POSITION PAPER

Stigma and Discrimination

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Introduction

Decreasing stigma and discrimination against people with mental illness and their families, and mental health professionals and systems is of the highest priority for Canadian psychiatrists and organized psychiatry. Across the globe, there has been increasing attention to the deleterious effects of stigma and discrimination and calls for psychiatrists to take on key roles in combating stigma and working toward its abolition.[1,2] Notwithstanding gains during the past century in decreasing stigma and discrimination based on gender, race, sexual orientation, and religion, and despite an increased openness in dealing with previously taboo medical diagnoses, such as cancer and human immunodeficiency virus–acquired immune deficiency syndrome, stigma and discrimination against people with mental illness and psychiatry remains prevalent. This paper is not only a call to action but also an invitation to individual Canadian psychiatrists and the Canadian Psychiatric Association (CPA) to take a leading role in addressing these crucial issues.

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What Do We Know About Stigma, Discrimination, and Social Inclusion?

Stigma marks a person as different and devalued. Goffman, in his classic work on stigma, noted that stigma diminishes a person "from a whole and usual person to a tainted discounted one."[3, p 3] Scambler has summarized Goffman's thinking, noting, "The term stigma conventionally refers to any attribute, trait, or disorder that marks an individual as being unacceptably different from the 'normal' people with whom he or she routinely interacts, and elicits some form of community sanction."[4, p 1054] Current understandings of stigma involve a multi-layered process[5,6]:

Labelling. The everyday activity of creating categories and classifications is a normal and useful part of modern life. Labelling becomes stigmatizing when it evolves to the steps described below;

Stereotyping. A link is created between the labelled individual and a stereotyped, undesirable social characteristic (for example, "schizophrenics are violent");

Separation. Placing the stereotyped person into a fundamentally different category from the rest of humanity (the "us" and "them" effect, resulting in beliefs such as "I cannot become mentally ill");

Emotional Reaction. The previous cognitive dimensions are accompanied by emotional reactions. The emotional range is not limited to anger, fear, or disgust, but can also involve pity, guilty feelings, or feeling responsible;

Discrimination. Discrimination occurs when stigmatization is acted on by concrete behaviours such as exclusion, rejection, or devaluation. Discrimination can take place on a personal level or be enacted through societal and structural inequalities;

Power Differential. Discrimination has negative and even devastating consequences when the stigmatized person is in a vulnerable position because of a power differential related to socioeconomic reasons (for example, poverty and little social capital), cultural affiliations (for example, marginalized ethnic groups), or for psychological reasons (for example, fragile self-esteem in depressed patients).

The adverse effects of stigma and discrimination on people with mental illness have been well documented[1,2] and include delay in seeking treatment, early treatment discontinuation, difficulties obtaining housing and employment, and adverse economic effects.[7] Stigma has been described as the "primary barrier" to treatment and recovery.[8] Stigma and discrimination are well-documented obstacles to people with lived experience of mental illness receiving adequate general medical care[9] and combined are one factor in diminished life expectancy. Life expectancy for people with schizophrenia is lower than the general population by as much as 15 years, and most excess mortality is due to coronary heart disease (both through increased risk factors and suboptimal preventive and curative treatments).[10] Life expectancy is also reduced in bipolar disorder, schizoaffective disorder, depressive disorder, and substance use disorder, with between 8.0 and 14.6 years lost for men and 9.8 and 17.5 years lost for women.[11] Diagnostic overshadowing (a process by which physical symptoms are misattributed to mental illness) has been described as a major contributing factor.[12] Family members of people with mental illness often report negative effects in their own lives. Stigma and discrimination have negative economic impacts, not only on individuals and their families but also on the broader society.[7] On a structural level, stigma and discrimination result in lower research funding for mental health, poorer and less organized clinical services than in other areas of health care, and the devaluation of those involved with these areas, leading to challenges in recruitment into the profession of psychiatry and the other mental health care professions.

Stigma has long been seen as distressing and important but more recently attention has focused on the reality of discrimination or enacted stigma and the potent negative effects that result for our patients and our profession. There is a growing consensus that we must move past consideration of stigma alone to the fundamental issue of discrimination against psychiatric patients, psychiatrists, and other health professionals involved in psychiatric care and move forward to social action through the active pursuit of social inclusion.

Uniting Voices for Change

The Stigma–Discrimination Working Group was established in the fall of 2007 with a mandate to explore and advise the CPA on priorities for addressing stigma. The group is inclusive of CPA members at all career stages, from residents through experienced clinicians, researchers, and political leaders, and includes patients and family members of people suffering from mental illness.

The group conducted a survey at the CPA's 2008 annual conference, with 394 respondents out of a potential 1083 attendees. Participants reported first-hand experiences of discrimination toward a patient (79 per cent), toward a mental health care provider (65 per cent), toward psychiatry as a profession (53 per cent), and observing other medical providers discriminating against a patient from psychiatry (53 per cent). The highest priority for action was reported to be stigma and discrimination toward people with mental illness in the emergency department (89 per cent) and addressing structural inequities within the health care system (86 per cent).

More recently, the Stigma–Discrimination Working Group published a CPA-supported position statement highlighting four concrete priorities for action[13]:

1. Enabling CPA members to reduce stigma–discrimination against the profession and against patients with a mental disorder or illness by developing a national educational initiative.

2. Providing leadership by demonstrating a commitment to act in collaboration with other national medical organizations.

3. Advocating against structural inequities within the health care system and advocating for parity.

4. Exploring ways that the CPA can optimize care by publishing a position paper on best practices to address stigma and discrimination.

Promoting change in the Canadian context is essential. While there are various potential frameworks with which to consider such action, the most persuasive evidence exists for the triad of protesting stigma and discrimination when they are encountered, using education to counteract stigma and discrimination, and encouraging contact with people with lived experience with mental illness.[14]

Education and Awareness

The first logical step in addressing stigma and discrimination is to make them visible, both to clinicians and patients and to the broader society. Unfortunately, this is easier said than done. There are no formal curricula addressing stigma and discrimination in the clinical training of psychiatrists. These phenomena may be difficult to identify, both in others and in oneself, as discussed below. Many of us have been unable to act when we witness stigma and discrimination because of our own internalized sense of stigma and a lack of knowledge and experience to guide us as to how to do this in a respectful and appropriate manner.

Provide Leadership in Working With Medical Students

Medical school has traditionally been described as a breeding ground for stigma and discrimination against people with mental illness and their caregivers.[1,2] It is potentially an important venue for directly addressing stigma and discrimination and for providing experiences for students that will inform their future professional lives and work with patients. Conventional education on mental illness and mental health alone does not help reduce stigmatizing attitudes and behaviours. Exposure to people who have recovered from mental illness through lectures, co-taught seminars, and role plays appears to be a powerful experience that changes medical students' attitudes.[2,15,16] The power of direct contact with people with mental illness who have recovered challenges negative stereotypes in a powerful manner.

Incorporate Stigma, Discrimination, and Social Inclusion in Postgraduate Psychiatric Curricula

Explicit education about stigma and discrimination must be included in postgraduate psychiatric training as well as education about how it can be combatted.[1] Training in the Canadian Medical Education Directives for Specialists (CanMEDS) roles of health advocate, manager, and professional must include explicit training in these areas. Residents should be trained in collaborating with the media.[17]

Be Appropriate Role Models for Trainees

Academic psychiatrists have a particular responsibility as role models. In addition to addressing their own attitudes and behaviours, they are called on to directly label stigma and discrimination when it is seen and to debrief and process these incidents with trainees. Role modelling directly addressing stigma and discrimination in the moment is very powerful for trainees. There should be a discussion with trainees if the supervisor believes in a given instance that it is not appropriate to address stigma or discrimination at that moment.

Be Aware of Our Own Issues and Modify Our Own Behaviour

Psychiatrists are not immune from harbouring and acting on their own stigmatizing attitudes toward people with mental illness and their profession. This is understandable given that psychiatrists are members of a society where such views are pervasive and present from our earliest socialization and that our medical training has been replete with such stigma. Psychiatrists may carry even more negative beliefs than the general public and be more pessimistic about prognosis and recovery[18] perhaps as a result of often caring for patients at the more severe and treatment-resistant end of the spectrum.[2] As Myers has noted, "Overcoming stigma in ourselves is a lifelong challenge."[19, p 908]

A significant minority of psychiatric patients and their families describe psychiatric treatment as dehumanizing and feel devalued in their encounters with psychiatrists.[12,20,21] This appears to be more common among patients with diagnoses such as personality disorder,[2] substance abuse,[21] and intellectual disability.[22] We must be cognizant of these experiences and constantly evaluate our own care to ensure that we are offering humane, professional care.

Label Stigma and Discrimination When We See It and Protest

We need to label stigma and discrimination when we see it and make it as socially unacceptable to stigmatize and discriminate against people with mental illness and

psychiatry as it is to voice racist sentiments or show racial or religious prejudice. It is imperative that we speak up to the many small injustices we witness in daily practice. Each of these incidents is an opportunity to confront stigma and discrimination and may be pivotal in causing transgressors to reflect on or change their behaviour. It is essential that we challenge discriminatory portrayals of people with mental disorders whenever we encounter them. We must be vigilant in addressing stigma and discrimination in the media.

Include Discussions of Stigma, Discrimination, and Social Inclusion in Our Clinical Work With Patients and Families

Psychiatrists need to raise and foster discussion of the issues of stigma, discrimination, and social exclusion in our work with patients and families. These issues are central to their lives and appropriate subjects for discussion and targets for intervention. Self-stigmatization and perceived discrimination are common experiences for people with mental illness.[12,23,24] Clinical work needs to focus on making this self-stigmatization explicit and working it through. It is essential that we focus on a patient's strengths as well as their illnesses and include an agenda of mental health promotion as well as amelioration of psychopathology in our clinical work. Excellent psychiatric care moves beyond a simple focus on psychopathology to cultivating mental health and well-being. It is important that we discuss with patients and families about disclosing their psychiatric history, including who they want to disclose to and what they are expecting from the disclosure. Discussion of how and when they will disclose is an important and often overlooked part of clinical care. Psychiatrists should become familiar with resources for individuals and families to build their own skills in combatting stigma and discrimination.[25]

Bridging the Divide Between "Us" and "Them"

When trying to understand how discriminatory behaviours persisted through modern history (such as slavery or the more recent example of apartheid in South Africa), one cannot fail to notice that well-intentioned and otherwise gentle people were involved in such practices. Discriminatory behaviours become psychologically acceptable when the other is denied essential human characteristics through their placement in the category of other or them as distinct from us. Moreover, power imbalances can prevent the discriminated person from reclaiming their human status, promoting further discrimination. Recognizing our common humanity, and bridging this perception of a divide, does much to reduce stigma and discrimination.

Practice Appropriate Self-Care

The deleterious effects of the us–them divide are dramatically exemplified by the reluctance of physicians and mental health workers to accept and seek help for their mental health problems. Psychiatrists are often reluctant to seek assistance to deal with their own mental and physical health concerns, despite high rates of psychological suffering and little peer support.[26] Anecdotal reports note the reluctance of psychiatrists to receive psychiatric care, to take psychotropic medications, and to respond to colleagues with mental illness.[19] Studies have shown high rates of self-treatment for depression among psychiatrists as well as a strong preference for self-medication rather than clinical care, should they develop depression.[27] Recent studies have documented that psychiatrists are often unwilling to take the very treatments that they prescribe.[28,29] Physicians' reluctance to seek or accept treatment for depression correlates with the degree of perceived stigma.[29]

How can one explain these cognitive and behavioural discrepancies of the very clinicians possessing expertise and extensive knowledge in mental health? The culture of expertise inherently emphasizes an objectifying separation between clinicians and patients. This can be further exacerbated by the perception of a lack of nonclinical, personal, direct contact with patients (especially in large urban academic settings), although this is actually a fallacy. We are all having daily personal direct contact with colleagues, neighbours, and friends who have successfully recovered from mental illness but do not disclose their experiences because of the potent forces of stigma and discrimination. For the ill physician, patienthood thus implies becoming a member of a group perceived as separate and with whom the clinician cannot identify without risking threat to self-esteem through internalized stigma and anticipated rejection from colleagues.

Advocate for Physician Health During Undergraduate and Postgraduate Training

The culture of medicine has promulgated high expectations and self-sacrifice and, until recently, has discouraged self-care. Despite recent efforts to emphasize the importance of physician health, including its explicit incorporation in the CanMEDS role of professional, describing a commitment to physician health and sustainable practice,[30] seeking care is still perceived as stigmatized by trainees.[31] Academic psychiatry must assist trainees in making a real commitment to physician health and sustainable practice. Accepting that one can simultaneously be a patient and a clinician is salutary not only for the many of us who experience or will experience mental health disorders but also for treating our colleagues in a humane and fair manner in such difficult moments.

Work to Advance Physician Health

Stigma exists within the medical community, as well as in the general community. The culture of medicine sets very high expectations for physicians. Physicians often view colleagues with mental illness negatively, judging them as being weak, flawed, or somehow at fault for becoming ill. The ill physician anticipates experiencing shame and judgment and fears regulatory reprisal. This can lead to reluctance to acknowledge illness, delays in seeking help, and self-diagnosis and -treatment by physicians. Self-treatment can sadly lead to further denial, incomplete treatment, and more serious outcomes, including suicide.[32]

Work must be done to advance physician health and make it easier for physicians with mental illness to reach out and seek help. A comprehensive physician wellness program includes a focus on prevention, education, intervention, resources, research, and advocacy.[33] All physicians require access to a primary care physician and encouragement regarding self-care. There needs to be increased fostering of awareness that stress is inherent in the practice of medicine and that physicians are not immune to illness. Continued medical educational efforts will help in informing physicians about stress, burnout, and mental illness, as well as positive treatment, recovery, and hope, and will lead to earlier identification and treatment. Promoting collegiality within medicine will help to create a safe environment in which mental illness is better understood and physicians can disclose illness, share stories, and receive help and support. There are physician health programs in every Canadian province that offer assistance to physicians in need, and these must be promoted, supported, and highlighted. Rigorous research in physician health is beginning and should offer data and evidence of the scope of the problem and best practices in managing it. Advocacy efforts can address and reduce unwanted and unintended consequences of seeking help, such as impact on regulatory practices, licensing, and privileges, as well as limits to remuneration and insurance coverage. We can envision a future in which physicians will be able to reach out for help when needed.

Promote and Teach Direct Personal Contact With Patients

Bridging the us–them divide with patients takes place when the patient is met not only in clinical contexts but also in a broader range of situations, thus showing that he or she is not merely a case, but a full human being. Direct personal contact is considered an essential dimension in fighting stigmatizing prejudice and stereotypes.[2,12,14,34] This can be incorporated into psychiatry training as a stigma preventive measure (for example, by organizing nonclinical meetings between trainees and patients).

Listening to Patients

Offering a central place to what patients have to say—to their voices—is essential. Doing so can effectively combat psychological deafness to the humanity of the other, empower patients, and promote a collaborative, less paternalistic relationship in line with the new directions of psychiatry.[35] Patients can be involved in diagnostic and treatment processes, in research, through participatory paradigms, and in the work of clinical service agencies and organizations, through asking for user input in designing treatment and clinical structures.

Social Dimensions: Promoting Best Practices, Parity, and Social Inclusion

Promote Best Practices in Our Own Clinical Setting

The World Psychiatric Association has argued that the implementation of best practices is essential to reduce stigma and discrimination.[1] In particular, they advocate that psychiatrists should pay particular attention to the "development of a respectful relationship with patients and their relatives,"[1, p 137] stay "abreast of advances in psychiatric research and practice,"[1, p 137] ensure "strict observance of ethical principles,"[1, p 137] both in clinical care and in service organization, and collaborate with the wide range of professionals involved in the care of patients with mental disorders.[1]

Advances in psychiatric research and practice have led to substantive gains in the treatment of people with mental illness, and yet often our service delivery is suboptimal, given the challenges in putting best practices into place in our own practice settings. Our society does not tolerate suboptimal care of cancer or cardiac patients and we can no longer tolerate suboptimal care of those with psychiatric disorders. As individual practitioners, we need to offer the best and most current care that we can within our own practice settings.

Best practices imply that, in our daily clinical practice, we need to focus on careful diagnosis and tailored, effective management strategies.[1,2] We need to provide information and education to our patients and their family members in ways that are accessible to them.[2] People working in clinic- and hospital-based settings need to stand up for the needs of their patients and their teams, and advocate for parity of resources for mental health with other health care professionals and administrators. Psychiatric facilities are often the poorest in a given clinical setting, despite an understanding of the importance of design issues in optimizing patient care.[36]

Define and Disseminate Best Practices in Psychiatry

By defining best practices in psychiatry, we can provide standards and benchmarks for excellent care. In addition to informing the work of the individual practitioner,

such standards are extremely helpful in interactions with hospital and clinic administrators and with governmental agencies. Dissemination of best practices in psychiatry raises the standard of psychiatric care across the country and assists busy practitioners in optimizing their clinical practice. Being clear that there are best practices in psychiatry and advocating for their adoption and implementation has been repeatedly described as a powerful anti-stigma, anti-discrimination tactic.[1]

Use Literature-Based Strategies in Addressing Stigma and Discrimination

During the past decade, a developing literature has emerged regarding effective strategies to address stigma and discrimination. National campaigns addressing stigma have been developed in numerous countries. New Zealand's "Like Minds, Like Mine" campaign was established in 1997.[37,38] Other prominent programs include Scotland's "see me" campaign,[39,40] the United Kingdom's "Time to Change,"[41,42] and the United States' program from the Substance Abuse and Mental Health Services Administration, whose messages include "Behavioral Health Is Essential to Health. Prevention Works. Treatment Is Effective. People Recover."[43] These campaigns all include sophisticated use of social media and social marketing techniques, are multi-faceted, deliver local programming, include consumers and providers, and emphasize recovery. They include elements of protest, education, and contact and are strategic, research-informed, and evaluated. The Mental Health Commission of Canada is developing its own social media campaign, "Opening Minds."[44]

While psychiatrists like to think that talking about the neurobiology of psychiatric disorders will help in destigmatization, the evidence suggests otherwise. Despite an increasing endorsement of a neurobiological understanding of mental illness by the public during the past decade, there has not been a concomitant decrease in stigma.[45] Focusing on biological factors as the cause of mental illness can reinforce assumptions of unpredictability and lack of control. Direct contact with people with lived experience of mental illness challenges stereotypes. Direct contact is consistently identified as the most effective means of producing sustained improvement in public attitudes.[2,12,14,34] Expert consensus suggests that focusing on recovery and on seeing the person, and counteracting the sense of otherness associated with mental illness, are more potent strategies in population-level interventions.[46]

Collaborate With Other Organizations and Ensure Transparency in Relationships

Canadian psychiatry must continue to work with our partners in the Canadian Alliance on Mental Illness and Mental Health, with the Canadian Medical Association

(CMA), the College of Family Physicians of Canada, the Royal College of Physicians and Surgeons of Canada, and other national specialty societies to ensure that issues of mental illness and mental health are central. We must continue to contribute to the important work of the Mental Health Commission of Canada. Provincial psychiatric organizations must build close working relationships with the health ministry in their province.

Organized psychiatry must work with its medical colleagues to effectively address discriminatory behaviour against psychiatric patients where they seek care—the emergency department, inpatient medical and surgical wards, ambulatory medical specialty settings, and family practice settings.

We need to ensure that our relationships with industry, including pharmaceutical and medical device companies, are transparent and consistent with the code of ethics of the CMA.[47]

Use the Media to Address Stigma and Discrimination

The media plays a central role in both perpetuating and fighting stigma and discrimination. Negative media stereotypes of people with mental illness, their families, and mental health care professionals are common and among the most hurtful to people. Such portrayals should be protested. A recent study comparing advertising for psychiatric and nonpsychiatric medications demonstrated substantive differences that perpetuate stigma.[48] Organized psychiatry needs to monitor the media and address discrimination when it is seen. It must work directly with the media to provide up-to-date information through local and national experts with skills in communicating and interacting with the media. Guidance on responsible reporting on mental health issues should be provided, as exemplified by the recent CPA guidelines on suicide reporting.[49]

Address Structural Inequities and Advocate for Parity

There are multiple structural inequities in the health care system, including disparities in funding and access to care, funding for mental health services within hospitals, and funding for mental health and psychiatric research.

Discrepancies between disease burden and funding are significant. The World Health Organization's 2005 report attributed 31.7 per cent of all years lived with disability to neuropsychiatric conditions.[50] Nevertheless, the percentage of health funds spent on clinical care and research for these conditions falls abysmally short of this mark. These conditions are estimated to cost the Canadian economy $51 billion yearly.[51] While mental illnesses constitute more than 15 per cent of the disease burden in Canada,[52] a disproportionately small fraction

of total health funding is allocated to mental health care—six per cent in Canada in fiscal year 2003/04,[53] which is below the level in most European[53] and other developed countries.[52] Research funding directed toward mental illness and mental health is disproportionately low, with 4.0 to 7.5 per cent of the total research budget of the Canadian Institute for Health Research being dedicated to mental illnesses and addictions.[54] When research funding is compared with the economic costs of disorders, mental illness receives eight-fold lower rates of research funding than research funding allocated for cardiac disease or cancer.[54] Structural discrimination can explain the otherwise puzzling exclusion of psychiatric hospitals from the Canada Health Act and the marginal position (one passing reference) of mental health funding in the original First Ministers' Accord on Health Care Renewal, enacted in 2004.

Psychiatrists must boldly advocate for access to treatment including both medications and psychotherapeutic treatments. No other area of medicine experiences such significant obstacles to access to care for those who are ill. It is essential that we advocate for access to services,[55] to new medications as they become available,[56] as well as for adequate human resources.[57]

Traditionally, psychiatrists, compared with other specialists, have been reluctant to address issues of discrepancies in remuneration, with a sense that this is self-serving and unseemly. More recently, it has been forcefully argued that disparities in specialist remuneration have a much broader impact than on just the specialists' income and include the potential to negatively impact recruitment and retention into the specialty and to increase barriers to accessing care, thus further entrenching the marginalization of psychiatric patients.[58]

Finally, it is essential that we advocate at the federal and provincial level for programs and funding directed toward the social determinants of mental health—poverty, homelessness, housing, addiction services, employment, and transportation. It is incumbent that we speak for people who cannot speak because of their illness and that we support patient advocacy groups and empower those with lived experience with mental illness to advocate on their own behalf.

Promote Social Inclusion

Social exclusion of mental health patients manifests in unemployment, lack of social networks, diminished social roles, and lack of economic and social participation. Because poverty, disability, and lack of social networks are in a mutually reinforcing relationship with discrimination and mental illness,[59] it is an ethical and pragmatic imperative to actively promote social inclusion in this population.[60–62] A deep cultural shift is needed to achieve social inclusion of patients with mental illness: both significant educational efforts for

mental health providers and involvement of patients in the process are considered necessary steps in such an enterprise.[61]

Focus on Recovery and Quality of Life

The recovery movement is a contemporary successful example of implementing patients' involvement in the clinical space. Recovery has a high valence for patients and families, although it has a checkered history from the perspective of some psychiatrists who have known it only within its use in an antipsychiatry context. Contemporary uses of the term recovery denote the processes by which people with lived experience with mental illness participate, work, learn, and live fully in their communities.[63–66] A recovery orientation includes a focus on empowerment of the individual to assume as much responsibility as possible for their recovery and an emphasis on cultivating hope, optimism, and a satisfying and meaningful life contributing to society.[64–66] Recovery can occur in the face of ongoing symptoms of illness, which, despite them, the individual can learn to cope with or adapt to and thrive.[63] The psychiatrist's role is to promote recovery through individualized, person-centred care, the use of a strengths- rather than a deficit-based model, empowering patients and encouraging self-direction and shared decision making. Cultivating hope is an essential component.

Conclusion

The CPA and its members must be dedicated to addressing stigma and discrimination on an active and ongoing basis, and on both an individual and a professional level. Medical students and residents are taught to formulate mental health issues within a biopsychosocial framework, yet the social dimension of mental illness—encompassing the twin phenomena of stigma and discrimination—is too often neglected. This document identifies key priorities for evidence-based interventions and best practices, drawing on the three pillars of stigma reduction[14]: protest–advocacy, education, and personal contact. Stigma and discrimination are societal issues that affect us all, and it is incumbent on the psychiatric profession to make its voice heard. By addressing our own internalized stigma, ensuring best practices in psychiatric care, including patient and family voices at every opportunity, enhancing education in the area and advocating for parity in mental health care, and for accountability and transparency in health policy, the CPA and its members can make a significant difference.

References

1. Sartorius N, Gaebel W, Cleveland H-R, et al. WPA guidance on how to combat stigmatization of psychiatry and psychiatrists. World Psychiatry. 2010;9:131–144.

2. Thornicroft G, Rose D, Mehta N. Discrimination against people with mental illness: what can psychiatrists do? Adv Psychiatr Treat. 2010;16:53–59.

3. Goffman I. Stigma: notes on the management of spoiled identity. Englewood Cliffs (NJ): Prentice-Hall; 1963.

4. Scambler G. Stigma and disease: changing paradigms. Lancet. 1998;352:1054–1055.

5. Link BG, Phelan JC. Conceptualizing stigma. Annu Rev Sociol. 2001;27:363–385.

6. Link BH, Yang LH, Phelan JC, et al. Measuring mental illness stigma. Schizophr Bull. 2004;30(3):511–541.

7. Sharac J, McCrone P, Clement S, et al. The economic impact of mental health stigma and discrimination: a systematic review. Epidemiol Psichiatr Soc. 2010;19(3):223–232.

8. US Dept of Health and Human Services. Mental health: a report of the surgeon general. Bethesda (MD): US Department of Health and Human Services; 1999.

9. Liggins J, Hatcher S. Stigma toward the mentally ill in the general hospital: a qualitative study. Gen Hosp Psychiatry. 2005;27(5):359–364.

10. Hennekens CH, Hennekens AR, Hollar D, et al. Schizophrenia and increased risks of cardiovascular disease. Am Heart J. 2005;150(6):1115–1121.

11. Chang C-K, Hayes RD, Perera G, et al. Life expectancy at birth for people with serious mental illness and other major disorders from a secondary mental health care register in London. PLoS One. 2011;6(5):e19590.

12. Thornicroft G. Shunned: discrimination against people with mental illness. Oxford (GB): Oxford University Press; 2006.

13. Charbonneau M, Moss P, Abbey S, et al. The psychiatrist's role in addressing stigma and discrimination. Can J Psychiatry. 2010;55(11 Insert):1–2.

14. Corrigan PW, Penn DL. Lessons from social psychiatry on discrediting psychiatric stigma. Am Psychol. 1999;54:765–776.

15. Coodin S, Chisholm F. Teaching in a new key: effects of a co-taught seminar on medical students' attitudes toward schizophrenia. Psychiatr Rehabil J. 2001;24(3):299–302.

16. Galletly C, Burton C. Improving medical student attitudes towards people with schizophrenia. Aust N Z J Psychiatry. 2011;45(6):473–476.

17. Campbell NN, Heath J, Bouknight J, et al. Speaking out for mental health: collaboration of future journalists and psychiatrists. Acad Psychiatry. 2009;33(2):166–168.

18. Schulze B. Stigma and mental health professionals: a review of the evidence on an intricate relationship. Int Rev Psychiatry. 2007;19(2):137–155.

19. Myers M. New century: overcoming stigma, respecting differences. Can J Psychiatry. 2001;46(10):907–914.

20. Corker E. Stigma caused by psychiatrists. Br J Psychiatry. 2001;178:379.

21. Corrigan PW, Lurie BD, Goldman HH, et al. How adolescents perceive the stigma of mental illness and alcohol abuse. Psychiatr Serv. 2005;56:544–550.

22. Chaplin R. Psychiatrists can cause stigma too. Br J Psychiatry. 2000;177:457.

23. Brohan E, Elgie R, Sartorius N, et al. Self-stigma, empowerment and perceived discrimination among people with schizophrenia in 14 European countries: the GAMIAN-Europe study. Schizophr Res. 2010;122:232–238.

24. Brohan E, Gauci D, Sartorius N, et al. Self-stigma, empowerment and perceived discrimination among people with bipolar disorder or depression in 13 European countries: the GAMIAN-Europe study. J Affect Disord. 2011;129:56–63.

25. Health Scotland. Scottish stigma: a guidebook for action [Internet]. Edinburgh (GB): Health Scotland; 2008. Available from: http://www.healthscotland.com/uploads/documents/6421Stigma_Guidebook_for_Action%202635.pdf.

26. Charbonneau M. "How are you doctor?". Can Psychiatry Aujourd'hui. 2007:3:3.

27. Balon R. Psychiatrist attitudes toward self-treatment of their own depression. Psychother Psychosom. 2007;76(5):306–310.

28. Rettenbacher MA, Burns T, Kemmler G, et al. Schizophrenia: attitudes of patients and professional carers towards the illness and antipsychotic medication. Pharmacopsychiatry. 2004;37:103–109.

29. Adams EF, Lee AJ, Pritchard CW, et al. What stops us from healing the healers: a survey of help-seeking behaviour, stigmatisation and depression within the medical profession. Int J Soc Psychiatry. 2010;56(4):359–370.

30. Frank JR, Jabbour M, Frechette D, et al, editors. Report of the CanMEDS Phase IV Working Groups. Ottawa (ON): The Royal College of Physicians and Surgeons of Canada; 2005 Mar.

31. Moutier C, Cornette M, Lehrmann J, et al. When residents need health care: stigma of the patient role. Acad Psychiatry. 2009;33:431–441.

32. Gautam M. Physicians and depression. In: Goldman L, Myers M, Dickstein L, editors. Handbook of physician health. Chicago (IL): American Medical Association; 2000. p 80–94.

33. Gautam M. Measuring and maintaining faculty health. In: Cole T, Gritz E, Goodrich TJ, editors. Faculty health in academic medicine. New York (NY): Humana Press; 2009. p 39–54.

34. Pinfold V, Thornicroft G, Huxley P, et al. Active ingredients in anti-stigma programmes in mental health. Int Rev Psychiatry. 2005;17(2):123–131.

35. Bracken PJ, Thomas P. Postpsychiatry: mental health in a postmodern world. Oxford (GB): Oxford University Press; 2006.

36. Karlin B, Zeiss R. Environmental and therapeutic issues in psychiatric hospital design: toward best practices. Psychiatr Serv. 2006;57(10):1376–1378.

37. Vaughan G, Hansen C. 'Like Minds, Like Mine': a New Zealand project to counter the stigma and discrimination associated with mental illness. Australas Psychiatry. 2004; 12(2):113–117.

38. Mental Health Foundation of New Zealand. 'Like Minds, Like Mine' [Internet]. Auckland (NZ): Mental Health Foundation of New Zealand; 2011 [cited 2011 Jul 20]. Available from: http://www.likeminds.org.nz.

39. Dunion L, Gordon L. Tackling the attitude problem. The achievements to date of Scotland's 'see me' anti-stigma campaign. Ment Health Today. 2005 Mar:22–25.

40. 'see me'. 'see me' [Internet]. Edinburgh (GB): 'see me'; 2011 [cited 2011 Jul 20]. Available from: http://www.seemescotland.org.

41. Henderson C, Thornicroft G. Stigma and discrimination in mental illness: Time to Change. Lancet. 2009;373:1928–1939.

42. Time to Change. Time to Change [Internet]. London (GB): Time to Change; 2011 [cited 2011 Jul 20]. Available from: http://www.time-to-change.org.uk.

43. Substance Abuse and Mental Health Services Administration [Internet]. Rockville (MD): SAMHSA; 2011 [cited 2011 Jul 20] Available from: http://www.samhsa.gov.

44. Mental Health Commission of Canada. Opening minds [Internet]. Calgary (AB): MHCC; 2011 [cited 2011 Jul 20]. Available from: http://www.mentalhealthcommission.ca/Eng/Pages/OpeningMinds.aspx.

45. Pescosolido BA, Martin JK, Long SC, et al. "A disease like any other"? A decade of change in public reactions to schizophrenia, depression and alcohol dependence. Am J Psychiatry. 2010;167:1321–1330.

46. Clement S, Jarrett M, Henderson C, et al. Messages to use in population-level campaigns to reduce mental health-related stigma: consensus development study. Epidemiol Psichiatr Soc. 2010;19:72–79.

47. Canadian Medical Association. CMA code of ethics (update 2004) [Internet]. Ottawa (ON): CMA; 2004 [cited 2011 Jul 20]. Available from: http://policybase.cma.ca/PolicyPDF/PD04–06.pdf.

48. Foster JLH. Perpetuating stigma? Differences between advertisements for psychiatric and non-psychiatric medication in two professional journals. J Ment Health. 2010;19(1):26–33.

49. Nepon J, Fotti S, Katz LY, et al. Media guidelines for reporting suicide [Internet]. Ottawa (ON): Canadian Psychiatric Association; 2008 [cited 2011 Jul 20]. Canadian Psychiatric Association Policy Paper. Approved 2008 Nov 10. Available from: http://publications.cpa-apc.org/media.php?mid=733.

50. Prince M, Patel V, Saxena S, et al. No health without mental health. Lancet. 2007;370:859–877.

51. Lim KL, Jacobs P, Ohinmaa A, et al. A new population-based measure of the economic burden of mental illness in Canada. Chronic Dis Can. 2008;28(3):92–98.

52. Institute of Health Economics, Alberta. How much should we spend on mental health? Edmonton (AB): Institute of Health Economics, Alberta; 2008.

53. Jacobs P, Yim R, Ohinmaa A, et al. Expenditures on mental health and addictions for Canadian provinces in 2003 and 2004. Can J Psychiatry. 2008;53(5):306–313.

54. Canadian Institutes of Health Research. 2005–2006—Your health research dollars at work [Internet]. Ottawa (ON): CIHR; 2006 [cited 2011 Jun 15]. Available from: http://www.cihr-irsc.gc.ca/e/32626.html.

55. Canadian Psychiatric Association. Wait time benchmarks for patients with serious psychiatric illness: a series of recommendations made by Canada's psychiatrists [Internet]. Ottawa (ON): Canadian Psychiatric Association; 2006. Policy Paper. Available from: http://publications.cpa-apc.org/media.php?mid=383.

56. Ramasubbu R. Access to newer medications [position paper]. Can J Psychiatry. 2011;56(7 Insert):1–8. Also available from: http://publications.cpa-apc.org/media.php?mid=1170.

57. Sargeant JK, Adey T, McGregor F, et al. Psychiatric human resources planning in Canada [position paper]. Can J Psychiatry. 2010;55(9 Outsert):1–20. Also available from: http://publications.cpa-apc.org/media.php?mid=1015.

58. Gaind KS. Parity in time-based models [position paper]. Can J Psychiatry. 2010;55(1 Insert):1. Also available from: http://publications.cpa-apc.org/media.php?mid=899.

59. Sartorius N. Social capital and mental health. Curr Opin Psychiatry. 2003;16(Suppl 2):S101–S105.

60. Sayce L. Social inclusion and mental health. Psychiatr Bull. 2001;25:121–123.

61. The Office of the Deputy Prime Minister. Mental health and social exclusion. Social exclusion unit report. Wetherby (GB): ODPM Publications; 2004.

62. Berry C, Gerry L, Hayward M, et al. Expectations and illusions: a position paper on the relationship between mental health practitioners and social exclusion. J Psychiatr Ment Health Nurs. 2010;17(5):411–421.

63. Anthony WA. Recovery from mental illness: the guiding vision of the mental health service system in the 1990s. Psychosoc Rehabil J. 1993;16:11–23.

64. Deegan P. Recovery as a journey of the heart. Psychiatr Rehabil J. 1996;19:91–97.

65. Roberts G, Wolfson P. The rediscovery of recovery: open to all. Adv Psychiatr Treat. 2004;10:37–48.

66. Whitley R, Drake RE. Recovery: a dimensional approach. Psychiatr Serv. 2010;61(12):1248–1250.