrete solutions, backed by data, would be most effective.

Going public about discrimination could also be useful in affecting change.

Promote innovative and effective models of care

THIS THEME EMERGED FROM ONE BREAKOUT GROUP DISCUSSION.

- Promote the adoption of collaborative models of care throughout life cycle by establishing working relationship between psychiatrists, emergency physicians and family physicians
- Move from pilot projects towards scalable prototype models

Innovative and effective models of care need to be promoted. The adoption of collaborative models of care is particularly important for a number of reasons: the treating parties see each other as equals; they work together to develop goals and care plans; and they are able to define a patient trajectory (what the patient journey should look like) and all this maximizes what each provider brings to the table. Furthermore, such models are cost-effective because they free up resources and the time of health care providers.

Structural, administrative support and system coordination are needed to run these types of programs. Establishing working relationships (e.g. between psychiatrists, ER physicians and family physicians) is a necessary first step in model development. When developing such models, it is important not to start from scratch, but to build on what already works, yet there may not be broad knowledge of effective alternative models of care. Finally, there is a need to move away from pilot projects and toward

prototype models, which can evolve, and prototype funding is linked to that. Only scalable prototype models should be supported.

Build support for generalists and for matching specialty outputs to needs

THIS THEME EMERGED FROM ONE BREAKOUT GROUP DISCUSSION.

- Ensure that the number of each type of residency training program matches population needs for specialists
- Within each specialty, the core competencies should include a mental health component that is scaled to the needs of the specialty
- Support generalists and continue to increase the effective engagement of family physicians
- Advocate for government support through policies and funding for these changes.

Models of training and care that match specialty outputs to needs and, at the same time, support generalists and increase the status of family physicians. Generalists and family practitioners are needed in the system as they serve as the doorway into the system of care for most people with a mental illness. In addition, it is most effective (in terms of both cost and quality care) to match specialty outputs to needs. Physicians should advocate for government support through policies and funding for these changes. This can be effective; for example, applications to family practice in British Columbia have increased because the government has emphasized the need for more generalizing and for matching specialty output to patient needs.

NEXT STEPS: DR. MAURA RICKETTS

The four collaborators, the Canadian Medical Association, Canadian Psychiatric Association, the Canadian Paediatric Society and the College of Family Physicians of Canada, have been meeting informally for more than a year to discuss a harmonized policy for mental health for the medical profession and how such an agenda could be implemented.

Dr. Ricketts emphasized the need to harmonize our key messages, orient around advocacy, build the right kinds of partnerships and work through provincial and territorial associations to affect change in the care of people with mental illness in Canada.

The report of this meeting will be circulated to all speakers and then to the workshop participants for comments. The presentations were captured on video and will be shared with participants, as soon as the consent of presenters is provided. A stakeholder list has been developed and the meeting report will be posted and circulated to key partners. The long-term goal of the undertaking is a broad statement of policy direction, endorsed by the four boards and then used to develop joint and individual communications and advocacy action plans.

APPENDIX A BIOGRAPHIES OF PRESENTERS

Mr. Michael CREEK

Mr. Creek sits on the board of the Toronto Social Planning Council and he is also a member of a network to reduce poverty in Ontario. He is a survivor of cancer, physical and mental abuse, homelessness and poverty. He is also a mental health consumer. His primary goal in life is to assist marginalized groups to speak out. The objective of Mr. Creek's presentation was to provide the patient perspective and put a human face on the effects of stigma.

Dr. Heather STUART

Dr. Stuart is a Professor in the Department of Community Health and Epidemiology, with cross appointments to the Department of Psychiatry and the School of Rehabilitation Therapy at Queens University. Dr. Stuart's main research interests are in the areas psychiatric epidemiology and mental health services research. Dr. Stuart has been the recipient of research funds from local, national, and international agencies and has made numerous contributions to the mental health literature. Dr. Stuart's main research and public health work pertains to stigma reduction. She has worked extensively with the World Psychiatric Association's Global anti-stigma program and is the Chair and co-founder of the World Psychiatric Association's Scientific Section on Stigma and Mental Disorders. She has been working with the Mental Health Commission with respect to anti-stigma activities and is currently collaborating with Statistics Canada to develop a stigma assessment module that can be incorporated into national health surveys.

Dr. Mamta GAUTAM

Dr. Gautam is a physician executive coach, author and internationally renowned speaker. For twenty years she was a psychiatrist in private practice in Ottawa, and a clinical Professor in the Department of Psychiatry, University of Ottawa. She is a specialist in Physician Health and Well-being and the founding director of the University of Ottawa Faculty of Medicine Wellness Program. This program served as the template for the Canadian Medical Association Centre for Physician Health and Wellbeing, where she consults as an Expert Physician Advisor. She is also the Co Chair of the Canadian Psychiatric Association Section on Physician Health. She is a recent past president of the Ontario Psychiatric Association; and the current President of the Ottawa chapter of the Federation of Medical Women of Canada. She has just launched the International Alliance for Physician Health.

Professor Graham THORNICROFT

Dr. Graham Thornicroft is Professor of Community Psychiatry, and Head of the Health Service Research Department at the Institute of Psychiatry, King's College London. He is a Consultant Psychiatrist working in a community mental health team in South London, and is Director of Research and Development at the South London and Maudsley NHS Trust. He chaired the External Reference Group for the National Service Framework for Mental Health, a ten-year national mental health plan for England. His areas of expertise include: mental health needs assessment, the development of new outcome scales, cost-effectiveness evaluation of mental health treatments, stigma and discrimination, and the development of community-based mental health services.

Dr. Jeffrey TURNBULL

Dr. Jeffrey Turnbull received his medical degree from Queen's University in 1978. He completed an internal medicine residency at the University of Western Ontario in 1982, and a master's degree in education at the same university in 1990. After completing his internal medicine residency, he joined the faculty at the University of Western Ontario where he combined clinical practice, education and research. Dr. Turnbull was recruited to the University of Ottawa in 1991, where he initially focused on medical education. He spent several years as Vice Dean for Medical Education, was a key figure in the Educating Future Physicians for Ontario Project, and served as president of the Medical Council of Canada. Known for his mentorship and wisdom, he was appointed Chair of the Department of Medicine in 2001, and then Chief of Staff at The Ottawa Hospital.

In the 1990s, Dr. Turnbull became increasingly interested in providing better clinical care to homeless men in Ottawa. Along with others, he wondered whether a medical program that combined supervised alcohol consumption with compassionate clinical care would improve health outcomes. He helped start Ottawa's Inner City Health Project, and has been its Medical Director since its inception. The Inner City Health Project has won numerous awards and received international acclaim for providing cost-effective care. For this and other contributions, Dr. Turnbull was recently awarded the Order of Canada.

Dr. Miriam KAUFMAN

Dr. Miriam Kaufman is a paediatrician and public educator. She graduated from Duke University School of Nursing in 1976 and Queen's University in 1980. Her first two years of paediatric residency were at McMaster and she then came to the Hospital for Sick Children in Toronto for a third year of residency and a fellowship in Adolescent Medicine. She joined the staff of the Hospital for Sick Children shortly thereafter. Dr. Kaufman's main clinical interest is with teenagers who have a chronic illness or disability. She works with these teens around issues of transition, coping, adherence, sexuality and reproduction, substance use and body image. She has written books and articles for teens and their parents and frequently speaks at schools, conferences and to the media.

Dr. Garey MAZOWITA

Dr. Garey Mazowita is the Chair of the Department of Family and Community Medicine at Providence Healthcare in Vancouver and a Clinical Associate Professor in the Department of Family Practice at the University of British Columbia. Prior to this, he was Medical Director of Primary and Long Term Care with the Winnipeg Regional Health Authority, and served for several years on the University of Manitoba Research Ethics Board. He is a Past President of the Manitoba College of Family Physicians. He is a member of the College of Family Physicians of Canada and co-chair of the College of Family Physicians of Canada/Canadian Psychiatric Association Shared Mental Health Care Working Group. In 2010, he received the Donald I. Rice Award from the College of Family Physicians in Canada in recognition for contributions to teaching, vision and leadership in the discipline of family medicine.